STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0017	A. BUILDING: _____ B. WING _____	04/07/2021

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

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L 000	Initial Comments A COVID-19 Focused Infection Control Survey was conducted on March 24, 2021 through April 7, 2021. Survey activities consisted of a review of 11 sampled residents. It was determined that the facility is not in compliance with the requirements of Title 22B District of Columbia Municipal Regulations, Chapter 32 Nursing Facilities. The resident census was 254. Listed below is a directory of abbreviations and/or acronyms that may be utilized throughout the body of this report: AV- arteriovascular/arteriovenous b/p - blood pressure ESRD - End Stage Renal Disease FR - French MAR - Medication Administration Record mcg- microgram MD - medical doctor MDS - Minimum Data Set mg- milligram PCC - Point Click Care PPE - Personal Protective Equipment Q - every r/t - related to Rt - right Sat - Saturday TAR - Treatment Administration Record Thu - Thursday Tue - Tuesday v/s - vital signs X - times	L 000	Disclaimer: Facility submits this plan of correction Under procedures established by the Department of Health to comply with the departments directives to change conditions which the department alleges are deficient under state regulations related to long term care. This should not be construed as either a waiver of the facility's right to appeal or to appeal or to challenge the accuracy or severity of the alleged deficiencies or any admission of any wrongdoings.	
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051	L051	

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L 051	Continued From page 1 (a)Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b)Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c)Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d)Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e)Supervising and evaluating each nursing employee on the unit; and (f)Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 11 sampled residents, the charge nurse failed to revise a resident's care for to include goals and approaches to address the resident's use of an indwelling urinary catheter. Resident #1. Findings included ... Resident #1 was admitted to the facility on 03/19/2021, with diagnoses that included Pyelonephritis, Hydro-nephrosis, Pre-diabetes, Hypertension, Spinal Stenosis, and Chronic lower back pain. Review of the nursing progress notes showed:	L 051	L051 Corrective action for residents affected. Resident #9 was assessed on 4/8/2021. Resident suffered no negative outcome, MD Updated. ADON/Designee conducted audit on all residents to identify residents that the facility staff did not ensure the responsible party was updated on the status of the resident. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. MEASURES TO PREVENT RECURRANCE: 1)ADON/ Designee will conduct house wide audit to ensure responsible parties are updated on residents' status by 4/21/21. 2) IDT Team will conduct audit to validate that nurses are updating responsible parties of resident's current health status by 4/21/21. 3) Unit Managers/Designee, will audit all documentations to ensure responsible parties are updated on residents' current health status by 4/21/21. 4) In-service will be provided to all clinical team by staff development team/ Designee, to all clinical staff to ensure responsible parties are notified of a change in resident's status by 4/21/21. MONITORING CORRECTIVE ACTIONS: IDT team will validate during grand rounds that nurses are updating responsible parties of residents' current health status by 4/21/21	4/21/2021 4/21/21

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L 051	Continued From page 2 "3/19/2021 21:19 [9:19 PM] Admission Note ...Resident admitted with 16 FR (French) Foley ..." Review of the admission care plan dated 03/23/2021, lacked documented evidence of goals or approaches to address Resident #1's use of an indwelling urinary catheter. During a telephone interview conducted on 03/26/2021, at 12:38 PM, Employee #5 (Unit Manager) acknowledged the finding and stated, "I create the care plans for new admissions. I must have missed it on the discharge summary paperwork." Facility staff failed to revise a care to include goals and approaches ro address Resident #1's use of an indwelling urinary catheter.	L 051		4/21/2021
L 091	3217.6 Nursing Facilities 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. This Statute is not met as evidenced by: Based on observation, record review and staff interview, the facility's Infection Control Committees failed to ensure the infection control procedure where followed to minimize the potential spread of infections in three (3) occurrences. Findings included ...	L 091	L091 CORRECTIVE ACTION FOR RESIDENTS AFFECTED: Resident # 10 was assessed on 4/8/21. Resident suffered no negative outcome, MD made aware. Unit Managers conduct rounds to ensure all residents are provided privacy during care. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents residing in the facility have the potential to be affected. MEASURES TO PREVENT RECURRANCE: 1)House wide in service provided by Staff Educators to all clinical staff members to	

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L 091	Continued From page 3 1. Employee #9 failed to maintain appropriate infection control practices when turning off a faucet in a quarantine room, Resident #9. A physician's order dated 03/18/2021, for Resident #9 showed the following, "Place resident on Quarantine Q (every shift) for 14 days ..." During an observation of Resident #9's room on 03/24/2021, at approximately 11:30 AM, showed Employee #9 (Unit Manager) wearing a gown, gloves, a surgical mask and face shield helping Resident #9 with hand hygiene. After helping the resident, Employee #9 removed her gown and gloves. The employee then balled the used gown into her hands, turned off the faucet using the gown, and then placed the gown on the vanity area near the sink. During a face-to-face interview conducted on 03/24/2021, at 11:32 AM, Employee #9 acknowledged the finding. At the time of the survey, Employee #9 failed to maintain appropriate infection control practices while turning off a faucet in Resident #9's room. 2. Employee #8 (Registered Nurse) failed to maintain infection control practices by placing a dirty object [bottle of hand sanitizer] with clean items. During an observation on unit 4 North on 03/24/2021, at approximately 12:00 PM,	L 091	provide privacy to All residents while providing incontinent care by 4/21/21. 2)ADON/ Designee will conduct house wide audit to ensure privacy is provided to all residents during incontinent care by 4/21/21. 3)Unit managers/Designee will carry out random audit to ensure residents are provided privacy during care by 4/21/21. 4)IDT team members will ensure residents are provided privacy to all residents' while providing care by 4/21/21. MONITORING CORRECTIVE ACTIONS: ADON//Designee will conduct random rounds to ensure all residents are provided privacy during incontinent care daily until 4/21/21. Findings will be addressed, and report given to Quality Assurance Committee weekly x4, then monthly x 3 until 4/21/21.	4/21/21

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L 091	Continued From page 4 Employee #8 was observed picking a bottle of hand sanitizer off the floor and placing it in the clean personal protective equipment (PPE) storage unit located on the wall between the resident room. During a face-to-face interview conducted on 03/24/2021, at approximately 12:10 PM, Employee #8 acknowledged the finding and left the hand sanitizer in the storage unit with the other clean items. At the time of the survey, Employee #8 failed to maintain infection control practices when she placed a dirty item in a clean PPE storage unit. 3. Facility staff failed to follow standards of practice for disposal of used PPE and performing hand hygiene. Review of the facility's policy entitled, "Infection Control (Personal Protective [Protective] Equipment- PPE) dated 01/2021, instructed staff to:" Remove gown ... dispose in [room] trash receptacle... Employee may now exit patient room. Perform hand hygiene ... wash hands with soap and water or use Alcohol Based Hand sanitizer ..." During a tour of unit 3 north on 03/24/2021, at approximately 10:50 AM, Employee #6 (Maintenance worker) was observed taking off his isolation gown as he walked out of a resident's room. It should be noted that the resident's room had signage that showed, "Quarantine Droplet/ Contact Precautions".	L 091		

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L 091	Continued From page 5 After removing the gown, Employee #6 walked down the hallway holding the used gown with his hands, then placing the used gown in a trash receptacle by the nurse's station. Additionally, Employee #6 failed to perform hand hygiene after placing the used gown in the trash receptacle. It should be noted that the employee walked by two working hand sanitizing stations. Review of the education sign in sheets dated 03/15/2021, on "Hand Hygiene", "Infection Control" and "Safely Remove and Don PPE" showed Employee #6 signed an attendance sheet, indicating he received the previously mentioned training. During a face-to-face interview conducted on 03/24/2021, with Employee #6 at approximately 10:50 AM, when asked why he did not discard the used gown before leaving the resident's room, he stated, "I didn't know I had to put it in the trash can inside the room." When asked if he knows when to perform hand hygiene, Employee #6 stated, "Yes, I was going to do it, it just slipped my mind." At the time of the interview, the employee acknowledged the findings. At the time of the survey, Employees' #8, #9, and #10 failed to follow standards of practice to minimize the potential spread of infections.	L 091		
L 521	3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by:	L 521	L521 CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS: No resident was directly affected.	4/21/2021

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L 521	Continued From page 6 Based on observation and staff interview, for one (1) of 11 sampled residents, the facility's staff failed to provide privacy for a resident while performing incontinent care. Resident #10. Findings included ... An observation on 03/24/2021, at approximately 12:00 PM on Unit 4 North revealed the following: -Residents' room #408 door was closed with signs indicating the two residents inside were on quarantine status. -After the surveyor knocked on the door and asked for permission to enter, Employee #10 (Certified Nursing Aide), gave the surveyor permission to enter. -Upon entering the residents' room, Resident #10 (408 A) was observed lying in bed, with her body uncovered from the waist down, exposing her buttocks. -Employee #10, was observed providing incontinent care for Resident #10. -A curtain between the two resident beds was pulled so that the resident in bed 408 B could not see the resident in bed 408 A at the time incontinent care was being provided. -However, the curtain toward the entry door had not been pulled, so Resident #10's uncovered body from the waist down was exposed to anyone walking in the door. During a face-to-face interview conducted on 03/24/2021, at approximately 12:15 PM,	L 521	IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED: All residents and employees in the facility have the potential to be affected. Employee #9: Progressive Coaching and Counselling provided. In-service provided to employee # 8 on were to place objects that are picked from the floor. Coaching and Counselling provided. Targeted in-service was done to employee #6 on doffing and donning of PPE'S. Coaching and Counselling provided.	4/21/21

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L 521	Continued From page 7 Employee #10 acknowledged the finding and stated that she did not pull the curtain all the way around the resident's bed because she had "closed the door." At the time of the survey, the facility's staff failed to provide privacy for Resident #10 while providing incontinent care.	L 521		4/21/2021