STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 COVID-19 Focused Infection Control Survey was conducted on March 4, 2021 through March 17, 2021. Survey activities consisted of a review of eleven (11) sampled residents. It was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. This includes the facility's non compliance with 42 CFR §483.80 infection control regulations. The resident census was 151. he 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 CPR- Cardiopulmonary Resuscitation 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 HSC Health Service Center	F 000	**SERENITY REHABILITATION AND HEALTH 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.	**04/14/21**

Funmilayo Fashola-LNHA — TITLE: Administrator — (X6) DATE: 4/30/21

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
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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	Continued From page 1 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) 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 Q- Every QIS - Quality Indicator Survey Rp, R/P - Responsible party SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Trach- Tracheostomy	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656	**F656** **Corrective Action for the Residents** **Affected:** The affected Resident #1 was assessed on 3/4/2021.Full vital signs including oxygen saturation was implemented according to the interventions specified in the comprehensive person centered care	**04/14/21**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 656	Continued From page 2 resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, for	F 656	plan of a COVID-19 positive resident and to reflect facility standard of practice to document full vital signs with O2 (oxygen) saturation for Covid-19 residents every shift and as needed. Resident#1vital signs Temp 97.2, Pulse 70, Respiration 18, Oxygen 98% room air, and Blood Pressure 120/64. Resident #1 did not suffer any negative outcome. **Identification of others with the Potential to be affected:** All residents with confirmed diagnosis of Covid-19, on quarantine or on monitoring related to Covid-19 in the facility have the potential to be affected. **a**. The Unit Manager/ Designee will complete an audit of all residents with active Covid-19 status, on quarantine or on monitoring related to Covid-19 to ensure implementation of the interventions specified in the comprehensive person-centered care plan of the residents including the full vital signs with O2 (oxygen) saturation. **b**. Any issue found during this audit will be addressed.. The compliance date for this intervention will be 4/12/21.	**04/14/21**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 656	Continued From page 3 one (1) of 11 sampled residents, facility staff failed to implement the interventions specified in the comprehensive person-centered care plan of a COVID-19 positive resident. Resident #1. Findings included . Review of the facility's policy entitled, "Facility Responses to a Positive or Suspected COVID-19" stated under section 4, " ... Monitor vital signs at a minimum every shift and as needed. Document vital signs in the medical record ..." Resident #1 was admitted to the facility on 11/07/2020, with diagnoses that included, Stroke, Hypertension, and Urinary Tract Infection. Review of Resident #1's medical record showed the following progress note: "2/20/2021 at 11:33 [AM] Nurse Practitioner Progress Note ... Asked to see patient will be moved to Isolation tested positive for COVID results reported this morning." Review of the physician's orders showed the following order: "02/21/2021 at 11:26 AM Observation due to positive COVID (COVID-19) result every shift for observation for 14 Days" Review of Resident #1's care plan with the initiation date of 02/26/2021, outlined the following interventions to address the resident's symptomatic positive COVID-19 status: "Observe the resident Q (every) 4 hours for s/sx	F 656	**Measures to Prevent Recurrence:** The facility Staff Development/ Designee will provide an education/ in-service to all facility licensed nurses. The in-service or education will explain the importance of implementing the interventions specified in comprehensive Person-centered care plan of the resident including the full vital sign with O2 (oxygen) Saturation. The compliance date for this Intervention will be 4/12 /21. **Monitoring Corrective Action:** **a.** The Unit Manager/ Designee will Conduct weekly audit for 3 months of all residents with confirmed Covid -19 diagnosis, on quarantine or on monitoring related to Covid-19 to ensure accurate implementation of the interventions specified in the comprehensive person-centered care plan of the residents including the full vital signs with O2 (Oxygen) saturation. The compliance date for this intervention will be 4/12/21. **b.** The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	04/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 656	Continued From page 4 (signs and symptoms) and monitor full vital signs including O2 (oxygen) saturation." Review of Resident #1's vital signs record revealed that there was no documented oxygen saturation assessments on dates March 1, 2, and 3, 2021 for all three shifts. During a telephone interview conducted on 03/15/2021, at approximately 11:45 AM, Employee #2 (Director of Nursing) stated, "Vital signs are to be done every four (4) hours at a minimum and as needed for residents who are confirmed COVID-19 positive and under quarantine or observation." During a second interview conducted on 03/17/2021, at 10:45 AM Employee #2 stated, "Vital signs include blood pressure, temperature, oxygen saturation, respirations and heart rate." At the time of the interview, Employee #2 acknowledged the findings. Facility staff failed to implement the interventions specified in Resident #1's comprehensive person-centered care plan.	F 656	**F684** **Corrective Action for the Residents Affected:** **a.**The affected Resident #1 was assessed on 3/4/2021.Full vital signs including oxygen saturation was implemented according to the interventions specified in the comprehensive person centered care plan of a COVID-19 positive resident, and in accordance with professional standard of practice; and documented full vital signs with O2 (oxygen) saturation every shift and as needed.Resident#1vital signs Temp 97.2, Pulse 70, Respiration 18, Oxygen 98% room air, and Blood Pressure 120/64 Resident #1 did not suffer any negative outcome.	04/14/21
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 684	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, for one (1) of 11 sampled residents, facility staff failed to ensure that Resdient #1 received treatment and care in accordance with the comprehensive person-centered care plan. Findings included ... Review of the facility's policy entitled, "Facility Responses to a Positive or Suspected COVID-19" stated under section 4, " ... Monitor vital signs at a minimum every shift and as needed. Document vital signs in the medical record ..." Resident #1 was admitted to the facility on 11/07/2020, with diagnoses that included, Stroke, Hypertension, and Urinary Tract Infection. Review of Resident #1's medical record showed the following progress note: "2/20/2021 at 11:33 [AM] Nurse Practitioner Progress Note ... Asked to see patient will be moved to Isolation tested positive for COVID results reported this morning." Review of the physician's orders showed the following order: "02/21/2021 at 11:26 AM Observation due to positive COVID (COVID-19) result every shift for observation for 14 Days" Review of Resident #1's care plan with the initiation date of 02/26/2021, outlined the following interventions to address the resident's	F 684	**b.** The facility Staff Development/Designee will provide education to the facility Licensed nurses on the importance of ensuring that residents receive treatment and care in accordance with the comprehensive person centered care plan and professional standards of practice; and also documenting full vital signs with O2 (Oxygen) saturation. The compliance date for this intervention will be 4/12/21. **Identification of others with the Potential to be affected:** All residents in the facility have the potential to be affected. **a.** The Unit Manager/ Designee will complete an audit of all facility residents to to ensure that they receive treatment and care in accordance with the comprehensive person-centered care plan and including full vital signs with O2 (Oxygen) saturation. **b.** Any issue found during this audit will be addressed. The compliance date for this intervention will be 4/12/21.	04/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 684	Continued From page 6 symptomatic positive COVID-19 status: "Observe the resident Q (every) 4 hours for s/sx (signs and symptoms) and monitor full vital signs including O2 (oxygen) saturation." Review of Resident #1's vital signs record revealed that there was no documented oxygen saturation assessment on dates March 1-3, 2021 for all three shifts. During a telephone interview conducted on 03/15/2021, at approximately 11:45 AM, Employee #2 (Director of Nursing) stated, "Vital signs are to be done every four hours at a minimum and as needed for residents who are confirmed COVID-19 positive and under quarantine or observation." During a telephone interview conducted on 03/17/2021, at 10:45 AM Employee #2 stated, "Vital signs include blood pressure, temperature, oxygen saturation, respirations and heart rate." At the time of the interview, Employee #2 acknowledged the findings. Facility staff failed to implement the interventions specified in Resident #1's comprehensive person-centered care plan.	F 684	**Measures to Prevent Recurrence:** The facility Staff Development/Designee will provide education to the facility Licensed nurses on the importance of ensuring that residents receive treatment and care in accordance with the comprehensive person centered care plan and professional standards of practice; and also documenting full vital signs with O2 (Oxygen) saturation. The compliance date for this intervention will be 4/12/21. **Monitoring Corrective Action:** **a.** The Unit Manager/ Designee will Conduct weekly audit for 3 months of all facility residents to ensure that they receive treatment and care in accordance with the Comprehensive Person-centered care plan; including full vital signs with O2 (Oxygen) saturation. The compliance date for this intervention will be 4/12/21. **b.** The findings of these audits will be presented monthly for 3 months to Quality Assurance Performance Improvement (QAPI) committee.	04/14/21
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880	**F880** **Corrective Action for the Residents Affected:** **1.**Employee #7 has been educated on 3/4/2021 on the Standard of Practice for donning a face shield and adhering to facility policies and procedures of infection prevention. No facility resident was affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 880	Continued From page 7 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 880	**2.**Employee #8 has been educated on 3/4/21 on following facility's Infection Control policy when doffing and disposing of a used gown and adhering to facility policies and procedures on infection prevention. No facility resident was affected. **Identification of others with the Potential to be affected.** All residents in the facility have the potential to be affected. **a.**The Facility Infection Preventionist will Conduct an audit/evaluation of the facility Training on the use of Personal Protective Equipment (PPE) (Donning & Doffing) and Proper disposal of used Personal Protective Equipment to evaluate if facility staff understood the training for the purpose of making future education revision; this will increase compliance. The compliance date for this intervention will be 4/12/21 **b.** Any issue found during this audit will be addressed. **Measures to prevent recurrence:** **1.**Staff Development/ Designee will provide in-services to all facility employees on Infection control practices to explain the use of Personal Protective Equipment (PPE) (Donning & Doffing) and proper disposal of used Personal Protective Equipment (PPE)	04/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 880	Continued From page 8 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility's staff failed to follow the Standard of Practice for donning a face shield (Personal Protective Equipment); and follow the facility's policy for disposing of used Personal Protective Equipment (PPE). Findings included... 1. Employee #7 failed to follow Standards of Practice when donning a face shield. According to the Center for Disease Control and Prevention's website, proper donning of face shields includes the following steps:	F 880	**2.** The unit managers/ designee will conduct shift huddles at the beginning of each shift to remind facility staff on following the facility Infection Control practices on Donning & Doffing Personal Protective Equipment (PPE) and proper disposal of used Personal Protective Equipment (PPE) to prevent the spread of infection. The compliance date for this intervention will be 4/12/21 **Monitoring corrective Action:** **1.** Assistant Director of Nursing/Designee will conduct random visual audit 3 times a week to ensure that the facility employees are wearing their face shield. appropriately in the resident care areas per the standard of practice to ensure they are .Finding of the random visual audit will be presented monthly for three months to Quality Assurance and Performance (QAPI) committee. **2.** Assistant Director of Nursing/Designee will conduct random visual audit 3 times a week to ensure that the facility employees are following facility policy on the disposal of Personal Protective Equipment (PPE) .Findings of this visual random audits will be presented monthly for three months to Quality Assurance and Performance (QAPI) committee. The compliance date for this intervention will be 4/12/21.	04/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 880	Continued From page 9 "Put on a full-face shield over the N95 respirator and surgical hood to provide additional protection to the front and sides of the face, including skin and eyes. Bending forward, hold on to the face shield with both hands, expand the elastic with your thumbs and place the elastic behind your head, so that the foam rests on your forehead. Once the shield is situated, check to make sure it covers the front and sides of the face and no areas are left uncovered." https://www.cdc.gov/vhf/ebola/hcp/ppetraining/n95respirator_gown/donning_13.html During an observation of the 2nd floor on 03/04/21, at approximately 11:50 AM, Employee #7 (Certified Nursing Aide- CNA) was observed in the hallway with her face shield not appropriately worn per the standards of practice. The faceshield was noted in her hairline directly above her forehead, pointed in an upward position, slightly away from her face leaving her surgical mask uncovered. During a face-to-face interview on 03/04/2021, at approximately 12:00 PM, Employee #7 was asked, is there a reason why her face shield was not covering her (surgical) face mask? The employee stated that the face shield slides upward. It should be noted that 34 of the 52 residents on this unit were on "Precautionary Observation" due to possible COVID-19 exposure. During a face-to-face interview on 03/04/2021, at approximately 1:15 PM, Employee #2 (Director of Nursing) acknowledged the finding and stated that administrative staff conducts daily	F 880		04/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 880	Continued From page 10 observations to ensure that staff are appropriately donning personal protective equipment. At the time of the survey, Employee #7 failed to follow the Standards of Practice while donning a face shield. 2. Employee #8 failed to follow the facility's policy for disposing PPEs. Review of the facility's document titled, "Infection Control (Personal Protective [Protective] Equipment-PPE)/ Donning & Doffing PPE" policy dated 01/2021, instructed staff to "remove gown ...dispose in [room] trash receptacle." During two observations on the 2nd floor on 03/04/2021, starting at approximately 12:10 PM, the following was observed: Observation #1 Employee #8 (CNA) was observed coming out of Room #243 with a blue disposable gown in her ungloved hands. -The employee walked up the hallway past the nursing station and touched the door of Room #207 to get a red trash bag that was stored on the door in a hanging storage unit. -Employee #8 put the blue gown in the trash bag. - After putting the blue gown in the trash bag, the employee walked to the dirty utility room and touched the keypad to open the door. -When the door opened, Employee #8 disposed of the blue gown in the trash receptacle.	F 880		04/14/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095015	A. BUILDING _____ B. WING _____	03/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERENITY REHABILITATION AND HEALTH CENTER LLC	1380 SOUTHERN AVE SE WASHINGTON, DC 20032

(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 880	Continued From page 11 -After disposing of the blue gown, the employee then walked to the nurse's station and washed her hands. During a face-to-face interview conducted on 03/04/2021, at approximately 12:15 PM, Employee #8 stated that she used the gown while caring for Resident #6 (who was on precautionary observation for possible exposure to COVID-19) in room #243. The employee then stated that the room did not have a red trash bag, so she walked out of the room to dispose of the gown. An observation of Room #243 was conducted on 03/04/2021, at approximately 12:20 PM revealed which that the room had a foot-operated trash can that contained a red-trash bag that was not full. During a second interview on 03/04/2021, at approximately 12:20 PM, Employee #8 stated, "I didn't realize it was red trash bag in the trash can." During a face-to-face interview conducted on 03/04/2021, at approximately 1:15 PM, Employee #1 (Administrator) acknowledged the findings and stated they would continue to provide education to the staff about infection control practices. At the time of the survey, Employee #8 failed to follow the facility's Infection Control policy when doffing and disposing of a used gown.	F 880		04/14/21