STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095019	A. BUILDING _____ B. WING _____	07/29/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, the facility failed to protect the resident's dignity during one (1) of two (2) dressing change observations. Findings include . Resident #135 was admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. During a tour of Unit 5 south on 7/28/2020 at 10:30 AM, the surveyor observed the following: Employee #14 was in the process of changing the dressing to Resident #135's sacral wound. During this time Employee #14 removed the resident's adult brief and sacral wound dressing with gloved hands. Employee #14 then removed the gloves and proceeded to wash his hands. After washing his hands, Employee #14 stated, There are no paper towels to dry my hands, and walked out of the resident's room, leaving the resident's buttocks and genital area uncovered and exposed. Employee #14 returned to the resident's room approximately two (2) minutes later and applied another pair of gloves. The facility staff failed to cover the resident's buttocks and genital area prior to leaving the room to retrieve paper towels to dry his hands. During a face-to-face interview, Employee #14 acknowledged the findings on 7/28/20 at 11:15 AM.
F 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview for one (1) of 66 sampled residents, the facility staff failed to ensure the physician's order for the resident's code status was reflective of Resident #196 wishes to be a DNR (do not resuscitate). Findings included . Policy: Advance Directives will be respected in accordance with state law and facility policy. Updated 7/1/2020. Procedure #4 The Unit Manager or designee will notify Physician or Nurse Practitioner of advance directives so that appropriate orders can be documented/updated in the resident's medical record. Resident #196 was admitted to the facility on [DATE] with diagnoses, which included Hypertension, [MEDICAL CONDITIONS] Joint Disease, Closed left Humeral Fracture, Alzheimer's, and Dementia. A review of the Social Worker's progress note dated 6/23/2020 at 17:33 showed, This worker assisted (resident's name) to call her son .Contacted the son back and discussed resident's status and progress. Confirmed that son is the POA/responsible party. He informed this worker that (Resident's name) will be a long-term care resident. She no longer has the apartment that she had before. We reviewed the assessment and made updates. Son reported that his mother is DNR and that she was always clear about that. He doesn't have email so requested this worker mail the documents that need signing to him in NC (North Carolina). This worker confirmed his address. Care plan was discussed and agreed upon. The Physician's order dated 7/15/2020 showed Full Code Facility staff failed to ensure that the physician's order for the resident's code status was updated to reflect Resident #196's wishes to be a DNR. During a face-to-face interview conducted on 7/24/2020 at 10:43 AM with Employee #5, he/she acknowledged the finding.
F 0584 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations made on July 22, 2020, at approximately 1:20 PM, and on July 23, 2020, at approximately 1:20 PM, facility staff failed to provide housekeeping services necessary to maintain a clean area evidenced by several surgical masks, plastic bottles, and debris that were observed in the staff parking lot area and in areas surrounding the emergency generator and the chiller, and a plastic container full of water and other debris that was stored in the loading dock area. Findings included . 1. Observed 15 surgical masks, empty plastic bottles, and other debris discarded on the facility grounds surrounding the staff parking lot, the emergency generator, and the chiller. 2. One (1) of one (1) plastic container, observed in the loading dock area filled with water and other debris and presented as a harborage site for insects. These observations were acknowledged on July 22, 2020, at approximately 1:30 PM, by Employee #13 and on July 23, 2020, at approximately 1:20 PM by Employee #12.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, facility staff failed to code accurately the Minimum Data Set (MDS) for one (1) of 66 sampled residents (Resident #231). Findings included . Resident #231 admitted to the nursing home on 12/10/19 with [DIAGNOSES REDACTED]. On 08/03/20 at 12:00 PM, review of the Physician's Discharge Summary note dated 5/8/20 at 17:54:05, showed that Resident #231 was admitted on [DATE] and discharged on [DATE]; Disposition: discharged home; and Rehabilitation Potential: Good. Nursing Note (5/11/20 at 22:21:44) Resident was discharged home today in stable condition at 1:15 pm. He was escorted by staff to the gate to meet with family. Medications were reviewed with family and were encouraged to assess residents (blood pressure) prior administering meds. They had no questions regarding the medications reviewed. Prescription slips, transition booklets to independent, and discharge medication list were handed to family. The family were encouraged to call facility for any concern or question . Social work note (5/12/20 at 07:21:49) Resident discharged home 5/11/20. His daughter provided transportation. PCA (personal care assistant) services arranged with (home health agency) and wheelchair ordered thru (medical supply company). 6-108 process completed. However, review of Resident #231's Discharge MDS dated [DATE] showed code as 03 Acute Hospital in Section (A2100 Discharge Status) indicating that the resident was discharged to a hospital. During a telephone interview on 08/03/20 at 1:25 PM, Employee #19 acknowledged the finding. At the time of the survey, facility staff failed to ensure accurately coded MDS for Resident #231.
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview for one (1) of 66 sampled residents the facility staff failed to develop a care

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) plan to address Resident #196's code status. Findings include . Resident #196 was admitted to the facility on [DATE] with diagnoses, which included Hypertension, [MEDICAL CONDITIONS] Joint Disease, Closed left Humeral Fracture, Alzheimer's, and Dementia. A review of the Social Worker's progress note dated 6/23/2020 at 17:33 showed, This worker assisted (resident's name) to call her son .Contacted the son back and discussed resident's status and progress. Confirmed that son is the POA/responsible party. He informed this worker that (Resident's name) will be a long-term care resident. She no longer has the apartment that she had before. We reviewed the assessment and made updates. Son reported that his mother is DNR and that she was always clear about that. He doesn't have email so requested this worker mail the documents that need signing to him in NC (North Carolina). This worker confirmed his address. Care plan was discussed and agreed upon. A review of the physician's orders [REDACTED]. status. During a face-to-face interview conducted on 7/24/2020, at 10:43AM with Employee #5, he/she acknowledged the finding.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview the facility failed to update two residents care plans to include the actions and interventions related to preparing one (1) resident for discharge and the code status for one (1) resident in two of 66 sampled residents. Residents' #43 and #159. Findings include . 1.The facility's staff failed to update Resident #43's Care Plan with person centered discharge planning approaches/interventions. Resident #43 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the progress note dated [DATE] at 17:07 - Social Work Progress: Resident #43 asked the (social worker) to assist him with locating appropriate housing. The (social worker) stated that she would assist him in exploring that option if it is feasible. The initial step is getting assistance in the community . He will need a new (level of care) for the community and a referral to (community agency) for assistance with transitioning to the community. The (social worker) has begun that process. The nurse has scheduled an appt. to come out on [DATE] to assess Resident #43 is pleased with the discharge planning process. Review of Resident #43's most recent care plan dated [DATE] showed the resident had a care plan that stated Resident 43 does not show potential for discharge . Review of the Resident #43's current medical record showed that while the social worker started the discharge process, the care plan was not reviewed or revised by the interdisciplinary team. Facility staff failed to revise Resident #43's previous care plan with goals, approaches, and interventions to address the resident being discharged to the community. During a face-to-face interview conducted with Employee #17 on [DATE] at 11:53 AM she acknowledged the finding. 2.The facility staff failed to update Resident # 159's current advance life care planning wishes. Resident #159 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Review of the care plan meeting note dated [DATE] at 13:20 noted, Special care plan meeting was held today in presence of (interdisciplinary team and resident's (representative)/daughter who participated over the phone. Patient remain alert and responsive with episode of confusion; ., adult failure to thrive; patient has had a generalized decline in condition/health needing more/total assistance with ADL's, (activities of daily living), incontinent to bowel and bladder, food texture has been downgraded to pureed diet, patient needs assistance with feeding; patient has History of noncompliance with plan of care; patient has refused to be transferred to the hospital for further evaluation due to worsening in condition; as per Resident 159's daughter, looking at her father decline, she wishes to change her father code status from full code to DNR/DNI/DNH (do not resuscitate, do not intubate, do not hospitalize); Education was provided to resident's daughter what it means to be DNR/DNI/DNH and she verbalized understanding; .(doctor) and (nurse practitioner) made aware; care plan has been reviewed, evaluated and it is appropriate for the resident's at this time; will continue with current plan of care. Review of the attending physician's orders [REDACTED]. Review of Resident #159's care plan in section Advance Life Care Planning noted: I have not chosen to make any decisions regarding end of life care. I understand I will be treated as a full code and am accepting of CPR (Cardiopulmonary resuscitation). This care plan was last updated [DATE]. There was no evidence that facility staff updated the Advance Life Care Plan for Resident #159 to reflect his/her current code status or end of life wishes. During face-to-face interview with Employee #17 on [DATE] at 11:53 AM, she acknowledged the findings.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations and staff interview, facility staff failed to prepare foods under sanitary conditions as evidenced by missing ceiling tiles in the main kitchen, a dusty electric fan in use in the food preparation area, two (2) of four (4) dietary staff members who failed to wear gloves while clearing off breakfast food trays, and erroneous documentation of dishwashing machine final rinse temperatures. Findings included . During a walk through of dietary services on July 20, 2020, at approximately 9:15 AM, and on July 21, 2020, at approximately 9:30 AM, the following were observed: 1. Ceiling tiles were missing from an area located by the dishwashing machine. 2. A fan, soiled with dust, was observed in use, in the food preparation and service area. 3. Two (2) of four (4) staff members failed to wear gloves while clearing off food trays. 4. During a review of the Dish Machine Temp Log from January 2020, to present, it was noted that the dish machine final rinse temperatures were recorded at less than the minimum, required temperature of 180 degrees Fahrenheit on several occasions. When asked if the dish machine had been inoperative during those days when the final rinse temperatures were documented at less than 180 degrees Fahrenheit, Employee #11 states, The dish machine had been operating fine with no issues and staff may be documenting dish machine temperatures during initial start-up, before allowing the machine to warm up. During a face-to-face interview on July 24, 2020, at approximately 11:40 AM, Employee #13, confirmed that the dish machine had been operating well throughout the year. However, a review of the Dish Machine Temp Log showed that final rinse temperatures, which are recorded twice a day by dietary staff, were documented at less than 180 degrees Fahrenheit as followed: 28 out of 62 occasions in January 2020 Five (5) of 62 occasions in March 2020 13 out of 60 occasions in April 2020 17 out of 62 occasions in May 2020 20 out of 60 occasions in June 2020 Three (3) out of 41 occasions in July 2020. There were no corrective actions documented during the times the dish machine final rinse temperatures were recorded at less than 180 degrees Fahrenheit. During the survey the dish machine temperature reached 180 degrees Fahrenheit greater than 10 times on July 20, 2020 at approximately 9:30 AM. Employee #11 on July 20, 2020 and on July 21, 2020 at approximately 11:30 AM, acknowledged these findings.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, facility staff failed to have adequate trash receptacles to dispose of used personal protective equipment (PPE) on the Person Under Investigation (PUI) and COVID-19 Unit; follow acceptable infection control standards to prevent the spread of infection in one (1) of two (2) dressing change observations; and follow acceptable standards to prevent the spread of infection between residents while using a glucose meter. Findings include . 1. The facility failed to have adequate trash receptacles to dispose of used personal protective equipment on the Person Under Investigation (PUI) and COVID-19 Unit. On 7/21/20 at approximately 2:00 PM, observation of rooms [ROOM NUMBER] revealed each room contained a white laundry basket with multiple holes. Three (3) of three (3) of the previously mentioned laundry baskets were lined with red plastic bags and contained used PPEs. The facility staff failed to ensure that used PPE were being properly discarded in the rooms of PUI and COVID positive residents. During a face-to-face interview on 7/21/20 at 2:30 PM, Employee #4 acknowledged the finding. 2. The facility failed to follow acceptable standards as to prevent the spread of infection during a dressing change observation. Resident #14 admitted to the facility on [DATE] with medical [DIAGNOSES REDACTED]. During a tour of Unit 5 South on 7/28/2020 at 10:30 AM, the surveyor observed the following: Employee #14 was in the process of changing the sacral wound dressing of Resident #135. During this time, Employee #14 removed the resident's adult brief and sacral wound dressing with gloved hands. Employee #14 then removed the gloves and proceeded to wash his hands. After washing his hands, Employee #14 stated, There are no paper towels to dry my hands. and walked out of the resident's room. Employee #14 then left the resident's room, returning to approximately two (2) minutes later and applied another pair of gloves. Employee #15 then entered the room with towels and cleaning supplies to wash the resident. Employee #14 told the Employee #15 to comeback. Employee #15 walked out of the room. Employee #14 proceeded to spray sacral

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) wound with wound cleanser. At this time, the resident observed to be incontinent with feces. The feces was located directly under the sacral wound. Employee #14 wiped the feces with 4x4 gauze and proceeded to wipe around sacral wound using the same gauze without providing incontinence care first. Resident was then asked if he was in pain, and he replied, It stings. Employee #14 stopped cleaning the wound to address resident's pain level. During a face-to-face interview on 7/28/2020 at 11:05 AM, Employee #15 confirmed Employee #14 asked her to come back later to wash the resident. During a face-to-face interview on 7/28/20 at approximately 11: 08 AM Employee #14 acknowledged findings. 3. The facility staff failed to follow acceptable infection control standards to prevent the spread of infection between residents while using a glucose meter. According to Centers for Prevention and Disease Control . Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared. https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html On 07/20/2020 at 12:50 PM, the surveyor observed Employee #16 checking Resident #135's blood glucose level. Employee #16 then started to proceed to go check the blood glucose level of Resident #43. As Employee #16 prepared him/herself to check the blood glucose level of Resident #43, the surveyor told the Employee to stop and first clean the glucose meter before checking the blood glucose level of Resident #43 At the time of the observation, Employee #16 acknowledged that he/she did not clean the glucose meter between residents and then proceeded to clean the blood glucose meter as specified by the manufacturer.