RapidRecovery AT

Deanwood
"The Dean"
REHABILITATION & WELLNESS CENTER

March 10, 2016

Sent via email: March 9, 2016

Cassandra Kingsberry
Supervisory Nurse Consultant
Government of the District of Columbia
Department of Health
899 North Capitol St., N.E 2nd Floor
Washington, D.C. 20002

Dear Ms. Kingsberry:

Enclosed you will find the Plan of Correction for a Recertification (Health) Quality Indicator Survey (QIS) survey and Licensure survey conducted by surveyors from the Department of Health (DOH),Health regulation and Licensing Administration on February 8, 2016 at Deanwood Rehabilitation and Wellness Center.

Please accept this letter, Plan of Correction and credible evidences as our allegation of compliance. If you have any questions or need additional information please feel free to contact me at (202) 399-7504 ext. 535.

Sincerely,

Amilia Alcema Dual BS, MBA, LNHA
Administrator

5000 Nannie Helen Burroughs Avenue N.E., Washington, DC 20019
TEL 202-399-7504 | FAX 202-399-0881

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 000	Initial Comments A Licensure Survey was conducted on February 1, 2016 through February 8, 2016. The following deficiencies are based on observations, record review, resident and staff interviews for 36 sampled residents. 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 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 HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - interdisciplinary team L - Liter Lbs - pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass)	L 000	Please begin typing here:	

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 000	Continued From page 1 mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury Neuro - Neurological NP - Nurse Practitioner 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 Rp, R/P- Responsible party Sol- Solution TAR - Treatment Administration Record Trach - Tracheostomy Vent - Ventilator	L 000	**DEANWOOD REHABILITATION AND WELLNESS CENTER DISCLAIMER.** 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 conditions 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 wrongdoing.	3-12-16
L 027	3207.2 Nursing Facilities The Medical Director shall: (a)Coordinate medical care in the facility; (b)Implement resident care policies; (c)Develop written medical bylaws and medical policies; (d)Serve as liaison with attending physician physicians to ensure the prompt issuance and implementation of order; (e)Review incidents and accidents that occur on the premises to identify hazards to health and	L 027	L 027 **Corrective action for resident affected:** The facility cannot retroactively correct this deficiency. Resident # 371 was safely discharged to the community. Resident suffered no negative outcome.	

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 027	Continued From page 2 safety; (f)Ensure that medical components of resident care policies are followed; (g)Assist the Administrator in arranging twenty-four (24) hours of continuous physician services a day for medical emergencies and in developing procedures for emergency medical care; and (h)Ensure that attending medical professionals who treat residents in the facility have current District of Columbia licenses, U.S. Drug Enforcement Agency and D.C. Controlled Substance registration on file in the facility, along with initial and annual certification of their freedom from communicable diseases. This Statute is not met as evidenced by: Based on record review and staff interview for one (1) of 36 sampled residents, it was determined that facility staff failed to ensure that Resident # 371 was examined attending physician within 72 hours of admission to the facility The findings include: A review of the clinical record for Resident #371 revealed that the resident was admitted to the facility on December 16, 2015. A review of the "History and Physical" form revealed that it was signed and dated by the physician on January 6, 2016. A face-to-face interview was conducted on	L 027	L 027 **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. Medical records//Designee will audit admissions in the last 30 days to identify any resident that has not been examined within 72 hours of admission. Any issues found during the audit will be addressed. **Measure to prevent recurrence:** In-service will be provided to the physicians to ensure the residents are being examined by attending physician within 72 hours of admission to the facility . The medical director will be sending a letter to all physicians of the regulations regarding attending physicians examining the residents within 72 hours of admission to the facility. **Monitoring Corrective action:** Random audits will be completed by Medical records//Designee to ensure the residents are being examined by attending physician within 72 hours of admission to the facility. Audits will be conducted weekly times 3 then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	3-12-16

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 027	Continued From page 3 February 8, 2016 at approximately 4:45 PM with Employee #14. He/she stated, "I thought there was another one [history and physical]." He/she searched to chart three (3) times page by page and was unable to locate another history and physical form. There was no evidence that the resident was seen by the attending physician within 72 hours of admission to the facility. The record was reviewed on February 8, 2016.	L 027	L 052 **Corrective action for resident affected:** Resident #323 and # 370 remain in this Facility. Resident #323 was assessed on 2/5/16 by the unit manager. The primary Physician was notified. Resident suffered No negative outcome. Resident #370 was assessed on 2/5/16 by the Assistant Director of Nursing; the attending physician was made aware and new order was obtained. Resident suffered no negative outcome. **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. 1. All assistant director of nursing/Designee Will Complete an audit to ensure facility staff Are assessing resident ' s breath sounds every shift in accordance with physician's orders. Any issues found will be resolved and or corrected during the audit. 2. All assistant director of nursing/Designee will complete an audit to ensure facility staff are obtaining physician clarification orders to differentiate when to administer "as needed" pain medication. Any issues found during the audit will be resolved.	3-12-16
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b)Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (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; (d) Protection from accident, injury, and infection; (e)Encouragement, assistance, and training in self-care and group activities; (f)Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in	L 052		

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 052	Continued From page 4 his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2)Use the dining room if he or she is able; and (3)Participate in meaningful social and recreational activities; with eating; (g)Prompt, unhurried assistance if he or she requires or request help with eating; (h)Prescribed adaptive self-help devices to assist him or her in eating independently; (i)Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review, resident interview and staff interview for two (2) of 36 sampled residents, it was determined that facility staff failed to ensure that one (1) resident ' s breath sounds were assessed every shift in accordance with physician's orders; and failed to clarify physician ' s orders for the administration of pain medication for one (1) resident whose pain medication regimen include more than one medication. Residents' #323 and # 370. The findings include: 1. Facility staff failed to ensure that Resident # 323's breath sounds were assessed every shift in accordance with the physician's orders. A physician's progress note dated December 21,	L 052	L 052 **Measure to prevent recurrence:** In-service of all license staff has been done of all to assure they are assessing resident ' s breath sounds every shift in accordance with physician's orders. Staff development coordinators provided In-services to license staff regarding obtaining physician clarification orders to differentiate when to administer "as needed" pain medication. **Monitoring Corrective action:** Assistant Director of Nursing/Designee will complete random audits of residents' medical records to ensure facility staff are assessing resident ' s breath sounds every shift in accordance with physician's orders weekly times 3 then monthly times 3. Any issues found during the audit will be addressed. Assistant Director of Nursing/Designee will complete random audits of residents' medical records to ensure facility staff are obtaining physician clarification orders to differentiate when to administer as needed" pain medication weekly times 3, then monthly times 3. Any issues found during the audit will be Resolved Audit findings will be reported to the Quality Assurance Improvement Committee.	3-12-16

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 052	Continued From page 5 2015 revealed Resident #323 had the following diagnoses: "COPD [Chronic Obstructive Pulmonary Disease, Hypertension and Deconditioning. " The physician's "Order Summary Report" dated January 5, 2016, directed, "Evaluate breath sounds every shift- COPD..." A review of the "COPD Care-Pathway " revealed, " ... Assess Lung Sounds Q (every) shift: Document findings in nurse ' s notes ([example], Rhonchi, Rales, Wheeze, etc.) Notify MD (Medical Doctor) if any of the above sounds are noted as new (You may Need to review previous nurse ' s notes to determine) ... Document assessment and interventions for all of the above, every shift!" A review of the nurses ' notes from January 2016 through February 3, 2016 lacked any evidence of breath sound assessments every shift according to the physician ' s orders and COPD clinical pathway. A face-to-face interview was conducted with Employees ' # 16 and #17 on February 5, 2016 at approximately 12:30 PM. They both acknowledged the aforementioned findings. The clinical record was reviewed February 5, 2016. 2. Facility staff failed to clarify the physician's orders to differentiate when to administer "as needed" pain medication for Resident #370. . The record revealed that Resident #370 was admitted to the facility on December 9, 2015 with diagnoses that included Stage III sacral pressure ulcer, and a Left Hip Fracture s/p [status post] ORIF [Open Reduction Internal Fixation].	L 052		

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 052	Continued From page 6	L 052		

A review of the physician's order dated December 9, 2015 revealed the following: " Oxycodone [narcotic pain medication] 10 MG (milligrams) to be given by mouth every four(4) hours for pain as needed; Tramadol [non-narcotic pain medication] 50 MG to be given every six (6) hours for pain as needed."

A review of the 'Pain Management Flow Sheet' from January 4, 2016 to January 31, 2016 revealed that Resident #370 received Oxycodone 10 MG at least one time daily, for a pain rating of four (4) to nine (9) out of ten on the pain scale. He/she received Tramadol one time on Monday January 18, 2016 for a pain rating of four (4) out of ten on the pain scale.

A review of the ' Pain Management Flow Sheet ' from January 4, 2016 to January 31, 2016 revealed that Oxycodone 10 mg was given as the follows:

Date	Time	Pain Rating
January 4, 2016	9:30AM	5/10
January 5, 2016	6:00PM	5/10
January 6, 2016	5:30PM	4/10
January 8, 2016	5:00PM	5/10
January 9, 2016	9:00AM	5/10
January 10, 2016	12:30AM	9/10
January 10, 2016	9:00AM	5/10
January 10, 2016	11:00AM	5/10
January 10, 2016	5:00PM	5/10
January 11, 2016	12:00PM	6/10
January 12, 2016	8:00PM	5/10
January 13,2016	8:00AM	6/10
January 13, 2016	10:00PM	5/10

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 052	Continued From page 7	L 052		

January 14, 2016 2:00PM 8/10

January 15, 2016 9:30AM 5/10
January 15, 2016 6:00PM 5/10
January 16, 2016 8:00PM 8/10
January 17, 2016 5:21PM 8/10
January 18, 2016 10:00AM 5/10
January 20, 2016 7:00PM 4/10
January 21, 2016 8:00PM 4/10
January 22, 2016 11:30AM 5/10
January 23, 2016 10:00AM 6/10
January 24, 2016 10:00AM 5/10
January 24, 2016 7:58PM 8/10
January 25, 2016 7:00PM 5/10

January 26, 2016 12:55PM 5/10
January 26, 2016 6:35PM 5/10
January 27, 2016 9:30AM 6/10
January 27, 2016 7:00PM 5/10
January 28, 2016 2:45[Am/Pm not specified] 8/10
January 28, 2016 9:00PM 5/10

January 29, 2016 11:00AM 5/10
January 29, 2016 5:00PM 5/10
January 30, 2016 7:00PM 5/10
January 31, 2016 9:00AM 6/10

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 052	Continued From page 8 January 31, 2016 3:30PM 5/10 A review of the ' Pain Management Flow Sheet ' from January 4, 2016 to January 31, 2016 revealed that Tramadol 50mg was given on January 18, 2016 at 6:00 PM and the pain rating was 4/10. Facility staff failed to clarify the physician's order to differentiate when to administer "as needed" pain medication; Tramadol, a non-narcotic pain medication versus Oxycodone, a narcotic pain medication. A face-to-face interview was conducted with Employee #2 on February 5, 2016 at approximately 11:00 AM. He/she made no comment regarding the aforementioned findings. A review of the clinical record was conducted on February 5, 2016.	L 052		
L 201	3231.12 Nursing Facilities Each medical record shall include the following information: (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers;	L 201		

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 9 (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history, allergies, physical examination, diagnosis, prognosis and rehabilitation; (i)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (j)Current status of resident's condition; (k)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (l)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (m)Nurse's notes which shall be kept in	L 201	L 201 **Corrective action for resident affected:** Resident #126 and # 370 remain in this facility. Resident # 151 no longer resides in this facility. Resident #126 was assessed on 2/2/16 by the unit manager; the primary physician was notified. Resident suffered no negative outcome. Facility staff obtained an updated dental note and the note was placed in the clinical record of the resident. Resident # 370 was assessed on 2/5/16 by the unit manager and pain assessment done. The primary physician was notified and new order obtained from the primary physician. Psych evaluation was completed as ordered on 2/4/16. Resident suffered no negative outcome.	3-12-16

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 10 accordance with the resident's medical assessment and the policies of the nursing service; (n)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (o)The plan of care; (p)Consent forms and advance directives; and (q)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on observation, resident and/or staff interview and record review for three (3) of 36 sampled residents, it was determined that facility staff failed to maintain clinical records in accordance with accepted professional standards and practices as evidenced by: failure to document the status of one (1) resident ' s oral treatment plan in the clinical record; accurately document medications administered to one (1) resident prior to dialysis treatment; and failure to document a pain assessment and an account of behaviors demonstrated by one (1) resident who verbalized pain and exhibited behaviors. Residents' #126, #151 and #370. The findings include: 1. The dentist failed to ensure that the status of Resident #126 ' s oral treatment plan was included in the clinical record.	L 201	L 201 **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. 1. All assistant director of nursing/Designee completed an audit to ensure facility staff are documenting the status of residents' oral treatment plan in the clinical records. Any issues found have been corrected during this audit. 2. A house wide audit has been completed to ensure facility staff are accurately documenting medication administration provided to the residents prior to dialysis. Any issues found during the audit have been addressed. 3. All assistant director of nursing/Designee completed an audit to ensure facility staff are properly documenting pain assessment and any account of behaviors demonstrated by the residents. Any issue found during this audit has been corrected.	3-12-16

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 11 An observation of Resident #126 on February 2, 2016 at approximately 11:07 AM revealed the resident had one tooth in his/her mouth. A review of the dental treatment notes in the clinical record revealed the most recent dental examination was June 19, 2015. The dentist recorded, " Completed Exam/Oral Cancer Screening... Tx [Treatment] Plan: Denture delivery (Resident had dentures started at another facility). " The clinical record lacked evidence of a dental evaluation subsequent to June 19, 2015. There was no additional documentation related to the status of dentures for the resident. Employee #16 was queried regarding the status of denture(s) for Resident #126 as recorded in the dental note of June 19, 2015. Employee #16 responded [after consulting with the dentist], the resident has one tooth, which he/she refused to have extracted. The tooth has to be removed, before dentures can be placed. A telephone interview was conducted with the [Dentist] on February 5, 2016 at approximately 11:30 AM regarding the aforementioned finding. He/she stated that the resident has a full denture fabrication, which was started at another facility. However, the dentures cannot be placed until the resident has the one tooth extracted from [his/her] mouth. The dentist failed to document the status of the oral treatment plan for Resident #126 , particularly as it relates to the status of dentures. On February 5, 2016 at approximately 12:00 PM, Employee #16 obtained an updated dental note	L 201	L 201 **Measure to prevent recurrence:** 1. Staff development coordinators provided In-services ensure nursing staff and unit secretaries understand the importance of documenting the status of residents' oral treatment plan in the clinical records 2. In-service of the license nursing staff regarding proper documentation of medication administration provided to the residents prior to dialysis has been completed. 3. In-service of all licensed nursing staff to assure facility staff are properly documenting pain assessment and any account of behavior demonstrated by the residents have been completed by the staff development coordinators. **Monitoring Corrective action:** Random audits of residents dental records, residents receiving medications prior to dialysis, residents receiving pain medications, residents who verbalized pain and exhibited behaviors will be weekly times 3 then monthly times 3 by Assistant Director of Nursing/Designee. The findings will be compiled and reported to the Quality Assurance Improvement Committee monthly for 3 months. The Director of Nursing/Designee will be responsible for compliance .	3-12-16

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 12 and included it in the clinical record. The clinical record was reviewed on February 5, 2016. 2. Facility staff failed to accurately document medications administered to Resident #151 prior to his/her February 1, 2016 dialysis treatment. A review of Resident #151 ' s physician order summary report dated February 1, 2016 revealed the following medications were ordered : Acetaminophen 325mg 2 tablets by mouth daily for mild pain Amiodarone 200mg 1 tablet daily by mouth for atrial flutter (irregular heart beat) Aspirin 81mg1 tablet daily by mouth for prevention of - cerebrovascular accident (CVA) Coreg12.5 mg 1 tablet two times a day by mouth for- hypertension Donepezil10mg 1 tablet daily by mouth for dementia Renvela 800mg 2 tablets by mouth with meals for End stage renal disease (kidney failure) Multivitamin 1 tablet daily by mouth for nutritional supplement Vitamin C 500mg daily by mouth for nutritional supplement A review of the Medication Administration Record revealed the following medications were given on February 1, 2016 at 9:00 AM prior to dialysis: Acetaminophen, Amiodarone, Multivitamin, and Vitamin C. The dialysis communication sheet dated February 1, 2016 in the section " medications given today " revealed the nurse documented: Aspirin,	L 201		

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 13 Tylenol, and Haldol as being administered prior to the resident ' s dialysis treatment. The nurse's note dated February 1, 2016 [no time indicated] revealed "Resident # 151 alert and oriented left unit for dialysis at 2:00 PM. " There was no evidence in the clinical record that Resident #151 was administered Haldol as documented on the dialysis communication sheet. On February 5, 2016 at approximately 11 AM, a face-to-face interview was conducted with Employee #34 who was assigned to the resident on February 1, 2016 and administered his/her 9AM medications. Employee #34 acknowledged that " Haldol " was not prescribed nor administered to Resident #151; he/she stated it was documented in error. Employee #34 initiated an incident report subsequent to the interview. The record was reviewed on February 5, 2016. 3. Facility staff failed to document a pain assessment on an occasion when the resident requested pain medication and failed to document an account of behaviors demonstrated by Resident #370. A review of the clinical record revealed that Resident #370 was admitted to the facility on December 9, 2015 with diagnoses that included Stage III sacral pressure ulcer, Insomnia, and Left Hip Fracture s/p [status post] ORIF [Open Reduction Internal Fixation]. A review of the facility ' s policy " Behavioral Assessment, Intervention and Monitoring " which	L 201		

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 14 stipulates: " ...3. The nursing staff will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition including ...c. Appearance and alertness of the resident and related observations ...4. New onset or changes in behavior will be documented regardless of the degree of risk to the resident or others ..." A review of the facility ' s policy "Administering Pain Medications" stipulated: "1. The pain Management program is based on facility-wide commitment to resident comfort. 2. Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident ...4. Be familiar with the physiologic and behavioral (non-verbal) signs of pain ...d. Behavior such as resisting care, irritability, depression ...6. Acute pain should be assessed every 30 to 60 minutes after the onset and reassessed as indicated after analgesic relief is obtained. 7. Pain assessment consists of gathering both subjective and objective data... Documentation...1. Results of the pain assessment is to be documented in the resident's medical record." A. Facility staff failed to document an account of behaviors demonstrated by Resident #370 as follows: On February 5, 2016 at approximately 9:30 AM, a face-to-face interview was conducted with Employee #25 regarding an incident involving Resident #370 on January 8, 2016 at approximately 11:00 PM. He/she explained that Resident #370 came to the nurses ' station to ask for pain medication, when the resident was told that the medication had already been given	L 201		

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 15 [the resident] became upset and started to throw books that were on the counter of the nurses ' station. Employee #25 wheeled Resident #370 to [his/her] room. While in the room the resident threw a cup of ice juice at [him/her]. The incident was reported to Employee #31. A review of the clinical record from January 8, 2016 to February 5, 2016 lacked documented evidence that Resident #370 exhibited any behaviors on January 8, 2016. On February 5, 2016 at approximately 3:15 PM, a face-to-face interview was conducted with Employee #19 regarding pain management, and the mental status, for Resident #370 on January 8, 2016. He/she stated that the resident was confused; that was confirmed by the resident's inability to state [his/her] birthday. Employee #19 went on to state that the resident's confusion was documented on the "Behavior Monthly Flow Sheet". When asked where on the form confusion would be documented, Employee #19 pointed to 'Confusion' on the "Side Effects Monthly Flow Sheet" for January 2016. A review of the "Behavior Monthly Flow Sheet" for January 2016 revealed that the form was coded to document episodes of depressed and withdrawn behavior.There was no evidence of documentation of behaviors exhibited by Resident #370 on January 8, 2016. A face-to-face interview was conducted on Friday, February 5, 2016 at approximately 4:00 PM with Employee #1 regarding the aforementioned finding. He/she acknowledged the findings. The record was reviewed on February 5, 2016. B. Facility staff failed to document a pain	L 201		

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 16 assessment on January 8, 2016 at approximately 11PM, when Resident #370 requested pain medication. On February 4, 2016 at approximately 3:15 PM a face-to-face interview was conducted with Resident #370. The resident stated that he/she went to the nurses' station [on 5 South, on January 8, 2016 at approximately 11 PM] to ask for pain medication and was told by staff that [he/she] had already received it. Resident #370 told the staff that pain medication was never received. The resident went on to say that [he/she] did not receive pain medication anytime that night. The resident was asked what the nature of [his/her] pain. The Resident stated that [he/she] has a "bad hip and a sore on my butt..." A review of physician ' s dated December 9, 2015 directed, "Oxycodone [narcotic pain medication] 10 MG (milligrams) to be given by mouth every four (4) hours for pain as needed; and Tramadol [non-narcotic pain medication] 50 MG to be given every six (6) hours for pain as needed." On February 5, 2016 at approximately 3:15 PM, a face-to-face interview was conducted with Employee #19, who was the primary nurse assigned to care for the resident. The interview was regarding pain management for Resident #370 on January 8, 2016. Employee #19 stated that [he/she] was made aware of a request for pain medication for the resident. Employee #19 stated that a pain assessment was completed, and the resident indicated that [he/she] was not in pain. In addition Employee #19 stated that the resident was confused; that was confirmed by the resident's inability to state [his/her] birthday. As a result of no complaint of pain, Employee #19 did not administer the " as needed " pain	L 201		

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 201	Continued From page 17 medication. There was no evidence that nursing staff documented a pain assessment to correlate with Resident #370 ' s request for pain medication on January 8, 2016 at approximately 11PM. A face-to-face interview was conducted with Employee #19 on February 5, 2016 at approximately 4:00 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on February 5, 2016.	L 201		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on record reviews, and interviews for one (1) of 36 sampled residents, it was determined that the facility staff failed to ensure that Resident #91 received adequate supervision and assistive devices to prevent accidents and the facility failed to ensure that the resident's environment remained as free of accident hazards as is possible as evidenced by a missing end cap from a handrail located across from room #426. The findings include: 1. Facility staff failed to ensure that Resident #91 received adequate supervision and assistive devices to prevent accidents. During a face-to-face interview on February 2, 2016 at 1:25 PM Resident # 91 stated, " I fell in	L 214	L 214 **Corrective action for resident affected:** Resident # 91 was assessed on 2/10/16 by the Assistant Director of Nursing: Physician was made aware and new order was obtained. Resident suffered no negative Missing end cap from a handrail located across from room #426 has been replaced. No other residents were identified as affected. **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. All residents residing in the facility who require a mechanical lift have the potential to be affected. An audit has been conducted and checked all handrails to ensure endcaps were secured. Nursing staff conducted an audit of residents Coded as requiring hoyer lifts to assure care Plans reflect lift status and interviewed staff Knowledge. Any issues found were corrected During the inspection.	3-12-16

Health Regulation & Licensing Administration

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	5000 BURROUGHS AVE WASHINGTON, DC 2001

(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
L 214	Continued From page 18 my room Sunday January 31, 2016 because the staff did not use the mechanical lift (Hoyer) when moving me from my bed to the chair. " According to the annual Minimum Data Set (MDS) dated October 14, 2015, Resident #91 was coded under Section G, Functional Status, as requiring two persons and the use of a mechanical lift for transfers. Resident #91's written care plan revised January 18, 2016 included the following focus and approach; " at risk for falls ... multiple risk factors related to MS (Multiple Sclerosis), transfer with mechanical lift (Hoyer) and assistance of 2 persons at all times. " A review of the radiology report for Resident #91 dated February 1, 2016, revealed " x-ray right knee, no acute fracture or dislocation " . A face-to-face interview was conducted on February 2, 2016 with Employee #15 at 3:00 PM. He/she stated the following, " When caring for Resident # 91 [he/she] refused to let me use the lift and kept saying [he/she] could stand and turn without it, before I knew it [he/she] was trying to stand up and started sliding down, I immediately assisted [him/her] to the floor." Facility staff failed to use the Hoyer lift during transfer from bed to wheelchair in accordance with the plan of care. A face-to-face interview was conducted with Employee #27 on February 2, 2016 at 2:30 PM. He/she acknowledged the aforementioned findings. The clinical record was reviewed on February 2, 2016.	L 214	L 214 **Measure to prevent recurrence:** The Director of Nursing has counseled the nursing assistant. Staff has been re-educated on the policy and procedure for use of a mechanical lift (Hoyer) and safe transfers. Staff development coordinators provided In-services to nursing and maintenance staff regarding the importance of ensuring that the residents' environment remain as free of accident hazards as is possible Education was provided to nursing and maintenance staff on placing items in need of repair into maintenance repair system . **Monitoring Corrective action:** random audits will be completed by Assistant Director of Nursing/Designee and Director of Engineering/Designee ensuring that the residents' environment remains as free of accident hazards as is possible. Director of Engineering/Designee will complete random environmental audits to check the handrails and ensure endcaps are secured. Assistant Director of Nursing/Designee will conduct random audits weekly times 3 then monthly times 3 to assure staff is using hoyer lifts for transfers residents coded as requiring hoyer lifts per residents plan of care. The findings will be compiled and reported to the Quality Assurance Improvement Committee monthly for 3 months.	3-12-16

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 214	Continued From page 19 2. Facility failed to ensure that an end cap to the handrail located across from room #426 was in place. An environmental tour of the facility was conducted on February 4, 2016 at approximately 12:15 PM. During that time, the end cap from the handrail located across from room #426 was observed missing and the edges [unfinished] of the handrail were exposed. These observations were made in the presence of Employee #8, Employee #9, and Employee #10 who acknowledged the findings.	L 214		3-12-16
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations made on February 4, 2016 between 11:30 AM and 4:00 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior as evidenced by soiled bathroom vents in five (5) of 47 resident rooms, unhooked privacy curtains in three (3) of 47 resident rooms, a soiled privacy curtain in one (1) of 47 resident rooms and expired containers of high protein nutrition and renal formulas in one (1) of six (6) clean utility rooms. The findings include:	L 410	L 410 **Corrective action for resident affected:** 1. Exhaust vents located in the bathroom resident rooms #402, #406, #426, #503 and #524 have been cleaned. 2. Privacy curtain hooks in resident rooms #328, #424 and #524 have been properly secured. 3. Privacy curtain located in room #532 (B) has been replaced. 4 and 5. Expired containers of high protein nutrition and renal formulas observed in 1 of 6 clean utility rooms have been discarded. The facility did not have any resident receiving Jevity 1.2 cal High Protein Nutrition with Fiber.The facility did not have any residents receiving prescribed eight-ounce " Nova Source Renal formula" on the units. Facility does not carry Novasource Renal oral supplements. Dietician spoke with contracted in-house dialysis center Administrator to ensure residents receiving Novasource Renal consume all supplements prior to leaving dialysis. 6. Wedge pillow located in room 202C has been replaced.	

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 410	Continued From page 20 1. Exhaust vents located in the bathroom of five (5) of 47 resident rooms surveyed were soiled with dust on the outside (#402, #406, #426, #503 and #524). 2. Privacy curtains were hanging loose, detached from curtain hooks in three (3) of 47 resident rooms (#328, #424 and #524). 3. The privacy curtain located in room #532 (B), one (1) of 47 resident rooms surveyed was soiled with numerous dark spots. 4. Four (4) of four (4) 1.5 liter bottles of "Jevity 1.2 Cal High Protein Nutrition with Fiber" were expired as of October 1, 2015. 5. Four (4) of six (6) eight-ounce "Nova Source Renal Formula" were expired. Two (2) of the four (4) expired as of December 9, 2015 and two (2) of four (4) expired as of January 31, 2016. These observations were made in the presence of Employee #8 and Employee #9 who acknowledged the findings. 6. One (1) of one (1) wedge pillow located in room 202C was torn/damaged. This observation was made on February 8, 2016 at approximately 6:00 PM in the presence of Employee # 18 who acknowledged the finding.	L 410	L 410 **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. An audit of all privacy curtains was completed to assure any soiled privacy curtains were removed and cleaned, as well as all privacy curtains were properly secured. An audit of all enteral formulas and Novasource Renal Formula was conducted to assure formulas were not expired. Any issues found during the inspection have been addressed properly to ensure the facility stays in compliance. No residents were identified as affected. **Measure to prevent recurrence:** Housekeeping and maintenance staff have been in-serviced on the importance of ensuring the any soiled privacy curtains are being removed and cleaned, as well as Properly securing all privacy curtains. In service was provided to the central supply Clerks to ensure they are checking the Expiration dates of all enteral formulas and Novasource Renal Formulas. **Monitoring Corrective action:** Random Environmental audits will conducted by the Director of maintenance/ Director of Engineering and Dieticians weekly times 3 then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	
L 442	3258.13 Nursing Facilities The facility shall maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	L 442		

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 442	Continued From page 21 This Statute is not met as evidenced by: Based on observations made on February 4, 2016 at approximately 9:45 AM and staff interview on February 4, 2016 at approximately 10:45 AM, it was determined that the facility failed to maintain essential equipment in safe working condition as evidenced by low, below normal final rinse temperatures from the dishwashing machine and a damaged baffle filter from the hood system. The findings include: 1. The dishwashing machine final rinse temperatures failed to reach the expected minimum of 180 degrees Fahrenheit. On February 4, 2016 at approximately 9:45 AM, six (6) consecutive, complete wash cycles were completed and the final rinse temperature was at 161 degrees Fahrenheit during that time. A face-to-face interview with Employees #1, #7 and #8 was conducted on February 4, 2016 at 10:45 AM. Employee #7 confirmed that the dishwashing machine final rinse temperatures were below 180 degrees Fahrenheit and Employee #8 agreed to contact a repairman immediately. Employee #1 and Employee #7 agreed to use paper plates and plastic utensils for lunch and possibly dinner meals. At approximately 4:45 PM on February 4, 2016, the dishwashing machine was repaired and the final rinse temperature was at 193 degrees Fahrenheit on consecutive, complete wash cycles. 2. One (1) of 13 baffle filters from the hood	L 442	**Corrective action for resident affected:** L442 No resident was identified in this F tag. The dishwashing machine was repaired the same day the incident occurred. The final rinse temperature was at 193 degrees Fahrenheit on consecutive, complete wash cycles. Call placed to a vendor to repair the damaged baffle filter from the hood system on February 4,2016. Vendor is waiting for custom –made part ordered. Baffled filter from the hood system will be repaired by 3/17/16. No residents were identified as affected. **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. **Measure to prevent recurrence:** Dietary staff will continue to monitor the dishwashing machine temperature daily. Staff development coordinators provided In-services to dietary and maintenance staff on the importance maintaining essential equipment in safe working condition. Dietary staff was educated on the guidelines of dishwashing machine temperature and to notify maintenance of any malfunctioning equipment.	

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 _____	02/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS	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
L 442	Continued From page 22 system located in the kitchen above the grease fryer was damaged and could not be closed. These observations were made in the presence of Employee #7 who acknowledged the findings.	L 442	L 442 **Monitoring Corrective action:** Random audits of dish machine temps will be completed by the Food Services Director to assure final rinse is within acceptable range . Random audits of dish machine temps will be completed weekly times 3 then monthly times 3 to assure dish machine temps are within sanitizing parameters Food Service Director will do weekly audits of essential kitchen equipment weekly times 3 then weekly times 3 to assure equipment is in proper working order. The findings will be compiled and reported to the Quality Assurance Improvement Committee monthly for 3 months.	3-12-16