May 27, 2014

Dr. Sharon Lewis
Program Manager
Government of the District of Columbia
Department of Health
Health Regulations Administration
899 North Capitol St., N.E. 2ND Floor
Washington, D.C. 20002

Dear Dr. Lewis:

Enclosed is the Plan of Correction for the cited deficiencies for the Re-Survey from May 15 and 16, 2014 at Deanwood Rehabilitation & Wellness Center.

All deficiencies were responded to with corrected final dates. All policies and procedures, protocols, guidelines, audits, and in-services were conducted, and/or implemented accordingly.

Should you have any questions, please feel free to contact me at (202) 399-7405, ext. 535.

Respectfully submitted,

Rose Marie Gilliam, BS, MHSA, LNHA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 000}	INITIAL COMMENTS A follow up inspection to the Quality Indicator Survey (QIS) recertification survey was conducted on May 15 to 16, 2014. The following deficiencies are based on observations, record reviews, resident and/or staff interviews for 18 sampled residents.	{F 000}	Please begin typing your responses here: F-156 1.The Social Services Department had turnover in staffing this month. A new Social Worker was hired to replace the previous social worker. The Director of Social Services was in the process of audits for the month of May. One notice of discharge was missed and not sent. Retrospectively we could not send the letter as the resident has already been discharged and did not get the opportunity to appeal. 2.All other Medicare A and B residents charts were audited to ensure no other resident was affected by this deficient practice. 3. A new system was developed by the Administrator. Moving forward the Rehab Department will send all notice of discharge to MDS Nurse and the Administrator via email. The MDS Nurse will then notify the responsible Social Worker, the Director of Social Services and the Administrator when to send the notice of discharge letter. The Social Worker once the letter is drafted will provide a copy to the Director of Social Services and the Administrator to ensure compliance. The Interdisciplinary team will review all residents on Medicare A and B weekly for continued need of skilled services and pending discharges.	
{F 156} SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or	{F 156}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Cullen	Administrator	5/27/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 156}	Continued From page 1 at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.	{F 156}	4.The new Social Services tool developed for monitoring will be used to track findings monthly which will be reported in June's QAPI meeting and subsequent monthly QAPI meetings.	5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 156}	Continued From page 2 The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 18 sampled residents, it was determined that facility staff failed to ensure that the "Notice of Medicare Non-coverage" was provided for Resident # T1. The findings include: A review of Resident #T1 ' s clinical record revealed that skilled therapy services were scheduled to end on May 14, 2014. A face-to-face interview was conducted with Employee #1 on May 16, 2014 at approximately 4:30 PM. He/she acknowledged that the clinical record lacked evidence that Resident #T1 was informed, in writing regarding his/her rights to appeal via a Notice of Medicare Non-Coverage [NOMC]. Facility staff failed to ensure that a "Notice of Medicare Non-coverage" was provided for	{F 156}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 156}	Continued From page 3 Resident #T1 and/or his/her responsible party when it was determined that skilled rehabilitative services were scheduled to end. The record was reviewed May 16, 2014.	{F 156}	F-Tag 441 1. The health files from employee's identified were reviewed and all employees either were given the PPD. All employees	
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	{F 441}	identified were offered the Hepatitis B vaccine and the employees who indicated they wanted the vaccine were given the vaccine. Those employees that refused the vaccine were given the declination form to sign that they refused the vaccine. Their health files were developed to include their PPD immunization Hepatitis B declination/ record of administration health history, and drug screen. All documents moving forward will be housed in Human Resources under employee health file. 2. All employee records were reviewed to ensure their health files include PPD immunization, Hepatitis B declination/record of administration, health history, and drug screen. Any employee file found lacking any of this information was updated with the necessary information and/or immunization needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 441}	Continued From page 4 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on personnel record review for seventeen (17) of seventeen newly hired employees reviewed and staff interview, it was determined that facility staff failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection as evidenced by failure to ensure that newly hired employees were screened for communicable disease and/or vaccinated prior to working and/or caring for the residents within the facility. Employees #1 - 17. The findings include: According to the Centers for Disease Control (CDC) www.cdc.org <http://www.cdc.org> Healthcare Personnel Vaccination Recommendations: " Healthcare personnel (HCP) who perform tasks that may involve exposure to blood or body fluids should receive a 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. Test for hepatitis B surface antibody (anti-HBs) to document immunity 1-2 months after dose #3 ... " Screening for tuberculosis in healthcare workers is a recognized infection control practice by the Centers for Disease Control (CDC). The two-step tuberculin skin test (TST) "is useful for the initial skin testing of adults who are going to be	{F 441}	3. The facility worked with HR Platinum on obtaining the appropriate policies and procedures to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection to ensure that newly hired employees were screened for communicable disease and /or vaccinated prior to working and/or caring for the residents within the facility. Training was provided to all management staff on the Safety Programs and policies from HR Platinum via HR Relias Web Based Program. The facility instituted a new protocol for managing employee health files in order to better manage and monitor the required information needed for the health files. Staff Development Director has been put in charge of managing the employee health program and ensuring that all requirements have been completed and turned into Human Resources. The files will be maintained in the HR office and the HR Director will track the files for completeness, and once completed will provide to the Administrator for signature. 4.The Staff Development Director will report to the Administrator every month on the status of all new hire employees. The existing employee files will be monitored every month to identify annual immunization requirements. Monthly audits will be completed on employee files to monitor compliance and results will be brought through the monthly QAPI process.	5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 441}	Continued From page 5 retested periodically, such as health care workers or nursing home residents. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection. " 1. A review of personnel records for facility employees hired on April 15, 2014 revealed that screening for communicable disease was inconsistent with recognized infection control practices as evidenced by the lack of tuberculosis screening tests [TST and/or radiologic exam] for ten (10) of seventeen records reviewed: Employees #2, 5, 6, 7, 9, 11, 12, 13, 14 and 15. 2. A review of personnel records for facility employees hired on April 15, 2014 revealed that immunizations and/or vaccinations were inconsistent with recognized infection control practices as evidenced by the lack of Hepatitis B vaccination. The records lacked evidence that the new hires were offered the Hepatitis vaccination; offered a serologic exam to test for immunity or evidence of a declination of either for seventeen (17) of seventeen records reviewed: Employees #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17. Facility staff failed to follow evidenced based infection control practices as stipulated by the Centers for Disease Control (CDC) guidelines as it relates to tuberculin screening and Hepatitis B vaccination for newly hired employees. The records were reviewed May 16, 2014.	{F 441}	F-490 1. Retrospectively all resident have the potential to be affected by this deficient practice. The Administrator terminated the RN employee previously responsible for the employee health program. The newly hired Staff Development Director was given oversight of the employee health Program. A meeting was held with the new Staff Development Director, HR, DON, and the Administrator to go over new roles, duties and expectations. Policies and Procedures and forms were reviewed at the meeting. 2.An audit of all employees newly hired and working was conducted to determine the status of their health files to include the PPD immunization, Hepatitis B declination/record of administration, health history and drug screen. Any employee file found lacking the necessary information was updated with the necessary information and/or immunization needed.	
{F 490} SS=D	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING	{F 490}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 490}	Continued From page 6 A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that administration failed to integrate, coordinate and monitor the facility ' s practices related to the residents care and safety as evidenced by a failure to ensure that residents were provided a written description of legal rights; maintain an infection control program to prevent the development and transmission of disease and infection; and ensure compliance with state and local laws. The findings include: The facility administration failed to: Ensure that residents that residents were provided a written description of legal rights. Cross reference CFR §483.10(b)(10) Resident Rights Ensure that a program designed to help prevent the development and transmission of disease and infection. Cross reference CFR §483.65 Infection Control Ensure compliance with state and local laws. Cross reference CFR §483.75(c) Relationship to Other HHS Regulations	{F 490}	3.The Administrator worked with HR Platinum on down loading all web based HR Platinum Safety Programs and Policies. All were placed in a manual and signed off by the appropriate disciplines. All staff on an annual basis have access to all policies, procedures and Programs via Relias mandatory education in-house system. All Department Heads/Managers were given Copies of HR Platinum Program Policies and procedure Manuals. 4.The Staff Development Director will report to the Administrator every month on the status of all new hired. The existing employee files will be monitored every month to identify annual immunization requirements. Monthly audits will be completed on employee files to monitor compliance and results of these audits will be brought through the monthly QAPI process.	5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 492} SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on record review of the facility ' s Personnel policies, it was determined that the policies provided lacked evidence of review and signature by the facility administration as required by Title 22B District of Columbia Municipal Regulation, Chapter 32, §3202.1 The findings include: On May 16, 2014 at approximately 2:30 PM the State Agency Representative asked to review the facility ' s policies related to human resource practice in the facility. At approximately 3:30 PM on May 16, 2014 the State Agency Representative was provided copies of the human resources policies entitled, "3.0 Employee Health Program" effective date 5/0/12012, "3.2 Tuberculosis Screening" effective date 5/01/2012, "3.5 Needle stick/Sharps Injury" effective date 5/01/2012, and "3.6 Hepatitis B Vaccination Administration", effective date 5/01/2012. After reviewing the aforementioned polices, there was no evidence that the facility's	{F 492}	F-492 1. The Administrator contacted HR Platinum third party consultant for Human Resources at Deanwood, and the web based programs policies and procedures were printed out that day by the Administrator and placed in a book for Administrator, DON, HR Director, Safety Director and Medical Director to review and sign. 2.No residents were affected by the deficient practice. All employees have had access to these web based programs, policies and procedures via the Relias education system at Deanwood, and are required as annual mandatory in-service educations for all employees. 3.All policies, procedures and programs were printed and placed in a binder and reviewed by required leadership per regulatory requirements. 4.Human Resources Director will report on required mandatory's for employees to complete upon hire and annually to quarterly QAPI meetings.	5/28/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 492}	Continued From page 8 administration/committee reviewed and signed the policies. It was further noted that the policies included a ' header ' that identified the name of the contractor that the provider secured to provide human resource services. There was no evidence of an attestation by the facility ' s administration that the provider was in agreement with the contractor. A review of personnel records for new hires revealed that new employees were not consistently screened for tuberculosis and/or offered Hepatitis B vaccination consistent with the facility ' s practice. A face-to-face interview was conducted with Employee #1 on May 16, 2014 at approximately 4:00 PM. He/she stated, " The policies are electronic. " A review of the electronic version of the personnel policies lacked evidence of an attestation signature and date to show evidence that the policies were reviewed and approved by the facility administration.	{F 492}		
{F 493} SS=D	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility	{F 493}	1.Retrospectively all residents have the potential to be affected by this deficient practice. The Administrator terminated the RN employee previously responsible for the employee health program. The newly hired Staff Development Director was given oversight of the employee health Program. A meeting was held with the new Staff Development Director, HR, DON, and the Administrator to go over new roles, duties and expectations. Policies and Procedures and forms were reviewed also at the meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	R 05/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEANWOOD REHABILITATION AND WELLNESS CENTER	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) COMPLETION DATE
{F 493}	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, it was determined that the Governing Body failed to integrate, coordinate and monitor the facility ' s practices related to the residents care and safety as evidenced by a failure to: ensure that residents were provided a written description of legal rights; maintain an infection control program to prevent the development and transmission of disease and infection; and ensure compliance with state and local laws. The findings include: The Governing Body failed to: Ensure that residents that residents were provided a written description of legal rights. Cross reference CFR §483.10(b)(10) Resident Rights Ensure that a program designed to help prevent the development and transmission of disease and infection. Cross reference CFR §483.65 Infection Control, F441. Ensure compliance with state and local laws. Cross reference CFR §483.75(c) Relationship to Other HHS (Health and Human Services) Regulations, F492.	{F 493}	2.An audit of all employees newly hired and working was conducted to determine the status of their health files to include the PPD immunization, Hepatitis B declination/record of administration, health history and drug screen. Any employee file found lacking the necessary information was updated with the necessary information and/or immunization needed. 3.The Administrator worked with HR Platinum on downloading all web based HR Platinum Safety Programs and Policies. All were placed in a manual and signed off by the appropriate disciplines. All staff on an annual basis have access to all policies, procedures and Programs via Relias mandatory education in-house system. 4.The Staff Development Director will report to the Administrator every month on the status of all new hires. The existing employee files will be monitored every month to identify annual immunization requirements. Monthly audits will be completed on employee files to monitor compliance and results of all policies and procedures will be reviewed, these audits will be brought through the annually, signed, and approved by the monthly QAPI process. Administrator, DON and Medical Director.	

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 _____	R 05/16/2014

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 follow up inspection to the licensure survey was conducted on May 15 to 16, 2014. The following deficiencies are based on observations, record reviews, resident and/or staff interviews for 18 sampled residents.	{L 000}	Please begin typing your responses here:	
L 007	3202.1 Nursing Facilities Personnel policies shall be in writing and maintained in an employee manual that is given to each employee during orientation and shall be made available to the licensing agency. This Statute is not met as evidenced by: Based on record review of the facility ' s Personnel policies, it was determined that the policies provided lacked evidence of review and signature by the facility administration as required by Title 22B District of Columbia Municipal Regulation, Chapter 32, §3202.1 The findings include: On May 16, 2014 at approximately 2:30 PM the State Agency Representative asked to review the facility ' s policies related to human resource practice in the facility. At approximately 3:30 PM on May 16, 2014 the State Agency Representative was provided copies of the human resources policies entitled, "3.0 Employee Health Program" effective date 5/0/12012, "3.2 Tuberculosis Screening" effective date 5/01/2012, "3.5 Needle stick/Sharps Injury" effective date 5/01/2012, and "3.6 Hepatitis B Vaccination Administration", effective date 5/01/2012. After reviewing the aforementioned polices, there	L 007	L007 1. The Administrator contacted HR Platinum Third party consultant for Human Resources at Deanwood, and the web based programs Policies and Procedures were printed out that day by the Administrator and placed in a book for Administrator, DON, HR Director, Safety Director and Medical Director to review and sign. 2.No residents were affected by the deficient practice. All employees have had access to these web based programs, policies and procedures via the Relias education system at Deanwood, and are required as annual mandatory in-service educations for all employees. 3.All policies, procedures and programs were printed and placed in a binder and reviewed by required leadership per regulatory requirements. 4.Human Resources Director will report on required mandatory's for employee to complete upon hire and annually to quarterly QAPI meetings.	5/28/14

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 _____	R 05/16/2014

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 007	Continued From page 1 was no evidence that the facility's administration/committee reviewed and signed the policies. It was further noted that the policies included a ' header ' that identified the name of the contractor that the provider secured to provide human resource services. There was no evidence of an attestation by the facility ' s administration that the provider was in agreement with the contractor. A review of personnel records for new hires revealed that new employees were not consistently screened for tuberculosis and/or offered Hepatitis B vaccination consistent with the facility ' s practice. A face-to-face interview was conducted with Employee #1 on May 16, 2014 at approximately 4:00 PM. He/she stated, " The policies are electronic. " A review of the electronic version of the personnel policies lacked evidence of an attestation signature and date to show evidence that the policies were reviewed and approved by the facility administration.	L 007		
L 024	3206.3 Nursing Facilties Policies shall be reviewed by the committee at least annually with written notations, signatures, and dates of review. This Statute is not met as evidenced by: Based on a review of the facilities human resources policies, it was determined that facility staff failed to ensure that the policies were reviewed by the committee at least annually with written notations, signatures, and dates of review.	L 024		

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 _____	R 05/16/2014

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 024	Continued From page 2 The findings include: On May 16, 2014 at approximately 2:30 PM the State Agency Representative asked to review the facilities policies related to human resources practice in the facility. At approximately 3:30 PM on May 16, 2014 the State Agency Representative was provided copies of the human resources policies entitled, "3.0 Employee Health Program" effective date 5/0/12012, "3.2 Tuberculosis Screening" effective date 5/01/2012, "3.5 Needle stick/Sharps Injury" effective date 5/01/2012, and "3.6 Hepatitis B Vaccination Administration", effective date 5/01/2012. After reviewing the aforementioned polices, there was no evidence that the facility's administration/committee reviewed the policies at least annually and signed the dates of review. A face-to-face interview was conducted with Employee #1on May 16, 2014 at approximately 4:00 PM. He/she stated, " The policies are electronic. " A State Agency representative reviewed the aforementioned polices on the facility ' s computer; however, there was no evidence of an attestation signature and date to show evidence that the policies were reviewed at least annually by the facility administration/committee.	L 024	L024 1. The Administrator contacted HR Platinum Third party consultant for Human Resources at Deanwood, and the web based programs Policies and Procedures were printed out that day by the Administrator and placed in a book for Administrator, DON, HR Director, Safety Director and Medical Director to review and sign. 2.No residents were affected by the deficient practice. All employees have had access to these web based programs, policies and procedures via the Relias education system at Deanwood, and are required as annual mandatory in-service educations for all employees. 3.All policies, procedures and programs were printed and placed in a binder and reviewed by required leadership per regulatory requirements. 4.Human Resources Director will report on required mandatory's for employee to complete upon hire and annually to quarterly QAPI meetings.	5/28/14

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 _____	R 05/16/2014

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 087}	Continued From page 3	{L 087}		
{L 087}	3217.2 Nursing Facilities The Chairperson of the Infection Control Committee shall be knowledgeable about or have experience in infection control. This Statute is not met as evidenced by: Based on personnel record review for seventeen (17) of seventeen newly hired employees reviewed and staff interview, it was determined that facility staff failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection as evidenced by failure to ensure that newly hired employees were screened for communicable disease and/or vaccinated prior to working and/or caring for the residents within the facility. Employees #1 - 17. The findings include: According to the Centers for Disease Control (CDC) www.cdc.org <http://www.cdc.org> Healthcare Personnel Vaccination Recommendations: " Healthcare personnel (HCP) who perform tasks that may involve exposure to blood or body fluids should receive a 3-dose series of hepatitis B vaccine at 0-, 1-, and 6-month intervals. Test for hepatitis B surface antibody (anti-HBs) to document immunity 1-2 months after dose #3 ... " Screening for tuberculosis in healthcare workers is a recognized infection control practice by the Centers for Disease Control (CDC). The two-step tuberculin skin test (TST) "is useful for the initial skin testing of adults who are going to be retested periodically, such as health care workers or nursing home residents. This two-step approach can reduce the likelihood that a	{L 087}	L087 1. The health files from employee's identified were reviewed and all employees either were given the PPD or showed proof that the PPD had been administered in the last 12 months. All employees identified were offered the Hepatitis B vaccine and the six employees who indicated they wanted this were given the vaccine. Those employees that refused the vaccine were given the declination form to sign that they refused the vaccine. Their health files were developed to include their PPD immunization Hepatitis B declination/record of administration health history, and drug screen. All documents moving forward will be housed in Human Resources under employee health file. 2. All employee records were reviewed to ensure their health files include PPD immunization, Hepatitis B declination/record of administration, health history, and drug screen. Any employee file found lacking any of this information was updated with the necessary information and/or immunization needed.	

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 _____	R 05/16/2014

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 087}	Continued From page 4 boosted reaction to a subsequent TST will be misinterpreted as a recent infection. " 1. A review of personnel records for facility employees hired on April 15, 2014 revealed that screening for communicable disease was inconsistent with recognized infection control practices as evidenced by the lack of tuberculosis screening tests [TST and/or radiologic exam] for ten (10) of seventeen records reviewed: Employees #2, 5, 6, 7, 9, 11, 12, 13, 14 and 15. 2. A review of personnel records for facility employees hired on April 15, 2014 revealed that immunizations and/or vaccinations were inconsistent with recognized infection control practices as evidenced by the lack of Hepatitis B vaccination. The records lacked evidence that the new hires were offered the Hepatitis vaccination; offered a serologic exam to test for immunity or evidence of a declination of either for seventeen (17) of seventeen records reviewed: Employees #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16 and 17. Facility staff failed to follow evidenced based infection control practices as stipulated by the Centers for Disease Control (CDC) guidelines as it relates to tuberculin screening and Hepatitis B vaccination for newly hired employees. The records were reviewed May 16, 2014.	{L 087}	3. The facility worked with HR Platinum on obtaining the appropriate policies and procedures to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection to ensure that newly hired employees were screened for communicable disease and /or vaccinated prior to working and/or caring for the residents within the facility. Training was provided to all management staff on the Safety Programs and policies from HR Platinum via HR Relias Web Based Program. The facility instituted a new protocol for managing employee health files in order to better manage and monitor the required information needed for the health files. Staff Development Director has been put in charge of managing the employee health program and ensuring that all requirements have been completed and turned into Human Resources. The files will be maintained in the HR office and the HR Director will track the files for completeness and once completed will provide to the Administrator for signature. 4.The Staff Development Director will report to the Administrator every month on the status of all new hire employees. The existing employee files will be monitored every month to identify annual immunization requirements. Monthly audits will be completed on employee files to monitor compliance and results will be brought through the monthly QAPI process.	5/28/14