Leewood Healthcare Center

Grace HEALTHCARE Facility

Serving you from our heart

August 31, 2016

Ms. Elaine Cacciatore, LTC Supervisor

Office of Licensure and Certification

Division of Long Term Care Services

9960 Mayland Drive, Suite 401

Henrico, Virginia 23233-1485

Re: Leewood Healthcare Center (Provider Number 495337)

Survey ending August 18, 2016

Dear Ms. Cacciatore,

Enclosed for your review, please find our plan of correction for the survey ending August 18, 2016. We submit this plan of correction as Leewood Healthcare Center's allegation of compliance. Please contact me directly if you have any questions or require additional information.

Sincerely,

Terrence Kee

Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	A. BUILDING _____ B. WING _____	R 08/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEEWOOD HEALTHCARE CENTER	7120 BRADDOCK ROAD ANNANDALE, VA 22003

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 7/12/16 through 7/14/16, was conducted 8/16/16 through 8/18/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 132 certified bed facility was 115 at the time of the survey. The survey sample consisted of 14 current Resident reviews (Residents 101 through 114) and no closed record reviews. One complaint was investigated.	{F 000}	**Plan of Correction** **Leewood Healthcare, 8/2016** This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	8/30/16
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on Observation, clinical record review, staff interviews, and facility documentation review, the facility staff failed to ensure the professional standards of nursing were followed for medication and treatment administration, for 2 Resident's, (Resident #104 and #103) in a survey sample of 14 residents.. 1. For Resident #104, the staff failed to document the administration of all medications at 9:00 a.m. on 8-17-16, and failed to reconnect a gastrostomy tube feeding at 12:00 p.m. on 8-17-16, per physician's orders.	{F 281}		

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

T J [illegible] | Administrator | 8/31/16

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 281}	Continued From page 1 2. For Resident #103, the facility staff failed to document the administration of a high blood pressure medication and peg tube water flushes. The findings include: 1. Resident #104 was admitted to the facility on 11-12-13, and readmitted on 3-17-14. Diagnoses included; Stroke (CVA), dysphagia, gastrostomy tube feeding, diabetes, dementia, anemia, and hypertension. Resident #104's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7-1-16 was coded as a quarterly assessment. Resident #104 was coded as completely dependent on staff, and severe cognitive impairment. Resident #104 had no mood or behavior problems. Review of the clinical record was conducted on 8-17-16, and the nursing progress notes were reviewed. The last note documented was dated 8-14-16 at 3:16 a.m. The note described dressings to pressure areas, and a Foley catheter assessment. The note went on to say that care and repositioning were provided, and that the Resident appeared comfortable during the care. Review of the Medication Administration Record (MAR) on 8-17-16 at 12:25 p.m., which was located on top of the medication cart across from Resident #104's room, revealed that none of the 9:00 a.m. medications were signed by the nurse on duty that day as having been administered. Observation of Resident #104 was conducted at 12:25 p.m., and 1:00 p.m. The Resident was seated in a reclining wheel chair with eyes closed,	{F 281}	**F 281 Services Provided Meet Professional Standards** Compliance Date: 8/30/16 **Immediate action taken for the resident found to have been affected include:** Resident # 104 was assessed on 8/17/16 by a Registered Nurse, Vital signs were within normal limits. No hypoglycemia noted. Enteral feeding connected and infusing at 12:40pm. All other scheduled medications administered and signed off in the MAR. MD and RP made aware. No new orders received. Resident # 103 was assessed on 8/18/16 by a Registered Nurse, no adverse reactions noted. MD and RP made aware. Vital signs monitored every 8 hours for two days, no abnormalities observed. Resident remains stable.	8/30/16

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{F 281}	Continued From page 2 dressed in street clothing. There was an enteral feeding pump located behind the Resident, which was not connected to the Resident. The label on the bottle of feeding formula read that it had been opened and connected the day before on 8-16-16 at 4:00 p.m. On 8-17-16 at 12:30 p.m. RN A was interviewed. The nurse stated she had administered all medications that morning, but had forgotten to sign off on them as having been administered. Registered Nurse (RN) A was asked when medications should be signed as administered, and she replied that they should be signed off as soon as they are given. She was asked why this documentation was important, and she replied, that someone else might administer them again if they did not know they had been given. On 8-17-16 at 12:40 p.m. RN A wrote a nursing progress note stating that she had administered all 9:00 a.m. medications. This documentation occurred after the surveyor alerted her to the fact that no medications that morning had been documented as given. On 8-17-16 at 1:00 p.m., the Administrator and Director of Nursing (DON) were alerted to the fact that these medications were not signed by the nurse as having been administered, and escorted the surveyor to the nursing unit to discuss this with the nurse. Upon entering Resident #104's room with the nurse, the surveyor, the Administrator, and the DON, it was observed by all that Resident #104's feeding tube was still not connected, and it was due to be reconnected at 12:00 p.m. revealing that the Resident had missed 60 milliliters of feeding during this lapse. The nurse stated she would reconnect it now.	{F 281}	**Identification of other residents having the potential to be affected.** All residents who receive medication, tube feeding and flushes enterally have the potential to be affected. All residents with tube feeding orders were audited by the Unit Managers on 8/17/16 to ensure feeding is infusing as ordered by the physician. No other residents were identified to be affected by this practice. An audit of all residents Medication Administration Record was conducted on 8/17/16 by the Unit Managers to ensure all medications, tube feeding orders and water flushes were signed off and documented on the MAR after administration. No other residents were identified to be affected by this practice.	8/30/16

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{F 281}	Continued From page 3 The physician's orders for Resident #104 were reviewed, and revealed current orders for all 7 medications due at 9:00 a.m.. Included was an order dated 2-1-16, for "Glucerna 1.0 at 60 cc's (cubic centimeters/milliliters) per hour for 20 hours to be on at 12:00 p.m., and turned off the following day at 8:00 a.m.." This would equal 20 hours. The DON gave "Lippincott" as the facility nursing standards reference. Guidance for nursing standards for the administration of medication is provided by "Lippincott": Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation." On 8-17-16, and 8-18-16 at the end of day debriefs, the Administrator, DON, and Corporate RN Consultant were made aware of the deficient practice. No further information was provided by the facility.	{F 281}	**Actions taken/systems put into place to reduce the risk of future occurrence.** Education, in-service program was conducted for all licensed nurses starting on 8/17/2016 by the Director of Nursing/Designee on the facility policy on medication administration and enteral feeding protocol to be completed by 8/29/16. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing/Designee will review the Medication Administration Record of all residents daily for two weeks, weekly for four weeks and monthly for two months to ensure all medications are documented after each administration and water flush orders are signed off as stated on the policy on medication administration and enteral feeding protocol.	8/30/16

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{F 281}	Continued From page 4 2. Resident #103 was an 79 year old who was admitted to the facility on 10/12/15. Resident #103's diagnoses included Cerebrovascular Disease, Hypertension, Dysphasia, Encounter for Attention to Gastrostomy, and Adult Failure to Thrive. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 7/18/16, coded Resident # 103 as having severely impaired cognitive skills for decision making. On 8/17/16, at 10:00 A.M. an observation was conducted of Resident #103. He was asleep in his room. On 8/17/16 a review was conducted of Resident #103's clinical record, revealing the following signed Physician's Orders:, 1.) 8/1/16 - "Norvasc 5 MG Tablet via Gast-Tube every day for Hypertension." 2.) 8/1/16 -"Enteral Protocol. Flush Tube with 100 ML of Water Every 6 hours - Total volume of Flush 400 CC/24 Hrs. Excluding Medication Flushes." On 8/17/16 a review of Resident #103's Medication and Treatment Administrations for August, 2016 was conducted. The following items were not documented as having been administered: Tube Flush on 8/10/16 at 12 A.M., 8/14/16 at 6 P.M., and 8/15/16 at 6 P.M. Norvasc 5 MG on 8/6/16 at 9 A.M., and 8/7/16 at 9 A.M.	{F 281}	The Director of Nursing/Designee will conduct audits on all residents with tube feeding orders to ensure timely infusion of enteral feeding as ordered by the physician. Audits will be conducted daily for two weeks, weekly for four weeks and monthly for two months. The Director of Nursing/Designee will present the results of reviews to the Quality Assurance Performance Improvement Committee for review and further recommendations. Quality Assurance Performance Improvement Team Members include: Administrator, Director of Nursing, Staff Development Coordinator, Director of Social Services, Director of Dietary, Director of Housekeeping, Director of Maintenance, Nurse Managers, Minimum Data Set Coordinator, Medical Director, Director of Rehab Services, and Pharmacy Consultant.	8/30/16

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{F 281}	Continued From page 5 On 8/17/16 a review was conducted of facility documentation, revealing the Enteral Feeding Policy (undated). It read, " Purpose -To assist the facility in ensuring that naso gastric, or gastric, tube feeding is used only after adequate assessments, and the resident's clinical condition makes this treatment necessary and in assessing and monitoring residents who require their nutrition by a naso-gastric or gastric tube feeding receives the appropriate treatment and services to prevent aspiration, pneumonia, diarrhea, vomiting, dehydration ... and to restore if possible, normal eating status." The Medication Management policy dated 11/13/15 was also reviewed. It read, "Sign MAR (Medication Administration Record) after administration." Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation."	{F 281}		

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{F 281}	Continued From page 6 On 8/17/16 at 3:00 P.M. an interview was conducted with the Unit Manager (RN B). When asked about the importance of administering and documenting the medication as ordered, she stated, "They can have a stroke if they're not getting their medication for blood pressure. It should have been documented, they are depending on us for hydration and nutrition." On 8.17/16 at 3:45 P.M., the Administrator (Employee A), and Director of Nursing (Employee B) were informed of the findings. No further information was received,	{F 281}		