

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 095019	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2020
NAME OF PROVIDER OF SUPPLIER DEANWOOD REHABILITATION AND WELLNESS CENTER		STREET ADDRESS, CITY, STATE, ZIP 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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
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 observation and staff interview, facility staff failed to ensure that four (4) of 13 hand sanitizer dispensers operated as intended. Findings included: Manufactures Guidance: Use PURELL Hand sanitizer products properly and according to the instructions on the label: wet hands thoroughly with product, and briskly rub hands together until dry. Purell formulated to exceed FDA healthcare personnel hand wash requirements with just 1.1milliliters of product. Hand Sanitizer products. Reference https://www.gojo.com/en/Industries/PURELL-Consumer/FAQ Upon entrance to the facility on [DATE] at approximately 9:15 AM one (1) of one (1) the hand sanitizer dispenser located in the outer lobby/vestibule of the facility failed to dispense enough solution to sanitize the hands of the writer. The finding was acknowledged by Employee #5 who was present at the time of the observation. During a tour of 2 North Unit on June 1, 2020 at approximately 10:30 AM two (2) of six (6) hand sanitizer dispensers failed to dispense enough solution to sanitize the hands of the writer. A face-to-face interview was conducted with Employee #3, who was present at the time of the observation, acknowledged the findings on 6/1/2020 at approximately 10:30 AM. During a tour of 2 South Unit on June 1, 2020 at approximately 10:15 AM one (1) of six (6) hand sanitizer dispensers failed to dispense enough solution to sanitize the hands of the writer. A face-to-face interview was conducted with Employee #3, who was present at the time of the observation, acknowledged the dispenser did not release enough solution on 6/1/2020 at approximately 10:15 AM.		

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.