Leewood Healthcare Center

September 21, 2017

Ms. Elaine Cacciatore, Long Term Care Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Richmond, VA 23233

Re: Leewood Healthcare Center (Provider Number 495337)

Dear Ms. Cacciatore:

Enclosed for your review, please find our plan of correction for our survey ending August 30, 2017. We submit this plan of correction as Leewood Healthcare's allegation of compliance. Please contact me directly if you have any questions or require additional information.

Sincerely,

Terrence Kee
Administrator

7120 Braddock Road • Annandale, Virginia 22003 • Phone: (703) 256-9770 • Fax: (703) 256-5105

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	495337		08/30/2017

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 standard survey and biennial State Licensure Inspection was conducted 8/28/2017 through 8/30/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 132 certified bed facility was 114 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 4 closed record reviews (Residents #21 through #24).	F 000	**Plan of Correction** **Leewood Healthcare, 9/2017** 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.	10/6/17
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 Cross Reference to F-240 12 VAC 5-371-250 12 VAc 5-371-250-(F) Cross Reference to F-279 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (A, C) Cross Reference to F-309 12 VAC 5-371-220 Nursing Services 12 VAC 5-371-220 (D) Cross Reference to F-328	F 001	Please refer to F-240 Please refer to F-279 Please refer to F-309 Please refer to F-328	

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TGK TITLE Administrator (X6) DATE 9/21/17

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F 001	Continued From Page 1 12 VAC 5-371-190 Safety and Emergency Progedures 12 VAC 5-371-190 (A) Cross Reference to F-518	F 001	Please refer to F-518	

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey Inspection was conducted 8/28/2017 through 8/30/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 132 certified bed facility was 114 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 4 closed record reviews (Residents #21 through #24).	F 000	**Plan of Correction** **Leewood Healthcare, 9/2017** 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.	10/6/17
F 240 SS=D	483.10(a)(1)(2) CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE (a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. (a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. This REQUIREMENT is not met as evidenced by: Based on on observation, staff interview, facility documentation review and clinical record review, the facility staff failed, for one resident (Resident #6) in the survey sample of 24 residents, to	F 240	**F 240 Care and Environment Promotes Quality of Life** Compliance Date: 10/6/17 **Immediate action taken for the resident found to have been affected include:**	10/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/21/17

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 240	Continued From page 1 provide a dignified living experience during medication administration. The facility staff applied a pain patch to Resident #6's back, asked her to lean forward, and then used a black marker to write the day, month and year on it. The Findings included: Resident #6 was a 92 year old who was admitted to the facility on 1/17/06. Resident #6's diagnoses included a facial bruise from a fall, Hypertension, Atrial Fibrillation, Cardiovascular accident, and Asthma. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/5/17, coded Resident #6 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. On 8/29/17 at 8:30 A.M. an observation was conducted of the facilities' medication administration process. The Licensed Practical Nurse (LPN-A) placed a Fentanyl Patch 25 milligrams (MG). on Resident #6's upper right back. LPN-A then asked Resident #6 to lean forward, she then used a black marker to write the month, day and year on the patch. On 8/29/17 at 8:35 A.M. an interview was conducted with LPN-A. When asked why she did not write the date on the patch prior to applying it to Resident #6, she stated, "I usually write the date first but it's easier to peel the backing off if you date it after it's on the resident. I know that it is a dignity issue."	F 240	Resident #6's physician was notified on 9/19/17 by LPN-Charge Nurse of the occurrence of the nurse applying a transdermal patch and marking the patch post application. The resident's representative was notified on 9/19/17 by LPN-Charge Nurse of the occurrence of the nurse applying a transdermal patch and marking the patch post application. The LPN-A received counseling on the application of transdermal patch on 8/29/2017 by the Director of Nursing. **Identification of other residents having the potential to be affected.** The facility has determined that residents receiving a transdermal patch have the potential to be affected.	

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F 240	Continued From page 2	F 240	**Actions taken/systems put into place to reduce the risk of future occurrence.**	
	On 8/29/17 a review was conducted of facility documentation, revealing the following Transdermal Delivery Policy (undated), "Remove new patch from package and envelope. Label patch with date and nurse's initials. Apply new patch firmly against skin." On 8/29/17 at 4:30 P.M. the facility Administrator (Administration A) and Director of Nursing (Administration B) were informed of the findings. No further information was received.		An in-service education program was conducted by the Quality Assurance Staff development director (QA/SDC) on the correct application of transdermal patches and dating prior to placement on the resident.	
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the 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	F 279	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The QA/SDC, unit managers or nursing supervisor will observe application of 5 transdermal patches daily for 2 weeks, then 3 times a week for two weeks then weekly for 4 weeks. The QA/SDC will present the results of audits 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	

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F 279	Continued From page 3 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 observation, staff interview, facility record review, and clinical record review, the facility staff failed to devise, and implement a	F 279	Pharmacy Consultant. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice. **F-279 Developing Comprehensive Care Plans** Compliance date: 10/6/17 **Immediate actions taken for the residents found to have been affected:** Resident #1's care was updated on 9/20/17, by the Unit Manager to reflect current problems with measurable goals and interventions. The skin intervention to massage bony prominences was removed. The MDS coordinator was educated by QA/SDC on 9/21/17, on the care planning process and using measurable goals and interventions.	10/6/17

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F 279	Continued From page 4 comprehensive care plan for the use IV (intravenous) potassium and antibiotics for one Resident (Resident #1) in a survey sample of 24 Residents. For Resident #1, IV antibiotics, fluids, and Potassium were not appropriately care planned, and skin breakdown was care planned inappropriately. The findings included: Resident #1 was admitted to the facility on 3-23-17. Resident #1's current diagnoses included; pneumonia, urinary tract infection, Dementia, congestive heart failure, and Hypertension. The most recent Minimum Data Set, (MDS) was a Significant change Assessment, with an Assessment Reference Date of 7-21-17. the MDS coded Resident #1 as severely cognitively impaired. Resident #1 was coded as being extensively dependent for all activities of daily living, and requiring a 1 person physical Assist. Resident #1 was first observed laying in bed, on her back, on 8-28-17 at 2:30 p.m., during entrance tour of the facility. Both of the Residents hands were swollen, and elevated on pillows, with pitting edema in both. The right hand was bruised on the back of the hand, in a circle approximately the size of a silver dollar. The Resident was unresponsive when LPN B attempted to arouse her by calling her name, and shaking her arm. There was an Intravenous (IV) medication pump in the room at bedside. Hanging from the pump was an open one liter bag of 5% dextrose, and 1/2 normal saline mixture, which had tubing connected to it, and it	F 279	**Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be affected. The MDS coordinators, unit managers and supervisors will review all care plans and update identified problems with measurable goals and interventions. **Action taken/systems put into place to reduce the risk of future occurrence include:** The MDS nurses, unit managers and supervisors will be educated by the QA/SDC on the care planning process, identifying problems, developing measurable goals and inventions.	

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F 279 Continued From page 5

was filled with fluid. The 1000 ml (milliliter) bag had no noticeable fluid missing, and was still 1000 ml., and no fluid was hooked to the Resident, and the infusion was turned off. A large piece of medical tape was stuck on the bag of fluid which documented that it had been hung at 6:00 a.m., that morning 8-28-17, and was to infuse at 75 ml per hour. No additives were documented as being in the fluid. LPN B was interviewed at that time, and stated that the Resident was supposed to have antibiotics for pneumonia, and a urinary tract infection (UTI), and that the Resident was receiving fluids because she was very sick and not drinking. LPN B went on to say that the peripheral IV access in the Resident's right hand had become infiltrated and had to be discontinued by the nurse working over night, and that had occurred at 7:00 a.m. that morning. She stated that a doctor's order had been received to insert a PICC (peripherally inserted central line catheter) Line in the Resident's upper arm for the fluid and antibiotic infusions. There was a single lumen (port) PICC line noted in the Resident's upper inner arm, covered with a clear occlusive dressing. A PICC line is inserted in a major vein in the upper arm which flows directly into the vena cava of the heart, and is considered a central line because of it's proximity to the heart. Peripheral IV's are located in lower hands, and arms in lesser veins.

On 8-28-17 several other observations of Resident #1 were conducted while waiting for clinical records to be copied and delivered to surveyors. An x-ray technician arrived at 5:00 p.m., with a portable x-ray machine and obtained an x-ray on Resident #1 to check placement of the PICC line for use. The technician stated the film would be read by a radiologist "in a couple of

F 279

How the corrective action will be monitored to ensure the practice will not recur:

The MDS coordinators will audit 5 care plans per day 5 days a week for 2 weeks then three times per week for 2 weeks then weekly for 2 months.

The MDS coordinator will present the results of audits 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. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice.

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F 279	Continued From page 6 hours, and results would be sent to the facility after that." The Resident remained unresponsive, and had not consumed any nutrition or fluids for at least 10 hours at this time, and it would be more hours before the IV could be accessed. Laboratory reports were reviewed in the clinical record and revealed that on 8-24-17 a complete blood count (CBC), basic metabolic profile (BMP), and urinalysis with culture and sensitivity (U/A with C&S) were obtained and resulted on 8-24-17 (4 days prior to survey). A review of Resident #1's clinical record was conducted after tour on 8-28-17 revealing an admission Care Plan dated 3-23-17, that had no measurable interventions, and denied the Resident's congestive heart failure history. A second care plan was derived on 3-30-17, and had been updated on 4-13-17, by the interdisciplinary team. No other records reveal any updates by the interdisciplinary team after 4-13-17 until the time of survey. There were interventions added in May 2017 for falls by the nursing staff, and in July 2017 for bed mobility and contractures by the nursing staff. On 8-24-17 interventions for IV antibiotics were added to the care plan, however the care plan stated the Resident had a PICC line, for the infusions which was incorrect, the Resident had a peripheral IV in her hand, and the fluids, and medications were not added to the plan. On 8-25-17 a skin breakdown problem was added to the care plan with no measurable goals, and an intervention to "massage bony prominences", was added, which is a strictly forbidden practice when skin breakdown is a potential. Physician progress notes were reviewed and	F 279	**F-309 Provide Care/Services for Highest Well Being** Compliance Date: 10/6/17 **Immediate action taken for the resident found to have been affected include:** Resident #1 physician was notified on 8/28/2017 and an order for PICC line insertion was obtained. The PICC line was inserted by and a confirmation X-Ray was performed on 8/28/2017. The resident's order was clarified to give an IV of D5 ½ Normal Saline with 20meq of KcL added. The IV was started by the nurse on 8/28/2017 @ 5:30 pm by PICC line. The Levaquin 250 mg was administered IV per PICC line 8/28/2017 at 9pm per order. The Zosyn one gram was administered 8/29/2017 at 6 am as ordered,	10/6/17

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F 279	Continued From page 7 revealed 2 visits during Resident #1's acute illness. The first visit was on 8-23-17, where the doctor describes the Resident as "seen for Obtundation". Webster's medical dictionary describes this definition as; "Obtundation refers to less than full alertness (altered level of consciousness), typically as a result of a medical condition or trauma." "The root word, obtund, means "dulled or less sharp" cf. obtuse angle." The note states the Resident is responsive non verbally to stimuli, has an altered mental status, and the doctor is ordering IV hydration and a palliative care consultation. Nursing progress notes were reviewed and revealed that the Resident had pneumonia, and a Urinary tract infection (UTI), and was unable to consume medications by mouth , and not able to swallow food, or drink, and drooled when attempts were made. No interventions for this new problem were care planned. Multiple order changes, medication and IV fluid changes occurred from 8-24-17 through 8-29-17, at the time of survey, with none of these implemented on the care plan. IV and PICC (peripherally inserted central line catheter) line care were not implemented on the care plan, and labs revealed new problems of high blood sodium, low blood potassium, and inability to consume food, medications, and fluids orally, which were not care planned. Clinical record Labs were reviewed, and revealed that a Normal sodium range is (137-145), and the Resident suffered from high sodium (hypernatremia) with a sodium level of (155) on 8-24-17, and (154) on 8-28-17. The Resident also experienced low potassium (hypokalemia),	F 279	The resident's #1 care plan was updated on 8/29/2017 to include measurable goals and interventions for pneumonia and urinary tract infections by the MDS coordinator. The intervention for massaging bony prominences was removed by the MDS coordinator. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected. No other residents were identified with IV medications, fluids or additives. The MDS coordinators, unit managers and supervisors will review all care plans and update identified problems with measurable goals and interventions.	

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F 279	Continued From page 8 which was (3.2) on 8-24-17, and worsening on 8-28-17 at (2.9), and (2.9) again on 8-29-17. A normal blood potassium range is (3.5-5.5), which is a very narrow range due to the serious threat of small changes in potassium levels in blood. Potassium is a major mineral (electrolyte) responsible for cardiac health. Low potassium, or high potassium, can result in death. Multiple care plan omissions occurred, and an inappropriate skin intervention was planned, preventing nursing staff from planning needed care, providing effective care, and assessing the outcomes of care. The facility was notified of this deficient practice on 8-29-17 at the end of day debrief. No further information was provided by the facility.	F 279	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program will be conducted by the QA/SDC for all nurses on medication administration, notifying physicians if there is going to be a delay in following physician orders or treatment d/t supplies and available services being delayed or not available, to give the opportunities to provide the orders in a different way or setting.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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	F 309	A list of available IV fluid and additives from the emergency pharmacy supplies will be placed on each medication cart for nurses to be able to communicate availability to the physician when receiving orders. The MDS nurses, unit managers and supervisors will be educated by the QA/SDC on the care planning process, identifying problems, developing measurable goals and inventions.	

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F 309	Continued From page 9 care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to maintain the highest practicable well being for 1 Resident (Resident #1) in the survey sample of 24 residents. For Resident #1, the facility failed to ensure IV (intravenous) medications were administered per physician's orders, and standards of professional practice. The facility staff further failed to obtain an IV access timely, and provide care and services during an acute illness. The findings included: Resident #1 was admitted to the facility on 3-23-17. Resident #1's current diagnoses included; pneumonia, urinary tract infection, Dementia, congestive heart failure, and Hypertension. The most recent Minimum Data Set, (MDS) was a Significant change	F 309	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The unit managers and nursing supervisors will audit nurses notes, orders and 24 hours reports for orders being implemented and note any potential delays of supplies or services and notify the physician for alternate care and treatment 5 days a week for 2 weeks then three times per week for 2 weeks then weekly for 2 months.	

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F 309	Continued From page 10 Assessment, with an Assessment Reference Date of 7-21-17. the MDS coded Resident #1 as severely cognitively impaired. Resident #1 was coded as being extensively dependent for all activities of daily living, and requiring a 1 person physical Assist. Resident #1 was first observed lying in bed, on her back, on 8-28-17 at 2:30 p.m., during entrance tour of the facility. Both of the Residents hands were swollen, and elevated on pillows, with pitting edema in both. The right hand was bruised on the back of the hand, in a circle approximately the size of a silver dollar. The Resident was unresponsive when LPN B attempted to arouse her by calling her name, and shaking her arm. There was an Intravenous (IV) medication pump in the room at bedside. Hanging from the pump was an open one liter bag of 5% dextrose, and 1/2 normal saline mixture, which had tubing connected to it, and it was filled with fluid. The 1000 ml (milliliter) bag had no noticeable fluid missing, and was still 1000 ml., and no fluid was hooked to the Resident, and the infusion was turned off. A large piece of medical tape was stuck on the bag of fluid which documented that it had been hung at 6:00 a.m., that morning 8-28-17, and was to infuse at 75 ml per hour. No additives were documented as being in the fluid. LPN B was interviewed at that time, and stated that the Resident was supposed to have antibiotics for pneumonia, and a urinary tract infection (UTI), and that the Resident was receiving fluids because she was very sick and not drinking. LPN B went on to say that the peripheral IV access in the Resident's right hand had become infiltrated and had to be discontinued by the nurse working over night, and that had occurred at 7:00 a.m.	F 309	The Director of Nursing will present the results of audits 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. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice.	

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F 309	Continued From page 11 that morning. She stated that a doctor's order had been received to insert a PICC (peripherally inserted central line catheter) Line in the Resident's upper arm for the fluid and antibiotic infusions. There was a single lumen (port) PICC line noted in the Resident's upper inner arm, covered with a clear occlusive dressing. A PICC line is inserted in a major vein in the upper arm which flows directly into the vena cava of the heart, and is considered a central line because of it's proximity to the heart. Peripheral IV's are located in lower hands, and arms in lesser veins. On 8-28-17 several other observations of Resident #1 were conducted while waiting for clinical records to be copied and delivered to surveyors. An x-ray technician arrived at 5:00 p.m., with a portable x-ray machine and obtained an x-ray on Resident #1 to check placement of the PICC line for use. The technician stated the film would be read by a radiologist "in a couple of hours, and results would be sent to the facility after that." The Resident remained unresponsive, and had not consumed any nutrition or fluids for at least 10 hours at this time, and it would be more hours before the IV could be accessed. Laboratory reports were reviewed in the clinical record and revealed that on 8-24-17 a complete blood count (CBC), basic metabolic profile (BMP), and urinalysis with culture and sensitivity (U/A with C&S) were obtained and resulted on 8-24-17 (4 days prior to survey). A review of Resident #1's clinical record was conducted after tour on 8-28-17 revealing an admission Care Plan dated 3-23-17, that had no measurable interventions, and denied the Resident's congestive heart failure history. A	F 309	**F-328 Treatment/Care for Special Needs** Compliance Date: 10/6/17 **Immediate action taken for the resident found to have been affected include:** Resident #1 physician was notified on 8/28/2017 and an order for PICC line insertion was obtained. The PICC line was inserted by and a confirmation X-Ray was performed on 8/28/2017. The resident's order was clarified to give an IV of D5 ½ Normal Saline with 20meq of KcL added. The IV was started by the nurse on 8/28/2017 @ 5:30 pm by PICC line. The Levaquin 250 mg was administered IV per PICC line 8/28/2017 at 9pm per order. The Zosyn one gram was administered 8/29/2017 at 6 am as ordered,	10/6/17

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F 309 Continued From page 12

second care plan was derived on 3-30-17, and had been updated on 4-13-17, by the interdisciplinary team. No other records reveal any updates by the interdisciplinary team after 4-13-17 until the time of survey. There were interventions added in May 2017 for falls by the nursing staff, and in July 2017 for bed mobility and contractures by the nursing staff. On 8-24-17 interventions for IV antibiotics were added to the care plan, however the care plan stated the Resident had a PICC line, for the infusions which was incorrect, the Resident had a peripheral IV in her hand, and the fluids, and medications were not added to the plan. On 8-25-17 a skin breakdown problem was added to the care plan with no measurable goals, and an intervention to "massage bony prominences", was added, which is a strictly forbidden practice when skin breakdown is a potential.

Physician progress notes were reviewed and revealed 2 visits during Resident #1's acute illness. The first visit was on 8-23-17, where the doctor describes the Resident as "seen for Obtundation". Webster's medical dictionary describes this definition as; "Obtundation refers to less than full alertness (altered level of consciousness), typically as a result of a medical condition or trauma." "The root word, obtund, means 'dulled or less sharp' cf. obtuse angle." The note stated the Resident was responsive non verbally to stimuli, has an altered mental status, and the doctor was ordering IV hydration and a palliative care consultation.

Nursing progress notes were reviewed and revealed that on 8-23-17 IV fluids of Dextrose 5% in 1/2 normal saline (D5 1/2 NS) were ordered by the doctor to begin at a rate of 75 ml (milliliters)

F 309

The resident's #1 care plan was updated on 8/29/2017 to include measurable goals and interventions for pneumonia and urinary tract infections by the MDS coordinator. The intervention for massaging bony prominences was removed by the MDS coordinator.

Identification of other residents having the potential to be affected.

The facility has determined that all residents have the potential to be affected.

No other residents were identified with IV medications, fluids or additives.

The MDS coordinators, unit managers and supervisors will review all care plans and update identified problems with measurable goals and interventions.

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F 309	Continued From page 13 per hour through a peripheral IV in the left hand. Also, a chest x-ray, and laboratory blood samples were ordered to be obtained, and were obtained. The following morning, on 8-24-17 further nursing notes document that the diagnostics results were sent to the doctor, and new orders were received from the doctor for 2 antibiotics. Those were; Zithromax 500 mg (milligrams) by mouth for 5 days for pneumonia, and Rocephin 1 gram daily IV for 5 days for UTI. Nursing notes go on to state that on 8-24-17 the Resident was not able to swallow the medication, food, or drink, and drooled when attempts were made. Nurses tried to contact the doctor with critical lab results, and were unable until 12:12 a.m., (midnight) 8-25-17 at which time the facility was not able to provide the Resident with the IV fluids (D5 1/2 NS) that the doctor had ordered, and the doctor agreed to give Dextrose 5%, since the D5 1/2 NS was unavailable, until the fluid could be obtained. This occurred on 8-25-17 at 11:39 p.m.(24 hours later). Nursing notes described Resident #1 as still having trouble swallowing on 8-25-17. On 8-26-17 at 8:26 a.m., the Resident was asking for water, and only able to take sips, still drooling and not able to take meds or fluids orally at 9:29 p.m. On 8-27-17 at 3:15 p.m., still drooling and unable to take medication by mouth, the doctor ordered to discontinue the IV Rocephin, and by mouth Zithromax which the Resident was never able to take, (4 days later) and ordered Levaquin 250 mg daily "by mouth or IV" for 5 days. Nursing notes and the Medication Administration Record (MAR) documented that on 8-28-17 at 7:09 a.m., the Resident's IV had to be removed.	F 309	**Actions taken/systems put into place to reduce the risk of future occurrence.** An in-service education program will be conducted by the QA/SDC for licensed nurses on medication administration, notifying physicians if there is going to be a delay in following physician orders or treatment d/t supplies and available services being delayed or not available, to give the opportunities to provide the orders in a different way or setting. A list of available IV fluid and additives from the emergency pharmacy supplies will be placed on each medication cart for nurses to be able to communicate availability to the physician when receiving orders. The MDS nurses, unit managers and supervisors will be educated by the QA/SDC on the care planning process, identifying problems, developing measurable goals and inventions.	

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F 309	Continued From page 14 The Resident had not received any IV antibiotic since 5:00 a.m., on 8-27-17 (26 hours previously). Resident #1 was due to receive a first dose of a new morning antibiotic "Levaquin IV", on 8-28-17, however, the facility could not infuse it, because there was no IV access. The nursing notes went on to state that the order for Levaquin on 8-27-17 by telephone order was discontinued on 8-28-17, and the (MAR) revealed the medication was given IV at 9:00 p.m. on 8-28-17 for one dose only (40 hours after the last antibiotic IV infusion on 8-27-17 at 5:00 a.m.). Clinical record Labs were reviewed, and revealed that a Normal sodium range is (137-145), and the Resident suffered from high sodium (hypernatremia) with a sodium level of (155) on 8-24-17, and (154) on 8-28-17. The Resident also experienced low potassium (hypokalemia), which was (3.2) on 8-24-17, and worsening on 8-28-17 at (2.9), and (2.9) again on 8-29-17. A normal blood potassium range is (3.5-5.5), which is a very narrow range due to the serious threat of small changes in potassium levels in blood. Potassium is a major mineral (electrolyte) responsible for cardiac health. Low potassium, or high potassium, can result in death. The following IV potassium information is taken from the "National Institutes of Health"; "potassium chloride in sodium chloride (Potassium Chloride and Sodium Chloride) injection, solution National Institutes of Health Rx only DESCRIPTION Intravenous solutions with potassium chloride (IV solutions with KCl) are sterile and nonpyrogenic	F 309	**How the corrective action(s) will be monitored to ensure the practice will not recur:** The unit managers and nursing supervisors will audit nurses notes, orders and 24 hours reports for orders being implemented and note any potential delays of supplies or services and notify the physician for alternate care and treatment 5 days a week for 2 weeks then three times per week for 2 weeks then weekly for 2 months. The Director of Nursing will present the results of audits 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. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice.	

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F 309	Continued From page 15 solutions in water for injection. They are for administration by intravenous infusion only. Acute treatment of symptomatic Hypokalemia for central venous infusions. Possible Adverse Reactions: 1. Hyperkalemia 2. PO administration may cause GI irritation, vomiting, diarrhea, bleeding. 3. IV administration may cause irritation, pain or phlebitis at the infusion site. 4. Rapid IV infusion may cause cardiac arrhythmias. Contraindications & Precautions Hypersensitivity to potassium chloride products Severe renal impairment or hyperkalemia Use with caution in patients with cardiac disease Nursing Implications Monitor serum potassium concentrations. If serum potassium level is not rising with effective potassium supplementation, consider checking a magnesium level. Continuous cardiac monitoring is mandatory for IV replacement especially for central infusions Watch IV site for signs of irritation or phlebitis. Give oral doses with the nearest feed. WARNINGS Solutions which contain potassium ions should be used with great care, if at all, in patients with hyperkalemia, severe renal failure and in conditions in which potassium retention is present. To avoid potassium intoxication, do not infuse these solutions rapidly. In patients with severe renal insufficiency or adrenal insufficiency, administration of potassium chloride may cause potassium intoxication. Solutions containing sodium ions should be used with great care, if at all, in patients with	F 309	**F-518 Train All Staff on Emergency Procedures/Drills** Compliance Date: 10/6/17 **Immediate action taken for the resident found to have been affected include:** No residents were identified. LPN-D and CNA-A were in-serviced on emergency procedures for fire safety, the emergency power plugs in the event of power outage and the activation of the emergency generator and elopement protocols, by the night supervisors on 9/21/2017. **Identification of other residents having the potential to be affected.** The facility has determined that all residents have the potential to be affected.	10/6/17

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F 309	Continued From page 16 congestive heart failure, severe renal insufficiency and in clinical states in which there exists edema with sodium retention. In patients with diminished renal function, administration of solutions containing sodium or potassium ions may result in sodium or potassium retention. The intravenous administration of these solutions can cause fluid and/or solute overloading resulting in dilution of serum electrolyte concentrations, congested heart failure states or pulmonary edema. The risk of dilutional states is inversely proportional to the electrolyte concentration of administered parenteral solutions. The risk of solute overload causing congested states with peripheral and pulmonary edema is directly proportional to the electrolyte concentrations of such solutions. Geriatric Use: Clinical studies of Potassium Chloride in Dextrose Injection, USP In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. These drugs are known to be substantially excreted by the kidney, and the risk of toxic reactions to these drugs may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function. PRECAUTIONS Potassium replacement therapy should be guided primarily by serial electrocardiograms. Plasma potassium levels are not necessarily indicative of	F 309	**Actions taken/systems put into place to reduce the risk of future occurrence.** The QA/SDC will do in-service education for all staff on the emergency procedures for fire safety, the emergency power plugs in the event of power outage and the activation of the emergency generator and elopement protocols. **How the corrective action(s) will be monitored to ensure the practice will not recur:** The QA/SDC and/or unit managers will interview 5 employees five days a week for two weekend then weekly for two months on their knowledge of the emergency procedure for fire, elopement protocols and the use of emergency plug during power outages and emergency generator is activated.	

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F 309	Continued From page 17 tissue potassium levels. High plasma concentrations of potassium may cause death through cardiac depression, arrhythmias or arrest. Potassium-containing solutions should be used with caution in the presence of cardiac disease, particularly in digitalized patients or in the presence of renal disease. Care should be exercised to insure that the needle (or catheter) is well within the lumen of the vein and that extravasation does not occur. Nausea, vomiting, abdominal pain and diarrhea have been reported with potassium therapy. The signs and symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, hypotension, cardiac arrhythmias, heart block, electrocardiographic abnormalities such as disappearance of P waves, spreading and slurring of the QRS complex with development of a biphasic curve and cardiac arrest." There were no physician visits or notes from 8-23-17 until the night of 8-28-17 (5 days later) after the survey team had entered, found and discussed with staff the issues with IV care for Resident #1, and surveyors had left the building for the night. The doctor diagnosed sepsis, from pneumonia and the UTI, and hyponatremia (low sodium), which was incorrect, the Resident actually was hypernatremic (high sodium) and there was no mention of the hypokalemia (low potassium) in the progress note. Physician orders were reviewed and revealed new orders on 8-29-17 for Potassium chloride 10 meq (milliequivalents) IV for 2 doses, due to low potassium STAT (give immediately) order, then	F 309	The QA/SDC 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. If issues are identified, then additional education will be provided and modification of the Plan of Correction will be made to address the deficient practice.	

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the order was changed to Potassium chloride 20 meq (milliequivalents) IV in dextrose 5% - 1/2 normal saline solution at 75 ml per hour for 1 liter bag dose, due to low potassium, after a stat BMP result is reported to the MD (doctor). The Resident had been hypokalemic for 5 days at this point, and the blood potassium issue had worsened.

The physician was interviewed on 8-30-17 at 9:00 a.m., The doctor was asked why no potassium had been given on 8-24-17 when labs showed hypokalemia. The doctor stated that some of the fluids that he ordered, and potassium for IV administration, had not been available to the facility at the time of his order, because nursing homes don't usually infuse potassium IV. He further stated that he had changed orders to accommodate the facility in regard to IV fluids as well, because they were having trouble getting Dextrose 5% with 1/2 normal saline, so he ordered just 5% dextrose instead. He was further asked why IV antibiotics had not been given timely, and he stated that the PICC line had taken awhile to be instilled in the Resident. When asked if these things could have been accomplished in a more timely manner for this Resident who was now septic, he stated "yes", she could have been sent to the hospital where these things would have been received immediately.

The facility policy on medication administration was reviewed, and stated that doctor's orders must be followed.

In summary of the evidence provided by the facility, Resident #1 was acutely ill with pneumonia, and a UTI. The Resident was not

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LEEWOOD HEALTHCARE CENTER	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(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 309	Continued From page 19 drinking or eating, and was unable to consume antibiotics by mouth for 5 days. Potassium IV, and ordered hydration fluids were not administered timely, and care was delayed because the facility was unable to provide the necessary services. The Resident was not transferred to an acute care setting (hospital) where those services could be provided timely. Fluids were unavailable because of lack of IV access for at least 12 hours. The Rocephin IV antibiotics were not administered from 5:00 a.m. 8-27-17 until the Levaquin was available at 9:00 p.m. on 8-28-17 (40 hours). By this time the Resident had been seen again by the doctor, and diagnosed as "Septic". Medications such as IV potassium were unavailable in this setting as needed, and no monitoring or EKG's (electrocardiograms) were performed before, during or after the potassium infusions. The facility was notified of this deficient practice on 8-28-17, 8-29-17, and 8-30-17 at the end of day debrief. No further information was provided by the facility.	F 309		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and	F 328		

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F 328	Continued From page 20 arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional	F 328		

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F 328	Continued From page 21 standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to provide specialized intravenous antibiotic and potassium infusion nursing care for 1 Resident (Resident #1) in the survey sample of 24 residents. For Resident #1, the facility failed to ensure IV (intravenous) medications were administered per physician's orders, and standards of professional practice. The facility staff further failed to obtain an IV access timely, during an acute illness. The findings included: Resident #1 was admitted to the facility on 3-23-17. Resident #1's current diagnoses included; pneumonia, urinary tract infection, Dementia, congestive heart failure, and Hypertension. The most recent Minimum Data Set, (MDS) was a Significant change Assessment, with an Assessment Reference Date of 7-21-17. the MDS coded Resident #1 as severely cognitively impaired. Resident #1 was coded as being extensively dependent for all activities of daily living, and requiring a 1 person physical Assist. Resident #1 was first observed laying in bed, on her back, on 8-28-17 at 2:30 p.m., during entrance tour of the facility. Both of the Residents hands were swollen, and elevated on pillows, with pitting edema in both. The right	F 328		

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F 328	Continued From page 22 hand was bruised on the back of the hand, in a circle approximately the size of a silver dollar. The Resident was unresponsive when LPN B attempted to arouse her by calling her name, and shaking her arm. There was an Intravenous (IV) medication pump in the room at bedside. Hanging fom the pump was an open one liter bag of 5% dextrose, and 1/2 normal saline mixture, which had tubing connected to it, and it was filled with fluid. The 1000 ml (milliliter) bag had no noticeable fluid missing, and was still 1000 ml., and no fluid was hooked to the Resident, and the infusion was turned off. A large piece of medical tape was stuck on the bag of fluid which documented that it had been hung at 6:00 a.m., that morning 8-28-17, and was to infuse at 75 ml per hour. No additives were documented as being in the fluid. LPN B was interviewed at that time, and stated that the Resident was supposed to have antibiotics for pneumonia, and a urinary tract infection (UTI), and that the Resident was receiving fluids because she was very sick and not drinking. LPN B went on to say that the peripheral IV access in the Resident's right hand had become infiltrated and had to be discontinued by the nurse working over night, and that had occurred at 7:00 a.m. that morning. She stated that a doctor's order had been received to insert a PICC (peripherally inserted central line catheter) Line in the Resident's upper arm for the fluid and antibiotic infusions. There was a single lumen (port) PICC line noted in the Resident's upper inner arm, covered with a clear occlusive dressing. A PICC line is inserted in a major vein in the upper arm which flows directly into the vena cava of the heart, and is considered a central line because of it's proximity to the heart. Peripheral IV's are located in lower hands, and arms in lesser veins.	F 328		

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F 328	Continued From page 23	F 328		

On 8-28-17 several other observations of Resident #1 were conducted while waiting for clinical records to be copied and delivered to surveyors. An x-ray technician arrived at 5:00 p.m., with a portable x-ray machine and obtained an x-ray on Resident #1 to check placement of the PICC line for use. The technician stated the film would be read by a radiologist "in a couple of hours, and results would be sent to the facility after that." The Resident remained unresponsive, and had not consumed any nutrition or fluids for at least 10 hours at this time, and it would be more hours before the IV could be accessed.

Laboratory reports were reviewed in the clinical record and revealed that on 8-24-17 a complete blood count (CBC), basic metabolic profile (BMP), and urinalysis with culture and sensitivity (U/A with C&S) were obtained and resulted on 8-24-17 (4 days prior to survey).

A review of Resident #1's clinical record was conducted after tour on 8-28-17 revealing an admission Care Plan dated 3-23-17, that had no measurable interventions, and denied the Resident's congestive heart failure history. A second care plan was derived on 3-30-17, and had been updated on 4-13-17, by the interdisciplinary team. No other records reveal any updates by the interdisciplinary team after 4-13-17 until the time of survey. There were interventions added in May 2017 for falls by the nursing staff, and in July 2017 for bed mobility and contractures by the nursing staff. On 8-24-17 interventions for IV antibiotics were added to the care plan, however the care plan stated the Resident had a PICC line, for the infusions which was incorrect, the Resident had a

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F 328 Continued From page 24 F 328

peripheral IV in her hand, and the fluids, and medications were not added to the plan. On 8-25-17 a skin breakdown problem was added to the care plan with no measurable goals, and an intervention to "massage bony prominences", was added, which is a strictly forbidden practice when skin breakdown is a potential.

Physician progress notes were reviewed and revealed 2 visits during Resident #1's acute illness. The first visit was on 8-23-17, where the doctor describes the Resident as "seen for Obtundation". Webster's medical dictionary describes this definition as; "Obtundation refers to less than full alertness (altered level of consciousness), typically as a result of a medical condition or trauma." "The root word, obtund, means "dulled or less sharp" cf. obtuse angle." The note states the Resident is responsive non verbally to stimuli, has an altered mental status, and the doctor is ordering IV hydration and a palliative care consultation.

Nursing progress notes were reviewed and revealed that on 8-23-17 IV fluids of Dextrose 5% in 1/2 normal saline (D5 1/2 NS) were ordered by the doctor to begin at a rate of 75 ml (milliliters) per hour through a peripheral IV in the left hand. Also, a chest x-ray, and laboratory blood samples were ordered to be obtained, and were obtained. The following morning, on 8-24-17 further nursing notes document that the diagnostics with results were sent to the doctor, and new orders were received from the doctor for 2 antibiotics. Those were; Zithromax 500 mg (milligrams) by mouth for 5 days for pneumonia, and Rocephin 1 gram daily IV for 5 days for UTI.

Nursing notes go on to say that on 8-24-17 the

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F 328	Continued From page 25 Resident was not able to swallow the medication, food, or drink, and drooled when attempts were made. Nurses tried to contact the doctor with critical lab results, and were unable until 12:12 a.m., (midnight) 8-25-17 at which time the facility was not able to provide the Resident with the IV fluids (D5 1/2 NS) that the doctor had ordered, and the doctor agreed to give Dextrose 5%, since the D5 1/2 NS was unavailable, until the fluid could be obtained. This occurred on 8-25-17 at 11:39 p.m.(24 hours later). Nursing notes described Resident #1 as still having trouble swallowing on 8-25-17. On 8-26-17 at 8:26 a.m., the Resident was asking for water, and only able to take sips, still drooling and not able to take meds or fluids orally at 9:29 p.m. On 8-27-17 at 3:15 p.m., still drooling and unable to take medication by mouth. The doctor ordered to discontinue the IV Rocephin, and by mouth Zithromax which the Resident was never able to take, (4 days later) and ordered Levaquin 250 mg daily "by mouth or IV" for 5 days. Nursing notes and the Medication Administration Record (MAR) documented that on 8-28-17 at 7:09 a.m., the Resident's IV had to be removed. The Resident had not received any IV antibiotic since 5:00 a.m., on 8-27-17 (26 hours previously). Resident #1 was due to receive a first dose of a new morning antibiotic "Levaquin IV", on 8-28-17, however, the facility could not infuse it, because there was no IV access. The nursing notes went on to state that the order for Levaquin on 8-27-17 by telephone order was discontinued on 8-28-17, and the (MAR) revealed the medication was given IV at 9:00 p.m. on 8-28-17 for one dose only (40 hours after the last	F 328		

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F 328	Continued From page 26 antibiotic IV infusion on 8-27-17 at 5:00 a.m.). Clinical record Labs were reviewed, and revealed that a Normal sodium range is (137-145), and the Resident suffered from high sodium (hypernatremia) with a sodium level of (155) on 8-24-17, and (154) on 8-28-17. The Resident also experienced low potassium (hypokalemia), which was (3.2) on 8-24-17, and worsening on 8-28-17 at (2.9), and (2.9) again on 8-29-17. A normal blood potassium range is (3.5-5.5), which is a very narrow range due to the serious threat of small changes in potassium levels in blood. Potassium is a major mineral (electrolyte) responsible for cardiac health. Low potassium, or high potassium, can result in death. The following IV potassium information is taken from the "National Institutes of Health"; potassium chloride in sodium chloride (Potassium Chloride and Sodium Chloride) injection, solution National Institutes of Health Rx only DESCRIPTION Intravenous solutions with potassium chloride (IV solutions with KCl) are sterile and nonpyrogenic solutions in water for injection. They are for administration by intravenous infusion only. ? Acute treatment of symptomatic Hypokalemia for central venous infusions. Possible Adverse Reactions: 1. Hyperkalemia 2. PO administration may cause GI irritation, vomiting, diarrhea, bleeding. 3. IV administration may cause irritation, pain or phlebitis at the infusion site. 4. Rapid IV infusion may cause cardiac arrhythmias. Contraindications & Precautions	F 328		

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F 328	Continued From page 27 ? Hypersensitivity to potassium chloride products ? Severe renal impairment or hyperkalemia ? Use with caution in patients with cardiac disease Nursing Implications ? Monitor serum potassium concentrations. If serum potassium level is not rising with effective potassium supplementation, consider checking a magnesium level. ? Continuous cardiac monitoring is mandatory for IV replacement especially for central infusions ? Watch IV site for signs of irritation or phlebitis. . Give oral doses with the nearest feed. WARNINGS Solutions which contain potassium ions should be used with great care, if at all, in patients with hyperkalemia, severe renal failure and in conditions in which potassium retention is present. To avoid potassium intoxication, do not infuse these solutions rapidly. In patients with severe renal insufficiency or adrenal insufficiency, administration of potassium chloride may cause potassium intoxication. Solutions containing sodium ions should be used with great care, if at all, in patients with congestive heart failure, severe renal insufficiency and in clinical states in which there exists edema with sodium retention. In patients with diminished renal function, administration of solutions containing sodium or potassium ions may result in sodium or potassium retention. The intravenous administration of these solutions can cause fluid and/or solute overloading resulting in dilution of serum electrolyte concentrations, congested heart failure states or pulmonary edema.	F 328		

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F 328	Continued From page 28 The risk of dilutional states is inversely proportional to the electrolyte concentration of administered parenteral solutions. The risk of solute overload causing congested states with peripheral and pulmonary edema is directly proportional to the electrolyte concentrations of such solutions. Geriatric Use: Clinical studies of Potassium Chloride in Dextrose Injection, USP In general, dose selection for an elderly patient should be cautious, usually starting at the low end of the dosing range, reflecting the greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy. These drugs are known to be substantially excreted by the kidney, and the risk of toxic reactions to these drugs may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function. PRECAUTIONS Potassium replacement therapy should be guided primarily by serial electrocardiograms. Plasma potassium levels are not necessarily indicative of tissue potassium levels. High plasma concentrations of potassium may cause death through cardiac depression, arrhythmias or arrest. Potassium-containing solutions should be used with caution in the presence of cardiac disease, particularly in digitalized patients or in the presence of renal disease. Care should be exercised to insure that the needle (or catheter) is well within the lumen of the vein and that extravasation does not occur. Nausea, vomiting, abdominal pain and diarrhea	F 328		

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F 328	Continued From page 29 have been reported with potassium therapy. The signs and symptoms of potassium intoxication include paresthesias of the extremities, flaccid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, hypotension, cardiac arrhythmias, heart block, electrocardiographic abnormalities such as disappearance of P waves, spreading and slurring of the QRS complex with development of a biphasic curve and cardiac arrest. There were no physician visits or notes from 8-23-17 until the night of 8-28-17 (5 days later) after the survey team had entered, found and discussed with staff the issues with IV care for Resident #1, and surveyors had left the building for the night. The doctor diagnosed sepsis, from pneumonia and the UTI, and hyponatremia (low sodium), which was incorrect, the Resident actually was hypernatremic (high sodium) and there was no mention of the hypokalemia (low potassium) in the progress note. Physician orders were reviewed and revealed new orders on 8-29-17 for Potassium chloride 10 meq (milliequivalents) IV for 2 doses, due to low potassium STAT (give immediately) order, then the order was changed to Potassium chloride 20 meq (milliequivalents) IV in dextrose 5% - 1/2 normal saline solution at 75 ml per hour for 1 liter bag dose, due to low potassium, after a stat BMP result is reported to the MD (doctor). The Resident had been hypokalemic for 5 days at this point, and the blood potassium issue had worsened. The physician was interviewed on 8-30-17 at 9:00 a.m., The doctor was asked why no potassium had been given on 8-24-17 when labs showed	F 328		

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F 328	Continued From page 30 hypokalemia. The doctor stated that some of the fluids that he ordered, and potassium for IV administration, had not been available to the facility at the time of his order, because nursing homes don't usually infuse potassium IV. He further stated that he had changed orders to accommodate the facility in regard to IV fluids as well, because they were having trouble getting Dextrose 5% with 1/2 normal saline, so he ordered just 5% dextrose instead. He was further asked why IV antibiotics had not been given timely, and he stated that the PICC line had taken awhile to be instilled in the Resident. When asked if these things could have been accomplished in a more timely manner for this Resident who was now septic, he stated "yes", she could have been sent to the hospital where these things would have been received immediately. The facility policy on medication administration was reviewed, and stated that doctor's orders must be followed. In summary of the evidence provided by the facility, Resident #1 was acutely ill with pneumonia, and a UTI. The Resident was not drinking or eating, and was unable to consume antibiotics by mouth for 5 days. Potassium IV, and ordered hydration fluids were not administered timely, and care was delayed because the facility was unable to provide the necessary services. The Resident was not transferred to an acute care setting (hospital) where those services could be provided timely. Fluids were unavailable because of lack of IV access for atleast 12 hours. The Rocephin IV antibiotics were not administered from 5:00 a.m. 8-27-17 until the Levaquin was available at 9:00	F 328		

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F 328	Continued From page 31 p.m. on 8-28-17 (40 hours). By this time the Resident had been seen again by the doctor, and diagnosed as "Septic". Medications such as IV potassium were unavailable in this setting as needed, and no monitoring or EKG's (electrocardiograms) were performed before, during or after the potassium infusions. The facility was notified of this deficient practice on 8-28-17, 8-29-17, and 8-30-17 at the end of day debrief. No further information was provided by the facility.	F 328		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on staff interview, the facility staff failed to ensure staff were trained in emergency procedures. Licensed Practical Nurse D (LPN D), and Certified Nursing Assistant A (CNA A) could not describe fully what response should be made to fire, disaster, and elopement protocols. The findings included: LPN D, and CNA A were interviewed by phone on 8-29-17 at 11:30 p.m. They both identified themselves, and were asked to describe what to do if a fire alarm sounded. Neither could state "Extinguish the fire" and continued to say	F 518		

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LEEWOOD HEALTHCARE CENTER	7120 BRADDOCK ROAD ANNANDALE, VA 22003

(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 518	Continued From page 32 "evacuate". When asked if they had emergency power, they stated yes at the nursing station, and seemed unaware of any other emergency power outlets for Resident use. When asked about elopement protocols both stated they would report to the supervisor, and the supervisor would report to the administrator, and the administrator would "call the state." Neither could answer how long that would take, and could not describe that police would be called even with cueing from the surveyor about calling the police if a Resident could not be located. The issues were reviewed with the Administrator, and Director of Nursing at the end of day meeting on 8-30-17.	F 518		