WOODBINE
REHABILITATION AND HEALTHCARE

Mr. Rodney L. Miller, LTC Supervisor
Division of Long Term Care
Department of Health
Office of Licensure and Certification
9960 Mayland Drive
Suite 401
Richmond, Virginia 23233
Rodney.Miller@vdh.virginia.gov

Via Email and Federal Express

July 7, 2017

Dear Mr. Miller,

Enclosed you will find the Plan of Correction for Woodbine Rehabilitation and Healthcare Center for the deficiencies noted during the Standard Survey ending on June 22, 2017. I hope that you find our plan of correction satisfactory.

I wish to take this opportunity to commend your Survey Team for their professionalism and expertise during the duration of survey.

Please feel free to contact me directly if you have any questions.

Sincerely,

Donna Shaw, Administrator
703-837-6501

Enclosure: Plan of Correction

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495019	A. BUILDING _____ B. WING _____	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBINE REHABILITATION & HEALTHCARE CENTER	2729 KING ST ALEXANDRIA, VA 22302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/20/17 through 06/22/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 303 certified bed facility was 257 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents 1 through 27) and 4 closed record reviews (Residents 28 through 31).	F 000	Woodbine shares the state focus on the health, safety, and wellbeing of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, it has implemented its plan of correction to demonstrate its continuing efforts to provide quality care to its residents. Any area cited by the survey team is placed into our Continuing Quality Improvement/Quality Assurance and Process Improvement process and monitored through this system to assure compliance.	
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 care plan, and the residents' choices, including but not limited to the following: (k) Pain Management.	F 309	**F 309** **Corrective Action** 6.21.17 Resident #24: Resident #24's physician was called to clarify the order for the antihypertensive medication. Based on the clarified order, the physician was made aware of the missed dose; there were no new orders given from the MD related to the missed dose. The clarified order was then entered into the Electronic Medical Record for the antihypertensive medication to be given twice per day. Another order	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 7.7.17

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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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 document review, and clinical record review, the facility staff failed to ensure the highest practicable well-being for 2 of 31 Residents, Residents #24 and #6.

The findings included.

1. For Resident #24, the facility staff failed to administer the Residents hypertensive medication as ordered on 06/20/17.

The record review revealed that Resident #24 had been admitted to the facility 01/12/2011. Diagnoses included, but were not limited to, hypertension, asthma, dementia, dysphagia, and peripheral vascular disease.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/05/2017 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points.

F 309 was entered for the residents' blood pressure and heart rate to be checked once per week. The resident representative was notified of resident missing one dose of the medication and the clarified orders.
Resident # 6:
Resident #6 was assessed by the RN unit manager on 6/21/17 at 4p.m. The residents' abdomen was noted to be soft not distended with positive bowel sounds in all four quadrants. The RN determined that Resident #6's bowel status were within normal limits. The attending physician was notified and no new orders were received. The resident representative was notified.

Identification

Resident #24 8.4.17

All current physician orders for hypertensives medications on the unit where Resident # 24 resides will be audited for accuracy.
Resident #6
Bowel movement records will be audited for all residents residing on the same unit as Resident #6. For

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On 06/21/2017 beginning at approximately 9:35 a.m. the surveyor observed LPN (licensed practical nurse) #1 during a medication pass and pour observation. Immediately after this observation the surveyor reconciled Resident #24's medications. This reconciliation revealed that the instructions on the eMAR (electronic medication administration record) for the hypertensive medication metoprolol had been changed on 06/20/2017 to read one time a week on Monday's.

After this reconciliation the surveyor interviewed LPN #1 regarding the order. LPN #1 verbalized to the surveyor that the pharmacy had called regarding the order and she was in the process of checking the order.

The surveyor then asked the DON (director of nursing) about the order.

On 06/21/2017 at approximately 1:15 p.m. the DON verbalized to the surveyor that the physician had changed the parameters on the order to read blood pressure and heart rate once a week on Mondays as these had been stable for some time. She then stated the nurse incorrectly entered the information into the electronic record resulting in the Resident missing his evening dose of metoprolol on 06/20/2017. The DON provided the surveyor with a copy of a medication error that had been completed on 06/21/17 at 12:29 p.m. and a progress note completed by RN (registered nurse) #1 indicating the nurse practitioner and responsible party had been notified of the error. The Residents blood pressure had also been documented as being 122/72 heart rate 71.

any resident found not to have had a BM documented within three days and without documentation of offering a PRN medication for relief; the nurse will complete an abdominal assessment including listening for bowel sounds and palpation. Clinical findings will be addressed as appropriate.
All licensed nurses will be re-educated on order entry medications and competencies will be conducted on each nurse to ensure all are able to enter orders correctly.
Licensed nurses and C.N.As will be educated on documentation and routine monitoring of bowel movements. Nurses will offer ordered PRN medication when there are no Bowel Movements for three days per policy.

Systemic Change

Resident #24

Night shift nurses will review the new day and evening shift orders for accuracy of entry of orders into the Electronic Medical Record. A completed audit will be submitted daily to unit managers or designee. Unit Manager or designee will clarify any unclear

8.4.17

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The administrative staff was notified of the medication error involving Resident #24 during a meeting with the survey team on 06/21/2017 at approximately 2:10 p.m.

No further information regarding this issue was provided to the surveyors prior to the exit conference.

2. For Resident #6 the facility staff failed to follow physician's orders for the administration of prn (as needed) medication for constipation.

Resident #6 was admitted to the facility on 09/08/16 and readmitted on 09/30/16. Diagnoses included but not limited to hypertension, dysphagia, aphasia, pressure ulcer, peripheral vascular disease, anorexia, acute kidney failure, gastroesophageal reflux disease, anemia, chronic kidney disease, depression, hip fracture, and cerebrovascular accident.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/10/17 coded the Resident as having both long and short term memory impairment with moderately impaired skills for daily decision making. This is a quarterly MDS. Resident #6's CCP (comprehensive care plan) was also reviewed at this time and contained a care plan for "constipation risk" which read in part "Administer stool softeners and laxatives as ordered. Record results when laxatives are administered."

Resident #6's clinical record was reviewed on 06/06/17. It contained a signed physician's order summary which read part "Dulcolax (bisacodyl) [OTC] suppository; 10mg; amt: 10mg; rectal Special instruction: one time daily PRN". Resident #6's MAR's for the months of

orders with the ordering physician.

Unit Manager will report any errors of transcription through the facility medication error reporting system. The ADON or designee will monitor errors of transcription weekly. and report the results to the Director of Nursing.

Resident #6

On the unit where resident #6 resides, the Unit manager or designee will review the bowel movements records twice per week (Monday and Thursday). Any resident without a bowel movement documented for three days will receive a laxative per physician order. 8.4.17

Monitoring

The Director of Nursing will review reports of any transcription errors found in the weekly report and will review the "no bowel movement" report from the Electronic Medical Record system biweekly. A quarterly report of compliance with Electronic Medical Record order entry and compliance with bowel protocols will be submitted to the quarterly QAPI Committee for review, discussion and recommendation. 8.4.17

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January-June were reviewed and contained an entry which read in part "Dulcolax (bisacodyl) [OTC] suppository; 10mg; amt: 10mg; rectal Special instruction: one time daily PRN". This entry had not been signed at any time as having been administered.

Resident #6's BM (bowel movement) records for the months of January-June were reviewed. For the month of January, there were 3 episodes where the Resident went longer than 3 days without a BM (01/10-01/18-total of 8 days, 01/23-01/27-total of 4 days, and 01/28-02/01-total of 4 days). For the month of February, there were 2 episodes where the Resident went longer than 3 days without a BM (02/05-02/14-9 days and 02/24-03/10-5 days). For the Month of March, there were 2 episodes where the Resident went longer than 3 days without a BM (03/09-03/170-7 days and 03/18-03/24-7 days). For the Month of April there were 3 episodes where the Resident went longer than 3 days without a bowel movement (04/06-04/10-4 days, 04/13-04/17-4 days, and 04/21-04/27-6 days). For the month of May there were 2 episodes where the Resident went longer than 3 days without a BM (05/05-05/15-5 days and 05/27-06/01-5 days).

Surveyor requested but was not provided a copy of the facility bowel protocol.

The concern of the facility staff not following physician's orders was discussed with the administrative staff during a meeting on 06/21/17 at approximately 1600. No further information was provided prior to exit.

F 312 SS=D 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS

F 312 **F 312**

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F 312	Continued From page 5 (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to provide personal care for 1 of 31 residents (Resident #15). The findings include: The facility staff failed to provide Resident #15 with personal care to include grooming. Resident #15 was observed with long whiskers on her chin. Resident #15's clinical record was reviewed 6/20/17 and 6/21/17. Resident #15 was admitted to the facility 5/4/13 and readmitted 6/14/17 with diagnoses that included but not limited to fractured right hip, Alzheimer's disease, dementia without behavioral disturbances, anxiety, osteoarthritis, Vitamin D deficiency, dysphagia, pressure ulcer left heel, urinary tract infection, seizures, and major depressive disorder. Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/2/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Section G Functional Status assessed Resident #15 to require extensive assistance of one person for personal hygiene and total dependence on one person for bathing.	F 312	**Corrective Action** Resident #15 was shaved on 6/21/17. The assigned C.N.A was counselled for not ensuring that the resident was well groomed, specifically female facial hair. **Identification** All female residents on the unit where resident #15 resides were assessed for proper grooming, including facial hair. All other female residents were found to be well-groomed and free of facial hair unless otherwise indicated in their individualized care plan. **Systemic Change** Certified nursing assistants were re-educated on personal care, including grooming with emphasis on shaving female residents unless otherwise specified in their individualized care plan. Unit managers or their designee will monitor grooming of female residents for facial hair daily on their routine rounds. **Monitoring** ADON or designee will inspect female residents on the unit where resident #15 resides daily. Variances in grooming standards will be reported to DON for	6.21.17 6.22.17 6.27.17 8.4.17

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F 312	Continued From page 6	F 312	remediation, including counselling and re-education. A quarterly report of compliance will be submitted to the QAPI committee for review, discussion and recommendation.	

Resident #15's comprehensive care plan dated 1/14/2015 and edited 6/1/17 included the problem category: ADL (activities of daily living) and read "Resident has demonstrated fluctuations in the amount and type of assistance needed for ADL. Resident's function varies due to impaired cognition and impaired mobility. Interventions: Honor resident preferences for bathing, eating and personal hygiene. If resident is resisting/refusing care, leave in a safe position and return later to attempt care."

The surveyor observed Resident #15 on 6/20/17 at 11:50 a.m. The resident was lying in bed, eyes closed. The surveyor observed on the resident's chin, jaw line, and upper lip approximately ½ inch gray/white facial hair. The facial hair appeared to be thick and coarse.

The surveyor observed Resident #15 again on 6/21/17 at 8:10 a.m. Resident #15 was observed in bed, neat, clean. Eyes were closed. The surveyor noted facial hair again on the chin, jaw line and upper lip. The hair was approximately ½ inch in length.

The surveyor reviewed the ADL flow sheets since readmission on 6/14/17. The ADL Category Report flow sheets documented Resident #15 required extensive to total assistance of one person for personal hygiene. The ADL Category Report had documentation that Resident #15 received daily bed baths from 6/14/17 through 6/20/17. There was no documentation to indicate the resident had refused personal hygiene care from 6/14/17 through 6/21/17.

The surveyor interviewed certified nursing assistant #1 (CNA #1) on 6/21/17 at 9:00 a.m. if

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Resident #15 resisted care. CNA #1 replied sometimes Resident #15 will resist care. C.N.A. #1 stated she would leave and return later and try to shave the resident.

The surveyor interviewed the unit manager (licensed practical nurse #1) on 6/21/17 at 11:25 a.m. The unit manager stated she would expect the residents to be shaved unless resistant to care and then the staff would try again.

The surveyor informed the administrator, the director of nursing, and the assistant administrator of the above concern during the end of the day meeting on 6/21/17 at 2:10 p.m. and again on 6/22/17 at 10:05 a.m.

No further information was provided prior to the exit conference on 6/22/17.

F 314 SS=D 483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

(b) Skin Integrity -

(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-

(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers

F 314 **F 314**

Corrective Action

Ordered protective devices were applied to Residents #6 and #15 immediately. The physicians of resident #6 and resident #15 were notified and no new orders were received. The resident representative of resident #6 and #15 were notified. Care plans and treatment orders for both residents were reviewed with the caregiving staff. 6.21.17

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from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review the facility staff failed to provide pressure area prevention for 2 of 31 Residents, Resident #6 and # 15.

The findings included:

For Resident #6, the facility staff failed to ensure Resident was wearing physician ordered heel protectors.

Resident #6 was admitted to the facility on 09/08/16 and readmitted on 09/30/16. Diagnoses included but not limited to hypertension, dysphagia, aphasia, pressure ulcer, peripheral vascular disease, anorexia, acute kidney failure, gastroesophageal reflux disease, anemia, chronic kidney disease, depression, hip fracture, and cerebrovascular accident.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 04/10/17 coded the Resident as having both long and short term memory impairment with moderately impaired skills for daily decision making. This is a quarterly MDS. Resident #6's CCP (comprehensive care plan) was also reviewed at this time and contained a care plan for "pressure ulcer" which read in part "Treatments as ordered. See TAR (treatment administration record)".

Resident #6's clinical record was reviewed and contained a signed POS (physician's order summary) which read in part "Heel protector to both heels every shift". The Resident's TAR was reviewed and contained an entry which read in

Identification

Any resident on the unit where resident #6 and resident #15 reside who have physician orders for heel protectors ("boots") were visually inspected for proper placement by the Unit Manager. No other residents were found to be without ordered protective devices. 6.21.17

Systemic Change

Unit managers, licensed staff and C.N.As will be in-serviced on the importance of following physician's orders to prevent the development of pressure ulcers. Any resident with physician orders for heel protectors will have the device added to resident profile in the Electronic Medical Record to ensure the C.N.As have the information to be in compliance. 8.4.17

Monitoring

The ADON or designee will randomly inspect 20% of residents with orders for protective devices weekly on the units where Resident #6 and Resident #15 reside and reported to the Director of Nursing. A quarterly report of compliance to the skin prevention plans on these two units will be 8.4.17

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part "Heel protector to both heels every shift". This entry had been signed as having been administered each shift for the month of June.

Surveyor observed Resident #6 on 06/20/17 at approximately 1135. Resident was seated in wheelchair, in hallway. Resident only had heel protector on R (right) foot. Surveyor observed Resident #6 again on 06/20/17 at approximately 1610. Resident was seated in wheelchair, in dining room. Resident only had heel protector on R foot. Surveyor observed Resident #6 on 06/21/17 at approximately 0805. Resident was seated in wheelchair in dining room, heel protector in place to R foot only. Surveyor spoke with unit manager regarding Resident #6's heel protector. Unit manager stated that Resident #6 was only supposed to wear both heel protectors while in bed. Surveyor showed unit manager the order stating "to both heels every shift". Unit manager stated that she would get the other heel protector for Resident #6.

The concern of the missing heel protector was discussed with the administrative team during a meeting on 06/21/17 at approximately 1600. No further information was provided prior to exit.

2. The facility staff failed to follow physician's order to apply a boot to the left foot while in and out of bed for Resident #15.

Resident #15's clinical record was reviewed 6/20/17 and 6/21/17. Resident #15 was admitted to the facility 5/4/13 and readmitted 6/14/17 with diagnoses that included but not limited to fractured right hip, Alzheimer's disease, dementia without behavioral disturbances, anxiety, osteoarthritis, Vitamin D deficiency, dysphagia, pressure ulcer left heel, urinary tract infection,

F 314 submitted quarterly to the QAPI Committee for further review, discussion and recommendations.

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seizures, and major depressive disorder.

Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/2/17 assessed the resident with short term memory problems, long term memory problems, and severely impaired cognitive skills for daily decision making. Section G Functional Status assessed Resident #15 to require extensive assistance of one person for bed mobility and personal hygiene, total dependence on one person for bathing, and total dependence on two people for transfers. Section M Skin Conditions assessed Resident #15 to be at risk for pressure ulcers.

Resident #15's current comprehensive care plan initiated 1/14/2015 and edited 6/20/17 identified the category of "Pressure Ulcers. Approaches: Apply boot to left foot while in and out of bed."

The surveyor observed Resident #15 on 6/20/17 at 11:50 a.m. The resident was lying in bed, eyes closed. The surveyor did not observe any type of boot on Resident #15's left foot.

The surveyor observed Resident #15 again on 6/21/17 at 8:10 a.m. Resident #15 was observed in bed, neat, clean. Eyes were closed. The surveyor did not observe any type of boot on Resident #15's left foot.

The surveyor interviewed certified nursing assistant #1 about the boot for Resident #15's left foot on 6/21/17 at 9:00 a.m. C.N.A. #1 pulled the covers back from the resident's lower extremities. Both feet were placed on a pillow for elevation but there was no boot. C.N.A. #1 checked Resident #15's closet. C.N.A. #1 found two boots in the

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closet.

The surveyor interviewed licensed practical nurse #1 on 6/21/17 at 9:05 a.m. L.P.N. #2 stated Resident #15 did not have the left foot boot on when she observed the resident with the surveyor.

The surveyor interviewed the unit manager (licensed practical nurse #1) on 6/21/17 at 11:25 a.m. The unit manager stated she would expect the resident to have the boot on unless the boot was dirty.

The surveyor informed the administrator, the director of nursing, and the assistant administrator of the above concern during the end of the day meeting on 6/21/17 at 2:10 p.m. and again on 6/22/17 at 10:05 a.m.

No further information was provided prior to the exit conference on 6/22/17.

F 332 SS=D 483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

(f) Medication Errors. The facility must ensure that its-

(1) Medication error rates are not 5 percent or greater;
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and during a medication pass and pour observation the facility staff failed to ensure a medication error rate of less than 5%. There were 5 errors in 25 observations, resulting in a medication error rate

F 332 **F 322**

Corrective Action

Resident #19 was assessed for any adverse effects of late medication administration. No adverse effects were noted. The MD was notified that the medications were administered late and the resident had no adverse effects. No new orders were received. The resident representative was notified. 6.21.17

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of 20% affecting 1 of 31 Residents, Resident #19.

The findings included:

For Resident #19 the facility staff failed to administer medications within the established time frames.

Resident #19 was admitted to the facility on 06/02/17. Diagnoses included but not limited to anemia, atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, hypothyroidism, cataracts, and peripheral vascular disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/09/17 coded the Resident as 10 out of 15 in section C, cognitive patterns. This is an admission MDS.

Surveyor observed Resident #19 receiving her medications during a routine medication pass and pour completed by LPN (licensed practical nurse) #1 on 06/20/17 at approximately 1140. Some of the medications observed being administered were famotidine 20mg, magnesium oxide 400mg 2 tabs, metoprolol 50mg, Senna 8.6 mg, and Vitron C 65mg/125mg. Surveyor observed LPN #1 chart medications immediately after administering as "charted late, administered on time" on the eMAR (electronic medication administration record).

Resident #19's medications were reconciled with the clinical record on 06/20/17 at approximately 1200. The clinical record contained a signed POS (physician's order summary) which read in part "famotidine tablet 20mg;amt: 1 TAB;oral. Twice a day at 9:00 am and 5:00 pm, magnesium oxide

Identification

Reports of medication administration compliance will be run by the Unit Manager/Nurse Supervisor or designee each shift on the unit where Resident #19 resides. 8.4.17

Systemic Change

Mandatory in-services will be conducted for licensed nurses to reinforce using appropriate medication pass protocols. Licensed nurses will be required to be observed for med passes. Any nurse found to have an error rate of <95% will be re-educated and be observed for med passes on weekly basis until 95% goal achieved deemed competent. Medication pass times will be individualized as appropriate to allow for timely medication administration. 8.4.17

Monitoring

The ADON or designee will observe a random medication pass weekly and send a report to the Director of Nursing. A quarterly report of observed medication pass rate will be submitted to the QAPI committee for further review, discussion and recommendations. 8.4.17

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tablet; 400mg; amt: 2 TABS; oral. Twice a day at 9:00 am and 5:00 pm, metoprolol tartrate tablet; 50mg; amt: 1 TAB; oral. Every 12 hours 9:00 am and 5 pm, Senna Plus tablet; 8.6-50mg; amt: 1 tab; oral. Twice a day 9:00 am and 5 pm, and Vitron C (iron, carbonyl-vitamin C) tablet, delayed release; 65mg iron-125mg; amt: 1 tablet; oral. Twice a day 9:00 and 5:00". The Resident's eMAR was reviewed and contained entries which read in part "famotidine tablet 20mg;amt: 1 TAB;oral. Twice a day at 9:00 am and 5:00 pm, magnesium oxide tablet; 400mg; amt: 2 TABS; oral. Twice a day at 9:00 am and 5:00 pm, metoprolol tartrate tablet; 50mg; amt: 1 TAB; oral. Every 12 hours 9:00 am and 5 pm, Senna Plus tablet; 8.6-50mg; amt: 1 tab; oral. Twice a day 9:00 am and 5 pm, and Vitron C (iron, carbonyl-vitamin C) tablet, delayed release; 65mg iron-125mg; amt: 1 tablet; oral. Twice a day 9:00 and 5:00". Each of these entries had been initialed with the notation of "charted late, administered late" with a time of 11:58 am.

Surveyor requested and was provided with a copy of policy entitled "Medication Administration" which read in part "Procedure: 1. Medications are given at the time ordered or within one (1) hour before or after the time designated. 2. The medication shall be charted as soon after administration as possible." Surveyor was also provided with a copy of "Medication Schedule" which read as follows:

Abbreviation	Interpretation	Adm. Times
b.i.d.	twice a day	9:00 am-6pm
q12h	every 12 hours	9:00 am-9:00 pm

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Surveyor spoke with LPN #1 on 06/21/17 at approximately 0955 regarding Resident #19. LPN #1 stated that she had realized her mistake in charting and changed it. Surveyor asked LPN #1 what her normal procedure was for administering medications and LPN #1 stated that she pulls the medications from the cart, prepares them for administration, administers them to the Resident, then charts the administration immediately after.

The concern of administering the medications outside the established time frame was discussed with the administrative staff during a meeting on 06/21/17 at approximately 1600.

No further information was provided prior to exit.

F 333 SS=D 483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

483.45(f) Medication Errors.

The facility must ensure that its-

(f)(2) Residents are free of any significant medication errors.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review the facility staff failed to ensure 1 of 31 Residents was free of significant med error, Resident #19.

The findings included:

For Resident #19 the facility staff failed administer the long-acting insulin Humulin as ordered by the physician.

F 333

F 333

Corrective Action

The physician of resident #19 was notified of the blood sugar results and the medication not being given on 6/2/2017. No new orders were received. The resident representative was notified. The nurse that documented that the medication was unavailable was re-educated on process for obtaining first dose and time sensitive medications from the "STAT box". 6.23.17

Identification

On the unit where resident #19 resides, the Electronic Medication Administration Records (eMARs) for new admissions will be audited for timely availability of 8.4.17

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Resident #19 was admitted to the facility on 06/02/17. Diagnoses included but not limited to anemia, atrial fibrillation, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, hypothyroidism, cataracts, and peripheral vascular disease.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 06/09/17 coded the Resident as 10 out of 15 in section C, cognitive patterns. This is an admission MDS.

Resident #19's clinical record was reviewed on 06/21/17. It contained a signed physician's order summary which read in part "Humulin 70/30 (insulin nph and regular human) suspension; 100 unit/ml (70/30); amt: 5 units; subcutaneous, once an evening 6:00 pm". Resident #19's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part "Humulin 70/30 (insulin nph and regular human) suspension; 100 unit/ml (70/30); amt: 5 units; subcutaneous, once an evening 6:00 pm". This entry had been initialed for 06/02/17 with parentheses around the initials. The comment section of the eMAR this entry read in part "06/02/17 6:00 pm 06/02/2017 07:08 pm Not administered: Drug/item unavailable".

The surveyor requested and was provided with a copy of the medications available in the stat box. This list contained an entry which read in part "Humulin 70/30 mix 100u/ml 10ml inj".

The concern of not administering the scheduled insulin was discussed with the administrative staff during a meeting on 06/22/17 at approximately 1000.

medications daily by the Unit Manager or designee.

Systemic Change

Mandatory in-servicing will be conducted for licensed nursing staff on availability of insulin in stat box (Omnicell) and physician notification for medications that are not available. On the unit where resident #19 resides, the Unit Manager or their designee will audit the eMAR's of new insulin orders of the residents daily. The Director of Nursing, physician and resident representative will be notified of variances. 8.4.17

Monitoring

The nursing supervisor or designee will print administration records for new admissions with orders for insulin to ensure administration consistent with residents' ordered diabetic management. Any variances will be reported to the Unit Manager, physician, and resident representative. The ADON or designee will audit 10% of residents admitted with insulin orders weekly and report compliance to the Director of Nursing. A quarterly report of 8.4.17

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No further information was provided prior to exit.

F 371 SS=D 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, the facility's staff failed to store, prepare and serve food in a safe and sanitary manner in the kitchen.

The findings include:

The initial tour of the kitchen was conducted on 6/20/17 at 9:15 am. The dietary manager gave

F 333 compliance will be submitted to the QAPI committee for review, discussion and recommendations.

F 371

F 371

Corrective action

Immediate action was taken: 6.22.17
Ice Cream Freezer: The items that were in the freezer were removed and discarded. The freezer was locked out/tagged out.
Maintenance service request was issued.
Food Temperatures: the employee that took the tray line temperatures received re-education on proper technique for taking food temperatures.
Dish machine: When the issue was identified, the dietary staff immediately implemented the alternate sanitation method to ensure that items being sent through the dishwasher received proper sanitation. Contractor came on site on 6/21/2017 to inspect rinse cycle and was not able to resolve the issue. Dietary staff were instructed to continue to utilize the alternate sanitization method until issue resolved.
Another contractor was contacted by facility staff and scheduled to

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the tour of the kitchen. The dishwasher was first observed the temperature for the rinse cycle did not reach 180 degrees during the observation. The dietary manager told the staff to do a final rinse in sanitation solution. She also contacted the maintenance department to check the dishwasher.

The refrigerators and freezers were observed. The walk-in-freezer door was coated with ice crystals and the temperature was 19 degrees not 0 or below, however the food was frozen hard. There were multiple stored boxes noted in the freezer. The walk in refrigerator was at 41 degrees but there was paper noted on the floor. Coolers #1, #2, and #4 were above 41 degrees. The dietary manager said the staff is in an out of them right now. The surveyor informed the dietary manager she would return and recheck the coolers and remaining freezers at a later time.

On 6/20/17 at 10:30, the surveyor returned to the kitchen she began rechecking the coolers and freezers.
The ice cream freezer was found to be at 22 degrees and the ice cream was soft and when the side of the ice cream cartons were pressed the ice cream oozed out around the lid. The dietary manager said she would move the ice cream to the walk in freezer.

The surveyor requested another surveyor return with her to the kitchen, to check the ice cream and the cooler. When the surveyors entered the kitchen and checked the ice cream, the dietary manager informed the surveyor she would throw the ice cream out.

The surveyor observed the dietary staff rinsing

come on-site for servicing.
Walk-in Freezer: Ice build-up around door perimeter was removed and the door seal was removed and replaced.

Identification

In order to ensure that no other residents would have potential for being affected, the following steps were taken. Dietary staff were in-serviced on: 8.4.17
Proper taking of freezer temperatures and when to discard food being stored in a freezer which is not maintaining proper temperature to keep food frozen solid and proper technique for lock-out/tag-out.
Initiation of alternate sanitization methods when final rinse cycle does not reach 180 degrees F and to continue the alternate method until the dishwasher was able to maintain the rinse cycle 180 degrees F for the duration of the cycle.
Sanitary methods to taking food temperatures cooks and supervisors will be observed for competency of proper technique.
Identification and removal of ice build-up of freezer doors. All freezers were checked to ensure

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the dishes in a sanitation solution. The dietary supervisor tested the solution for the surveyor and it was found to be at 400 ppm.

At 12:00, the surveyor returned to the kitchen to check the tray line temperatures. The dietary supervisor checked the temperatures when the surveyor asked if someone would check them. All the temperatures were correct but he placed the thermometer in the pan of mashed potatoes and in the carrots allowing the plastic top to touch the food. When he checked the corn he touched the probe of the thermometer with his bare hand while it was still in the corn.

After the tray line temperatures were completed the surveyor accompanied the dietary manager to the walk in freezer to recheck the temperature. It was down to 12 degrees. Some of the boxes stacked in the middle of the freezer had fallen onto the floor. The dietary manager stated, "My guys must have done this."

On 6/21/17, the surveyor returned to the kitchen to find the dishes were still being hand dipped in the sanitation solution because the dishwasher was not reaching 180 degrees. The ice cream freezer was not fixed.

On 6/22/17 the administrator informed the surveyor that maintenance put a new seal around the walk in freezer door after removing the ice crystals. She also shared that the ice cream cooler was to be replaced and the dishwasher contractor was to come and fix the dishwasher. On 6/20/17 at 4:00 pm, the administrator, director of nurse and other administrative staff were informed of the issues and concerns found in the kitchen.

proper temperatures were maintained and ice was not building up around the door perimeters. No other freezer was found out of compliance.

Systemic change

New signage will be added to the front of all freezers indicating the required temperature range and steps to take if temperature found out of proper range. Lock-out/Tag-out checks will be added to the daily opening and closing check-list. 8.4.17

Annual competencies for taking food temperatures will be completed for cooks and supervisors.

Staff assigned to dish room will monitor dish machine temperature each hour during use and maintain a log. If temperature is found to be out of compliance manual sanitation procedure will commence and will immediately report issue to supervisor.

Freezer door check added to daily opening and closing checklist for check for ice buildup around perimeter.

Monitoring

To ensure compliance, the Dietary Manager or her designee will 8.4.17

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F 371	Continued From page 19 Prior to exit on 6/22/17 the surveyor was not provided further information related to the above issues in the kitchen.	F 371	complete the following and submit a weekly report to the Assistant Administrator: Inspect all freezers weekly to ensure that they are maintaining proper temperature without ice build-up around the perimeter. If any area is found out of compliance, immediate corrective action as appropriate will be taken. Monitor dish machine randomly once per week for 15 minutes to ensure temperatures for rinse cycle are maintaining to proper temperature. Any discrepancy will immediately activate the alternate sanitation method and any other appropriate action. 3 random observations of proper food temperature checks will be completed weekly. A compliance report will be submitted to the Quarterly QAPI committee for review, discussion and recommendation.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 514	**F514** **Corrective Action** Corrective action/education was provided to C.N.As assigned to resident # 4 who did not complete proper documentation of bowel movements accurately in the	6.30.17

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(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 1 out of 31 Resident's (Residents #4).
The facility staff failed to maintain accurate documentation to indicate that facility staff was monitoring Resident #4's bowel movements. Resident #4 was admitted to the facility on 11/23/11, with diagnoses that included but not limited to esophageal reflux disorder, bipolar disorder, fracture of the first lumbar vertebra, pain, high blood pressure, diabetes mellitus, and constipation.

A review of Resident #4's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 5/27/17, the facility staff assessed the resident to understand and to be understood. She was assessed to have a cognitive summary score of 15.

Resident #4's care plan with problem start date of 1/30/16, read in part under problem: Constipation risk;
Resident is at risk for constipation and GI (gastrointestinal) upset. Under Goal: Resident will maintain a pattern of bowel elimination of no less then every 3 days and will experience no discomfort related to constipation. Under approach it read: Administer stool softeners and laxatives as ordered. Record results when laxatives are administered.

The surveyor reviewed the bowel movement record that showed the resident had no bowel

Electronic Medical Record.

Identification

On the unit which resident #4 resides, a 100% audit will be conducted bowel movement records. For any resident found not to have had a bowel movement documented within three days and without documentation of offering a PRN medication for relief; the nurse will complete an abdominal assessment including listening for bowel sounds and palpation. Clinical findings will be addressed as appropriate. 8.4.17

Systemic Change

Licensed nurses and C.N.As will be in-serviced on accurate documentation of bowel movements in the Electronic Medical Records. 8.4.17
On the unit where resident #4 resides, the Unit manager or designee will review bowel movement records twice a week (Monday and Thursday). Any resident without Bowel Movements documented for three days will receive a laxative per physician order.

Monitoring

The Director of Nursing will review 8.4.17

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495019	A. BUILDING _____ B. WING _____	C 06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBINE REHABILITATION & HEALTHCARE CENTER	2729 KING ST ALEXANDRIA, VA 22302

(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 514	Continued From page 21	F 514	the "no bowel movement" report from the Electronic Medical Record system biweekly. A quarterly report of compliance with bowel protocols will be submitted to the quarterly QAPI Committee for review, discussion and recommendation.	

movements documented from 6/1/17 through 6/8/17. The form had the word "none" documented. The surveyor asked the director of nurses if there was documentation in the clinical record for bowel movements. She said "I will check the CNA's documentation."

Further review of the resident's clinical record revealed her physician's orders showed she had Senna with docusate sodium 8.6-50mg (milligram) 2 tablets every 12 hours as needed (PRN). She also had Bisacodyl 5 mg, 2 delayed release tablets PRN. The medication administration record did not show documentation that the medications had been given.

On 6/21/17, the director of nurses informed the surveyor of the following, "the CNA's aren't charting correctly for Resident#4".

On 6/21/17, at approximately 4:30 pm the survey team met with the administrative staff. The absence of accurate documentation to indicate that the facility staff were monitoring and treating concerns related to Resident #4's bowel function was discussed with the facility's administrator and director of nursing.

Resident #4 was interviewed on 6/22/17; she was asked how often her bowels moved. Resident #4 said, "About every day, I am not having a lot of diarrhea now, they have me on a new diet. This week I had one on Monday and Wednesday. At the first of June, I was having a lot of diarrhea."

Prior to exit at the on 6/22/17, no further information was provided to the surveyor related to the inaccurate bowel movement documentation.

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