December 2, 2016

VIA EMAIL

Ms. Wietske G Weigel-Delano,
LTC Supervisor, Div. of Long Term Care
Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, VA 23233

Re: Loudoun Nursing and Rehabilitation Center
Provider Number 495275

Dear Ms. Weigel-Delano:

With reference to your e-mail dated November 29, 2016, please find attached our Plan of Correction ("PoC".) This PoC responds to the CMS 2567 for the survey completed November 16, 2016.

If you have any questions or need additional information from us at this time, please contact us at 703-771-2841.

Respectfully,
Elizabeth Kaeser

Elizabeth Kaeser, RN, MSN, LNHA, CPHQ
Administrator

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 11/15/16 through 11/16/16. 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 100 certified bed facility was 96 at the time of the survey. The survey sample consisted of 17 current resident reviews (Residents #1 through # 17) and seven closed record reviews (Residents # 18 through # 24).	F 000	F 000 COMMENTS: We would like this Plan of Correction to constitute as allegation of compliance to deficiencies.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278	**F 278** **CORRECTIVE ACTION:** The MDS for Residents # 4 and # 11 were modified to correct the coding error in Section D for these two residents. **OTHER POTENTIAL RESIDENTS:** All residents are potentially affected; however, the most recent MDS for all residents were reviewed / audited for the presence of this coding error. Any MDS found to be affected were modified to correct the error.	11/17/2016 11/22/2016

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

Elizabeth P. Kaeser, RN, MSN, LNHA, CPHQ Administrator 12/2/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 278	Continued From page 1	F 278		

penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete an accurate MDS (minimum data set) assessment for two of 24 residents in the survey sample, Residents #4 and #11.

1. The facility staff failed to complete the interview for mood on the 7/1/16 significant change MDS assessment for Resident #4.

2. The facility staff failed to complete the interview for mood on the 7/7/16 admission MDS assessment for Resident #11.

The findings include:

1. Resident #4 was admitted to the facility on 4/20/11, and most recently readmitted on 5/31/16 with diagnoses including, but not limited to: end stage kidney failure, history of a stroke, high blood pressure and depression. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 10/29/16, Resident #4 was coded as being moderately impaired for making daily decisions.

A review of the significant change MDS with an assessment reference date of 7/1/16 revealed in Section B0700 Resident #4 was coded as -

SYSTEMIC CHANGES:
The MDS Coordinator will conduct an in-service training for all Social Workers on the MDS RAI Manual Section D, including interview process and coding of interviews. 12/23/2016

The MDS Coordinators and Social Workers will together review their documentation prior to closure of the MDS in order to ensure the accuracy and completeness of the MDS coding for Section D; and to ensure coding is consistent with Section BO700.

MONITORING:
In addition to the MDS documentation review described above, the MDS Coordinators will audit a random sampling of five (5) MDS's weekly for Section D coding accuracy for four (4) weeks to ensure compliance. Any non-compliance will be immediately 12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 278	Continued From page 2	F 278		

sometimes understood. Review of the resident interview portion of Section D "Mood" revealed it was not completed. Section D-0100 "Should Resident Mood Interview be Conducted?" was coded "No" as evidenced by a "0" in the box for this section (enter "1" for "yes" - continue with resident interview and "0" for "no" - resident is rarely/never understood - skip to and complete....Staff Assessment for Mental Status). The resident was coded as "0" for rarely/never understood. The "Staff Assessment" portion of Section D was completed instead. This conflicted with what was coded in Section B0700 - sometimes understood.

On 11/16/16 at 10:55 a.m., OSM (other staff member) #4, the social worker, was interviewed. She stated that she was responsible for completing section D on the 7/1/16 assessment for Resident #4. When asked her process for completing Section D-0100, OSM #4 stated: "I go in and see if the resident is interested in talking to me. If they are not or they won't answer questions, I go to the chart." She stated she also talks with the nurses and CNAs (certified nursing assistants) to complete the staff portion for Section D of the MDS. When asked if her answer in D-0100 was consistent with what was coded in B-0700, OSM #4 stated: "I'm not sure. I don't really look at it. I don't have anything to do with Section B." When asked if she uses any reference document if she has questions regarding completion of the MDS, she stated that she does not.

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator, were informed of these concerns.

F 278

corrected. The results will be reported to the Director of Nursing for analysis of trends and patterns. A summary report of the audits will be provided to the Performance Improvement Committee for additional review and recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 278	Continued From page 3	F 278		

A review of the facility policy entitled "Care Planning - 3.0 MDS and CAA (Care Area Assessment) Summary Completion" revealed, in part, the following: "Generally each member of the Interdisciplinary Team will complete their respective sections of the MDS...Social Service will complete sections A, D, E and Q."

No further information was provided prior to exit.

2. Resident #11 was admitted to the facility on 6/30/16, and was most recently readmitted on 8/26/16 with diagnoses including, but not limited to: dementia without behaviors, brittle bones, high cholesterol, high blood pressure, anxiety and depression. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 10/6/16, Resident #11 was coded as being severely impaired for making daily decisions.

A review of the admission MDS with assessment reference date 7/7/16 revealed in Section B0700, Resident #11 was coded as - sometimes understood. A review of the resident interview portion of Section D "Mood" revealed it was not completed. Section D-0100 "Should Resident Mood Interview be Conducted?" was coded "No" as evidenced by a "0" in the box for this section (enter "1" for "yes" - continue with resident interview and "0" for "no" - resident is rarely/never understood - skip to and complete....Staff Assessment for Mental Status). The resident was coded as "0" for rarely/never understood. The "Staff Assessment" portion of Section D was completed instead. This conflicted with what was coded in Section B0700 - sometimes understood.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 278	Continued From page 4 On 11/16/16 at 10:55 a.m., OSM (other staff member) #4, the social worker, was interviewed. OSM #4 stated that she was responsible for completing section D on the 7/7/16 assessment for Resident #11. When asked her process for completing Section D-0100, OSM #4 stated: "I go in and see if the resident is interested in talking to me. If they are not or they won't answer questions, I go to the chart." She stated she also talks with the nurses and CNAs to complete the staff portion for Section D of the MDS. When asked if her answer in D-0100 was consistent with what was coded in B-0700, OSM #4 stated: "I'm not sure. I don't really look at it. I don't have anything to do with Section B." When asked if she uses any reference document if she has questions regarding completion of the MDS, she stated that she does not. On 11/16/16 at 3:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator, were informed of these concerns. No further information was provided prior to exit.	F 278		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to	F 281	**F281** **CORRECTIVE ACTION:** In order to immediately correct the cited deficiency, the LPN was counseled regarding standards of professional	11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 281	Continued From page 5 follow professional standards of practice for one of 24 residents in the survey sample, Resident #11. The facility staff documented that physician-ordered protective sleeves (geri sleeves) had been applied on the arms of Resident #11 on 11/16/16 when the protective sleeves had not been applied. The findings include: Resident #11 was admitted to the facility on 6/30/16, and was most recently readmitted on 8/26/16 with diagnoses including, but not limited to: dementia without behaviors, brittle bones, high cholesterol, high blood pressure, anxiety and depression. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 10/6/16, Resident #11 was coded as being severely impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility, transfers, and bathing; and as being completely dependent on one staff member for dressing, eating, toileting and personal hygiene. On 11/16/16 at the following times, Resident #11 was observed lying in her bed and was not wearing protective sleeves on her arms: 7:40 a.m., 10:55 a.m., and 1:45 p.m. On 11/16/16 at 11:45 a.m., Resident #11 was observed sitting in her wheelchair in the dining room and was not wearing protective sleeves on her arms. A review of the physician's orders for Resident #11 revealed the following order, most recently signed by the physician on 10/8/16: "Geri-Sleeves to Hand Left. Hand Right...Apply	F 281	practice in relation to documentation of geri-sleeves as ordered by the physician and documented on the Treatment Administration Record (TAR). The nurse was further counseled to validate that the service has been provided prior to her documentation on the TAR. **OTHER POTENTIAL RESIDENTS:** All residents of LPN #3 are potentially affected by the deficient practice. The importance of an accurate medical record and accurate documentation of services provided has been reviewed in writing with LPN #3. **SYSTEMIC CHANGES:** All nursing staff will be re-educated by the Geriatric Education Coordinator on the standards of professional practice and the importance of complete and accurate documentation of services	11/17/2016 12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 281	Continued From page 6 Geri-Sleeves on both arms for protection. Remove at bedtime." A review of the comprehensive care plan for Resident #11 dated 10/17/16 revealed, in part, the following: "Problem: Resident is at risk for/has impaired skin integrity...Apply geri-sleeves." A review of the Pictorial Care Card for Resident #11 posted on the door of her closet revealed, in part, the following: "Other: Geri-Sleeves both arms for protection. Remove at bedtime." A review of the TAR (treatment administration record) for Resident #11 revealed two initials in the box for the day shift nurse to sign on 11/16/16 for the following treatment: "Geri-Sleeves to Hand Left. Hand Right...Apply Geri-Sleeves on both arms for protection. Remove at bedtime." On 11/16/16 at 1:55 p.m., LPN (licensed practical nurse) #3 and CNA (certified nursing assistant) #2 accompanied the surveyor to Resident #11's bedside. The surveyor asked both staff members if they noticed anything that Resident #11 should have been wearing that she currently did not have on her body. CNA #2 stated: "No." The surveyor asked both staff members if Resident #11 was supposed to be wearing anything else on her arms. LPN #3 stated: "No. Not anything I can think of." Both staff members accompanied the surveyor to the medication cart. LPN #3 was asked if she was aware that Resident #11 had orders for geri sleeves on both arms. She stated: "No, I'm not." When asked to check the physician's orders, she did so. LPN #3 stated: "Yes, I remember now." When asked to check the TAR for Resident #11, LPN #3 showed the	F 281	provided to the residents. In addition, the nurses will be re-educated to verify that the services were provided prior to documentation on the Treatment Administration Record (TAR). **MONITORING:** An audit of five (5) Treatment Administration Records (TAR) of the nursing staff will be conducted monthly by the Unit Manager. As a second step, a validation audit of the same residents will be conducted to ensure the actual service and/or treatment is being provided to the resident as ordered by the physician. The results of these monthly audits will be reported to the Director of Nursing for analysis of trends and patterns. The Performance Improvement Committee will review a summary analysis of the monthly audits and provide	12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 281 Continued From page 7

surveyor the above-referenced entry for 11/16/16 for the geri sleeves. When asked if the initials in the box were hers, she stated: "Yes." When asked what her initials in the box mean, LPN #3 stated: "That it was done." When asked if she should have signed off the geri sleeves as having been applied on 11/16/16, LPN #3 stated: "No." When asked if she had looked at Resident #11 before she had signed the TAR to indicate the geri sleeves were applied, LPN #3 stated: "I usually look."

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator, were informed of these concerns. At this time, ASM #2 stated that the facility utilizes the online Lippincott Procedures as their professional standard of practice.

A review of a document entitled "Lippincott Procedures - Documentation, long-term care" dated 11/11/16 revealed, in part, the following: "Never tamper with a documentation or any part of a clinical record; tampering includes...inserting inaccurate information in the record."

No further information was provided prior to exit.

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced

F 281

additional recommendations, including the frequency of the continued audits.

F 282

F282

CORRECTIVE ACTION:
In order to immediately correct the cited deficiency for Resident #11 for not following the Comprehensive Care Plan 11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 282	Continued From page 8	F 282		

by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for one of 24 residents in the survey sample, Resident #11.

The facility staff failed to apply physician-ordered protective sleeves (geri sleeves), per the written plan of care, on the arms of Resident #11 on 11/16/16.

The findings include:

Resident #11 was admitted to the facility on 6/30/16, and was most recently readmitted on 8/26/16 with diagnoses including, but not limited to: dementia without behaviors, brittle bones, high cholesterol, high blood pressure, anxiety and depression. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 10/6/16, Resident #11 was coded as being severely impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility, transfers, and bathing; and as being completely dependent on one staff member for dressing, eating, toileting and personal hygiene.

On 11/16/16 at the following times, Resident #11 was observed lying in her bed and was not wearing protective sleeves on her arms: 7:40 a.m., 10:55 a.m., and 1:45 p.m. On 11/16/16 at 11:45 a.m., Resident #11 was observed sitting in her wheelchair in the dining room and was not wearing protective sleeves on her arms.

A review of the physician's orders for Resident #11 revealed the following order, most recently

guiding the resident's care in regard to wearing geri sleeves, the geri sleeves were placed on the resident.

OTHER POTENTIAL RESIDENTS:
All residents who wear geri sleeves are potentially affected by the deficient practice. A review of all residents' treatment records and care plans was conducted to identify those residents who have orders to wear geri sleeves. All affected residents were audited to ensure the geri sleeves were in place as ordered by the physician and as written in the individualized Comprehensive Care Plan. All residents were found to be in compliance with the Comprehensive Care Plan. 11/18/2016

SYSTEMIC CHANGES:
An educational in-service will be conducted by the Geriatric Education Coordinator for the nursing staff reviewing the purpose of the Comprehensive 12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 282	Continued From page 9	F 282		

signed by the physician on 10/8/16: "Geri-Sleeves to Hand Left. Hand Right...Apply Geri-Sleeves on both arms for protection. Remove at bedtime."

A review of the comprehensive care plan for Resident #11 dated 10/17/16 revealed, in part, the following: "Problem: Resident is at risk for/has impaired skin integrity...Apply geri-sleeves."

A review of the Pictorial Care Card for Resident #11 posted on the door of her closet revealed, in part, the following: "Other: Geri-Sleeves both arms for protection. Remove at bedtime."

On 11/16/16 at 1:55 p.m., LPN (licensed practical nurse) #3 and CNA (certified nursing assistant) #2 accompanied the surveyor to Resident #11's bedside. The surveyor asked both staff members if they noticed anything that Resident #11 should have been wearing that she currently did not have on her body. CNA #2 stated: "No." The surveyor asked both staff members if Resident #11 was supposed to be wearing anything else on her arms. LPN #3 stated: "No. Not anything I can think of." Both staff members accompanied the surveyor to the medication cart. CNA #2 was asked how she became aware of physicians' orders for residents. CNA #2 stated: "The nurse tells me. It's also on the care card on the back of the closet." When asked if she had looked at Resident #11's pictorial care card on 11/16/16, CNA #2 stated: "No, I did not look today." LPN #3 was asked if she was aware that Resident #11 had orders and a care plan intervention for geri sleeves on both arms. LPN #3 stated: "No, I'm not." When shown the above-referenced item regarding geri sleeves from Resident #11's care

Care Plan which describes the services that are to be provided to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being by guiding the resident's care with a written action plan for the treatments and services.

Additionally, staff will be educated on where to find the information on the Comprehensive Care Plan and understanding what employees are to do for the resident based on this Individualized Plan of Care.

MONITORING:

An observational audit of 10% of Comprehensive Care Plans for all residents will be conducted monthly to ensure all physicians' orders for resident services are documented on the Comprehensive Care Plan. 12/23/2016

As a second step, a validation audit of the same residents will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 282 Continued From page 10

plan, LPN #3 stated: "Yes, I see it now."

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator, were informed of these concerns.

A review of the facility policy entitled "Long-term Care Plan Preparation" revealed, in part, the following: "A comprehensive care plan guides the resident's care from admission to discharge. A care plan can also serve as a database...A care plan is an individualized written action plan for the resident's care, treatment, and services that's based on nursing assessments, reassessments, diagnostic test results and the resident's individual goals...The comprehensive care plan embodies the components of the nursing process: assessment, diagnosis, planning, implementation and evaluation."

No further information was provided prior to exit.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

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, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, it

F 282

be conducted to ensure the actual service is being provided to the resident as documented on the Individualized Care Plan.

The results of these monthly audits will be reported to the Director of Nursing for analysis of trends and patterns. The Performance Improvement Committee will review a summary analysis of the monthly audits and provide additional recommendations, including the frequency of the continued audits.

F 309

F309

CORRECTIVE ACTION:
In order to immediately correct the cited deficiency for Resident #11 for not following the Physician's order in for geri sleeves, the geri sleeves were placed on the resident by the nursing staff. 11/17/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11	F 309		

was determined that the facility staff failed to follow a physician's order for one of 24 residents in the survey sample, Resident #11.

The facility staff failed to apply physician-ordered protective sleeves (geri sleeves) on the arms of Resident #11 on 11/16/16.

The findings include:

Resident #11 was admitted to the facility on 6/30/16, and was most recently readmitted on 8/26/16 with diagnoses including, but not limited to: dementia without behaviors, brittle bones, high cholesterol, high blood pressure, anxiety and depression. On the most recent MDS (minimum data set), a quarterly assessment with an assessment reference date of 10/6/16, Resident #11 was coded as being severely impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility, transfers, and bathing; and as being completely dependent on one staff member for dressing, eating, toileting and personal hygiene.

On 11/16/16 at the following times, Resident #11 was observed lying in her bed and was not wearing protective sleeves on her arms: 7:40 a.m., 10:55 a.m., and 1:45 p.m. On 11/16/16 at 11:45 a.m., Resident #11 was observed sitting in her wheelchair in the dining room and was not wearing protective sleeves on her arms.

A review of the physician's orders for Resident #11 revealed the following order, most recently signed by the physician on 10/8/16:
"Geri-Sleeves to Hand Left. Hand Right...Apply Geri-Sleeves on both arms for protection. Remove at bedtime."

OTHER POTENTIAL RESIDENTS:
All residents who have an order to wear geri sleeves are potentially affected by the deficient practice. A review of all Physician's orders, residents' treatment records and care plans was conducted to identify those residents who have orders to wear geri sleeves. All affected residents were audited to ensure the geri sleeves were in place as ordered by the physician and as written in the individualized Comprehensive Care Plan. All residents were found to be in compliance with the Physician's order. 11/18/2016

SYSTEMIC CHANGES:
An educational in-service will be conducted by the Geriatric Education Coordinator for the nursing staff reviewing the purpose of the Physician's orders which describes the services that are to be provided 12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12	F 309		

A review of the comprehensive care plan for Resident #11 dated 10/17/16 revealed, in part, the following: "Problem: Resident is at risk for/has impaired skin integrity...Apply geri-sleeves."

A review of the Pictorial Care Card for Resident #11 posted on the door of her closet revealed, in part, the following: "Other: Geri-Sleeves both arms for protection. Remove at bedtime."

A review of the TAR (treatment administration record) for Resident #11 revealed the two initials in the box for the day shift nurse to sign on 11/16/16 for the following treatment: "Geri-Sleeves to Hand Left. Hand Right...Apply Geri-Sleeves on both arms for protection. Remove at bedtime."

On 11/16/16 at 1:55 p.m., LPN (licensed practical nurse) #3 and CNA (certified nursing assistant) #2 accompanied the surveyor to Resident #11's bedside. The surveyor asked both staff members if they noticed anything that Resident #11 should have been wearing that she currently did not have on her body. CNA #2 stated: "No." The surveyor asked both staff members if Resident #11 was supposed to be wearing anything else on her arms. LPN #3 stated: "No. Not anything I can think of." Both staff members accompanied the surveyor to the medication cart. CNA #2 was asked how she became aware of physicians' orders for residents. CNA #2 stated: "The nurse tells me. It's also on the care card on the back of the closet." When asked if she had looked at Resident #11's pictorial care card on 11/16/16, CNA #2 stated: "No, I did not look today." LPN #3 was asked if she was aware that Resident #11

to attain or maintain the resident's highest practicable physical, mental, and psycho-social well-being by following the Physician's orders for treatments and services.

MONITORING:

An observational audit of five (5) medical records of Physician orders for resident treatments will be conducted monthly. 12/23/2016

As a second step, a validation audit of the same residents will be conducted to ensure the actual service and/ or treatment is being provided to the residents as ordered by the physician.

The results of these monthly audits will be reported to the Director of Nursing for analysis of trends and patterns. The Performance Improvement Committee will review a summary analysis of the monthly audits and provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13	F 309		

had orders for geri sleeves on both arms. LPN #3 stated: "No, I'm not." When asked to check the physician's orders, she did so. LPN #3 stated: "Yes, I remember now." When asked to check the TAR for Resident #11, LPN #3 showed the surveyor the above-referenced entry for 11/16/16 for the geri sleeves. When asked if the initials in the box were hers, LPN #3 stated: "Yes." When asked what her initials in the box mean, LPN #3 stated: "That it was done." When asked if she should have signed off the geri sleeves as having been applied on 11/16/16, LPN #3 stated: "No." When asked if she had looked at Resident #11 before she had signed the TAR to indicate the geri sleeves were applied, LPN #3 stated: "I usually look."

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator, were informed of these concerns.

A review of the facility policy entitled "Charting - Guidelines and Required Nursing Documentation" revealed no information related to following physicians' orders. On 11/16/16 at 4:20 p.m., ASM #2 stated: "I don't have a specific policy on [following a doctor's orders]. That is something nurses learn in nursing school."

No further information was provided prior to exit.

In Fundamentals of Nursing, 6th edition, 2005, Patricia A. Potter and Anne Griffin Perry, Mosby, Inc; Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

additional recommendations, including the frequency of the continued audits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review it was determined that the facility staff failed to administer oxygen according to physician's orders for one of 24 residents in the survey sample, Resident # 2.

The facility staff failed to administer Resident # 2's oxygen at the flow rate prescribed by the physician; the physician order was 2 (two) L/M (liter per minute) and on separate observations the flow meter on Resident #2's oxygen concentrator was observed set at one and a half liters per minute.

The findings include:

Resident # 2 was admitted to the facility on 5/23/16 with diagnoses that included but were not limited to: heart failure, neurogenic bladder (1), diabetes mellitus (2), cerebral vascular disease

F 328

CORRECTIVE ACTION:
In order to immediately correct the cited deficiency, Resident # 2 oxygen was adjusted to deliver the prescribed two (2) liters. 11/16/2016

OTHER POTENTIAL RESIDENTS:
All Residents receiving oxygen therapy are potentially affected. However, no other observations of non-compliance were observed. 11/16/2016

SYSTEMIC CHANGES:
Re-education of nursing staff via in-services will be conducted by the Geriatric Education Coordinator on proper administration of oxygen therapy. 12/23/2016

MONITORING:
The Facility Compliance Monitoring tool has been revised to include observation of administration of oxygen therapy flow rate according to 12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 328	Continued From page 15	F 328		

(3), seizure disorder, depression, asthma, urinary tract infection (4), chronic obstructive pulmonary disease (5), and coronary artery disease (6).

The most recent comprehensive MDS (minimum dada set), a significant change assessment with an ARD (assessment reference date) of 9/16/16 coded Resident # 2 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions. A review of Section O "Special Treatments, Procedures and Programs" of Resident # 2's significant change MDS assessment with an ARD of 9/16/16 coded Resident # 2 with "Oxygen therapy."

An observation on 11/16/16 at approximately 8:35 a.m. revealed Resident # 2 dressed, sitting up in a wheelchair chair watching television receiving oxygen by nasal cannula (7). Further observation of Resident # 2's oxygen concentrator (8) revealed the flow meter on the concentrator set at one and a half liters per minute.

An observation on 11/16/16 at approximately 2:30 p.m. revealed Resident # 2 dressed, sitting up in a wheelchair chair watching television receiving oxygen by nasal cannula. Further observation of Resident # 2's oxygen concentrator revealed the flow meter on the concentrator set at one and a half liters per minute.

The "Physician's Order Record" signed by the physician on 11/9/16 documented, "O2 (oxygen) via (by) nasal cannula & (and) O2 concentrator at 2(two) L/M (liters per minute)."

Resident # 2's respiratory care plan dated of 10/16/16 documented, "Administer oxygen per

physician's orders.

A random sample of 10% of residents on oxygen therapy will be monitored weekly for four (4) weeks. Where non-compliance is reported, responsible staff will be re-educated immediately and corrective action taken. The results of the weekly audit will be reported to the Director of Nursing for analysis of trends and patterns. The Performance Improvement Committee will review a summary analysis of the weekly audits and provide additional recommendations including the frequency of continued audits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 328	Continued From page 16	F 328		

physician's order."

On 11/16/16 at 11:45 a.m. an interview was conducted with RN (registered nurse) # 4. When asked how the oxygen flow rate is set, RN # 4 stated, "The middle of the ball should pass through the flow rate line. For example if the rate should be two liters the middle of the ball should be at the two liter line." When asked what Resident # 2's oxygen flow rate should be, RN # 4 looked at the physician's order for Resident # 2 and stated, "Two liters per minute." RN # 4 was then asked to read Resident # 2's oxygen flow rate on Resident # 2's oxygen concentrator. After entering Resident # 2's room and reading the oxygen flow rate on the oxygen concentrator, RN # 4 stated, "It's below two liters." When asked how often Resident # 2's oxygen flow rate is checked, RN # 4 stated the oxygen flow rate is checked every shift. RN # 4 further stated that she was Resident # 2's nurse and that she should have checked the oxygen flow rate during her assessment of Resident # 2 at 7:30 a.m. that morning.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

According to Lippincott's Manual of Nursing Practice, 8th edition, (2006). pg. 213, "Oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 328	Continued From page 17	F 328		

saturation is measured using a pulse oximetry. A pulse oximetry functions by passing a light beam through a vascular bed, such as the finger, to determine the amount of blood that is saturated with oxygen."

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing and ASM # 3, the assistant administrator, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition. This information was obtained from the website: https://medlineplus.gov/ency/article/000754.htm.

(2) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

(3) When blood flow to your brain stops. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/stroke.html.

(4) An infection in the urinary tract. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm.

(5) Disease that makes it difficult to breath that can lead to shortness of breath). This information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 328	Continued From page 18 was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (6) Common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html. (7) A nasal cannula consists of two small plastic tubes, or prongs, that are placed in both nostrils. This information was obtained from the website: http://www.nhlbi.nih.gov/health/health-topics/topics/oxt/howdoes. (8) An oxygen concentrator (also sometimes called "oxygen generator") is a medical device used to deliver oxygen to those who require it. People may require it if they have a condition that causes or results in low levels of oxygen in their blood. Oxygen concentrators are powered by plugging in to an electrical outlet or by battery. If the concentrator is powered by an electric battery, that battery will need to be charged by plugging into an outlet. Several parts make up a concentrator, including a compressor, sieve bed filter, and circuit boards. This information was obtained from the website: http://www.inogen.com/resources/oxygen-concentrators/how-does-an-oxygen-concentrator-work/.	F 328		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334	**F334** **CORRECTIVE ACTION:** In order to immediately correct the cited deficiency for Residents #15, #16 and resident	11/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 19 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334	# 17, the resident and/or the legal representative for the cited residents were contacted and provided education regarding the benefits and potential side effects of the influenza immunization. The education provided was documented in the resident's medical records. **OTHER POTENTIAL RESIDENTS:** All residents who received the flu vaccination are potentially affected by the deficient practice. A chart review of all residents receiving the flu vaccination was completed to ensure that education regarding benefits and potential side effects was given. Any non-compliance found was addressed by contacting the resident or the legal representative of the resident and education was provided regarding the benefits and potential side effects of the immunization. This was documented in the medical record.	11/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 20 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide education prior to the administration of the influenza vaccine for three of 24 residents in the survey sample, Resident # 16, #17, and #15 1. The facility staff failed to provide education about the influenza vaccine prior to administering the vaccine on 10/1/16 to Resident #16. 2. The facility staff failed to provide education about the influenza vaccine prior to administering the vaccine on 10/1/16 to Resident #17. 3. The facility staff failed to provide education about the influenza vaccine prior to administering the vaccine on 10/4/16 to Resident #15.	F 334	**SYSTEMIC CHANGES:** An educational in-service will be conducted with the Infection Preventionist by the Director of Nursing in regard to CMS guidelines for the education of the resident or legal representative prior to influenza immunizations. The Infection Preventionist or designee will conduct the education for all residents and/or legal representative prior to offering the influenza immunizations. This will be documented in the medical record for all residents. Educational in-services will be conducted by the Geriatric Education Coordinator with the nursing department directing nurses to check the medical record to ensure that education of the resident or legal representative is documented prior to administering the flu vaccine.	12/23/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 21	F 334	**MONITORING:** The facility Influenza Vaccination Log that identifies, tracks and monitors resident's vaccination status will be revised to include a column for documentation of education provided to the resident or legal representative, with date this occurred, and evidence of documentation in the chart. Until the close of the current flu immunization season, the Infection Preventionist will audit 100% of resident medical records for documentation of education provided regarding the benefits and potential side effects of the immunization. Any non-compliance will be corrected immediately. The results will be reported to the Director of Nursing for analysis of trends and patterns. A summary report of the audits will be provided to the Performance Improvement Committee until the close of the current flu season in March/ April of 2017.	12/23/2016

The findings include:

1. The facility staff failed to provide education about the influenza vaccine prior to administering the vaccine on 10/1/16 to Resident #16.

Resident #16 was admitted to the facility on 6/8/13 with diagnoses that included but were not limited to insomnia, edema, high cholesterol, anxiety, depressive disorder, glaucoma, high blood pressure, and hypothyroidism. Resident #16's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 8/16/16. Resident #16 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of 15 on the BIMS (brief interview for mental status) exam. Resident #16 was coded as requiring extensive assistance with locomotion, dressing, eating, and personal hygiene; and total dependence on staff with toileting and bathing.

Review of Resident #16's clinical record revealed the following order dated 9/30/16: "1. Check temperature prior to administration if the flu vaccine and then every shift for 24 hours after administration. 2. Fluzone quadrivalent (1) Intramuscular Injectable 0.5 ml (milliliters) I.M. (Intramuscular) 3-11 shift 10/1/16; deltoid site."

Review of Resident #16's immunization and vaccination record revealed that Resident #16 received the flu vaccine on 10/1/16.

Review of Resident #16's nursing notes revealed the following note dated 10/1/16 at 11:55 p.m.: "T (temperature) 97.6 Flu vaccine was administered in the right deltoid with no adverse reactions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 22	F 334		

noted, denies pain. PO (by mouth) fluids encouraged and taken well."

Further Review of Resident #16's clinical record failed to provide evidence that Resident #16 was educated about the influenza vaccine prior to it being administered.

On 11/16/16 at 1:36 p.m., an interview was conducted with RN (registered nurse) #1, the infection control nurse. RN #1 stated that she goes over education with the resident about the influenza vaccine, but she does not have the resident sign a form stating that the resident was educated. RN #1 stated that she did not administer the vaccine to Resident #16; a floor nurse administered the vaccine on 10/1/16.

On 11/16/16 at 1:40 p.m., an interview was conducted with Resident #16. Resident #16 stated that she was not provided education about the flu vaccine prior to it being administered. Resident #16 stated, "It was just given to me and then it was done. It hurt for a few days after. I don't think my husband got information about the flu shot." Resident #16 stated the flu shot was a vaccine that she received every year even when she was not in the facility. Resident #16 stated, "I get it every year to prevent the flu."

On 11/16/16 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #7, the nurse who administered the vaccine to Resident #16. When asked the process prior to administering the influenza vaccination, LPN #7 stated, "I check the order, check the patient, and check to make sure the patient does not have allergies to the vaccination. I tell the patient what I am going to do and tell them that the vaccination

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 23	F 334		

prevents the flu, why it is given, how I will give it and explain adverse reactions." When asked if flu vaccination education was provided to Resident #16 prior to the administration of the vaccination, LPN #7 stated, "Yes, I did. I educate all my patients."

On 11/16/16 at 4:05 p.m., an interview was conducted with RN #3, the unit manager. RN #3 stated, "I could not find anything on (Name of Resident #3) that she was educated. Sorry."

On 11/16/16 at approximately 3:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the assistant administrator were made aware of the above findings.

Facility policy titled, FLU (Influenza) Policy documents the following:
Procedure Resident:
Pharmacy-Vaccine order will occur by E-mail in June
Mail out notification to Family/POA (power of attorney) -VDH (Virginia Department of Health) Information Sheet, CDC (Centers for Disease Control) -in September.
Standing orders will be obtained from physician.
Residents will be informed of the program and start date in Resident Council, Family Meetings, Flyers, and Monthly Newsletter.
Staff to be updated on dated and education classes offered to staff with IM training and review of contraindications...
Nurses will be re-in-serviced annually for appropriate and regulated documentation in nurse notes and flu vaccination records/
Infection Control Preventionist (sic) will maintain a record of vaccinations and surveillance log.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 24	F 334		

When the Flu Vaccination Record is completed it will be sent to the DON for compliance review. The Flu Vaccination Record is will be reviewed by the Education Coordinator for Quality Assurance for submission to the Performance Committed quarterly.
A list of the completed vaccinations of residents will be sent to the Finance Department by December."

No further information was provided prior to exit.

(1) Fluzone quadrivalent Intramuscular Injectable-influenza virus vaccine suspension. FLUARIX QUADRIVALENT is a vaccine indicated for active immunization for the prevention of disease caused by influenza A subtype viruses and type B viruses contained in the vaccine. FLUARIX QUADRIVALENT is approved for use in persons aged 3 years and older. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ebeb1c66-deab-4358-a5c0-d4f58c8d8ae7

2. The facility staff failed to provide education about the influenza vaccine prior to administering the vaccine on 10/1/16 to Resident #17.

Resident # 17 was admitted to the facility on 2/26/13 with a readmission of 3/2/15 with diagnoses that included but were not limited to: anxiety (1), heart disease, cerebral vascular accident (2), and edema (3).

The most recent MDS (minimum dada set), a quarterly assessment with an ARD (assessment reference date) of, 9/5/16 coded Resident # 17 as scoring a 7 (seven) on the brief interview for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 25	F 334		

mental status (BIMS) of a score of 0 - 15, 7 (seven) - being severely impaired of cognition for making daily decisions.

The "Physician's Telephone Order" for Resident # 17 dated 9/30/16 documented, "1. Check temperature prior to administration if the flu vaccine and then every shift for 24 hours after administration. 2. Fluzone quadrivalent (4) Intramuscular Injectable 0.5 ml (milliliters) I.M. (Intramuscular) 3-11 shift 10/1/16; deltoid site"

Review of Resident #17's immunization and vaccination record revealed that Resident #17 received the flu vaccine on 10/1/16.

Review of Resident #17's clinical record failed to evidence that Resident #17 or Resident # 17's responsible party was educated about the influenza vaccine prior to it being administered.

On 11/16/16 at 1:25 p.m., an interview was conducted with RN (registered nurse) #1, the infection control nurse about providing education of the influenza vaccine prior to its administration. RN #1 stated that she send out a letter with the influenza vaccine information and education to the family's for those residents who are not their own responsible party. When asked for evidence that Resident # 17's family received education of the influenza vaccine RN # 1 stated, "I don't get acknowledgement that they received it."

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing and ASM # 3, the assistant administrator, were made aware of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 26	F 334		

No further information was provided prior to exit.

References:

(1) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(2) When blood flow to your brain stops. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/stroke.html.

(3) A swelling caused by fluid in your body's tissues. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/edema.html.

(4) Fluzone quadrivalent Intramuscular Injectable-influenza virus vaccine suspension. FLUARIX QUADRIVALENT is a vaccine indicated for active immunization for the prevention of disease caused by influenza A subtype viruses and type B viruses contained in the vaccine. FLUARIX QUADRIVALENT is approved for use in persons aged 3 years and older. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=ebeb1c66-deab-4358-a5c0-d4f58c8d8ae7

3. The facility staff failed to provide education about the influenza vaccine prior to administering the vaccine on 10/4/16 to Resident #15.

Resident #15 was admitted to the facility on 7/29/15 with diagnoses including, but not limited to: chronic obstructive pulmonary disease (1),

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 27	F 334		

heart disease, and diabetes. On the most recent MDS (minimum data set), an annual assessment with an assessment reference date of 11/2/16, Resident #15 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of the clinical record for Resident #15 revealed the following physician's order, written on 10/4/16 by RN (registered nurse) #1, the infection control nurse, and signed by the physician on 10/11/16: "Fluzone Quadrivalent (influenza vaccine) Intramuscular (in the muscle) injectable 0.5 ml (milliliters) I.M. (in the muscle)."

A review of the October 2016 MAR (medication administration record) for Resident #15 revealed that Resident #15 received the influenza vaccine on 10/4/16.

Further review of the clinical record failed to review evidence that Resident #15 received education regarding the risks and benefits of the vaccine before receiving the vaccine.

On 11/16/16 at 1:45 p.m., Resident #15 was interviewed. When asked what the facility staff members had told him about the vaccine before he received it on 10/4/16, he stated: "Absolutely nothing. They just came in here and gave me the shot and left."

On 11/16/16 at 2:10 p.m., RN (registered nurse) #1 stated that she was continuing to look for the evidence of the education provided to Resident #15. RN #1 stated: "I am in the process."

On 11/16/16 at 3:15 p.m., ASM (administrative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 334	Continued From page 28 staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator, were informed of these concerns. No further information was provided prior to exit. (1) "COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. " Progressive" means the disease gets worse over time." This information is taken from the website http://www.nhlbi.nih.gov/health/health-topics/topics/copd.	F 334		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 24 residents in the survey sample, Residents # 9 and # 11.	F 514	**F514** **CORRECTIVE ACTION:** In order to immediately correct the cited deficiency, the DDNR for Resident #9 was completed by the Attending Physician in person at the facility on 11/16/2016, as verified by the Surveyor at 4:20 PM. For Resident #11, the immediate corrective action was in accordance with facility policy, a Millennium Pharmacy Omission Form was completed to accurately correct the documentation on the TAR.	11/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 29	F 514		

1. The facility staff failed to complete the DDNR (Durable Do Not Resuscitate) order for Resident # 9.

2. The facility staff inaccurately documented on the TAR (treatment administration record) on 11/16/16 for Resident #11.

The findings include:

1. The facility staff failed to complete the DDNR (Durable Do Not Resuscitate) order Resident # 9.

Resident # 9 was admitted to the facility on 5/25/16 with diagnoses that included but were not limited to: anemia (1), atrial fibrillation (2), hypertension (3), gastroesophageal reflux disease (4), and dementia (5).

The most recent comprehensive MDS (minimum dada set), an admission assessment with an ARD (assessment reference date) of 6/1/16 coded Resident # 9 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions.

Review of the clinical record for Resident # 9 revealed a DDNR (Durable Do Not Resuscitate) order for Resident # 9 dated 5/25/16, signed by the physician on 5/25/16 and also signed by the responsible party. The DDNR documented: "I further certify (must check 1 or 2):

1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. (Signature of patient

OTHER POTENTIAL RESIDENTS: 11/18/2016
All residents are potentially affected. A review of all residents with a DDNR was conducted and found to be complete.

In addition, a review of all residents with an order for geri-sleeves was conducted and any evidence of non-compliance was corrected immediately, per facility policy.

SYSTEMIC CHANGES:
All DNR orders will be audited by the RN Unit Managers to ensure that the DDNR form is completed and accurate in the medical record. 12/23/2016

In addition, an educational in-service will be conducted for the nursing staff on the importance of complete and accurate documentation of services provided to the residents, including but not limited to geri-sleeves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 30 is required) 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision. If you checked 2 above, check A, B or C below: A. While capable of making an informed decision, the patient has executed a written advanced directive which directs that life-prolonging procedures be withheld or withdrawn. B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent on the Patient's Behalf is required.) C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent on the Patient's Behalf is required.)" Further review of the DDNR revealed that the order was incomplete, # 1 and # 2 and A, B, and C were left blank. On 11/16/16 at 2:20 p.m. an interview was conducted with RN (registered nurse) # 2, unit manager. When asked who was responsible for	F 514	**MONITORING:** The Facility Compliance Monitoring Tool has been revised to include auditing of the medical record to ensure all DDNR forms are complete and accurate. An audit of all new DNR orders will be completed to ensure 100% compliance. The results of these audits will be reported to the Director of Nursing for analysis of trends and patterns. A summary report of the audit will be provided to the Performance Improvement Committee for additional review and recommendations. In addition, an audit of five (5) Treatment Administration Records (TAR) of the nursing staff will be conducted monthly by the Unit Manager. As a second step, a validation audit of the same residents will be conducted to ensure the actual service and/or treatment is being provided to the resident as	12/23/20106

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 31	F 514		

ensuring the DDNR was complete RN # 2 stated, "Anyone who is in the chart and the unit manager, unit secretary, medical records." After reviewing the DDNR for Resident # 9, RN # 2 stated, "It needs to be complete. The areas should have been checked when the family and the physician filled it out."

On 11/16/16 at 4:20 p.m. ASM (administrative staff member) # 2, the director of nursing provided this surveyor with a completed copy of the DDNR for Resident # 9.

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing and ASM # 3, the assistant administrator, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(2) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html.

(3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

ordered by the physician.

The results of these monthly audits will be reported to the Director of Nursing for analysis of trends and patterns. The Performance Improvement Committee will review a summary analysis of the monthly audits and provide additional recommendations, including the frequency of the continued audits.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 32	F 514		

(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(5) A group of symptoms caused by disorders that affect the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/dementia.html.

2. The facility staff inaccurately documented on the TAR (treatment administration record) on 11/16/16 for Resident #11.

Resident #11 was admitted to the facility on 6/30/16, and was most recently readmitted on 8/26/16 with diagnoses including, but not limited to: dementia without behaviors, brittle bones, high cholesterol, high blood pressure, anxiety and depression. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 10/6/16, Resident #11 was coded as being severely impaired for making daily decisions. She was coded as being completely dependent on two staff members for bed mobility, transfers, and bathing; and as being completely dependent on one staff member for dressing, eating, toileting and personal hygiene.

On 11/16/16 at the following times, Resident #11 was observed lying in her bed and was not wearing protective sleeves on her arms: 7:40 a.m., 10:55 a.m., and 1:45 p.m. On 11/16/16 at 11:45 a.m., Resident #11 was observed sitting in her wheelchair in the dining room and was not wearing protective sleeves on her arms.

A review of the physician's orders for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 33	F 514		

#11 revealed the following order, most recently signed by the physician on 10/8/16: "Geri-Sleeves to Hand Left. Hand Right...Apply Geri-Sleeves on both arms for protection. Remove at bedtime."

A review of the comprehensive care plan for Resident #11 dated 10/17/16 revealed, in part, the following: "Problem: Resident is at risk for/has impaired skin integrity...Apply geri-sleeves."

A review of the Pictorial Care Card for Resident #11 posted on the door of her closet revealed, in part, the following: "Other: Geri-Sleeves both arms for protection. Remove at bedtime."

A review of the TAR (treatment administration record) for Resident #11 revealed two initials in the box for the day shift nurse to sign on 11/16/16 for the following treatment: "Geri-Sleeves to Hand Left. Hand Right...Apply Geri-Sleeves on both arms for protection. Remove at bedtime."

On 11/16/16 at 1:55 p.m., LPN (licensed practical nurse) #3 and CNA (certified nursing assistant) #2 accompanied the surveyor to Resident #11's bedside. The surveyor asked both staff members if they noticed anything that Resident #11 should have been wearing that she currently did not have on her body. CNA #2 stated: "No." The surveyor asked both staff members if Resident #11 was supposed to be wearing anything else on her arms. LPN #3 stated: "No. Not anything I can think of." Both staff members accompanied the surveyor to the medication cart. LPN #3 was asked if she was aware that Resident #11 had orders for geri sleeves on both arms. LPN #3 stated: "No, I'm not." When asked to check the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 34	F 514		

physician's orders, she did so. LPN #3 stated: "Yes, I remember now." When asked to check the TAR for Resident #11, LPN #3 showed the surveyor the above-referenced entry for 11/16/16 for the geri sleeves. When asked if the initials in the box were hers, LPN #3 stated: "Yes." When asked what her initials in the box mean, LPN #3 stated: "That it was done." When asked if she should have signed off the geri sleeves as having been applied on 11/16/16, LPN #3 stated: "No." When asked if she had looked at Resident #11 before she had signed the TAR to indicate the geri sleeves were applied, LPN #3 stated: "I usually look."

On 11/16/16 at 3:15 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the assistant administrator, were informed of these concerns. At this time, ASM #2 stated that the facility utilizes the online Lippincott Procedures as their professional reference.

A review of a document entitled "Lippincott Procedures - Documentation, long-term care" dated 11/11/16 revealed, in part, the following: "Never tamper with a documentation or any part of a clinical record; tampering includes...inserting inaccurate information in the record."

No further information was provided prior to exit. According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins, Philadelphia PA, page 23: "Nursing documentation is a highly significant issue since documentation is a fundamental feature of nursing care. Patient records are legally valid, and need to be accurate and comprehensive so that care can be communicated effectively to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 35	F 514		

health care team. Unless the content of documentation provides an accurate depiction of patient and family care, quality of care may not be possible. Many nurses do not realize that what they document or fail to record can produce an enormous effect on the care that is provided by other members of the health care team."