				"IECEIVE-	
	MENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES		OUG 15 2016 PRINTED: 0	PROVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTODHOLC (X3) DATE S COMPLI	URVEY
	· ·	495019	B. WING	C 07/24	10040
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12010
WOODBI	NE REHABILITATION	& HEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302	أوري والمستعدد
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) OMPLETION DATE
F 000	INITIAL COMMENT	rs [.]	F 00	2016 STATE SURVEY PLAN OF CORRECTION	
,	survey was conduct 07/21/16. Five com- during this survey. (compliance with 42	Medicare/Medicaid standard ted 07/19/16 through uplaints were investigated Corrections are required for CFR Part 483 Federal Longments. The Life Safety Code Illow.	The company and the company an	Woodbine shares the state focus on the health, safety, and well-being 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.	
	259 at the time of the consisted of 27 curi	307 certified bed facility was ne survey. The survey sample rent Resident reviews 19th #27) and 7 closed record #28 through #34).	*** And Production an	The deficiencies cited by the surveyor will be put into the Continuing Quality Improvement/Quality Assurance and Process Improvement process and monitored through this system to assure compliance.	
		TO REFUSE; FORMULATE	F 15	5	
SS=D	ADVANCE DIRECT	TVES	<u>F 155</u>		
	The resident has th	e right to refuse treatment, to	,	REFUSE: FORMULATE	
	refuse to participate and to formulate an	e in experimental research, advance directive as uph (8) of this section.	Corrective	E DIRECTIVES Action:	٠
	specified in subpart related to maintaini procedures regardit requirements include	inply with the requirements I of part 489 of this chapter ng written policies and ng advance directives. These le provisions to inform and	reviewed fo appropriate and interdis	ns identified during survey were r accuracy and completed by after discussion with the RP, MD ciplinary team. on 7/21/16)	7/21/16
	concerning the right or surgical treatmer option, formulate ar includes a written d	nt advance directives and	affected; a residents forms. Any	ensure that no other residents were 00% audit will be conducted on DNR r accurate completion of the DDNR forms found out of compliance will with the resident, RP, MD and	

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Almini Frator

completed appropriately. (Completed by 8/31/16)

8/31/16 (X6) DATE

Any deficiency statement ending with a sterisk (*) 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.

Interdisciplinary team and

DEPARTMENT		AND HU SERVICES		•	RINTED: 08/03/2016 FORM APPROVED MB NO. 0938-0391		
STATEMENT OF DEI AND PLAN OF CORF	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
	.	495019	B. WING		C 07/21/2016		
NAME OF PROVID	ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBINE REHABILITATION & HEALTHCARE CENTER			·	2729 KING ST ALEXANDRIA, VA 22302			
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F 155 Con	inued From pa	ige 1	F	155:	· .		
by: Bas and the f accu 2 of #18 The 1. ensi	ed on staff into the Code of Vi acility staff failurate Durable I 34 Residents and #7. Findings Inclu	#18 the facility staff failed to and accurate Durable Do Not	The interpretation of the complete confere progres	erdisciplinary team and Attending ian will be re-educated on the proper etion of DDNR forms through in-servicing. eleted by 8/31/16) forms will be reviewed and discussed at re plan meeting for accuracy and proper tion; it will be documented in care note form note as well as in social services is notes that the Code Status was reviewed to the proper forms are in place.	8/31/16		
adminch den The loca ass (AR Res imp (2) of E	nitted on 5/26/1 uded, but were nentia, osteopo most current ited in the clinic essment with a D) of 7/4/16. Ident #18 had airment (1/1) a with daily deci	a 78 year old female who was 3. Admitting diagnoses not limited to: Alzheimer's, prosis, anxiety and dysphasia. Minimum Data Set (MDS) cal record was an Annual MDS an Assessment Reference Date The facility staff coded that short and long term memory and was moderately impaired sion making regarding Activities DL's) The facility staff also ent #18 required extensive with ADL's.	will aud resident If any fi reviewe attendin Any are quarterl	ector of social services or her designee dit the 100% DDNR forms and new its admitted weekly to ensure compliance. form was incorrectly completed, it will be and with the interdisciplinary team, RP and and MD and the form will be corrected. The sas of non-compliance will be reported by to QAPI team for discussion and further mendations. (Completed by 8/31/16)	8/31/16		

On July 19, 2016 at 3:50 p.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced a Durable Do Not Resuscitate (DDNR). The DDNR was dated 5/28/13. Review of the DDNR sheet revealed that the DDNR was not accurate/complete. The DDNR had not documented whether Resident

DEPARTMENT OF HEALTH AND HINN SERVICES

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F 155	Continued From pa	 200 2	F	155				
, ,	#18 was Capable of informed decision a	or Incapable of making an about providing, withholding or comment or course		155 ·				
	Durable Do Not Res Do Not Resuscitate physician for his par fide physician/patien the guidelines of the with the consent of a minor or is otherw informed decision re order, upon the requ	of Virginia § 512.1-2987.1. Suscitate Orders. A. A Durable of Order may be issued by a stient with whom he has a bona on the relationship as defined in the Board of Medicine, and only the patient or, if the patient is wise incapable of making an regarding consent for such an juest of and with the consent of the patient's					,,	
	notified a Licensed who was the Unit M DDNR was incorred reviewed the clinica surveyor reviewed to The surveyor pointed staff had not determ was Capable or Incodecision about proving the staff had not proving the staff had not determ was Capable or Incodecision about proving the staff had not determ was Capable or Incodecision about proving the staff had not determ was Capable or Incodecision about proving the staff had not determined the staff ha	t 3:55 p.m. the surveyor Practical Nurse (LPN #6) and Manager, that Resident #18's ct/inaccurate. The surveyor al record with LPN #6. The the DDNR with the LPN (#6). ed out that the physician/facility mined whether Resident #1 capable of making an informed riding, withholding or c medical treatment or course nt.						•
	with the Administrate Nurses (DON). The sadministrative Team	t 2 p.m. the survey team met tor (Adm) and Director of surveyor notified the n (AT) that the facility staff omplete and accurate DDNR						

No additional information was provided prior to

	TMENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES		0	PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-039
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NAME OF	PROVIDER OR SUPPLIER		' Т	STREET ADDRESS, CITY, STATE,	07/21/2016 ZIP CODE
WOODB	INE REHABILITATION	& HEALTHCARE CENTER	an annumentative state in State	2729 KING ST ALEXANDRIA, VA 22302	
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F 155	Continued From pa	ge 3	F 16	. ' EE	
	exiting the facility as to ensure a comple Resident #18.	the facility staff failed to		00	
	ensure a completed resuscitate) form.	I DDNR (durable do not			
	01/14/15 and readn included but not lim cerebrovascular ac	Imitted to the facility on nitted on 01/20/15. Diagnoses ited to hyperlipidemia, cident, dementia, epilepsy, dysphagia, glaucoma, and			
	an ARD (assessme coded the Resident	DS (minimum data set) with nt reference date) of 05/06/16 as 00 of 15 in section C, This is a quarterly MDS.			<i>.</i>
,	07/19/16. It contains 01/01/16 which read The clinical record a	al record was reviewed on ed a physician's order dated d in part "Code status: DNR". also contained a copy of the t of Health DDNR form which	, ! 		
	informed decision .	is CAPABLE of making an is INCAPABLE of making an			
	[] A. While capat decision, the patient advanced directive	ove, check A, B, or C below: ble of making an informed has executed a written he of making an informed	·		

decision, the patient has executed a written advanced directive which appoints a "Person

	MENT OF HEALTH	AND HU SERVICES					FORM	: 08/03/2016 APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT A. BUILDIN		ISTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
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F 155	Continued From pa Authorized to Conse	ge 4 ent on the Patient ' s Behalf "	F 15	5					
	[] C. The patient advanced directive	has not executed a written	:						
	DDNR form. The se DDNR form had be	cks in any of the boxes on the ection at the bottom of the en signed by the physician POA (power of attorney)."							
	07/20/16 at approxi	ith the administrative staff on mately 1330 the incomplete ought to their attention.							
,	surveyor with a com	of nursing) provided the inpleted copy of the DDNR approximately 1640.							
	No further informati 483.20(b)(1) COMP ASSESSMENTS	on was provided prior to exit. REHENSIVE	F 27	2	·		٠	•	
	a comprehensive, a	nduct initially and periodically ccurate, standardized ment of each resident's	F 272 COMPRE	<u>EHENST</u>	<u>VE ASSESSMENT</u>		TO Salada magaza.		
	resident assessment by the State. The assess the following:	a comprehensive sident's needs, using the sident's needs, using the at instrument (RAI) specified assessment must include at emographic information;	modified b	for residency the MI cumental	lents #14 and #15 were OS manager to reflect to tion in clinical record.	e he		7/20/16	
	Mood and behavior								

Mood and behavior patterns;

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MURTIPLE CONSTRUCTION						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED					
495019 B. WING	C					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	07/21/2016					
WOODBINE REHABILITATION & HEALTHCARE CENTER 2729 KING ST	~					
ALEXANDRIA, VA 22302						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOWS A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPLICATION DEFICIENCY)	OULD BE COMPLETION					
F 272 Continued From page 5 F 272						
Psychosocial well-being;						
Physical functioning and structural problems:						
Continence;						
Disease diagnosis and health conditions; In order to ensure that no other residents were						
Demai and nutritional status;						
OMIT OUTGINGS,	unit for the last quarter where residents #14					
riourity parouit,	and #15 resides for documentation of dates in clinical					
Special treatments and procedures; record for section V of the CAA summary. Any						
Discharge potential; areas of non-compliance will be reported to the						
Documentation of summary information regarding MDS Manager for correction and the staff						
the additional assessment performed on the care member that completed the MDS will receive areas triggered by the completion of the Minimum re-education. (Completed by 8/31/16)	8/31/16					
Data Set (MDS); and	0/31/10					
Documentation of participation in assessment.						
Systemic Change						
Mandatory re-education will be conducted for						
MDS nurses for documentation of dates in	•					
clinical record for section V of the Care Area						
Assessments. The MDS team will audit 20% of the MDSs completed monthly. Any errors found						
This requirement is not met as evidenced will be reported to the MDS manager and will be						
Dy:	•					
Based on staff interview and clinical record review, the facility staff failed to ensure a						
complete and accurate Minimum Data Set (MDS) (Completed by 8/31/16) for 2 of 34 residents (Residents #14 and #15).	8/31/16					
Monitoring						
The findings included: The MDS manager will audit 20% of completed						
MDSs. Any areas of non-compliance will be						
1. The facility staff failed to document the corrected and corrective action completed with						
dates of the documentation in Resident #14's the MDS nurse. A report of non-compliance will clinical record for Section V of the Care Area be submitted quarterly to the QAPI team for						
Assessment (CAA) Summary of the Minimum discussion and further recommendations.						
Data Set (MDS). (Completed by 8/31/16/)	8/31/16					

Resident #14 was admitted to the facility on 2/10/16 with the following diagnoses of, but not

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

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CENTER	RS FOR MEDICARE	& MEDI SERVICES			OMB NO. 0938-0391
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		495019	B. WING		C 07/21/2016
		& HEALTHCARE CENTER	272	REET ADDRESS, CITY, STATE, ZIP CO 29 KING ST .EXANDRIA, VA. 22302	
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	anxiety, respiratory ventilator, tracheost admission MDS (an ARD (Assessment is coded the resident is Mental Status) of 3 Resident #14 was a dependent on 2 or indressing, personal is The clinical record is on 7/19/16, at which MDS with ARD of 2/4 Area Summary (CA documented for Psy Physical Restraints, were noted to be do documented areas of nursing and assist notified of the above Resident #14 is clinical record in the model of the model.	d pressure, diabetes, aphasia, failure, dependent on tomy and gastrostomy. The n assessment protocol) with an Reference Date) of 2/17/16 with a BIMS (Brief Interview out of a possible score of 15. also coded as being totally more staff members for hygiene and bathing. was reviewed by the surveyor h time it was noted that on the 1/17/16, in Section V titled Care A) Summary, dates were not ychotropic Drug Use and . The locations of these areas ocumented in the above of the CAA Summary. Ind of the day conference with issistant administrator, director stant director of nursing were e documented findings in nical record.	Transmitted to the transmitted t		
	interviewed in the co approximately 6 pm. stated to the survey would have to "look doesn't happen aga provided to the surve education to the MD and Date Training the The surveyor was all corrected CAA Sumi	onference room at The MDS Coordinator or that she was new and k better and make sure this pain ". A sign in sheet was reyor that documented DS staff of the CAA Location nat was conducted on 7/20/16. Iso given a copy of the imary that had been corrected th the above documented			

, training.

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	PROVIDER OR SUPPLIER INE REHABILITATION	I & HEALTHCARE CENTER	272	REET ADDRESS, CITY, STATE, Z 19 KING ST EXANDRIA, VA 22302	IP CODE		i I/AU IV	
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F 272	Continued From pa	ige 7	F 272					
		ion was provided to the e exit conference on 7/21/16.	· · · · · · · · · · · · · · · · · · ·					
	of the documentation record for Section V	of failed to document the dates on in Resident #15 's clinical of the Care Area Summary of the Minimum						
-	5/17/16 with the following block of the state of the stat	readmitted to the facility on lowing diagnoses of, but not ia, seizure disorder, itory failure, stroke, kidney per, gastrostomy, and imission MDS (an assessment RD (Assessment Reference aded the resident with short memory problems and in decision making. Resident dias being totally dependent for dressing, personal hygiene						
	on 7/20/16, at which MDS with ARD of 5/ Area Summary (CA documented for Urin Pressure Ulcer and locations of these as	was reviewed by the surveyor in time it was noted that on the 1/24/16, in Section V titled Care (A) Summary, dates were not inary Incontinence, Falls, I Psychotropic Drug Use. The areas were noted to be above documented areas of						
	the administrator, as of nursing and assis	nd of the day conference with ssistant administrator, director stant director of nursing were e documented findings in	:::::::::::::::::::::::::::::::::::::::					

Resident #15 's clinical record.

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	UP DI ANI DE COPPECTION I INCINTERCATION NUMBER.		(X2) MUI A. BUILE		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
,	6 -	495019	B. WING	·			1	C 21/2016	
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WOODBI	NE REHABILITATION	& HEALTHCARE CENTER	and actions consumer		29 KING ST EXANDRIA, VA: 22302	**************************************		and the second second second second	
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F 272	Continued From pa	ge 8	· F:	272		•			
	stated to the survey would have to "loo doesn't happen ag with the information that documented the MDS staff of the CA that was conducted was also given a consummary that had time with the above	onference room at a. The MDS Coordinator yor that she was new and ok better and make sure this gain " . A sign in sheet along was provided to the surveyor e education provided to the A Location and Date Training on 7/20/16. The surveyor ppy of the corrected CAA been corrected at the same a documented training.							
F 309 SS=D	surveyor prior to the	ion was provided to the e exit conference on 7/21/16. CARE/SERVICES FOR EING	F	309			·/ *	, , ,	
	provide the necess or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment	(1) Correct Immediate the dialy	tive Ac ate cor ysis cer	rective action was taken by her to complete their part ent #21 and resident # 22.	of the Γhe			
	by: Based on observar document review, a facility staff failed to highest practicable (Resident #22, and	NT is not met as evidenced tion, staff interview, facility and clinical record review provide services for the well-being of 2 of 34 residents #21) ialysis services with facility	facility s the form	staff al	so completed the second p th residents. 7/21/16)	ortion of		7/21/16	

DEPARTMENT OF HEALTH AND HAMAN SERVICES PRINTED: 08/03/2016 CENTERS FOR MEDICARE & MEDICARE FORM APPROVED AID SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER-(X3) DATE SURVEY A. BUILDING COMPLETED C 495019 **B. WING** NAME OF PROVIDER OR SUPPLIER 07/21/2016 STREET ADDRESS, CITY, STATE, ZIP CODE **WOODBINE REHABILITATION & HEALTHCARE CENTER 2729 KING ST** ALEXANDRIA, VA. 22302 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 309 Continued From page 9 F 309 ~ Orders regarding notifying the physician of Accucheck readings over 350 for #21. Identification Findings: To identify other residents who may have been impacted by this practice a 100% audit of all 1. Resident #22 was admitted to the facility on dialysis residents will be conducted by unit 7/18/14. The diagnoses included End Stage managers to ensure that status reports Renai Disease, hypertension, seizures, anxiety documenting interchange of useful care and depression. The resident's record was information is sent with residents to and received reviewed on 7/20/16 at 3:30 PM. from dialysis for each visit and all issues are addressed and report placed in resident's medical The latest MDS (minimum data set assessment) chart; any instance that proper communication dated 6/6/16 coded the resident with slight was not documented, the nursing staff will cognitive impairment. She required the contact the dialysis center to complete and the assistance of staff members to accomplish all ADLs (activities of daily living.) The resident was nurse will complete the facility information. continent of bowel and bladder. Under special (Completed by 8/31/16) 8/31/16 treatments, she was coded for dialysis. Systemic Change The latest CCP (comprehensive care plan) was revised on 6/13/16. The plan included Dialysis Nursing staff will be in-serviced to ensure treatment as a possible cause for infections. compliance with this process. A dialysis respiratory distress and edema. communication form will be initiated for each dialysis resident which will accompany residents CCP interventions included observing the to and from dialysis appointments for exchange resident for s/s of infection, respiratory distress of information, orders, recommendations and and edema. The dialysis site was to be checked follow-ups. The facility nurse will complete the for s/s of infection, irritation, and checked for bruit form by entering the vital signs of the resident and thrill (graft/fistula.) Dialysis treatment as prior to leaving the facility. The dialysis center ordered.

Resident #22 had physician's order for Dialysis on Mon, Wed, and Fri, at 11:30 AM at (name of a local dialysis facility.) The order was signed and dated by the physician on 7/19/14.

The dialysis communication sheets used to share the flow of information between the facility and dialysis (three days a week) were reviewed from

will be expected to send a completed form back with the resident Vital signs and weights for pre and post dialysis and any other special instructions to care for the resident. If the dialysis center fails to do this, the unit manager or Nursing Supervisor will call the dialysis center to obtain the information needed.

A 100% weekly audit of all dialysis residents will be conducted to validate completion of the form.

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F 309	Continued From pa	ge 10	F 3	00:		
		/16. These forms had a				
	section for facility si	aff to fill out prior to transport	Any disc	repancies found will result in	11	
	to the dialysis cente	r. This section included	disciplina	ary action with staff involved.		
,	information on vital	signs (blood pressure, pulse.	Comple	ted by 8/31/16)		8/31/16
•	respirations, temper transport.	rature) and weight prior to	Monitor	ing		
	vital signs and a pre and after dialysis. It status and any perti Between 8/7/15 and observed a total of which were incomplinformation, the dial	included the aforementioned a- and post - weight for before also included the patient nent messages from dialysis. 1.7/18/16 the surveyor 59 communication sheets ete for either the facility ysis center or contained a	month. A communi action with compliant QA meeti	ON or her designee will audit 20% of the d dialysis transfer documents each any non-compliance of dialysis cation forms will result in disciplinary th staff involved. A report of non-ce will be submitted to the Quarterly ng for discussion.		8/31/16
	The administrator a	tion from either party. nd the DON were informed of		· · · · · · · · · · · · · · · · · · ·		
	these findings on 7/	20/16 at 5:15 PM. They were elicontract with the dialysis	(2) Corrective			•
	signed by both parti contained the follow current clinical reco	lysis Services Agreement es on 12/12/06 and 12/13/06 ing statement, "To maintain rds of such services, and to s to the nursing facility as	# 21 were n administeri scale on 7/9 also inform resident blo 7/10/16. No	ian and responsible party for resident notified about the error of any wrong dose of insulin per sliding 19/16 and 7/10/16. The physician was sed of failure to notify him when the pod sugar read 353 at 11:30a.m on o new orders were obtained and the		
		as provided prior to exit.	consequenc	not experience any adverse res. The licensed nurses involved I counselling and were re-educated on		
	diagnoses included	s admitted on 7/8/16. Her respiratory failure diabetes, ery disease and atrial	7/22/16.	by 7/22/16)		7/22/16

Resident # 21's latest MDS (minimum data set) dated 7/15/16, coded the resident as unimpaired

fibrillation.

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Vinia 2

PRINTED: 08/03/2016

	MEM OF HEVETH			()		FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OV	IB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I .	TIPLE CONSTRUCTION NG	,	(X3) DATE SURVEY COMPLETED
		495019	B. WING_			C 07/21/2016
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	IP CODE	
WOODBI	NE REHABILITATION	& HEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		and the second s
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD E THE APPROPRI	BE COMPLETION
F 309	Continued From pa cognitively. The ME note the resident's	S-as yet incompletedid not	F 30			
	problem of "nutrition monitor nutrition-re accuchecks.	resident's diabetes under the number in." Interventions included atted lab values and	affected; M resident's audited for reported to will receiv	ensure that no other residents were MARS for residents residing on # 21's unit for the last 30 days will reaccuracy. Any errors found will be the physician and the nurses involute counseling. d by 8/31/16)	l be	77045
	dated 7/8/16, indica unit/ml; amount: Polif blood sugar is les If blood sugar is 0-If blood sugar is 20 If blood sugar is 25 If blood sugar is 30 If blood sugar is 30 If blood sugar is gresubcutaneous Special instructions scale. (Diagnosis: 1	ated sliding scale Novolog 100 er sliding scale: s than 70, call MD. 150, give 0 units 1 to 200, give 1 unit. 1 to 250, give 2 units. 1 to 300, give 3 units. 1 to 350, give 4 units. eater than 350, MD.	Mandatory licensed nu and admin with emph amount or physicians		ars the	7/22/16
	Bedtime; 07:30 AM PM. On 7/9/16 @ 11:30 No insulin was prov On 7/9/16 @ 4:30 No insulin was prov On 7/10/16 @ 11:3 353. 4 units of insul than the 5 units on the state of the province of the state of the province of the pro	AM, the accucheck was 223. ided. AM, the accucheck was 230. ided. O AM, the accucheck was 230. ided. o AM, the accucheck was in were administered rather the sliding scale orders.	administratinsulin per making sur are greater corrected a	anagers and supervisors will print tion records of residents receiving sliding scale for compliance and re physicians are called when reading than 350. Any errors found will be and physicians will be notified.	e	
	nursing staff had no	prementioned errors, the t called the physician to report ucheck on 7/10/16 at 11:30				

AM was over 350 units.

DEPARTMENT OF HEALTH AND HUND SERVICES

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	RS FOR MEDICARE	& MEDICAID SERVICES	•	The state of the s	FORM APPROVED
			000 100 2		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
	*	495019	B. WING _		C 07/21/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0112112010
,				2729 KING ST	
MOODB	INE REHABILITATION	I & HEALTHCARE CENTER		ALEXANDRIA, VA 22302	Management of the state of the
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR	ULD BE COMPLETION
				DEFICIENCY)	-
F 309	Continued From pa	me 12	F 05	•	
	= =	_	F 30	9	
	additional documen	ss notes were reviewed. No nation could be found	The ADO	N or hondestand trans	
	pertaining to the mi	edication errors or the lack of	4 residente e	N or her designee will check 10% of	
	notification to the p	hveidan	recorde wa	eceiving insulin per sliding scale	
	notineation to the p	nysician.	non-comp	ekly for compliance. Any areas of	
	On 7/20/16 at 2:45	PM the director of nursing was	action A	iance will be subjected to corrective	
	informed of the sur	veyors findings. The	enhmittad	to the supply to	
	administrator was i	nformed at 5:15 PM the same	dismesion	to the quarterly QAPI meeting for	
	day.	morniou de octo i in ano camo	(Complete	and further recommendations. d by 8/31/16)	
	-		Complete	1 by 6/3 1/16)	8/31/16
	No additional inform	nation was provided.		•	
F 329		EGIMEN IS FREE FROM	F 32	Q:	
SS=E			F 329		
		,		EGIMEN IS FREE FROM	
	Each resident's dru	g regimen must be free from		SSARY DRUGS	
	unnecessary drugs	. An unnecessary drug is any	UNITED	SOART DRUGS	,
		excessive dose (including	Correctiv	e Action	* •
	duplicate therapy);	or for excessive duration; or	Correctiv	- Action	
	without adequate m	nonitoring; or without adequate	The physic	cians for resident # 6, # 7, and #8 were	•
	indications for its us	se; or in the presence of	notified of	failure of staff to hold Metoprolol	
	adverse consequer	nces which indicate the dose	when the	systolic blood pressure was less than	
	snould be reduced	or discontinued; or any	110 and n	ulse less than 60. Resident # 11's	
	combinations of the	reasons above.		were also informed of failure to hold	
	Popod on a compre	bosolice of an analysis of a		l when her systolic Blood pressure was	
		hensive assessment of a must ensure that residents	less than 1	00 and pulse was greater than 100.	
		antipsychotic drugs are not		d on 7/20/16)	7/00/37
		inless antipsychotic drug	, compress		7/20/16
		y to treat a specific condition	Identifica	tion	
	as diagnosed and c	locumented in the clinical			
	record: and residen	ts who use antipsychotic	In order to	ensure that no other residents were	
•		ual dose reductions, and		f the units in which residents #6, #7,	·
		tions, unless clinically	#8 and #11	reside medications which have blood	•
	contraindicated. in	an effort to discontinue these		arameters will be audited for the last 30	•
	drugs.			sure that all medications were given	
	-		annronrist	ely. Any areas of non-compliance, the	
			-hh. oh. m.	way and an one or mone combinance, the	

will receive corrective action. (Completed by 8/31/16)

attending physician will be notified and the nurse

8/31/16

DEPARTMENT OF HEALTH AND HIM N SERVICES

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CENTERS FOR MEDICARE	S MEDITOR SERVICES			FORM	M APPROVED
				OMB NO	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
4	495019	B. WING		07	C //21/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII		
WOODBINE REHABILITATION	& HEALTHCARE CENTER	androus securitabilis e d	2729 KING ST ALEXANDRIA, VA 22302	The state of the s	a galak salam sala saga samunga manan salam salam salam saga saga saga saga saga saga saga sa
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 329 Continued From pa	age 13	· F 3	329	•	
	•		$(x_1, \dots, x_n) = (x_1, \dots, x_n) \in \mathbb{R}^n$		w
	NT is not met as evidenced	Systemic	Change		
review it was deter failed to follow phys parameters on 4 of survey, Resident # and Resident #11. The Findings Included to the follow physician or Metoprolol. Resident #6 was a configurably admitted 12/21/15. Admittin were not limited to tracheostomy, asthe depression, hypogli	34 Residents in the sample 6, Resident #7, Resident #8	licensed norders for managers administra Metoprolo to validate appropriate will be repthe nurses (Complete Monitorin The ADON audit on we compliance A report of the quarter	y in-services will be conducted for sursing staff on following physician blood pressure parameters. Unit will be tasked to print electronic ation records for residents on ol with Blood pressure parameters date if the medications were administered by per physician orders. Errors found to the attending physicians and involved will receive corrective actions by 8/31/16) Nor her designee will conduct 10% eekly basis. Any areas of noneewill be subjected to corrective actions from compliance will be submitted to the QAPI meeting for discussion and commendations.	ed id id on.	8/31/16
assessment locate clinical record was with an Assessmer 6/2/16. The facility had a Cognitive Su facility staff also co	Minimum Data Set (MDS) d in the electronic and paper a Quarterly MDS assessment at Reference Date (ARD) of staff coded that Resident #6 mmary Score of 15. The ded that Resident #6 required ce (3/3) with Activities of Daily	(Completed	d by 8/31/16)		8/31/16
	t 1 p.m. the surveyor reviewed ronic and paper clinical record				

Review of the electronic and paper clinical record

DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-0391

CENTENO	LOW MEDICAKE	A MEDICAID SERVICES			<u> </u>	<u> NNR NO</u>	<u>. 0938-0391</u>		
STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COV	(X3) DATE SURVEY COMPLETED		
		495019	B. WING			i	C /21/2016		
NAME OF PRO	VIDER OR SUPPLIER		. 1	ł	EET ADDRESS, CITY, STATE, ZIP CODE				
WOODBINE	REHABILITATION	& HEALTHCARE CENTER	•	L	9 KING ST EXANDRIA, VA-22302	Margan and the second and a second a second and a second			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE		
F 329 Co	ontinued From pa	age 14	F:	329					
pro Signification (1): SE OI Se Ho Co clin Ac Ju Re 7/// Re 7/// Re 7// Re 7// Re 7// Re 7/// Re 7/// Re 7/// Re 7// Re 7/// Re 7// Re 7// Re 7// Re 7/// Re 7/// Re 7// Re 7// Re 7/// Re 7/// Re 7/// Re 7/// Re 7/// Re 7/// Re 7/// Re 7// Re 7//// Re 7///	roduced signed phigned physician or mited to the follow ablet 25 mg; amt (a 2.5mg); oral Special Philosophy (a 2.5mg); oral Philosophy (a 2.5mg	hysician orders dated 7/6/16. Inders included, but were not ving order: "metoprolol tartrate (amount): ½ tab (tablet) Icial Instructions: HOLD FOR (pressure) < (less than) 110, < 60 {DX (diagnosis): Insion, unspecified} Every 12 D PM." (sic) Insion the electronic and paper fluced the July 2016 Medication cords (MAR's). Review of the evealed the following: Independent of the electronic and paper fluced the July 2016 Medication cords (MAR's). Review of the evealed the following: In pressure was 100/52 on electronic and paper fluced the following: In pressure was 100/52 on electronic and paper fluced the following: In pressure was 100/52 on electronic and pressure was 100/60 on fluctoric and pressure was 106/60 on fluctoric and pressure was 107/62 on fluctoric and pulse/heart rate fluctoric and pulse/heart rate	To the month of th	3291					
fol pa	llowed the physici arameters. The si	ian ordered Metoprolol curveyor reviewed the er clinical record with the UM.							

The surveyor pointed out the specific order for the

DEPAR*	TMENT OF HEALTH	AND H AN SERVICES & MEDICAID SERVICES	,			INTED: 08/03/2016 FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	F	(X3) DATE SURVEY COMPLETED
		495019	B. WING			C 07/21/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, C	ITY, STATE, ZIP CODE	VIIZ 1120 10
WOODB	NE REHABILITATION	& HEALTHCARE CENTER	· /wo 25/4/24/48/48/49/4/	2729 KING ST ALEXANDRIA, VA	22302	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPRI DEFICIENCY)	(X5) BE COMPLETION IATE DATE
	the pulse and blood reviewed the July 20 surveyor specifically Metoprolol was not 7/17/16 and 7/18/16 pulse were less than that 60. On December 2, 20 team met with the A Director of Nursing 6 the Administrative To failed to follow physical parameters on Metothe AT that the facilities Metoprolol on 7/4/16 7/18/16 when Resid less than 10 or pulse No additional inform exiting the facility as to follow physician of parameters for Resid 3. The facility staff ordered blood press #8. The facility staff mg on 7/10/16 at 9:0 should have been he ordered blood press medication was to be medication was to be surveyed.	sician ordered parameters for pressure. The surveyor then D16 MAR's with the UM. The pointed out that the held on 7/4/16, 7/5/16, 7/7/16, when the blood pressure or in 110 systolic or the pulse less of 14 at 3:15 p.m. the survey dministrator (Adm) and (DON). The surveyor notified eam (AT) that the facility staff ician ordered medication oppole. The surveyor notified by staff had not held the 3, 7/5/16, 7/7/16, 7/17/16 and ent #6's blood pressure was a was less than 60. ation was provided prior to to why the facility staff failed redered medication dent #6. ailed to follow physician ure parameters for Resident administered Metoprolol 25 to a.m. when the medication and based on the physician ure parameters. The enheld if the systolic blood an 110. Resident #8's blood	F3	29		

The clinical record of Resident #8 was reviewed 7/19/16. Resident #8 was admitted to the facility 2/22/16 and readmitted 4/21/16 with diagnoses that included but not limited to respiratory failure, respirator dependent, tracheostomy, gastrostomy,

DEPARTMENT OF HEALTH AND HEALTH A PRINTED: 08/03/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED C 495019 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2729 KING ST WOODBINE REHABILITATION & HEALTHCARE CENTER** ALEXANDRIA, VA. 22302 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 Continued From page 16 F 329 dysphagia, epilepsy, contractures both hands. enterocolitis due to Clostridium difficile, venous thrombosis and embolism, urinary tract infection, hypertension, persistent vegetative state, anxiety, constipation, neuronal ceroid lipofuscinosis. Vitamin D deficiency, and gastroesophageal reflux disease. Resident #8's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/28/16 assessed Resident #8 in a persistent vegetative state in Section B. The July 2016 physician orders were reviewed and included one for the administration of Metoprolol tartrate tablet; 25 mg; amt (amount): 1 tab (tablet); gastric tube Special Instructions: Dx (diagnosis)-HTN (hypertension) HOLD FOR SBP (systolic blood pressure) < (less than) 110 Every 12 hours; 09:00AM, 09:00PM. The surveyor reviewed the July 2016 electronic medication administration records (eMAR). The blood pressure recorded for 9:00 a.m. on 7/10/16 was 106/55. The medication box was initialed by "JO". Initialed medication boxes indicate medications are administered. The surveyor reviewed the 7/10/16 progress notes. The progress note for 7/10/16 at 3:31 p.m. did not

include information concerning Resident #8's blood pressure. The vitals report for 7/10/16 was reviewed. The blood pressure documented prior to the administration of the 9:00 a.m. Metoprolol was 106/55 obtained at 7:37 a.m.—the same blood pressure reading on the eMAR.

The surveyor discussed the above concern with the unit manager registered nurse #1 on 7/20/16

PRINTED: 08/03/2016 DEPARTMENT OF HEALTH AND H AN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495019 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2729 KING ST WOODBINE REHABILITATION & HEALTHCARE CENTER** ALEXANDRIA, VA. 22302 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 329 Continued From page 17 F 329 at 9:00 a.m. R.N. #1 reviewed the clinical record and informed the surveyor the nurse should have held the medication based on the physician orders. The surveyor informed the administrator, the assistant administrator, and the director of nursing of the above finding on 7/20/16 at 2:00 No further information was made available prior to the exit conference on 7/21/16. 4. The facility staff failed to follow physician ordered blood pressure parameters for the administration of the antihypertensive medication for Resident #11. The facility staff administered Metoprolol 12.5 mg on 7/4/16 at 6:00 p.m. The medication should have been held based on the physician ordered blood pressure parameters. The medication was ordered to be held if the systolic blood pressure was less than 100 and to be given if the heart rate was greater than 100. Resident #11's blood pressure was 99/51 at 6:00 p.m. The clinical record of Resident #11 was reviewed 7/20/16. Resident #11 was admitted to the facility 1/27/16 with diagnoses that included but not

limited to respiratory failure, tracheostomy, gastrostomy, pneumonitis, severe sepsis with septic shock, hypotension, Down Syndrome, dysphagia, bilateral pneumonia, iron deficiency anemias, enterocolitis due to Clostridium difficile.

ileus, candidiasis, urinary tract infection,

gastroesophageal reflux disease, sacral pressure ulcer stage 4, right hip pressure ulcer stage 3, right heel pressure ulcer stage 1, Vitamin D deficiency, diabetes mellitus, seizure disorder,

		HAND HAN SERVICES					FORM.	08/03/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE	U936-U391 E SURVEY PLETED
		495019	B. WING	·	Marie Company of the		07/2	21/2016
	PROVIDER OR SUPPLIER INE REHABILITATION	N & HEALTHCARE CENTER		2729	EET ADDRESS, CITY, STATE, ZIF 9 KING ST EXANDRIA, VA. 22302	PCODE		116010
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ION SHOULD HE APPROPI	DBE	(X5) COMPLETION DATE
F 329	Continued From page	-	F:	329				
	· ·	ome, secondary hypertension,						
	assessment with an (ARD) of 4/28/16 as and short term men	rterly minimum data set (MDS) n assessment reference date ssessed the resident with long mory problems and severely skills for daily decision making.						
	and included one fo Metoprolol tartrate to 12.5 mg; gastric tub FOR HR > (heart ra FOR SBP < 100 [D)	sician orders were reviewed or the administration of tablet; 25 mg; amt (amount): be Special Instructions: GIVE ate greater than) 100 HOLD X: Other secondary ry 12 hours; 06:00AM,						
	medication administ blood pressure reco was 99/51. The me "RP". Initialed medi medications are administrations are administration and the reviewed the 7/4/16 progress notes for 7 p.m. did not include Resident 11's blood for 7/4/16 was review documented prior to 6:00 p.m. Metoproloi report on 7/4/16 3:30 106.	wed the July 2016 electronic stration records (eMAR). The orded for 6:00 p.m. on 7/4/16 edication box was initialed by lication boxes indicate ministered. The surveyor 8 progress notes. The 7/4/16 at 4:08 p.m. and 10:33 information concerning pressure. The vitals report ewed. The blood pressure the administration of the pl was 99/51 on the vitals 60 p.m. and the heart rate was						
1	the unit manager reg licensed practical nu	ssed the above concern with gistered nurse #1 and urse #1 on 7/20/16 at 4:00 red the clinical record and						- The state of the

informed the surveyor the nurse should have held

PRINTED: 08/03/2016 DEPARTMENT OF HEALTH AND HEALTH A FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495019 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2729 KING ST **WOODBINE REHABILITATION & HEALTHCARE CENTER** ALEXANDRIA, VA 22302 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE . REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 329 Continued From page 19 F 329 the medication based on the physician orders. L.P.N. #1 stated it was a holiday weekend. The surveyor informed the administrator, the assistant administrator, and the director of nursing of the above finding on 7/20/16 at 2:00 No further information was made available prior to the exit conference on 7/21/16. 2. For Resident #7 the facility staff failed to follow physician ordered parameters for the administration of the anti-hypertensive medication atenolol. Resident #7 was admitted to the facility on 01/14/15 and readmitted on 01/20/15. Diagnoses included but not limited to hyperlipidemia. cerebrovascular accident, dementia, epilepsy, psychotic disorder, dysphagia, glaucoma, and hypertension. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/06/16 coded the Resident as 00 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #7's clinical record was reviewed on

60 Once A Day; 08:00 AM"

07/19/16. It contained a physician's order dated 01/01/16 which read in part "atenolol tablet; 25mg;amt: 1 tab; oral Special instructions: HOLD FOR SYSTOLIC BLOOD PRESSURE LESS HAN 110 AND HEART RATE LESS THAN

Resident #7's MAR (medication administration record) was reviewed and contained the following entry which read in part "atenolol tab 25mg once a day hold for systolic blood pressure less

PRINTED: 08/03/2016 DEPARTMENT OF HEALTH AND HU FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495019 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2729 KING ST WOODBINE REHABILITATION & HEALTHCARE CENTER** ALEXANDRIA, VA 22302 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 329 | Continued From page 20 F 329 than110 and heart rate less than 60". The entry for 07/17/16 was signed as having been administered with a notation in the comments sections which read in part "07/17/16 12:21 PM Late administration: Charted late Comment: On time. The recorded heart rate for this entry was listed as 58. The surveyor spoke with the unit manager regarding whether or not the medication should have been administered and the unit manager stated that the medication should have been held per the physician's orders. During a meeting with the administrative staff on 07/20/16 at approximately 1330 the concern of not holding the medication was brought to their attention. No further information was provided prior to exit. F 333 483.25(m)(2) RESIDENTS FREE OF F 333 SIGNIFICANT MED ERRORS SS=D F 333 The facility must ensure that residents are free of RESIDENTS FREE OF SIGNIFICANT any significant medication errors. MED ERRORS Corrective Action This REQUIREMENT is not met as evidenced

This REQUIREMENT is not met as evidenced by:

The facility failed to ensure 1 of 34 residents was free of a significant medication error. (Resident 21.)

Findings:

Resident #21 was admitted on 7/8/16. Her diagnoses included respiratory failure diabetes, chronic coronary artery disease and atrial fibrillation.

The attending physician and responsible party for resident # 21 were notified about the error of administering wrong dose of insulin per the sliding scale on 7/9/16 at 11:30a.m., 4:30p.m. and on 7/10/16 @11:30a.m. The attending physician was also informed that on 7/10/16 the licensed staff failed to inform him that the resident blood sugar reading was 353 at 11:30 a.m. No new orders were received. The nurses that were involved in these errors received 1:1 counseling. (Completed on 7/21/16)

7/21/16

PRINTED: 08/03/2016 DEPARTMENT OF HEALTH AND HUNN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495019 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2729 KING ST WOODBINE REHABILITATION & HEALTHCARE CENTER** ALEXANDRIA, VA 22302 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 333 Continued From page 21 F 333 Resident # 4's latest MDS (minimum data set) dated 7/15/16, coded the resident as unimpaired Identification cognitively. The MDS-as yet incomplete-did not note the resident's functional status. To ensure no other residents were affect a 100% audit will be conducted on residents who receive The interim care plan, dated 7/8/16, insulin per sliding scale on the unit where acknowledged the resident's diabetes under the Resident # 21 resides. The attending physician problem of "nutrition." Interventions included will be notified of medications that were given monitor nutrition-related lab values and outside the prescribed parameters and the nurses accuchecks. involved will receive 1:1 counseling. (Completed by 8/31/16) The admitting physician's orders, signed and 8/31/16 dated 7/8/16, indicated sliding scale Novolog 100 Systemic Change unit/ml; amount : Per sliding scale: If blood sugar is less than 70, call MD. If blood sugar is O-150, give 0 units Licensed staffs will be in-serviced on obtaining If blood sugar is 151 to 200, give 1 unit. blood sugars and administration of insulin per If blood sugar is 201 to 250, give 2 units. sliding scale with emphasis on administering If blood sugar is 251 to 300, give 3 units. correct dosage ordered by physicians. Unit If blood sugar is 301 to 350, give 4 units. managers will print insulin administration records If blood sugar is greater than 350, MD. daily to ensure that correct dosages are being subcutaneous administered per ordered sliding scale. Special instructions: Give Novolog per sliding (Completed by 8/31/16) 8/31/16

On 7/9/16 @ 11:30 AM, the accucheck was 223. No insulin was provided.

Bedtime; 07:30 AM, 11:30 AM, 04:30 PM, 09:00

scale. (Diagnosis: Type II diabetes mellitus without complications.) Before meals and at

On 7/9/16 @ 4:30 AM, the accucheck was 230. No insulin was provided.

On 7/10/16 @ 11:30 AM, the accucheck was 353. 4 units of insulin were administered rather than the 5 units on the sliding scale orders.

In addition to the aforementioned errors, the nursing staff had not called the physician to report Resident #21's accucheck on 7/10/16 at 11:30

ADON or designee will audit 20% of resident's on insulin per sliding scale weekly. Any areas of

non-compliance will be subject to corrective action and any areas of non-compliance will be reported to the Quarterly QAPI meeting for discussion and further recommendations.

discussion and further recommendations. (Completed by 8/31/16)

8/31/16

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD	LTIPLE CONSTRUCTION DING		B NO. 0938-0391 (3) DATE SURVEY COMPLETED
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F 333	Continued From pa	-	F;	333:		
	additional documen pertaining to the me notification to the pl	tation could be found edication errors or the lack of hysician.	:	·		
	informed of the sun	PM the director of nursing was veyors findings. The nformed at 5:15 PM the same	F			
F 371 ⁻ SS=E	483.35(i) FOOD PR	nation was provided. ROCURE, SERVE - SANITARY	<u>F 371</u> FOOD	371 PROCURE		·
	(1) Procure food fro considered satisfac authorities; and	m sources approved or tory by Federal, State or local distribute and serve food litions	Correct	etive action aff members that were respondented food temperatures retion action for failure to docume. (Completed by 7/22/16)	nsible to take ceived ument at each	7/22/16
	This REQUIREMEN	NT is not met as evidenced	Identii	fication	entropolitica de la companya del companya de la companya del companya de la compa	
	Based upon staff in review, the facility s	nterview and facility document taff failed to document tray or each meal in the facility	have be membe proper	idents receiving food from the een impacted. As a result, the ers were observed during mea documentation of food tempor	e staff al times for eratures by	
	The findings include		were fo	manager to ensure proper problems. Dietary staff membered on proper monitoring of fo	ers were re-	
	kitchen on 7/20/16,	umentation of the facility it was noted by the surveyor	tempera	atures and documentation of leted on 7/27/16)	the temperatures.	7/27/16

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

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PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-0391

<u>CENTER</u>	RS FOR MEDICARE	& MEDI SERVICES		No.	<i>"</i>	MB NO. 0938-0391
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NAME OF F	PROVIDER OR SUPPLIER	493019	B. WING			07/21/2016
	INE REHABILITATION	& HEALTHCARE CENTER	2	STREET ADDRESS 2729 KING ST ALEXANDRIA, 1	VA 22302	
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F 371 :	Continued From pa	=	F 371	1		
	dates were left blan	mperatures for the following nk: 7/19/16 dinner, 7/12/16	Systemic ch	J		
	dinner 5/13/16 dinner	r, 5/6/16 dinner, 5/12/16	Dietary cool	ks and supervisor	rs were re-educated	
	breakfast, 5/31/16	ner, 5/24/16 lunch to 5/31/16 dinner to 4/9/16 breakfast,	on proper m	onitoring and doc	cumentation of food	
	4/10/16 lunch, 4/11/	/16 dinner, 4/14/16 dinner.	(Completed			
	4/15/16 dinner, 4/18	8/16 dinner, 4/19/16 dinner.		011 1120110)		7/28/16
	4/22/16 dinner, 4/23	3/16 dinner,	An updated	form will be deve	eloped to clearly	
	The dietary manage	er was asked by the surveyor	indicate tem	peratures to docu	ment with sign off	
	for a copy of the po	er was asked by the surveyor licy and procedure on	of cook and	supervisor.	-	
	obtaining and docur	menting tray line	(Completed 1	by 8/31/16)		8/31/16
	temperatures. A "	Food Temperatures " policy	The dietary r	manacan as bas d		
	was provided to the	surveyor which stated the	complete a d	manager or her de	esignee will food temperatures.	
	following: " I he ter	mperatures of the food items	Any areas of	finon-compliance	ood temperatures.	
	will be taken and primeal."	roperly recorded for each	immediately	corrected and the	e staff member	P
	moai.		responsible fi	or taking the tem	peratures will	
	The dietary manage	er was notified of the above	receive corre	ective action.	F	
	documented finding	s on 7/21/16 at approximately	(Completed 8	3/31/16)		8/31/16
	8 am in the confere	nce room. The surveyor	N.E identina			
	asked what the experience	ectation of the staff was in g and documenting tray line	Monitoring		P	
	temperatures. The	and documenting tray line dietary manager stated "The	To ensure cor	mpliance the diet	ary manager will	!
	staff knows they are	supposed to write the	audit the food	d temperature log:	s on a weekly	I
	temperatures down	each time they are taken. "	basis. Copies	s of the food temp	p log will be	1
			submitted to t	the Assistant Adn	ninistrator	
	I he administrator, a	assistant administrator,	monthly. Any	y areas of non-co	mpliance will be	
	nursing was notified	and assistant director of it is discussed in the above documented	dietary manac	mediate corrective	action. The	
	findings on 7/21/16		compliance or	ger will submit a nuarterly to the QA	report of non-	
	room.		discussion and	d further recomm	endations	
	ين مورو مد حمد م	((Completed by	y 8/31/16)	chations,	9/21/12
	No further information	on was provided to the		•		8/31/16
F 428	483.60(c) DRUG RE IRREGULAR, ACT	exit conference on 7/21/16. EGIMEN REVIEW, REPORT ON	F 428			

		AND I JAN SERVICES & MEDICAID SERVICES			FORM	08/03/201 APPROVEI
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE	0938-039 E SURVEY PLETED
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F 428	Continued From pa	ge 24	· F4	28		
	The drug regimen of	of each resident must be noce a month by a licensed	<u>F 428</u> DRUG R	EGIMEN REVIEW, REPORT JLAR, ACT ON		
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon.	notifying Novembe did compl	e action e action was taken immediately by the pharmacist of the missing review in r. Upon clinical review, the pharmacist ete the pharmacy review for December orther recommendations. The resident		
٠.	by:	IT is not met as evidenced	attending	ve any adverse consequences. The physician was notified.		
	review it was determined that the monthly Drug Regir	nined that the facility staff the pharmacy staff completed nen Reviews (DRR's) for 1 of sample survey, Resident #6.	Complete	ed on 7/20/16)		7/20/16
	The Findings Includ	ed:	Identific	ation		. 2
	that monthly Drug F were completed. R	facility staff failed to ensure legimen Reviews (DRR's) eview of the electric and I did not produce a November	a 100% a pharmac residents reported	ify that no other residents were affected; audit will be conducted to ensure that y reviews are being completed on all at the Any areas of noncompliance will be to the pharmacist and attending in for immediate review.		
	Resident #6 was a	71 year old female who was		ted by 8/31/16)		8/31/16

Resident #6 was a 71 year old female who was originally admitted on 8/5/15 and readmitted on 12/21/15. Admitting diagnoses included, but were not limited to: acute kidney failure, tracheotomy, asthma, pressure ulcer, depression, hypoglycemia, hypertension, dysphasia, pain disorder and a urinary tract infection.

The most current Minimum Data Set (MDS) assessment located in the electronic and paper clinical record was a Quarterly MDS assessment

Systemic Change

Unit managers will re-educated on reviewing resident's electronic medical records to ensure the pharmacy consultants is completing the monthly drug review regimen on all residents to ensure completion.

(Completed by 8/31/16)

8/31/16

DEPARTMENT OF HEALTH AND HUMON SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDIČA Ó SERVICES			OM	B NO. 0938-0391
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F 428	6/2/16. The facility had a Cognitive Su facility staff also convex extensive assistant Living (ADL's). On July 19, 2016 at Resident #6's elect Review of the elect produced monthly lelectronic and paper November 2015. On July 19, 2016 at notified a Registere Unit Manager (UM) completed a November 2015. On July 19, 2016 at notified a Registere Unit Manager (UM) completed a November Compointed out that the record failed to produce out that the record failed to produce out that the record failed to produce out the Direct Composer	at Reference Date (ARD) of staff coded that Resident #6 mmary Score of 15. The ded that Resident #6 required that Resident record to the resident experience and paper clinical record that the part of the resident experience and that the pharmacy had not a resident that the pharmacy had not have 2015 DRR on Resident eviewed the electronic and that the UM. The surveyor electronic and paper clinical duce the November 2015 ewed the electronic and paper was unable to locate the RR. It 3:30 p.m. the surveyor that the surveyor notified the DON that a November 2015 riewed the electronic and that and was unable to locate the relection of the electronic and the electronic and the paper was unable to locate the reward that the electronic and the electronic and the paper was unable to locate the reward that the electronic and the paper was unable to locate the reward that the electronic and the paper was unable to locate the reward that the paper was unable to locate the paper was unable	electronic m pharmacy re Any areas o immediately physician ar submitted qi discussion a (Completed		1	8/31/16

(AT) that the facility staff failed to ensure that the pharmacy completed monthly DRR's for Resident

DEPARTMENT OF HEALTH AND HIMAN SERVICES PRINTED: 08/03/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495019 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2729 KING ST WOODBINE REHABILITATION & HEALTHCARE CENTER** ALEXANDRIA, VA 22302 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 428 Continued From page 26 F 428 #6. The surveyor notified the AT that a DRR was not completed for November 2015. No additional information was provided prior to exiting the facility as to why the facility staff falled to ensure that the pharmacy completed monthly DRR's for Resident #6. F 441 483.65 INFECTION CONTROL, PREVENT F 441 SS=D SPREAD, LINENS INFECTION CONTROLPREVENT The facility must establish and maintain an SPREAD LINENS Infection Control Program designed to provide a safe, sanitary and comfortable environment and Corrective Action to help prevent the development and transmission of disease and infection. The Certified nursing assistant who was involved in this incident received 1:1 counseling and was (a) Infection Control Program The facility must establish an Infection Control re-educated on proper hand washing techniques. Program under which it -An apology was rendered to the resident #8. (1) Investigates, controls, and prevents infections (Completed on 7/20/16) 7/20/16 in the facility: (2) Decides what procedures, such as isolation, Identification should be applied to an individual resident; and (3) Maintains a record of incidents and corrective To ensure that no other resident were affected by actions related to infections. CNA # 1; C.N.A. # 1 was re-educated and observed for competency with performing (b) Preventing Spread of Infection perineal care and hand washing. (1) When the Infection Control Program (Completed by 8/15/16) 8/15/16 determines that a resident needs isolation to prevent the spread of infection, the facility must Systemic Change isolate the resident.

(2) The facility must prohibit employees with a

communicable disease or infected skin lesions

(3) The facility must require staff to wash their

direct contact will transmit the disease.

hand washing is indicated by accepted

from direct contact with residents or their food, if

hands after each direct resident contact for which

action.

(Completed by 8/31/16)

Nursing supervisors and unit managers will

technique. Any certified nursing assistant

observe ten certified nursing assistants during

perineal care with focus on proper handwashing

observed not in compliance will receive corrective

8/31/16

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					NTED: 08/03/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		B NO. 0938-039 X3) DATE SURVEY COMPLETED
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F 441 Continued From pa professional practic		F 44	11		
(c) Linens Personnel must had transport linens so infection.	Personnel must handle, store, process and transport linens so as to prevent the spread of		tion control nurse will observe ter nursing assistant for perineal care with focus on handwashing. Any a	areas	
This REQUIREMENth by: Based on observate document review, a facility staff failed to guidelines for glove for 1 of 34 residents	and the in action. A submitted discussion	mpliance will be corrected immed dividual will be subjected to corre report of non-compliance will be quarterly to the QAPI team for a and further recommendations. Bed by 8/31/16)	ective	8/31/16	
The findings include	ed:				•
removing one láyer perineal care to Res assistant #1 (C.N.A disposable gloves o (Inzo cream) to Res	ed to wash hands after of gloves after providing sident #8. Certified nursing .#1) had a second pair of n and applied perineal cream ident #8's buttocks without d layer of gloves and washing	·			•

The clinical record of Resident #8 was reviewed 7/19/16. Resident #8 was admitted to the facility 2/22/16 and readmitted 4/21/16 with diagnoses that included but not limited to respiratory failure, respirator dependent, tracheostomy, gastrostomy, dysphagia, epilepsy, contractures both hands, enterocolitis due to Clostridium difficile, venous thrombosis and embolism, urinary tract infection, hypertension, persistent vegetative state, anxiety, constipation, neuronal ceroid lipofuscinosis, Vitamin D deficiency, and gastroesophageal

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F 441	reflux disease. Resident #8's signif minimum data set (assessment referer assessed Resident state in Section B. The surveyor entere 7/19/16 at 1:55 p.m assistants (C.N.A. # providing ADL (activ Resident #8. Resid side and C.N.A. #1' care. Resident #8 vincontinent of bowel incontinence care, C.The surveyor noted C.N.A. #1's hands. double-gloved. She the gloves or tears. Resident #8's barrie C.N.A. #1 removed washed her hands. The surveyor discuss practical nurse #1 or #1 stated that practic stated "The C.N.A. soff, both pairs, clean	icant change in assessment MDS) assessment with an accedate (ARD) of 4/28/16 #8 in a persistent vegetative and Resident #8 's room on Two certifled nursing and C.N.A. #2) were rities of daily living) care to ent #8 was turned to her left was providing incontinence	F 4	41			

currently doing competencies for perineal care."

The surveyor requested the C.N.A. #1's perineal competency and the facility policy on glove removal and hand washing.

The surveyor reviewed the facility policies titled "Handwashing/Sanitizing and Infection Control"

DEPARTMENT OF HEALTH AND HIM SERVICES

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÜL A. BUILD	LTIPLE CONSTRUCTION DING		B) DATE SURVEY COMPLETED
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WOODBIN		N & HEALTHCARE CENTER		2729 KING ST ALEXANDRIA, VA 22302		and the second of the second o
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	procedure "2. Exar This is not intended Before putting on gloves." The Infect "9. Standard Preca providing care to the fit. iii Wear disposaresident care. iv Rewith the individual refacility protocol. v. 6	-	To the Committee of the Control of t	441		
	The surveyor informassistant administration nursing of the infect end of the day mee. The surveyor intervinurse registered nurse registered nurse. May 2016. C.N.A. for perineal care was	med the administrator, the rator, and the director of cition control concern during the eting on 7/20/16 at 2:00 p.m. viewed the infection control curse #2 on 7/21/16 at 9:10 a.m. ineal competencies started in #1's most recent competency as 7/22/13. R.N. #2 stated uld not be done but to remove ands.			,	•
F 514 SS=D	exit conference on 7 483.75(I)(1) RES RECORDS-COMPL LE The facility must ma resident in accordar	LETE/ACCURATE/ACCESSIB aintain clinical records on each	F514 RECOR	514 <u>RDS-</u> <u>LETE/ACCURATE/ACCESSIBLE</u>		
:	accurately docume	ptices that are complete; nted; readily accessible; and	Correcti	tive Action		

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

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PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-0391

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NAME OF	PROVIDER OR SUPPLIER		t	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		7/21/2016	
WOODD	thir mettant manual				KING ST			
MOODR	INE REHABILITATION	& HEALTHCARE CENTER			XANDRIA, VA 22302			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	Er Datemin and a sec	PROVIDER'S PLAN OF CORRECT		<u> </u>	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 514	Continued From pa	ge 30	F	514				
	systematically orga	nized.						
			The lice	nsed nu	rse who made the wrong entry in			
•		must contain sufficient	resideni	# 2's ch	art received 1:1 counseling. She			
• .	information to ident	ify the resident; a record of the	apologi:	zed to the	e surveyor that she had made the			
c.	services provided;	ents; the plan of care and	entry in	error. Si	ne corrected her note after she			
	nreadmission scree	ening conducted by the State;	spoke w	ım me S	urveyor on 7/20/16.			
	and progress notes		The RN	nurcino	supervisor who failed to			
	, p 	•	docume	nt her fin	idings for resident #31 received			
			correctiv	e action	for failure to document findings			
		NT is not met as evidenced	on 7/23/	16.	to document initings			
	by:		(Comple	ted by 7.	/23/16)		7/23/16	
		rview and clinical record taff failed to maintain a	Identifi	ation			//23/16	
	complete and accur	rate clinical record for 2 of 34	To ensur	e that no	other residents were affected by			
	Residents, Residen	ts #2 and #31.		nurse #3	; a 100% review of the resident		,	
Ē	The Coultman to short		charts' ti	at L.P.N	I. #3 cared for the last 30 days		•	
	The findings include	ed	will be a	udited fo	or errors by the Unit Manager			
	1 For Resident #2	the facility staff documented	Any erro	rs found	will be reported to the DON and		•	
	in the clinical record	i on two different dates that	corrected	if appro	ppriate per nursing standard			
	the Resident had a	restraint in place. The	of practic					
	restraint had been o	discontinued.	(Comple	ted by 8	/31/16)		8/31/16	
	Desident #01 II		To ensur	that no	residents were affected, all			
	Resident #2 nad be	en admitted to the facility	expired r	sidents	in the last 30 days, clinical		>	
•	limited to respirator	s included, but were not y failure, dysphagia,	records v	ill be au	dited for complete		~	
	hypertension, atrial	fibrillation, diabetes,	documen	ation of	findings by the RN.			
	contracture, and ap	hasia.	(Complet	ed by 8/3	31/16)		8/31/16	
	•				** *** *** *** *** *** *** *** *** ***		9/31/10	
	Section C (cognitive	patterns) of the Residents						
•	quarterly MDS (min	imum data set) assessment						
	With an AKD (asses	sment reference date) of I 1/1/2 to indicate the						
		ems with long and short term	:				_	
		oderately impaired in					•	
		aily decision making. Section						
	P (restraints) was co	oded to indicate the Resident						

did not use a restraint.

		AND HUMAN SERVICES			PRINTED: 08/03/2016 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	•	495019	B. WING		C 07/21/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE
WOODB	INE REHABILITATION	& HEALTHCARE CENTER		2729 KING ST	
•		<u> A. J. S. L. S. S.</u>		ALEXANDRIA, VA 22302	est international minimaterial descriptional or to trade in more than any descriptions or principles.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLETION
F 514	Continued From pa	ge 31	F 5	514	
	A review of the Resorders indicated that (mitten on Resident from pulling medicated)	cal record included a signed int dated March 1, 2016. Idents current physician at the Residents restraint t's left hand to prevent them al equipment out at all times)	Licensed documen record. T # 3 works weekly be	staff will be re-educated on thing accurately in residents clinical he unit manager on the unit where LPN is will audit her nurse's notes for errors on asis, any errors found will be reported DN and LPN#3 will be informed and if	ı
	Resident #2 had "		action.	o progress LPN #3 will face disciplinary ed by 8/31/2016)	8/31/16
	surveyor interviewed notes LPN #3 verbased and not had charted in erro approximately 11:0 the surveyor that the	5 a.m. LPN #3 verbalized to pley gave the Resident a wash ey had been told in stand up	documen pronounce The Unit residents documen is found a correct do counselin	ervisors will be re-educated on atting their findings when residents are used to have expired in the clinical record. Manager or designee will audit charts of who have expired daily to ensure that tation is in place. If any documentation missing the RN will be notified to occumentation and will receive 1:1 ag.	8/31/16
		s of Resident #2 the Resident a wash cloth in his left hand.	Monitori	·	6/31/16
	were notified of the survey team on 07, p.m. During a seco	and DON (director of nursing) above in meeting with the 20/16 at approximately 1:55 nd meeting with the survey at approximately 9:45 a.m. the	clinical re monthly i compliance	ON or her designee will audit 100% of ecords of residents that have expired in the facility. Any areas of nonce will be corrected immediately and the jected to corrective action. A report of	

been discontinued.

DON verbalized to the survey team that the

No further information regarding this issue was provided to the survey team prior to the exit

restraint was removed from the room when it had team for discussion and further recommendations.

(Completed by 8/31/16)

non-compliance will be submitted to the QAPI

8/31/16

PRINTED: 08/03/2016 DEPARTMENT OF HEALTH AND HUNN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495019 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **2729 KING ST WOODBINE REHABILITATION & HEALTHCARE CENTER** ALEXANDRIA, VA 22302 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 514 Continued From page 32 F 514 conference. 2. The facility staff failed to maintain a complete and accurate clinical record for Resident #31. Resident #31 expired on 11/27/15. The registered nurse who pronounced Resident #31's death failed to document the findings in the clinical record. The clinical record of Resident #31 was reviewed 7/20/16 and 7/21/16. Resident #31 was admitted to the facility 6/15/15 and readmitted 11/20/15 with diagnoses that included acute respiratory failure, tracheostomy, gastrostomy, dysphagia, persistent vegetative state, hypertension, left knee contracture, anxiety, chronic pain, dyspnea, constipation, and gastroesophageal reflux disease. Resident #31's 30 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/12/15 assessed the resident in Section B as in a persistent vegetative state. During Resident #31's hospitalization 11/3/15 through 11/20/15, Resident #31 was compassionately weaned from the ventilator.

When Resident #31 was readmitted to the facility 11/20/15, physician orders included orders for hospice consult. Resident #31 expired 11/27/15. The progress note dated 11/27/15 at 3:30 a.m. read "Resident was noted with no vital signs at 3:20am. Expired at 3.20 am. Supervisor (registered nurse #6) came in and resident was pronounced by supervisor. MD (medical doctor) was called and notified and order received to release body to funeral home of family's choice." Three other progress notes were written on 11/27/15 at 3:45 a.m., 4:30 a.m., and 6:00 a.m. All progress notes written 11/27/15 were by

		AND HE AN SERVICES & MED. AID SERVICES				FO	ED: 08/03/2016 RM APPROVED NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495019	B. WING				C 07/24/2040
NAME OF	PROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP CODE		07/21/2016
WOODB		& HEALTHCARE CENTER			9 KING ST EXANDRIA, VA 22302		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 514	documentation by the hospice register expired. The surveyor inform 7/21/16 of the above concerning Resident death by a registere nursing provided the report for 11/26/15. hour report for the vwritten by registered "Expired @ 3.20 a.m. BP (blood pressure) (respirations)." The surveyor inform assistant administral and the director of concern in documents.	arses. There was no ne facility registered nurse or ed nurse when Resident #31 need the director of nursing on a lack of documentation at #31's pronouncement of d nurse. The director of a surveyor with the 24 hour Written on the 11/26/15 24 entilator unit was the following I nurse #6 for Resident #31 n. Pronounced by me. No no pulse no respect the administrator, the tor, the director of nursing, linical operations of the above station on 7/21/16 at 9:45 a.m.	F	514:			

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If continuation sheet 1 of 2

STATE FORM



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
	•	495019)	B. WING		07/2	21/2016	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		+112410	
WOODBI	NE REHABILITATION	& HEALTHCARE CEI	2729 KING					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	/ ÉULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
F 001	Continued From Pa	age 1		F 001				
	12 VAC 5-371-340-	-Cross reference to F	⁼ tag 371	Please cr	oss reference F Tag 371 on Page	23 of POC		
	Pharmaceutical Ser 12 VAC 5-371-300 428	rvices (D, H)-Cross referen	ice to F tag	Please cross reference F Tag 428 on Page 24 of POC				
	Infection Control. 12 VAC 5-371-180 441	12 VAC 5-371-180 (C)-Cross reference to F tag		Please cross reference F Tag 441 on Page 27 of POC				
	Clinical Records. 12 VAC 5-371-360 F-514	12 VAC 5-371-360 (A, E.4)-Cross reference		Please c	ross reference F Tag 514 on Pago	e 30 of POC		
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