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 _____	04/30/2018

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 An Annual Licensure survey was conducted at Deanwood Rehabilitation & Wellness Center from April 23 through April 30, 2018. The deficiencies are based on observation, record review, resident and staff interviews for 53 sampled residents. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: Abbreviations AD- Associate Director AMS - Altered Mental Status ARD - assessment reference date BID - Twice- a-day BIMS- Brief Interview for Mental Status B/P - Blood Pressure cm - Centimeters CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CFU Colony Forming Unit CRF - Community Residential Facility D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C Discontinue DI - deciliter DMH - Department of Mental Health DON - Director of Nursing EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) G-tube Gastrostomy tube HSC Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team L - Liter LPN- Licensed Practical Nurse	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 wrong doing.	6/10/18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA — (X6) DATE: 5/31/2018

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Corrective Action for resident affected.

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L 000	Continued From page 1 LTC- Long Term Care 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 PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POS - physician ' s order sheet Prn - As needed Pt - Patient PU- Partial Upper PL- Partial Lower Q- Every QIS - Quality Indicator Survey Rap, R/P - Responsible party RN- Registered Nurse SCC Special Care Center Sol- Solution SSD- Social Services Director TAR - Treatment Administration Record Trach- Tracheostomy TX- Treatment	L 000		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051	**L051** **Corrective action for the residents affected:** 1. Resident # 207 was reassessed on 4/26/18. Resident was reassessed again on 5/29/18 Nutrition care plan was revised and updated On 4/26/18 to reflect the physician order of Regular diet, Regular texture, thin Consistency (double portion), No seafood. Resident suffered no negative outcome.	6/10/18

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L 051	Continued From page 2 (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 observation, record review and staff interview for two (2) of 53 sampled residents, the charge nurse failed to revise the care plan for one (1) resident's change in diet and to develop a smoking care plan for one (1) resident who was identified as a smoker upon admission to the facility. Residents' #207, and #383. Findings included... 1. The charge nurse failed to revise the care plan with new approaches to address Resident #207's change in diet.	L 051	**Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. The interdisciplinary team will review and revise care plans to assure nutrition care plans are updated with appropriate diet order in a timely manner. Any issues found during the audit will be addressed. No Residents were identified as affected. **Measure to prevent Recurrence:** Interdisciplinary team and all staff involved in the Care planning process will be in-serviced to ensure Nutrition care plan is revised and modified in a timely manner. **Monitoring Corrective Action:** Lead Dietitian/Director of Nursing or designee will complete random audits of resident's Medical records to ensure the interdisciplinary team is reviewing/modifying nutrition care plan to reflect any diet changes in a timely manner. Findings will be reported to the Quality. Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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L 051	Continued From page 3 Resident #207 was admitted to the facility February 12, 2018, with diagnoses to include End-stage Renal Disease with dependence on renal dialysis. The resident was coded as having a therapeutic diet under Section K0510 (Nutritional Approaches) on the Admission MDS completed on February 19, 2018. The current care plan initiated date February 13, 2018, and reads: "Focus: The resident is at nutritional risk r/t [related to] ESRD [end stage renal disease] w [with]/hemodialysis and requiring therapeutic diet (Renal/LCS) with fluid restriction. Goal: The resident will maintain intake of 75% of at least 2 [two] meals/Day. Intervention: Provide Renal/LCS [low concentrate sweet] diet, regular texture (double portion) per preference." The Physician's Order dated April 17, 2018, directed, "Regular diet, Regular texture, Thin consistency, (double Portion), No seafood." A review of the resident's current care plan for diet lacked evidence that facility revised the plan with new goals and approaches to address the resident change in diet. Employee #15 acknowledged the finding during a face-to-face interview on April 26, 2018, at 11:00 AM and he presented a copy of the care plan updated on April 26, 2018. 2.The charge nurse failed to develop a smoking	L 051	**LO51** **.Corrective action for the residents affected:** 2.Resident #383 was reassessed on 4/26/18 The smoking section of comprehensive care plans were modified and updated on 4/26/18. Resident suffered no negative outcome.	**6/10/18**

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L 051	Continued From page 4 care plan for Resident # 383 who was identified as a smoker upon admission to the facility. The resident was admitted to the facility on April 18, 2018, with diagnoses which included Schizophrenia, Unspecified, Type 2 Diabetes Mellitus without Complications, Chronic Viral Hepatitis C, Bipolar Disorder, Altered Mental Status, Unspecified, and Noncompliance with other Medical Treatment and Regimen. Review of the "Smoking Evaluation" form completed on April 18, 2018, revealed the resident was assessed as being a smoker and determined by the interdisciplinary team to be a safe smoker. Review of the resident's care plans failed to reveal a care plan with goals and interventions to address safe smoking. During a face-to-face interview with Employee #10 at approximately 4:00 PM on April 25, 2018, the employee acknowledged the record lacked a smoking care plan.	L 051	**Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. 1.All the Assistant Director of Nursing/Designee will complete house wide assessment/audit of residents' smoking status. 2. Assistant Director of Nursing/ Designee will develop comprehensive care plan within 7 days after completion of the comprehensive assessment. 3. All the Assistant Director of Nursing/Designee will review, and revise care plans to assure smoking care plans are initiated/ modified in a timely manner. Any issues found during the audit/ assessment will be resolved and or modified. No residents were identified as affected. **Measures to prevent recurrence** Licensed Nurses will be in-serviced on the Importance of ensuring comprehensive assessment of residents' and Initiating/modifying smoking care plans in a timely manner. **Monitoring Corrective Action:** Assistant Director of Nursing/ Designee will complete house wide Assessment /audit of residents' smoking status weekly times 4, then monthly times 3 months. Findings will be reported to the Quality Assurance Performance Improvement Committee Monthly for the next 3 months.	6/10/18
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations made on April 23, 2018,	L 099	**L099** **Corrective action for resident affected:** 1.The identified ice machine located in the main kitchen was cleaned on 4/24/18. 2. The identified fire suppression plastic covers were cleaned on 4/24/18	6/10/18

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L 099	Continued From page 5 between 8:55 AM and 3:00 PM, it was determined that the facility failed to prepare foods under sanitary conditions as evidenced by one (1) of one (1) soiled ice machine, six (6) of six (6) soiled fire suppression covers and stained kitchen hood baffles. Findings included... 1. One (1) of one (1) ice machine located in the main kitchen was soiled on the inside with a moist, yellowish substance. 2. Six (6) of six (6) fire suppression plastic covers were soiled with a sticky substance. 3. Kitchen hood baffles were soiled with grease deposits. These observations were made in the presence of Employee #20 who acknowledged the findings.	L 099	3. Kitchen hood baffles were soiled with grease deposits and they were cleaned on 4/24/18. **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. The interdisciplinary team will review and revise care plans to assure nutrition care plans are updated with appropriate diet order in a timely manner. Any issues found during the audit will be addressed. No Residents were identified as affected. **Measure to prevent Recurrence:** Interdisciplinary team and all staff involved in the Care planning process will be in-serviced to ensure Nutrition care plan is revised and modified in a timely manner. **Monitoring Corrective Action:** Lead Dietitian/Director of Nursing or designee will complete random audits of resident's Medical records to ensure the interdisciplinary team is reviewing/modifying nutrition care plan to reflect any diet changes in a timely manner. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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L214	3234.1 Nursing Facilities Surge protectors were not mounted or secured in three (3) of 53 resident rooms. 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 observations made on April 24, 2018, between 9:45 AM and 3:30 PM, it was determined that the facility failed to maintain resident's environment free of accident hazards as evidenced by surge protectors that were not secured in three (3) of 53 resident's rooms. Findings included... Surge protectors were not mounted or secured in three (3) of 53 resident rooms. These observations were made in the presence of Employee #21 and/or Employee #22 who acknowledged the findings.	L214	**Corrective action for resident affected:** Identified surge protectors in resident were mounted and secured on 4/24/18 **Identification of others with the Potential to be affected:** All residents residing in the facility have the potential to be affected. An inspection throughout the facility has been conducted to inspect surge protectors. Any issues found during the inspection was Corrected on 4/24/18 **Measures to prevent recurrence:** Maintenance staffs have been in-serviced to assure that surge protectors are well mounted and secured.in resident rooms. **Monitoring Corrective action:** Random Environmental audits will be conducted by the Director of Engineering or designee weekly times 3, then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee monthly for the next 3 months.	6/10/18

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L 359	3250.1 Nursing Facilities Each food service areas shall be planned, equipped, and operated in accordance with Title 23 DCMR, Chapter 22, 23 and 24, and with all other applicable District laws and regulations. This Statute is not met as evidenced by: Based on observations made on April 23, 2018, between 8:55 AM and 3:00 PM, it was determined that the facility failed to ensure that drain lines from one (1) of two (2) garbage disposal system and from one (1) of one (1) three-compartment sink system were maintained with the appropriate air gap to prevent backflow. The 2012 District of Columbia Food Code states: "2403.1 An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than twenty-five millimeters (25 mm) or one inch (1 in)." Findings included ... 1. One (1) of four (4) drain lines from the three-compartment sink extended too far into the drain. 2. Three (3) of four (4) drain lines from the garbage disposal system located close to the fryer extended too far into the drain. These observations were made in the presence of Employee #20 who acknowledged the findings.	L 359	L359 **Corrective action for resident affected:** The identified drain lines from the three-Compartment sink extended too far into the drain and it was fixed on 4/23/18. 2. The identified drain lines from the Garbage disposal system located close to the Fryer extended too far into the drain and it was fixed on 4/23/18. **Identification of others with the potential to be affected.** All residents residing in the facility have the Potential to be affected. An inspection was done throughout the facility to ensure the all drain lines don't come too close to the drain. **Measure to Prevent Recurrence:** Maintenance, Housekeeping and Food & Nutrition Services staff will be in-serviced on the Importance of ensuring the drain lines not be extended too far into the drain **Monitoring Corrective Action:** Random audits will be conducted by the Director Maintenance or designee, Director Food and Nutrition services or designee, Lead Dietitian or designee and Director of housekeeping or designee weekly times 3. Then monthly times 3. Findings will be reported to the Quality Assurance Performance Improvement Committee Monthly for the next 3 months	6/10/18

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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 April 24, 2018, between 9:45 AM and 3:30 PM, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable as evidenced by dusty window blinds in seven (7) of 53 resident's rooms, one (1) of six (6) malfunctioning hopper sink and two (2) of six (6) soiled water dispensers. Findings included ... 1. Window blinds were dusty in seven (7) of 53 resident rooms. 2. The hopper sink located on 5 South did not flush when tested, one (1) of six (6) hopper sinks in the facility. 3. The water dispensers from the ice machines on 2 North and 2 South were soiled throughout, two (2) of six (6) water dispensers in the facility. These observations were made in the presence of Employee #21 and/or Employee #22 who acknowledged the findings.	L 410	**L410** **Corrective action for resident affected:** 1.The identified window blinds in resident rooms were cleaned on 4/24/18. 2.The hopper sink located on 5 South was repaired on 4/30/18 3. The water dispensers from the ice machines on 2 North and 2 South were cleaned 4/24/18. **Identification of others with the potential to be affected:** All residents residing in the facility have the potential to be affected. 1.An audit of all window blinds was completed to assure any dusty blind were cleaned. No residents were identified as affected. 2. An inspection throughout the facility has been conducted to inspect Hopper sinks Any issues found during this Inspection have been addressed to ensure the facility stays in compliance No residents were identified as affected. 3. An inspection throughout the facility has been conducted to inspect the water dispensers from the ice machines to assure the facility stays in compliance. No residents were identified as affected. **Measure to Prevent Recurrence:** Housekeeping/Maintenance staff has been in-Serviced on the importance of importance of Providing necessary housekeeping services to to maintain a sanitary, orderly and comfortable interiors. **Monitoring Corrective Action:** Random environmental audit will be conducted By Director of Engineering/ Director of house Keeping services weekly times 3, then monthly times 3. Findings will be reported to Quality Assurance Performance Improvement Committee monthly For the next 3 months.	6/10/18

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