STATE FORM

PRINTED: 09/05/2018 FORM APPROVED

PLAN	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
					<u> </u>		
AME OF	PROVIDER OR SUPPLIER	4951		B. WING _		08/2	23/2018
	HOLLOW HEALTHCA	DE CENTER			STATE, ZIP CODE		
			ANNAN	DLUMBIA PK DALE, VA 220	03		
X4) ID REFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	DVELLI	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOLLD DE	COMP DAT
F 000	Initial Comments			F 000	DEFICIENCY)		-
				100000000	F 000 - The statemen	te.	
	An unannounced bi	iennial State Licon	Ouro		made in the following		
	Inspection was con	ducted 8/20/18 the	rough		and the same of th		
	8/23/18. The facility	v was not in comp	liance with		plan of correction are		
	ule virginia Rules a	nd Regulations to	r the		not an admission to		
	Licensure of Nursin	g Facilities. Six c	omplaints		and do not constitute		
	were investigated d	uring the survey.			an agreement with th	e	
	The census in this 2	22 licensed had f	!!!L		alleged deficiencies ne	or	
	193 at the time of the	le survey The su	acility was		the reported		
	consisted of 38 curr	ent Resident revie	ws and 4		conversations and		
close	closed record review	Wo dild 4		other information cite	d		
					in support of the		
001	Non Compliance			F 001	alleged deficiencies.		
				F 001			
	The facility was out	of compliance with	the		The facility sets forth		
	following state licens	sure requirements	:		the following plan of		
	This PULL is not w				correction to remain i	n	
	This RULE: is not m 12VAC5-371-220 (A	Nursing Services	by:		compliance with all		
	Cross reference to F	-550 and F-680	5,		federal and state		
					regulations. The facilit	У	
	12VAC5-371-220 (A)	Nursing Services			has taken or will take		
	Cross Reference to I	F-656.	.,		the actions set forth in		
	10\405.074.000				the plan of correction.		
	12VAC5-371-360 (E) Cross reference to F	Clinical Records,					
	Closs reference to F	-842.			The following plan of		
	12VAC5-371-140 (E.	1 h) Policies and	-		correction constitutes		
	Procedures,	1.b.) I olicles and			the facilities allegation		
	Cross Reference to F	-606:			of compliance. All		
	10) // 0=				alleged deficiencies		
	12VAC5-371-140 (A)	Policies and Proc	edures.		cited have been or wil		
	Cross Reference to F	-607.			be corrected by the		
	COV 32.1-126.01 (A)				date or dates indicated	d.	
- 1	Cross-Reference to F	-606 and F-607					
(12 VAC 5-371-210 (B Cross Reference to F) Nurse Staffing, -726.					
TORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESEN	NTATIVE'S SIGNA	ATURE	TITLE		0) D :==
7.	2/				IIILE	(X	6) DATE

PRINTED: 09/05/2018 State of Virginia FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PK **ANNANDALE, VA 22003** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)CROSS-REFERENCED TO THE APPROPRIATE COMPLETE TAG DATE DEFICIENCY) F 001 Continued From Page 1 F 001 F 550 1. Certified Nursing 12VAC5-371-370 (E) Maintenance and Assistant that sat on Housekeeping, Cross Refence to F-925. resident #49's couch to complete activity of daily living was educated not to infringe on resident privacy by completing her ADL's sitting on resident couch on 8/23/18. 2. All residents have the 09/26/18 potential to be affected. On 8/23/18 rounds were conducted on all units. Rounds were conducted on all rooms by Director of Nursing to ensure no **Certified Nursing** Assistants are

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completing their

 All Certified Nursing Assistants will be educated not to infringe on resident privacy by completing the ADL's in resident

ADL's

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were found.

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Manager will conduct an audit on 50% of all new dietary hires. Any deviation will be

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If continuation sheet 2 of 2

RECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N	JMBER:			(X3) DAT	E SURVEY
	495155	5	B. WING			
R OR SUPPLIER		STREET AL			08	/23/2018
		6700 COLUMBIA PK ANNANDALE, VA 22003				
EGULATORY OR L	SC IDENTIFYING INFORMA	S	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	CHOILEDE	(X5) COMPLI
C5-371-370 (E) Maintenance and		F 001	forwarded to the Executive Director of designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18. F 607 1. Criminal Backgro check for Dietary Aide #1 was completed on 8/28/18. No identifiable recommend. 2. All residents have to potential to be affed due to not	or ound ds he	09/26/1
				abuse policy and procedure to obtain Criminal Background Check. 100% audit all current dietary	d of al	
	SUMMARY STA EACH DEFICIENCY EGULATORY OR LE DESCRIPTION OF LE C5-371-370 (E	A95155 ER OR SUPPLIER DW HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY EGULATORY OR LSC IDENTIFYING INFORMATION IN THE PROPERTY OF	495155 ER OR SUPPLIER DW HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) nued From Page 1 C5-371-370 (E) Maintenance and ekeeping.	495155 ER OR SUPPLIER DW HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) DIVIDING 10 PREFIX TAG ID PREFIX TAG PREFIX TAG F 001	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8700 COLUMBIA PK ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION) INUED From Page 1 F 001 F 001	A BUILDING B. WING B.

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PRINTED: 09/05/2018 State of Virginia **FORM APPROVED** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PK ANNANDALE, VA 22003 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5)CROSS-REFERENCED TO THE APPROPRIATE TAG COMPLETE DATE DEFICIENCY) F 001 Continued From Page 1 F 001 records were found. **Human Resources** 12VAC5-371-370 (E) Maintenance and Manager will review Housekeeping, Cross Refence to F-925. criminal background check for all new dietary employees prior to hire to ensure completion of criminal background check. 3. Human Resources Manager educated dietary manager on 09/26/18 ensuring criminal background checks are completed prior to hiring dietary employee on 9/7/18. 4. Human Resources Manager will conduct an audit on 50% of all new dietary hires. Any deviation will be forwarded to the **Executive Director or** designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for

monthly x 3.

PRINTED: 09/05/2018 State of Virginia FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/23/2018 SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PK ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X5)TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETE DATE DEFICIENCY) F 001 Continued From Page 1 F 001 5. Date of compliance 09/26/18 12VAC5-371-370 (E) Maintenance and Housekeeping, F 656 Cross Refence to F-925. 1. Care plan for resident #162 was revised on 8/19/17 to indicate elopement history. 2. All residents have the potential to be affected. Care plans for all current residents on the secured dementia unit will be revised to 09/26/18 include at-risk for elopement. For all new admissions that are on the locked dementia unit their care plan will include an at-risk for elopement. 3. All licensed nursing staff will be educated on revising and updating care plan for residents at-risk for elopement on the secured dementia unit by the Assistant

Director of Nursing

PRINTED: 09/05/2018 State of Virginia FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 08/23/2018 SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PK ANNANDALE, VA 22003 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) DATE F 001 Continued From Page 1 F 001 on or before 09/26/18 12VAC5-371-370 (E) Maintenance and 4. Unit Managers will Housekeeping, Cross Refence to F-925. audit 10% of care plans in locked dementia unit weekly for 3 weeks and then monthly. Any deviation will be forwarded to the Director of Nursing or designee and QAPI (Quality Assurance Performance 09/26/18 Improvement) committee for recommendations monthly x3 and ongoing. 5. Compliance date 09/26/18 F 689 1. For resident #241,

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#47, and #28 smoking

secured by Executive Director outside of the designated smoking area on

materials were

8/22/18.

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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PK ANNANDALE, VA 22003 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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 001 Continued From Page 1 F 001 2. All residents have the potential to be 12VAC5-371-370 (E) Maintenance and affected. Smoking Housekeeping, materials for all Cross Refence to F-925. current residents were secured by **Executive Director on** 8/22/18. For all new smokers their smoking materials will be secured per policy. 3. All staff will be educated on the 09/26/18 smoking policy by the **Assistant Director of** Nursing or designee on or before 09/26/18 4. Executive Director or designee will conduct rounds 3 times a week on residents that smoke to ensure that their smoking materials is secured for 3 weeks and then monthly. Any deviation will be

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dialysis have the potential to be affected. All licensed nursing staff will be educated on how to assess arteriovenous

(AV) fistula

hemodialysis access

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AND PLAN	OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY IPLETED
NAME OF	PROVIDER OR SUPPLIER	4951		B. WING _		08	/23/2018
A CONTRACTOR OF THE PARTY OF TH	HOLLOW HEALTHC		6700 CC	DDRESS, CITY, S DLUMBIA PK DALE, VA 220			
(X4) ID PREFIX TAG	REGULATORY OR	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFO	ICIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDE	(X5) COMPLETE DATE
F 001	12VAC5-371-370 (Housekeeping, Cross Refence to	E) Maintenance a	nd	F 001	site for bruit and thrill on all hemodialysis residents. 3. Assistant Director Nursing or designed will continue to educate newly hird licensed nursing ston orientation and annually. 4. Observations will be done by Unit Managers 3 times week on licensed nursing staff assessing arteriovenous (AV) fistula hemodialysis access site for print and thrill weekly x3 and then monthly. Any deviation will be forwarded to the Director of Nursing designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and	ee ed caff l oe a	09/26/18

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If continuation sheet 2 of 2



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ND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N	IER/CLIA UMBER:		TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
IAME OF		495158	5	B. WING			
SI FEDV	PROVIDER OR SUPPLIER		STREET AL		STATE, ZIP CODE	30	3/23/2018
V-7.5	HOLLOW HEALTHCA		6700 CO	LUMBIA PK ALE, VA 22			
(X4) ID PREFIX TAG	REGULATORY OR L	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	ES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDE	(X5) COMPLET DATE
F 001	Toma Familia	E) Maintenance and		F 001	ongoing. 5. Date of compliance 09/26/18 F 842 1. Resident #440 was discharged 6/1/17. Resident #240 was discharged 5/30/17. 2. All residents have the potential to be affected. Medical Records department will ensure that medical records are complete, accurate, systematically organized, and readily accessible from date of acquisition – 5/1/17 per policy. 3. Assistant Director of Nursing or designee will educate medical records staff on having complete, accurate, systematically organized, and readily accessible medical records per policy on or before		09/26/18

If continuation sheet 2 of 2



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and offices # 324, #328 #329. The following room were

inspected and treated by Bay city

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3. Residents and staff

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CTATELLEL	T OF DEPICIENCE	CHIEDIOAID GERVICES	T-		OMB NO). 0938-039 [,]
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495155	B. WING			С
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	80	/23/2018
SLEEPY	HOLLOW HEALTHO	ARE CENTER		6700 COLUMBIA PIKE ANNANDALE, VA 22003	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	The statements made in	the	
				following plan of correcti		
	An unannounced	Emergency Preparedness		are not an admission to a		
	Corrections are re-	cted 8/20/18 through 8/23/18. Quired for compliance with 42		do not constitute an	iiiu	
	CFR Part 483.73.	Requirement for Long-Term		agreement with the alleg	red	
	Care Facilities. No	emergency preparedness		deficiencies nor the	eu	
E 004	complaints were in	vestigated during the survey.	ı	reported conversations	nd	
E 004	CFR(s): 483.73(a)	Review and Update Annually	E 004	other information cited in		
33-0	Of 11(8). 400.73(8)			support of the alleged		
	[The [facility] must	comply with all applicable		deficiencies. The facility s	cots	
	Federal, State and	local emergency		forth the following plan of		
	develop establish	irements. The [facility] must and maintain a comprehensive		correction to remain in	л	
	emergency prepare	edness program that meets the		compliance with all feder	ral	
	requirements of thi	s section.]		and state regulations. Th		
	* [Ear beesitele et f	400 45 1 0 4 11		facility has taken or will t		
	6485 625(a):1 The	482.15 and CAHs at [hospital or CAH] must comply		the actions set forth in th		İ
	with all applicable F	ederal, State, and local		plan of correction. The		
	emergency prepare	edness requirements. The		following plan of correcti	ion	
	[hospital or CAH] n	nust develop and maintain a		constitutes the facilities		
	program that meets	ergency preparedness s the requirements of this		allegation of compliance	ΔII	
	section, utilizing an	all-hazards approach.		alleged deficiencies cited		
and the same of th				have been or will be		
	The emergency pre	eparedness program must limited to, the following		corrected by the date or		
1	elements:]	illilited to, the following		dates indicated.		
	(a) Emergency Plan	n. The [facility] must develop				
The state of the s	and maintain an en	nergency preparedness plan wed], and updated at least		RECE	IVED	
	* IF FORD			SEP 24	2018	
	Plan. The ESRD facility	ies at §494.62(a):] Emergency cility must develop and				
	maintain an emerge	ency preparedness plan that], and updated at least		VDH/	OLC	

LABORATORY DIRECTOR'S OR PROVIDER'S UPPLIER REPRESENTATIVE'S SIGNATURE

DIRECTUR

(X6) DATE

FXEC 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 of 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.

PRINTED: 09/04/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION A. BUILDING C 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6700 COLUMBIA PIKE SLEEPY HOLLOW HEALTHCARE CENTER** ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 004 E 004 Continued From page 1 E 004 The facility risk assessment annually. will be completed on or 09/26/18 This REQUIREMENT is not met as evidenced before 09/26/18. 2. The facility risk assessment Based on record review, and staff interview, the facility staff failed to have documentation of the will be completed on or facilities Emergency Preparedness Plan identified before 09/26/18. risk assessment. 3. Assistant Executive Director The findings included: or designee will in-service all staff on the facility risk During an interview on 08/22/18 at 11:40 A.M. assessment on or before with the Administrator, he was asked for 09/26/18. documentation of the facilities community-based 4. The risk assessment will be risk assessments that will assist the facility in addressing the needs of their patients. The reviewed bi-annually or as Administrator stated the facility had not necessary and updates will conducted a risk assessment of it's emergency be made to the risk preparedness plan. The Administrator presented a summary of a Hurricane Evacuation Plan which assessment. Any deviation he stated was the result of a workshop. will be forwarded to the **Executive Director or** The facility staff failed to have documentation of designee and QAPI (Quality identified risk assessments of the emergency preparedness plan. **Assurance Performance** E 006 Plan Based on All Hazards Risk Assessment E 006 Improvement) committee SS=C CFR(s): 483.73(a)(1)-(2) for recommendations for monthly x 3 and ongoing. [(a) Emergency Plan. The [facility] must develop Compliance date 09/26/18 and maintain an emergency preparedness plan 09/26/18

that must be reviewed, and updated at least annually. The plan must do the following:]

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*

*[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and

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all-hazards approach, including missing residents. "[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. (2) Include strategies for addressing emergency events identified by the risk assessment. (3) Include strategies for addressing emergency events identified by the risk assessment. (4) Include strategies for addressing emergency events identified by the risk assessment. (5) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility staff failed to have documentation of the facility population. 2. The hazard risk assessment will be used to develop the strategies in determining the needs of the facility population. 3. Assistant Executive Director or designee will in-service all staff on the strategies for the risks and strategies identified on or before 09/26/18 4. The hazard risk assessment will be reviewed monthly x3 and updates will be made to the risk assessment. 4. The hazard risk assessment will be reviewed monthly x3 and updates will be meeds of the facility population. 5. The hazard risk assessment will be reviewed to the strategies in determining the needs of the facility population. 6. The hazard risk assessment will be reviewed to the risk assessment will be reviewed monthly x3 and updates will be made to the risk assessment.	09/26/18

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E 007 SS=C	CFR(s): 483.73(a): [(a) Emergency Plaand maintain an erthat must be review annually. The plan (3) Address patien but not limited to, parvices the [facilit an emergency; and including delegation plans.** *Note: ["Persons a hospice, PACE, History: PACE, History: Based on record reacility staff failed to facilities identified emergency and demergency. The findings include the facilities identified emergency. The findings include the facilities identified emergency and demergency. The findings include the facilities identified emergency and demergency a	an. The [facility] must develop mergency preparedness plan wed, and updated at least must do the following:] t/client population, including, persons at-risk; the type of y] has the ability to provide in discontinuity of operations, and of authority and succession trisk" does not apply to: ASC, HA, CORF, CMCH, RHC, acilities.] NT is not met as evidenced eview, and staff interview, the o have documentation of the population at risk during an elegation of authority during an	E 007	 Facility will conduct a meeting to determine delegation of authority before 09/26/18 Facility will conduct a meeting to determine delegation of authority before 09/26/18 Assistant Executive Dir or designee will in-servisks identified. The delegation of authority will be reviewed mont and updates will be matthe Emergency Prepare Manual. Any deviation be forwarded to the Executive Director or designee and QAPI (Quantum Assurance Performance Improvement) committee recommendations for monthly x 3 and ongoi Compliance date 09/26 	y on or rector vice all for the nority hly x3 ade to edness will uality re ree for

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	SUMMARY ST (EACH DEFICIENT REGULATORY OR Intinued From prining and even if the authority the eived training for they all stated cumentation of emergency. If facilities identification and implementation of emergency. If facilities identification and proceed in the eived training for they all stated cumentation of emergency. If facilities identification are repeated in the entire identification and proceed in set forth in particular and part	A95155 IDER OR SUPPLIER LOW HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 4 Intinued From page A Intinued From page 4 Intinue	IDENTIFICATION NUMBER: 495155 B. WING IDER OR SUPPLIER LOW HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 4 rining and evening shifts were asked if they if the authority to act during an emergency and elived training for acting during an emergency if they all stated "No." The facility did not have sumentation of delegation of authority during emergency. In a facilities identified population at risk and sumentation of delegation of authority during emergency. In a facilities identified population at risk and sumentation of delegation of authority during emergency. In a facility staff failed to have documentation of facilities identified population at risk and sumentation of delegation of authority during emergency. In a facility staff failed to have documentation of facilities identified population at risk and sumentation of delegation of authority during emergency. 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The procedures, Efacilities must eleop and implement emergency preparedness cless and procedures, based on the emergency in set forth in paragraph (a) of this section, risk easient at paragraph (a) of this section, isk essent at paragraph (b) of section. 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	*[For Inpatient Hos Policies and proceed (6) The following and hospice-operated in The policies and profollowing: (iii) The provision of hospice employees evacuate or shelter imited to the follow (A) Food, water, supplies. (B) Alternate sour following: (1) Temperature and safety and for the following: (2) Emergency (3) Fire detections REQUIREMENTY: Based on record reacility staff failed to the emergency preparations of subsist vater and sewage of the findings include the facility emergency preparations of subsist vater, and fuel during the design of the facility emergency and fuel during the design of the facility emergency and fuel during the facility emergency and facility emergency emergen	waste disposal. pice at §418.113(b)(6)(iii):] dures. re additional requirements for inpatient care facilities only. recedures must address the f subsistence needs for and patients, whether they in place, include, but are not ing: medical, and pharmaceutical reces of energy to maintain the res to protect patient health the safe and sanitary storage r lighting. ion, extinguishing, and alarm waste disposal. IT is not met as evidenced review and staff interview, the provide documentation that baredness plan addressed tence including food and lisposal services.	E 015	Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committe for recommendations for monthly x 3 and ongoin 5. Compliance date 09/26/18	or	09/26/18

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	During a review of plan with the admi A.M. he was asked contracts for food, disposal services. Division Director of they would provide water, and fuel. No during the survey. Operations's provide 2:15 P.M. during the Proposal dated 10/2 internal grease training Roles Under a Wai CFR(s): 483.73(b)(c) [(b) Policies and proceed plan set forth in parassessment at para and the communication this section. The poreviewed and updaminimum, the policies and proceed and updaminimum, the policies and proceed and updaminimum, the policies and proviewed and updaminimum, the policies and proceed and updaminimum, the policies and proceed and updaminimum, the policies and proceed and updaminimum, the policies and the communication of the provision of care are site identified in officials. *[For RNHCIs at §4] Proceedures. (8) The waiver declared by	the emergency preparedness nistrator on 08/22/18 at 11:30 d for documentation for vendor water, fuel, and sewage The administrator and the f Facility Maintenance stated, ed contracts for the food, o contracts were provided The Regional Director of ded this surveyor on 8/23/18 at the exit conference with a (5/17 to pump and clean (3) os. occurred by Secretary 8) occedures. The [facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ted at least annually. At a lies and procedures must	E 026	1. Facility will had documentation the facility's reproviding care before 09/26/2. 2. Facility will had documentation the facility's reproviding care before 09/26/2. 3. Assistant Exect or designee will all staff on designee on 09/26/18. 4. The document the facility's reproviding care reviewed month deviation will be to the Executive designee and Office Assurance Performent of the for recommend monthly x 3 and 5. Compliance dates	n describing ole in off-site on or 18. It is describing ole in off-site on or 18. It is Director of 18. It is describing the or before or befor	09/26/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE SLEEPY HOLLOW HEALTHCARE CENTER ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG TAG DEFICIENCY) E 026 | Continued From page 7 E 026 at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to have documentation describing the facilities role in providing care in an alternate care site. The findings included: During an interview with the administrator on 08/22/18 at 11:57 a.m. the administrator was asked for documentation describing the facilities role in providing care in an alternate care site. The administrator stated, he did not have any documentation describing the facilities role or the care that would be provided at an alternate care site. During interviews with various nursing staff on several units, they were asked if they had training on providing care at alternate care sites during an emergency. The staff responded they had not had training nor had they been provided with what roles they would carry out during an emergency. The facility staff failed to have documentation describing the facilities role in providing care in an alternate care site. E 033 Methods for Sharing Information E 033

CFR(s): 483.73(c)(4)-(6)

[(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include

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	documentation for parents and continued for the release patient information (5) A means, in the release patient information (5) A means, in the release patient information (5) A means, in the release patient information (6) [(4) or (5)] A means (6) [(4) or (6)] A means (aring information and medical patients under the [facility's] with other health providers to uity of care. event of an evacuation, to rmation as permitted under 45 ii). [This provision is not under §484.22(c), CORFs and RHCs/FQHCs under ons of providing information produced and location of facility's] care as permitted 510(b)(4). 03.748(c):] (4) A method for and care documentation for the care	E 033	1. The facility will add facility communical plan to the Emerge Preparedness Man or before 09/26/18 2. Facility will add fact communication plat the Emergency Preparedness Man or before 09/26/18 3. Assistant Executive Director or designed in-service all staff of facility communication plan on or before 09/26/18 4. The facility communication plan be reviewed month Any deviation will be forwarded to the Executive Director of the Exe	ention ency ual on ility on to ual on e will on tion n will ly x3.
	164.510(b)(4). This REQUIREMEN by: Based on record rev facility staff failed to communication plan	T is not met as evidenced view and staff interview, the have documentation that the included a method for and medical documentation		designee and QAPI (Quality Assurance Performance Improvement) common for recommendation	ns for

to maintain continuity of care.

monthly x 3 and ongoing.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE SLEEPY HOLLOW HEALTHCARE CENTER ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) E 033 5. Compliance date Continued From page 9 E 033 09/26/18 09/26/18 The findings included: E034 During an interview on 08/22/18 at 12:08 p.m. The facility will provide with the administrator, he was asked for evidence that the facility had a method for sharing documentation and have information and medical care for residents with means of providing other health care providers to maintain continuity information about facilities of care. The administrator stated, he did not have needs and our ability to documentation for sharing information and medical care needs for residents in an alternate provide assistance on or care site. before 09/26/18The facility will utilize Virginia Hospital The facility staff failed to have documentation that Alert and Status System and the communication plan included methods for walkie-talkie's to provide sharing information and medical care with other health care providers. information about facilities E 034 Information on Occupancy/Needs E 034 needs and our ability to SS=C CFR(s): 483.73(c)(7) provide assistance on or before 09/26/18 [(c) The [facility] must develop and maintain an emergency preparedness communication plan 2. The facility will provide that complies with Federal, State and local laws documentation and have and must be reviewed and updated at least means of providing annually.] The communication plan must include information about facilities all of the following: needs and our ability to (7) [(5) or (6)] A means of providing information provide assistance on or about the [facility's] occupancy, needs, and its before 10/2/18. The facility ability to provide assistance, to the authority will utilize Virginia Hospital having jurisdiction, the Incident Command Center, or designee. Alert and Status System and walkie-talkie's to provide *[For ASCs at 416.54(c)]: (7) A means of information about facilities providing information about the ASC's needs, and needs and our ability to its ability to provide assistance, to the authority

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having jurisdiction, the Incident Command

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E 036	EP Training and Test CFR(s): 483.73(d)	ting	E 036	5.	Date of compliance 09/26/18		09/26/18
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4E4011

Facility ID: VA0227

If continuation sheet Page 11 of 77



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER **6700 COLUMBIA PIKE** ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 11 E 036 E036 based on the emergency plan set forth in 1. The facility will develop paragraph (a) of this section, risk assessment at 09/26/18 paragraph (a)(1) of this section, policies and an emergency procedures at paragraph (b) of this section, and preparedness training the communication plan at paragraph (c) of this and testing program on section. The training and testing program must be reviewed and updated at least annually. or before 09/26/18 2. The facility will develop *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency an emergency preparedness training and testing preparedness training program that is based on the emergency plan set and testing program on forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, or before 09/26/18 policies and procedures at paragraph (b) of this 3. Assistant Executive section, and the communication plan at paragraph (c) of this section. The training and Director or designee will testing program must be reviewed and updated at in-service all staff on least annually. The ICF/IID must meet the emergency preparedness requirements for evacuation drills and training at §483.470(h). training and testing program on or before *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must 09/26/18 develop and maintain an emergency 4. Assistant Executive preparedness training, testing and patient Director or designee will orientation program that is based on the emergency plan set forth in paragraph (a) of this monitor compliance with section, risk assessment at paragraph (a)(1) of the emergency this section, policies and procedures at paragraph preparedness training (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and testing program and orientation program must be reviewed and monthly x3. Any updated at least annually. This REQUIREMENT is not met as evidenced deviation will be forwarded to the Based on record review and staff interview the

facility staff failed to have an emergency preparedness training and testing program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495155		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER SLEEPY HOLLOW HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COE 8700 COLUMBIA PIKE ANNANDALE, VA 22003	DE	0123120 18
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	AOUILD RE	COMPLETION DATE
	The findings included buring an interview with the administrate documentation of the program. The administrate vidence was present evidence was program. EP Training Program. EP Training Program ASCs, PACE organ and dialysis facilities (i) Initial training in evidence was proceed and evidence of the evide	v on 08/22/18 at 12: 27 p.m. stor, he was asked for the facility's training and testing inistrator stated the facility had no program however, no ented during the survey of a edness Test or Staff Training.	E 037	Executive Director designee and QAPI (Quality Assurance Performance Improvement) comfor recommendation monthly x 3 and on 5. Date of compliance 09/26/18.	nmittee ons for ngoing.	09/26/18

STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II T	IPLE CONSTRUCTION	OMB N	RM APPROVE 10. 0938-039
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IG		OATE SURVEY OMPLETED	
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E 037			E 03	7 E 037		
	(ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.			 The facility staff did have initial emergen preparedness training. Assistant Executive E or designee will in-seall current staff on emergency prepared training on or before 09/26/18 Assistant Executive D or designee will in-seall new hires during orientation and all stabe in-serviced annual Assistant Executive D or designee will monicompliance with the emergency preparedr training monthly x3. A deviation will be forwate to the Executive Direct designee and QAPI (Qin Assurance Performance Improvement) commit for recommendations 	g. birector rvice ness irector rvice aff will by. rector tor ness any arded tor or uality se ttee	09/26/18
	preparedness trainin (iii) Demonstrate stat procedures.	f knowledge of emergency		monthly x 3 and ongoi 5. Date of compliance 09/26/18	ng.	09/26/18

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495155		(X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER HOLLOW HEALTHCA	ARE CENTER	67	TREET ADDRESS, CITY, STATE, ZIP CODE 700 COLUMBIA PIKE NNANDALE, VA 22003	08	/23/2018	
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	(i) Initial training in e policies and procedustaff, individuals pro arrangement, contra volunteers, consiste (ii) Provide emergent least annually. (iii) Demonstrate state procedures, includin what to do, where to case of an emergence (iv) Maintain docume "[For CORFs at §488 CORF must do all of (i) Provide initial train preparedness policies and existing staff, includer arrangement, a with their expected received the contract of the contract	o all of the following: emergency preparedness ures to all new and existing viding on-site services under actors, participants, and nt with their expected roles. Iccy preparedness training at iff knowledge of emergency g informing participants of go, and whom to contact in cy. entation of all training. 5.68(d):](1) Training. The the following: hing in emergency is and procedures to all new dividuals providing services and volunteers, consistent bles. Cy preparedness training at ntation of the training. If knowledge of emergency personnel must be oriented c responsibilities regarding locy plan within 2 weeks of the training program must the location and use of gnals and firefighting	E 037				
10	ne CAH must do all	nergency preparedness					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER **6700 COLUMBIA PIKE** ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) E 037 Continued From page 15 E 037 reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have an initial emergency preparedness training program. The findings included: During an interview on 08/22/18 at 12: 32 P.M. with the administrator, he was asked for

documentation for an initial training program in emergency preparedness policies and

procedures for all new new and existing staff. The

STATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES			OMB NO	0. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495155 NAME OF PROVIDER OR SUPPLIER SLEEPY HOLLOW HEALTHCARE CENTER		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	DPE	COMPLETION DATE
SS=C	administrator state trained and tested for Emergency Pre evidence of an Initi presented during the The facility staff fail Emergency Prepare EP Testing Require CFR(s): 483.73(d)(c) Testing. The [facility and OPOstest the emergency [facility, except for Fall of the following: "[For LTC Facilities The LTC facility must the emergency plan unannounced staff (procedures. The LTC following:] (ii) Participate in a furth community-based or exercise is not acceptacility-based. If the actual natural or main requires activation of facility] is exempt from the community-based or full-scale exercise for the actual event. iii) Conduct an additional of the conduct of th	d, the facility staff had been on the Initial Training Program paredness. However, no al Training Program was ne survey. led to have an Initial edness Training Program. In the edness Training Program edness to the	E 03	 The facility will con a table-top exercise or before 09/26/18 Assistant Executive Director or designe 	e on e e e-	09/26/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) E 039 Continued From page 17 E 039 (B) A tabletop exercise that includes a group committee for review discussion led by a facilitator, using a narrated, monthly x 3 and clinically-relevant emergency scenario, and a set of problem statements, directed messages, or ongoing. prepared questions designed to challenge an 5. Date of compliance emergency plan. (iii) Analyze the [facility's] response to and 09/26/18 09/26/18 maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced Based on record review and staff interview the

analysis and response.

The findings include:

facility staff failed to have documentation of the facility's Emergency Preparedness exercise

During an interview on 08/22/18 at 12:35 P.M. with the administrator, he was asked for

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULT	IPLE CONSTRUCTION OMB	FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIES	495155	B. WING_		C
	HOLLOW HEALTHO	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE ANNANDALE, VA 22003	08/23/2018
PREFIX	IMPACT LEFT LEFT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
E 039	staff did not conduce exercise nor did the	age 18 he facility's table top exercise nistrator stated, the facility ct an analysis of the table top e facility staff revise the edness Plan as a result.	E 03	9	
F 000	The facility staff fail the facilities exercis INITIAL COMMENT	ed to have documentation of se analysis and response. IS	F 000		
	survey was conduct Corrections are requirements. The survey/report will fol investigated during to	Life Safety Code low. 6 complaints were the survey.		following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and othe information cited in support of the	
550	193 at the time of th	rcise of Rights	F 550	alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and	09/26/1
s	iccess to persons a	Rights. ght to a dignified existence, nd communication with and nd services inside and cluding those specified in		state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facilities allegation	
re	esident in a manner romotes maintenant er quality of life, reci	ty must treat each resident ity and care for each and in an environment that ce or enhancement of his or ognizing each resident's ity must protect and		of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	MANAGAMAN AND AND AND AND AND AND AND AND AND A

FORM CMS-2587(02-99) Previous Versions Obsolete

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 09/04/2018 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS. CITY, STATE ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) MPLETION DATE TAG DEFICIENCY) F 550 Continued From page 19 F 550 F 550 promote the rights of the resident. 1. Certified Nursing §483.10(a)(2) The facility must provide equal Assistant that sat on access to quality care regardless of diagnosis, severity of condition, or payment source. A facility resident #49's couch must establish and maintain identical policies and to complete activity practices regarding transfer, discharge, and the provision of services under the State plan for all of daily living was residents regardless of payment source. educated not to §483.10(b) Exercise of Rights. infringe on resident The resident has the right to exercise his or her privacy by completing rights as a resident of the facility and as a citizen or resident of the United States. her ADL's sitting on resident couch on §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without 8/23/18 interference, coercion, discrimination, or reprisal 2. All residents have the from the facility. §483.10(b)(2) The resident has the right to be

by: Based on observations, clinical record review, staff and resident interview, and facility

free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her

exercise of his or her rights as required under this

rights and to be supported by the facility in the

This REQUIREMENT is not met as evidenced

documentation, the facility staff failed to respect the dignity and privacy for 1 of 42 (Resident #49) residents in the survey sample.

1. The facility staff routinely sat on Resident #49's couch in her room to complete Activities of Daily Living (ADL) documentation which infringed upon her privacy.

potential to be affected. On 8/23/18 rounds were conducted on all units. Rounds were conducted on all rooms by Director of Nursing to ensure no **Certified Nursing** Assistants are completing their

subpart.

ADL's

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495155					PRINTED: 09/04/2 FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
			Y HOLLOW HEALTHCA			STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	ANNANDALE, VA 22003		
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F 550	Resident #40 was admitted to the		F 556			
					ng	
	Parkinson's disease.	oses that included stroke and		Assistants will be		
		and discountry and a second se		educated not to		
	The most recent Minimum Data Set (MDS)			infringe on residen	t	
	coded Resident #40 on the District and		privacy by complet	ina		
		5) With a score of 15 out of a 5 which indicated the resident ct in the skills needed for daily eximately 2:00 p.m., a CNA #1 sitting on Resident		the ADL's in residen	ıt	
	was cognitively intact			room by Assistant	1	
1	decision making.			Director of Nursing	or	
- 1	On 8/21/18 at approve			designee on or before	70	
				09/26/18.	е	
	#49's couch using an similar to a cell phone			4 Unit Man		
	to a cell priorie	•		4. Unit Manager or		
	On 8/22/18 at 10:00 a	.m., during a group		designee will conduct		
1 11	ivel aleas arith in tacing	residents, they stated the stants use their cell phones		random rounds week	У	
	THE POLITY OF A LAC	IIIOF Beeie Desident		on 5 resident's room	1	
1.00	42 Indicated the CNA	As sit in her room and use		per unit for		
u	neir cell phones.			compliance. Any deviation will be		
C	n 8/22/18 at 4:15 p.n	n., Resident #49 stated		forwarded to the		
W	men the CNAs came	into her room to talk on the love seat, thus she would	To the state of th	Director of Nursing and	_	
P	ull her curtain for pers	sonal privacy.	100	QAPI (Quality	u	
				Assurance Performance		
W	as conducted with Ci	.m., a telephone interview NA#1. She stated she ch in the resident's room to prmation on her assigned 8 other CNAs in other resident	-	Improvement)		
rc	putinely used the coud			committee for		
re	sidents, as well do of			recommendations for		
rc	oms. She stated the	residents may think the	-	monthly x 3.		
De	a cell phone, but is	may appear to residents to a 6 inch electronic pad			00	9/26/18
de	esigned to enter ADL	documentation on each		5. Date of compliance		, 20, 10
resident. When asked if she or other CNAs			09/26/18			

TATEMENT ND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER HOLLOW HEALTHC		STREET ADDRESS, CITY, STATE ZIP CODE 6700 COLUMBIA PIKE ANNANDALE, VA 22003				
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F 550	document on their daily practice infring stated, "I have thos	age 21 s to sit in their rooms to electronic pads, or that this ged on resident privacy, she se residents in that area and it or me to chart on my residents	F 55	o			
	with the Administrat (DON). The DON or residents thought we electronic tablets us information. The Dothe CNAs were using and document via the Administrator stated place to document or rooms and it was an accordance or the composition of the	p.m., a debriefing was held tor and the Director of Nursing verified the devices that vere cell phone were the sed by the CNAs to enter ADL ON stated she was not awareing the resident's rooms to sit heir electronic tablets. The dithere should be a better other than in the resident's ninvasion on their privacy.					
F 606	Rights dated 8/11/1 state worthy of hone which was a resider belongings, space a	Staff w/ Adverse Actions	F 606				
	§483.12(a) The faci	lity must-					
	individuals who- (i) Have been found exploitation, misapp mistreatment by a c (ii) Have had a findin nurse aide registry o	ng entered into the State concerning abuse, neglect, atment of residents or			A Company		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 22 F 606 (iii) Have a disciplinary action in effect against his F 606 or her professional license by a state licensure body as a result of a finding of abuse, neglect, 1. Criminal Background exploitation, mistreatment of residents or check for Dietary Aide misappropriation of resident property. 09/26/18 #1 was completed on §483.12(a)(4) Report to the State nurse aide 8/28/18, No. registry or licensing authorities any knowledge it identifiable records has of actions by a court of law against an employee, which would indicate unfitness for were found. service as a nurse aide or other facility staff. 2. All dietary employees This REQUIREMENT is not met as evidenced have the potential to Based on an Employee Record Review, staff be affected. 100% audit interviews, and facility document review, the of all current dietary facility staff failed to obtain a Criminal Background Check for 1 staff member, Dietary employee's criminal Aide #1 record were reviewed on 9/7/18. No The facility staff failed to obtain a Criminal Background Check for Dietary Aide #1, with a hire identifiable records date of 9/15/17. were found. Human Resources Manager will The findings included: review criminal On 8/22/18 an Employee Record Review was background check for conducted on 25 current employees from 8/20/16 to 8/20/18. The employee record for Dietary Aide all new dietary #1, with hire date of 9/15/17 did not contain employees prior to hire Virginia State Police criminal background check. to ensure completion On 8/23/18 at 10:24 AM an interview was of criminal background conducted with the Human Resources Manager check on or before and she was asked to present documentation of the criminal background check for Dietary Aide 09/26/18. #1, hired on the date of 9/15/18. The Human Resources Manager stated, "We do not have it, I

even checked with dietary department and

corporate and we don't have it."

STATEMENT AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	and the second	TIPLE CONS		(X3) DATE SURVEY COMPLETED		
		495155	B WING				08/23/2018	
	PROVIDER OR SUPPLIER HOLLOW HEALTHC	ARE CENTER		6700 CO	ADDRESS, CITY, STATE, ZIP CODE LUMBIA PIKE DALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI ROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 606	On 8/23/18 at 12:1 conducted with the and he stated, "I had he done on all employed by the facility policy to the reviewed and is do to the procedure: I. Screening I. Employees seek application including references as well three (3) positions a. Following the performendation of check will be performed to the performed to the facility policy to the facility policy to the facility policy to 1/20/10 was review as follows: POLICY STATEME It is the policy of Co (CHS) to be an equilifications and a Unless otherwise pwith CHS is considered.	1 PM an interview was a facilities Executive Director ave spoken with the Human er and understand we do not also criminal background check. It is to ployees working in this facility." It is a state background check is to ployees working in this facility." It is a state background check is to ployees working in this facility." It is a state background check in part, as follows: It is a state background check in part, as follows: It is a state background in part, as follows: It is a state background in part, as follows: It is a state background in the interview and upon in the interview and upon in the interview and upon in the interview in background in the interview in part, In the interview in the in	F 6	4.	Human Resources Manager educated dietary manager on 9/7/18 ensuring criminal background checks are completed prior to hiring dietary employee. Human Resources Manager will conduct an audit on 50% of all new dietary hires. An deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. Date of compliance 09/26/18.	y Y	09/26/18	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE		PRINTED: 09/04/2018 FORM APPROVED	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The state of the s	PLE CONSTRUCTION G	(X3) D/	<u>O. 0938-0391</u> ATE SURVEY OMPLETED
		495155	B WING_			C
	PROVIDER OR SUPPLIER / HOLLOW HEALTHCA	Steel SV TO A STORE CONTROL OF THE STORE S		STREET ADDRESS, CITY, STATE, ZIP COI 6700 COLUMBIA PIKE ANNANDALE, VA 22003	DE	B/23/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
F 607 SS=D	responsible for conditional responsible for employer will be refused employed, may be to conditional responsible for employed, may	ision to hire the applicant, the roes Representative is ducting the following steps: inal background check in Ideral and state requirements. Id, medical, or any other ation discloses any in the application form, or g that the individual is not ent with CHS, the applicant comment or, if already erminated. PM a pre-exit conference was administrator, Director of Clinical Nurse, Chief and Assistant Administrator formation was shared. Prior to leation was shared. Prior to leation was shared. Abuse/Neglect Policies (1)-(3) Ity must develop and esident property, ish policies and procedures challegations, and the training as required at	F 607	theck for Dietary #1 was complete 8/28/18. No identifiable reco were found. 2. All residents hav potential to be a due to not implementing th abuse policy and procedure to ob Criminal Backgro Check. 100% aud current dietary employee's crim record were rev on 9/7/18. No identifiable reco were found. Hu Resources Mana review criminal background che all new dietary employees prio to ensure comp of criminal back	Aide ed on rds rethe effected ne ditain a bund dit of all ninal riewed ords man ager will eck for or to hire oletion	09/26/18
	I DIS KEQUIREMEN	is not met as evidenced		check.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 4E4011

Facility ID: VA0227

If continuation sheet Page 25 of 77



TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB N	O. 0938-0:	
	495155	B. WING			COMPLETED	
NAME OF PROVIDER OR SUPPLIEF	2		TOPET ADDRESS OF	0	8/23/2018	
SLEEPY HOLLOW HEALTHO		67	TREET ADDRESS, CITY, STATE, ZIP CODE 700 COLUMBIA PIKE NNANDALE, VA 22003			
TOTAL DEFICIENT	ATEMENT OF DEFICIENCIES YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE	
facility staff failed to and procedure to o Check for all newly The facility staff failed to and procedure to o Check for all newly The facility staff failed to the conducted to the conducted to the conducted on 25 current employee (Didate of 9/15/17 did repolice criminal back) On 8/23/18 at 10:24 conducted with the hand she was asked to criminal background record with hire date Resources Manager even checked with dicorporate and we do On 8/23/18 at 12:11 I conducted with the faind he stated, "I have Resources Manager have this employee's Our policy is a state to done on all employee	ployee Record Review, staff ility document review, the primplement their abuse policy btain a Criminal Background hired employees. ed to obtain a criminal for 1 current staff member that hire date of 9/15/17. ed: loyee Record Review was record to the employees hired from The employees hired from The employee record for 1 bietary Aide #1) with a hire not contain a Virginia State ground check. AM an interview was duman Resources Manager to present documentation of check for Dietary Aide #1's of 9/15/18. Human stated, "We do not have it, I letary department and it have it."	F 607	 Human Resources Manager educated dietary manager on ensuring criminal background checks a completed prior to hiring dietary employee on 9/7/18. Human Resources Manager will conduct an audit on 50% of al new dietary hires. An deviation will be forwarded to the Executive Director or designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. Date of compliance 09/26/18 	t II Iy	9/26/18	

PRINTED: 09/04/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6700 COLUMBIA PIKE** SLEEPY HOLLOW HEALTHCARE CENTER ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) WPLETION DATE PROVIDER'S PLAN OF CORRECTION 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX TAG TAG DEFICIENCY) F 607 Continued From page 26 F 607 reviewed and is documented in part, as follows: Procedure: I. Screening 1. Employees seeking hire will complete an application including three (3) personal references as well as a work history of the last three (3) positions held, if applicable. a. Following the personal interview and upon recommendation of the interviewer, a background check will be performed. 2. A criminal background check will be completed, per the requirements of SB 160. The facility policy titled "Hiring" last modified 1/20/10 was reviewed and is documented in part. as follows: The facility policy titled "Hiring" last modified 1/20/10 was reviewed and is documented in part, as follows: **POLICY STATEMENT** It is the policy of CommuniCare Health Services (CHS) to be an equal opportunity employer and to hire individuals solely upon the basis of their qualifications and ability to do the job to be filled. Unless otherwise provided in writing, employment

Procedure:

and for any lawful reason.

with CHS is considered to be at-will, so that either party may terminate the relationship at any time

(e) Following a decision to hire the applicant, the local Human Resources Representative is responsible for conducting the following steps:

Complete a criminal background check in accordance with federal and state requirements.

(g) If the background, medical, or any other

The survivors and the survivors of the s		B MEDICAID SERVICES	7		On	MB NU.	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUC	CTION	(X3) DATE COMP	LETED
		495155	B. WING				3/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP CODE	JUIZ	V-EV 10
SLEEPY	HOLLOW HEALTHC	ARE CENTER		6700 COLUMI ANNANDAL	BIA PIKE E, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	Continued From pa	age 27	F 607	F 623			
		gation discloses any	1 007		Resident #45, #142,	1	
	misrepresentation	on the application form, or ng that the individual is not			and #91 were	- 1	09/26/18
	suited for employm	ent with CHS, the applicant			discharged to the		
	will be refused emp	ployment or, if already			hospital without		
	employed, may be	terminated.		-	notifying the		
	On 9/22/40 at 4:24	DM o pro suit conformes			Ombudsman prior to		
	conducted with the	PM a pre-exit conference was Administrator, Director of					
	Nursing, Cooperate	Clinical Nurse, Chief			8/20/2018.		
	Executive Officer, a	and Assistant Administrator		2.	All residents have the		
	where the above in	formation was shared. Prior to			potential to be		
E 600		mation was shared.	F 623		affected. Ombudsman		
	CFR(s): 483.15(c)(Requirements Before Transfer/Discharge			was notified of all		
30=E	CFR(8). 403. 13(C)(3)-(0)(6)			discharged from		
	§483.15(c)(3) Notice	e before transfer.			_		
	Before a facility train	nsfers or discharges a			1/1/2018 to 8/31/2018		
	resident, the facility				on 9/12/2018 by		
		nt and the resident's f the transfer or discharge and			Admissions Director.		
		move in writing and in a			Ombudsman will be		
		ner they understand. The			notified monthly by fax		
	facility must send a	copy of the notice to a			of all discharges and		
	representative of th	e Office of the State			transfers to the		
	Long-Term Care O	mbudsman.					
		ons for the transfer or sident's medical record in			hospital monthly by		
		aragraph (c)(2) of this section;	1		Admissions Director or		
	and				designee.		
	(iii) Include in the n	otice the items described in		3.	Admissions Director		
	paragraph (c)(5) of	this section.			was educated by		
	§483.15(c)(4) Timis	ng of the notice					
		ig of the notice. fied in paragraphs (c)(4)(ii) and			Executive Director on		
	(c)(8) of this section	n, the notice of transfer or			8/23/18.		
	discharge required	under this section must be			recommendations for		
	made by the facility	at least 30 days before the			monthly x 3.		

	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	O(2) MIJI 1	TIPLE CONS	STRUCTION		O. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		STRUCTION	(X3) DATE SURVEY COMPLETED	
		495155	B. WING			C 08/23/2018	
NAME OF	PROVIDER OR SUPPLIER		T	STREET	ADDRESS, CITY, STATE, ZIP CODE		UI EUI EU TO
SLEEPY	HOLLOW HEALTHC	ARE CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	COMPLETION DATE
F 623	Continued From pa		F 62	23 4	. Executive Director or	r	
	(ii) Notice must be	red or discharged. made as soon as practicable			designee will conduc	t	
	before transfer or d	discharge when-		2	an audit monthly on		
	(A) The satety of in be endangered und	ndividuals in the facility would der paragraph (c)(1)(i)(C) of		d signal	the fax receipt of all		
	this section;				discharges and trans	fer	
	(B) The health of in be endangered, un	ndividuals in the facility would oder paragraph (c)(1)(i)(D) of			to ensure the discha		
	this section;				log was sent to		
	(C) The residents r	health improves sufficiently to ediate transfer or discharge.			Ombudsman office.		
	under paragraph (c	c)(1)(i)(B) of this section;			Any deviation will be)	
	(D) An immediate to required by the resi	1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs,			forwarded to the		
	under paragraph (c	c)(1)(i)(A) of this section; or			Executive Director or	•	
	(E) A resident has r days.	not resided in the facility for 30			designee and QAPI		
					(Quality Assurance		
	notice specified in r	ents of the notice. The written paragraph (c)(3) of this section			Performance		
	must include the fol	flowing:			Improvement)		
	(ii) The effective da	transfer or discharge; ite of transfer or discharge;			committee for		
	(iii) The location to	which the resident is			recommendations fo	r	
	transferred or disch (iv) A statement of t	narged; the resident's appeal rights,			monthly x 3		
	including the name,	, address (mailing and email),					
	receives such requi	nber of the entity which ests; and information on how		5	. Date of compliance		
1	to obtain an appeal	form and assistance in and submitting the appeal			09/26/18.		09/26/18
	hearing request;						
	(v) The name, address	ress (mailing and email) and of the Office of the State					
	Long-Term Care Or	mbudsman;					
	and developmental	ility residents with intellectual disabilities or related iling and email address and		Anna deliga estado	* 4.7		

STATEMENT	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• K	LE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY	
			A. BUILDING			COMPLETED	
		495155	B WING		08	3/23/2018	
	PROVIDER OR SUPPLIER HOLLOW HEALTHC		•	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 COLUMBIA PIKE			
(X4) ID	SI MAMADY ST	ATEMENT OF DEFICIENCIES		ANNANDALE, VA 22003			
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD SE	(X5) COMPLETIO DATE	
F 623	the protection and developmental disist C of the Developmental Bill of Rights A codified at 42 U.S. (vii) For nursing fact disorder or related email address and agency responsible advocacy of individes tablished under for Mentally III Individes the information in effecting the transfirmust update the reas practicable once becomes available. §483.15(c)(8) Notice In the case of facility the administrator of written notification protection of the reason	of the agency responsible for advocacy of individuals with abilities established under Part inental Disabilities Assistance (cct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the efforthe protection and luals with a mental disorder the Protection and Advocacy viduals Act. Inges to the notice. In the notice changes prior to deer or discharge, the facility cipients of the notice as soon efforthe the protection and advocacy viduals Act. Inges to the notice of facility closure the updated information The facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility must provide prior to the impending closure of the facility mus	F 623				

STATEMENT	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	MB NO	APPROVED . 0938-039 E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			APLETED
		495155	B. WING		C 08/23/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE] 00/	23/2010
SLEEPY	HOLLOW HEALTHCA	ARE CENTER	- 1	6700 COLUMBIA PIKE ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 623	Continued From pa	ge 30	F 623			
	State Long-Term C: #45's discharge to t	failed to notify the office of the are Ombudsman of Resident the hospital on 4/6/18. failed to notify the office of the				
	State Long-Term Ca #142's discharge to	are Ombudsman of Resident the hospital on 6/20/18.				
	State Long-Term Ca	ailed to notify the office of the are Ombudsman of Resident the hospital on 6/13/18.				
	The finding include:					
The second secon	facility on 5/16/17 w	s admitted to the nursing ith a diagnoses that included foot and ankle and diabetes				
mana da i Adi ya ci mina a ma	assessment was an coded the resident of Mental Status (BIMS possible score of 15	Annual dated 5/18/18 and on the Brief Interview for S) with a score of 15 out of a which indicated the resident unitive skills for daily decision				
	The discharge track dated 4/6/18.	ing MDS assessment was				
	indicated Emergence	ated 4/6/18 at 6:48 a.m., y Medical Services (EMS) ymplaints of left shoulder pain tingling.				
	The Transfer Discha	irge Report indicated				

FORM CMS-2667(02-99) Previous Versions Obsolete

on 4/6/18.

Event ID 4E4011

Facility ID: VA0227

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6700 COLUMBIA PIKE SLEEPY HOLLOW HEALTHCARE CENTER** ANNANDALE, VA 22003 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 623 Continued From page 31 F 623 The Re-entry MDS was dated 4/9/18. The nurse's notes dated 4/9/18 at 6:59 p.m., indicated Resident #45 was re-admitted to the nursing facility from the local hospital. On 8/21/18 at 12:30 p.m., during an interview with the Social Worker, she stated, "I do not notify the Ombudsman of transfers to local hospital or discharges from the nursing facility." On 8/21/18 at 12:35 p.m., the Business Office Manager (BOM) was not aware of a process to notify the local Ombudsman of discharges from the nursing facility. The BOM stated, "I'm not sure who does that." On 8/21/18 at 12:43 p.m., the Director of Admissions stated, "Here, never. We are not doing that." On 8/23/18 at 1:35 p.m., a pre-exit debriefing was held with the Administrator and Director of Nursing (DON). They validated there was no system in place to report discharges to the local Ombudsman's office. No further information was shared prior to survey exit.

disease (COPD).

2. Resident #142 was admitted to the nursing facility on 1/3/18 with a diagnoses that included age related osteoporosis, swallowing problems, dementia and chronic obstructive pulmonary

The most recent Minimum Data Set (MDS) assessment was an Significant Change in Status assessment dated 7/5/18 and coded the resident PRINTED: 09/04/2018

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 08/23/2018		
-	PROVIDER OR SUPPLIER HOLLOW HEALTHC		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	on the Brief Interviewith a score of 13 which indicated the cognitive skills for of the discharge trace dated 6/20/18. The discharge trace dated 6/20/18. The nurse's notes indicated Emergent was called due to a complaints of right. The Transfer Disch Resident #142 was hospital on 6/20/18. The Re-entry MDS The nurse's notes indicated Resident nursing facility from On 8/21/18 at 12:3 the Social Worker, Ombudsman of trace discharges from the On 8/21/18 at 12:3 Manager (BOM) was notify the local Omithe nursing facility. Sure who does that On 8/21/18 at 12:4 Admissions stated, doing that."	ew for Mental Status (BIMS) but of a possible score of 15 a resident was intact in the daily decision making. king MDS assessment was dated 6/20/18 at 3:15 p.m., cy Medical Services (EMS) a fall and the resident's hip pain. harge Report indicated a transferred to the local dated 6/28/18 at 12:37 p.m., #142 was re-admitted to the name the local hospital. O p.m., during an interview with she stated, "I do not notify the nsfers to local hospital or e nursing facility." 5 p.m., the Business Office as not aware of a process to budsman of discharges from The BOM stated, "I'm not	F 62	3			

	to i dividipatora	AL & MILDIONID OFIVIORS			OWRING	J. 0938-039 [°]
STATEMEN' AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING _		(X3) DATE SURVEY COMPLETED	
		495155	B. WING		0	C B/23/2018
	PROVIDER OR SUPPLIE HOLLOW HEALTH	***	670	REET ADDRESS, CITY, STATE, ZIP (00 COLUMBIA PIKE INANDALE, VA 22003	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSG IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 623	held with the Adm Nursing (DON). To system in place to	ninistrator and Director of They validated there was no o report discharges to the local fice. No further information was	F 623			
	3. Resident #91 was originally admitted to the facility on 01/08/16. Diagnosis for Resident #91 included but not limited to *Generalized Anxiety Disorder.					
	you are frequently things. Even wher are still not able to	is a mental condition in which worried or anxious about many there is no clear cause, you o control your anxiety us.gov/ency/patientinstructions/				
	significant change Assessment Refer coded the resident score of 15 on the	num Data Set (MDS), a assessment with an rence Date (ARD) of 6/28/18 t with a 15 out of a possible Brief Interview for Mental cating no cognitive impairment.				
And the state of t	6/13/18-discharge	OS assessment was dated for return anticipated; resident facility on 6/19/18.				
	documentation, Re	ding to the facility's esident #91 was picked up by e transported to local hospital a.m.				
	Worker (SW) on 8 p.m., who stated, "when a resident ha	conducted with the Social /21/18 at approximately 12:30 If do not notify the Ombudsman as been discharged out the check with the Business of				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495155	(X2) MUL A. BUILD B. WING		UCTION	COM	E SURVEY IPLETED
	PROVIDER OR SUPPLIER HOLLOW HEALTHC	ARE CENTER		6700 COLU	DRESS, CITY, STATE, ZIP CODE MBIA PIKE ALE, VA 22003	08/	23/2018
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	interview was cond stated, "I'm not sun Ombudsman when the hospital but we business office." An interview was conditional and the hospital but we business office." An interview was conditional and the hospital but we business office." An interview was conditional and the hospital and the hos	coximately 12:35 p.m., an lucted with the BOM, who e who notifies the a resident is discharged out to do not do that her in the conducted with Director of 21/18 at approximately 12:43 Here, never, we are not doing rector of Admissions stated by the Ombudsman when a discharged out to the hospital." Itration was informed of the refing on 08/23/18 at p.m. The facility did not information about the findings. Policy Before/Upon Trnsfr 1)(2) of bed-hold policy and returnate before transfer. Before a resident to a hospital or in therapeutic leave, the to provide written information to dent representative that the state bed-hold policy, if he resident is permitted to	F 63	1.	issued a bed hold notice and policy prior to discharge to the hospital on 4/6/18. Resident #142 was not issued a bed notice are policy prior to discharge to the hospital on 6/20/18. Resident #91 was not issued a bed notice are policy prior to discharge to the hospital on 6/13/18. Resident #68 was not issued a bed notice are policy prior to leave of absence from 8/20/18 absence from 8/20/18. Resident #68 was not issued a bed notice and policy prior to leave of absence from 8/20/18 absence from 8/20/18 absence and policy prior to leave of absence from 8/20/18 absence and policy prior to leave of absence from 8/20/18 absence and policy prior to leave of absence from 8/20/18 absence and policy prior to leave of absence from 8/20/18 absence and policy	ot and and of 8	09/26/18
	return and resume ifacility; (ii) The reserve bed plan, under § 447.4	payment policy in the state 0 of this chapter, if any; ility's policies regarding			prior to leave of absence on 8/16/18. Resident #175 was no issued facility's bed	ot	

STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 625	paragraph (e)(1) or resident to return; (iv) The information of this section. §483.15(d)(2) Bed the time of transfer hospitalization or the facility must provide resident represent specifies the durated described in paragraphis REQUIREMED by: Based on clinical and facility document to issue bed-hold residents in the sure #142, #91, 68, #991. The facility staff notice and policy to discharge to the hold in the facility staff notice and policy to discharge to the hold.	which must be consistent with of this section, permitting a and and specified in paragraph (e)(1) -hold notice upon transfer. At rof a resident for herapeutic leave, a nursing le to the resident and the ative written notice which ion of the bed-hold policy graph (d)(1) of this section. ENT is not met as evidenced record review, staff interviews, ent review the facility staff failed notices and policy for 7 of 42 rivey sample (Resident #45, 0, #175 and #162). If failed to issue a bed-hold of Resident #45 prior to ospital on 4/6/18. If failed to issue a bed-hold of Resident #142 prior to	F 625	hold policy and reserbed payment policy of discharge/transfer to hospital on 8/17/18. Resident #162 was not issued facility's bed high policy and reserve been payment policy upon discharge/transfer to hospital on 7/10/18. 2. All residents have the potential to be affected for current residents the will discharge to the hospital a bed hold not and policy will be issued prior to discharge. For current residents that go on leave of absence bed hold notice and policy will be issued prior to leave of absence. For residents who are discharged/transferred	upon the ot old d the		
	notice for Resident Absence (LOA), 8/ 5. The facility staff	failed to issue a bed-hold #68 prior to a Leave of 20/18 through 8/23/18. failed to issue a bed-hold #89 prior to LOA on 8/16/18		the hospital a bed hole policy and reserve bed payment policy will be issued prior to discharge/transfer to hospital.	l :		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			ATE SURVEY OMPLETED
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	6. The facility start #175 was issued to reserve bed paymetransfer/discharge 7. The facility start #162 was issued a bed payment policitie the hospital on 7/1 The finding include 1. The facility staff to Resident #45 pron 4/6/18. Resident #45 was on 5/16/17 with a costeomyelitis of lef mellitus. The most recent Massessment was a coded the resident Mental Status (BIM possible score of 1 was intact in the comaking. The discharge tracked 4/6/18. The nurse's notes indicated Emergen was called due to cowith numbness and	if failed to ensure that Resident the facility's bed hold policy and ent policy upon to the hospital on 08/17/18. If failed to ensure that Resident a facility bed-hold and a reserve by upon transfer/discharge to 0/18. If failed to issue a bedhold notice for to discharge to the hospital admitted to the nursing facility diagnoses that included the foot and ankle and diabetes and the Brief Interview for IS) with a score of 15 out of a 5 which indicated the resident or	F 62	 3. All Nursing staff, all Office staff, all Social staff, and all Admissi will be educated on bed hold policy on or 09/26/18. 4. Social Services department will monthly 10% of residents that wissued a bed hold notice and policy to discharge/trait to the hospital alleave of absence deviation will be forwarded to the Executive Director designee and QA 	audit all ere d y prior nsfer nd e. Any	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
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F 625	on 4/6/18. The Re-entry MDS The nurse's notes of indicated Resident nursing facility from On 8/21/18 at 12:30 the Social Worker, bedhold notices to representatives at thospital." On 8/21/18 at 12:30 Manager (BOM) was issue bedhold notice representatives at thospital. The BOM does that." On 8/21/18 at 12:40 Admissions stated, doing that." On 8/23/18 at 1:35 held with the Admir Nursing (DON). The system in place to the resident or the the time of transfer No further informatic exit.	was dated 4/9/18. dated 4/9/18 at 6:59 p.m., #45 was re-admitted to the in the local hospital. 0 p.m., during an interview with she stated, "I do not issue residents or their the time of discharge to the 5 p.m., the Business Office as not aware of a process to the time of discharge to the 1 stated, "I'm not sure who 3 p.m., the Director of "Here, never. We are not p.m., a pre-exit debriefing was histrator and Director of hey validated there was no issue bedhold notices to either resident's representative at or discharge to the hospital. It on was shared prior to survey if failed to issue a bedhold #142 prior to discharge to the	F	625	(Quality Assurance Performance Improvement) committee for recommendations for monthly x 3. 5. Date of compliance 09/26/18		09/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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F 625	Resident #142 wa on 1/3/18 with a drelated osteoporo dementia and chridisease (COPD). The most recent lassessment was assessment date on the Brief Interwith a score of 13 which indicated the cognitive skills for The discharge tradated 6/20/18. The nurse's notes indicated Emerge was called due to complaints of right. The Transfer Disc Resident #142 was hospital on 6/20/1 The Re-entry MD The nurse's notes indicated Resider nursing facility from 12/1/18 at 12: the Social Worker bedhold notices to the second control of the	as admitted to the nursing facility liagnoses that included age sis, swallowing problems, conic obstructive pulmonary Minimum Data Set (MDS) an Significant Change in Status d 7/5/18 and coded the resident view for Mental Status (BIMS) to ut of a possible score of 15 are resident was intact in the redaily decision making. Cking MDS assessment was a dated 6/20/18 at 3:15 p.m., ancy Medical Services (EMS) a fall and the resident's at hip pain.	F 625	DEFICIENC			

STATEMEN' AND PLAN	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495155		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED C	
	PROVIDER OR SUPPLIES	R	STI 670	REET ADDRESS, CITY, STATE, ZIP 00 COLUMBIA PIKE INANDALE, VA 22003	CODE	3/23/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	ORRECTION IN SHOULD BE E APPROPRIATE	COMPLETION DATE		
F 625	Manager (BOM) was not aware of a process to issue bedhold notices to the residents or their representatives at the time of discharge to the hospital. The BOM stated, "I'm not sure who does that." On 8/21/18 at 12:43 p.m., the Director of Admissions stated, "Here, never. We are not doing that." On 8/23/18 at 1:35 p.m., a pre-exit debriefing was held with the Administrator and Director of Nursing (DON). They validated there was no system in place to issue bedhold notices to either the resident or the resident's representative at the time of transfer or discharge to the hospital.		F 625				
	exit. 3. Resident #91 w. facility on 01/08/16 included but not lir Disorder. *Anxiety disorder is you are frequently things. Even when are still not able to (https://medlineplu.000685.htm). The current Minim significant change Assessment Referenceded the resident score of 15 on the	as originally admitted to the 3. Diagnosis for Resident #91 mited to *Generalized Anxiety s a mental condition in which worried or anxious about many there is no clear cause, you control your anxiety s.gov/ency/patientinstructions/ um Data Set (MDS), a assessment with an rence Date (ARD) of 6/28/18 with a 15 out of a possible Brief Interview for Mental cating no cognitive impairment.					

PRINTED: 09/04/2018 DEPARTMENT OF HEALTH AND HUMAN 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 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE **SLEEPY HOLLOW HEALTHCARE CENTER** ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 625 Continued From page 40 F 625 The Discharge MDS assessments was dated for 6/13/18-discharge return anticipated: resident re-admitted to the facility on 6/19/18. On 6/13/18, according to the facility's documentation, Resident #91 was Nothing by mouth after midnight. Norvasc 2.5 mg administered as ordered, scheduled Percocet 5-325 mg administered with sip of water. Resident picked up by transportation to be transported to local hospital on 6/13/18 at 5:50 a.m. An interview was conducted with the Social Worker (SW) on 8/21/18 at approximately 12:30 p.m., who stated, "I do not issue the bed hold policy to the residents when they are discharged out the hospital; you can check with the Business of Manager (BOM)." On 8/21/18 at approximately 12:35 p.m., an interview was conducted with the BOM, who stated, "I'm not sure who issues the Bed Hold Policy but we do not do that here in the business office." An interview was conducted with Director of Admissions on 08/21/18 at approximately 12:43 p.m., who replied, "Here, never, we are not doing that here; giving the resident or their representative a copy of the bed hold policy." The facility administration was informed of the

(Reviewed: 4/20/17)

findings during a briefing on 08/23/18 at approximately 2:00 p.m. The facility did not present any further information about the findings.

The facility's policy titled: Bed Hold Policy

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495155 B WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER **6700 COLUMBIA PIKE** ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X6) MPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 41 F 625 -It is the intent of this facility to obtain the proper authorization to hold a resident bed when the resident returns to the hospital or goes on a leave. -The bed hold authorization form may be signed prior to the patient leaving the building, or within 24 hours of the resident leaving the facility or the following business day if the resident leaves on the weekend or a holding. Procedure: -The nurse of designee will obtain the residents or responsible party's signature on the bed hold authorization form each time the resident leaves on a bed hold. If the bed hold authorization form cannot be signed prior to the resident leaving and needs to be mailed, it must be mailed certified return receipt requested by the BOM or designee. 4. For Resident #68, the facility staff failed to offer a bed hold prior to a three-day leave of absence from 8/20/18-8/23/18. Resident #68 was a 48 year old who was admitted to the facility on 6/5/15. Resident #68's diagnoses included Schizoaffective disorder, and Dementia. The Minimum Data Set, which was an Annual Assessment with an assessment reference date of 6/13/18, coded Resident #68 as having a Brief Interview of Mental Status Score of 11. A score of 11 is indicative of modified independence in daily

decision making.

On 8/20/18, an interview was conducted with Resident #68 in his room. His son and daughter

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	were present. Residence very happy to be got three days (8/20/18 On 8/20/18 a review #68's clinical record Pass Medication /Le 8/16/18. The facility the pharmacy to obt Resident #68 to take absence. On 8/21/18, at appresident #68 to take absence. On 8/21/18, at appresident #68 has had. She further state currently developing would be implement information was received with bed hold information was received the properties of the resident was additional record was received the properties of the latest MDS (min dated 7/3/18, coded impaired cognitive furstaff for completion of daily living).	dent #68 stated that he was bing to visit his children for 1 - 8/23/18). If was conducted of Resident II, revealing a Request for eave of Absence, dated that made arrangements with tain the medications for e with him during his leave of ewith him during his leave of eximately 9:00 A.M. an acted with the Director of inistration B). The DON stated and not been offered a bed atted that the facility was a bed hold procedure that ed as of 8/22/18. No further elived. If to provide Resident # 99 atton prior to a leave of alization. Resident # 99's eviewed on 8/23/18. Imitted to the facility on is included diabetes.	F 625				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID. 4E4011

Facility ID: VA0227

If continuation sheet Page 43 of 77



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (X5) COMPLETION DATE **PREFIX** TAG TAG DEFICIENCY) Continued From page 43 F 625 Nurse-LPN I said the resident was on leave of absence with family members since 8/16/18 and she didn't know when she would be returning. On 8/21/18 at 10:30 AM LPN I and Social Worker-SW I were interviewed regarding the resident's absence from the facility. Neither employee knew when the resident was due to return to the facility. LPN I made several phone calls to unidentified staff members and finally established the resident had actually been discharged from the facility on Saturday, 8/18/18, after his family admitted him to a hospital. SW I and LPN I were asked if the resident was on a bed hold or if he was actually discharged. They did not know what a bed hold was. On 8/21/18 at 4:18 PM the DON was asked if the resident or his family members had been issued bedhold information prior to his leave of absence and discharge to the hospital. The DON said they didn't provide any bedhold information prior to the resident leaving the facility. No other information was forthcoming prior to the survey team exit. 6. The facility staff failed to ensure that Resident #175 was made aware of the facility's bed hod and reserve bed payment policy upon transfer/discharge to the hospital on 8/17/18.

cerebrovascular accident.

Resident #175 was a 98 year old that was admitted to the facility originally on 7/23/18 and readmitted on 8/20/18, with a diagnosis of (1) -

The most recent Minimum Data Set (MDS)

PRINTED: 09/04/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8700 COLUMBIA PIKE SLEEPY HOLLOW HEALTHCARE CENTER ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY) F 625 Continued From page 44 F 625 assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/30/18. The Brief Interview for Mental Status (BIMS) for Resident #175 was a 10 out of possible 15 which indicated the resident was mildly cognitively impaired. Resident #175 Progress Notes dated 8/17/18 were reviewed and are documented in part, as follows: Date: 8/17/18 Resident was observed with weakness of the left arm and right leg. Resident was unable to move the left side of her body. Resident was alert and responsive, V/s B/P 120/70 P86/R 18. Md called. Order to send resident to ER for evaluation. Sister was at the bedside.

On 8/22/18 at 1:30 PM an interview was conducted with the Unit Manager Registered Nurse-RN #5 and she was asked if Resident #175's Responsible Party was notified of the facility's bed hold policy upon transfer/discharge to the hospital on 8/17/18. RN #5 stated, "I don't see anything like that in the chart, I don't know if we do that and I don't know who is responsible for giving family that."

On 8/23/18 at 1:31 PM a pre-exit conference was conducted with the Administrator, Director of Nursing, Corporate Clinical Nurse, Chief Executive Officer, and Assistant Administrator where the above information was shared. Prior to the exit no further information was shared.

(1). Cerebrovascular Accident: an abnormal condition of the brain characterized by occlusion by an embolus, thrombus, or cerebrovascular

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	hemorrhage or vas	norrhage or vasospasm, resulting in ischemia		20		
	The above definition Dictionary of Medic Professions 8th Ed	on was derived from Mosby's cine, Nursing, and Health dition.				
	#162 was issued a	f failed to ensure that Resident a facility bed-hold and a reserve by upon transfer/discharge to 0/18				
	facility originally on on 7/18/18 with diag	s a 70 year old admitted to the a 6/29/17 and then re-admitted agnoses of (1). Dementia, (2). and (3). Communication	String and Administrative Property			
	anticipated assessr Reference Date of S submitted for Resid					F B-HINNEYS & JAK S BACK
- 1	with an Assessmen	tet (MDS) Entry assessment of Reference Date of 7/18/18 d submitted for Resident #162.				Orienment doze 1 kitaloud dat juga
4 1	Resident #162's Pro and are documente	rogress Notes were reviewed ed in part, as follows:				en - 1
1	result seen by MD (transfer patient via r patient picked up at	4 P.M.) Nurses Note: Lab (medical doctor) order to non emergency transportation, t 5:30 pm report given to ospital Name) ER (emergency re.				

7/11/18 7:13 A.M. Nurses Note: Follow up call

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	made to (Hospital admitted for obsellar made to (Hospital admitted for obsellar made to current material materi	nurse on duty said patient is rvation. Physician Orders were reviewed ted in part, as follows: patient to ER via non emergency despital After Visit Summary indicated a hospital stay from 18/18. Is Report for Resident #162 was ocumented in part, as follows: 10/18 LING charge Date 18/18 dmission P.M. the Administrator tatement regarding Bed Hold ats which was reviewed and is	F 625				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING C 495155 B WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE SLEEPY HOLLOW HEALTHCARE CENTER ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 625 Continued From page 47 F 625 further stated that the facility was currently developing a bed hold procedure that would be implemented as of 8/22/18. The facility policy titled "Bed Hold Policy" effective 2/17/17 was reviewed and is documented in part, as follows: **POLICY STATEMENT** It is the policy of this facility to provide resident centered care that meets the psychosocial. physical and emotional needs and concerns of the residents. It is the intent of this facility to obtain the proper authorization to hold a resident bed when the resident returns to the hospital or goes on a leave. The bed hold authorization form may be signed prior to the patient leaving the building or within 24 hours of the resident leaving the facility or the following business day if the resident leaves on the weekend or a holiday. Procedure: 1. In the event a resident returns to the hospital or goes on a leave, the following process will be followed by the facility: a. The Admissions Director or designee will notify the resident and/or responsible party of the days available under their Medicaid benefits or the private pay cost associated with holding the bed will be explained, within 24 hours of the patient leaving the facility, or the following business day if the patient leaves on the weekend or a holiday. b. The nurse or designee will obtain the residents

or responsibly party's signature on the bed hold authorization form each time the resident leaves on a bed hold. If the bed hold authorization form cannot be signed prior to the resident leaving and

STATEMEN	IT OF DEFICIENCIES	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391	
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	needs to be mailed return receipt requivalent receipt requivalent receipt requivalent receipt requivalent receipt requivalent receipt receipt receipt receipt receipt resident or the resident resident or the resident receipt receip	d, it must be mailed certified lested by the Business Office nee. PM a pre-exit conference was administrator, Director of the Clinical Nurse, Chief and Assistant Administrator afformation was shared. The the ated there was no system in mold notices to either the dent's representative at the discharge to the hospital. Prior formation was shared. It comprehensive Care Plan 1) The chensive Care Plans facility must develop and the ehensive person-centered resident, consistent with the porth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tiffied in the comprehensive care plan must not mental and psychosocial tiffied in the comprehensive care plan must not are to be furnished to attain dent's highest practicable of psychosocial well-being as 3.24, §483.25 or §483.40; and it would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse	F 656	1. Care plan for resider #162 was revised on 8/19/17 to indicate elopement history. 2. All residents have the potential to be affected. Care plans fall current residents of the secured demential unit will be revised to	e for on a	09/26/18

NAME OF PROVIDER OR SUPPLIER SLEEPY HOLLOW HEALTHCARE CENTER (A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICEMY WING THE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING IMPORMATION) F 6566 Continued From page 49 rehabilitative services the nursing facility will provide as a result of PASARR, it must indicate its rationale in the resident's medical record. ((v)In consultation with the resident and the resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was easseed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility document review the facility staff failed to develop and implement a comprehensive person-centered care plan to include the risk of unsafe wandering after the resident was identified as a "significant risk of getting to a potentially dangerous place" on the admission Minimum Data Set (MDS) for Resident #162 who eloped from the facility on 8/19/17.		ATEMENT OF DEFICIENCIES			OMB NO. 0938-03			
NAME OF PROVIDER OR SUPPLIER SLEEPY HOLLOW HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, PREFIX TAG) F 656 Continued From page 49 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record, (iv)In consultation with the resident and the resident's social potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the reculierments est forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility document review the facility staff failed to develop and implement a comprehensive person-centered care plan to include the risk of unsafe wandering for 1 of 42 resident in the survey sample, Resident #162. The facility staff failed to develop and implement a comprehensive person-centered care plan to include the risk of unsafe wandering after the resident was identified as a "significant risk of getting to a potentially dangerous place" on the admission Minimum Data Set (MDS) for Resident #162 who eloped from the facility on 8/19/17.	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	No. of the second			COMPLETED	
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F 656 Continued From page 49 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's professentative(s). (A) The resident's professentative(s). (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility document review the facility staff falled to develop and implement a comprehensive person-centered care plan to include the risk of unsafe wandering for 1 of 42 resident was identified as a "significant risk of getting to a potentially dangerous place" on the admission Minimum Data Set (MDS) for Resident #162 who eloped from the facility on 8/19/17.		HOLLOW HEALTHC	ARE CENTER		8700 COLUMBIA PIKE	PCODE		
rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv/in consultation with the resident and the resident's representative(s)- (A) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews, and facility document review the facility staff failed to develop and implement a comprehensive person-centered care plan to include the risk of unsafe wandering after the resident was Identified as a "significant risk of getting to a potentially dangerous place" on the admission Minimum Data Set (MDS) for Resident #162 who eloped from the facility on 8/19/17.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE	
The intelliga included.		rehabilitative service provide as a result recommendations, findings of the PAS rationale in the res (iv)In consultation vesident's represer (A) The resident's desired outcomes. (B) The resident's future discharge. F whether the resident community was as local contact agencial	ces the nursing facility will of PASARR If a facility disagrees with the SARR, it must indicate its ident's medical record. with the resident and the ntative(s)- goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate rose. In the comprehensive care in accordance with the orth in paragraph (c) of this in paragraph (c) of this in not met as evidenced thous, clinical record review, if facility document review the odevelop and implement a son-centered care plan to insafe wandering for 1 of 42 by sample, Resident #162. The develop and implement a son-centered care plan to insafe wandering after the ited as a "significant risk of ally dangerous place" on the n Data Set (MDS) for Resident on the facility on 8/19/17.	F 656	audit 10% of cain locked deme weekly for 3 we then monthly. A deviation will be forwarded to the Director of Nurse designee and Q (Quality Assurant Performance Improvement) committee for recommendation monthly x3 and ongoing.	re plans ria unit eeks and Any e ne sing or API nce	09/26/18	

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1	the facility originall re-admitted on 7/1 Dementia, (2). Liv Communication Domentia, (2). Liv Communication Domentia, (2). Liv Communication Domentia, (2). Liv Communication Domential Set (MDS) as Reference Date (A The Brief Interview a 4 out of a possib Resident #162 was Under Section E-B Wandering-Present #162 was coded at occurred 1 to 3 day-Impact A. (Does the resident at signification potentially dangered the facility) Resident #162's Cowas initiated on 6/3 was reviewed. The Goal, or Interventical addressed on the Communication of the Communica	y on 6/29/17 and then 8/18 with diagnoses of (1). er Carcinoma, and (3). efficit. 2's Admission 5 day Minimum assessment with an Assessment RD) of 7/6/17 was reviewed. If of Mental Status (BIMS) was le 15 which indicated that a severely cognitively impaired. The ehavior E0900 are and frequency Resident as a 1-Behavior of this type and frequency Resident as a 1-Behavior of this type and risk of getting to a sus place e.g stairs, outside of the wandering place the ant risk of getting to a sus place e.g stairs, outside of the wander of the	F 656			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A BUILDING COMPLETED 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE** ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 51 F 656 Name (Resident #162) will remain safely in the facility through next review. Date Initiated: 8/19/17 Interventions/Tasks: *Apply Wanderguard. Check for placement and functioning every shift. Date Initiated: 8/19/17 *Complete elopement risk assessment quarterly and as needed. Date Initiated: 8/19/17 *Notify physician and family of behavior changes. Date Initiated: 8/19/17 *Staff will direct Name (Resident #162) away from exit doors by offering alternative activities and conversation. Name (Resident #162) should be free to ambulate around the unit daily otherwise. Date Initiated: 8/19/17 Provide diversionary activities. Activity staff to take resident outside twice a week. Date Initiated: 8/19/17 Resident #162's Wandering Observation Tool dated 6/29/17 was reviewed and indicated the resident was a Low Risk for wandering. Resident #162's Wandering Observation Tool dated 8/19/17 was reviewed and indicated the resident was a Low Risk for wandering. Resident #162's Wandering Observation Tool dated 8/21/17 was reviewed and indicated the resident was a Moderate Risk for wandering.

On 8/21/18 at 11:15 A.M. an interview was conducted with the MDS Director. The MDS Director was asked if the Resident #162 should be care-planned as an elopement/wandering risk. The MDS Director stated, "Yes, because she is

PRINTED: 09/04/2018 **DEPARTMENT OF HEALTH AND HUMAN 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 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6700 COLUMBIA PIKE** SLEEPY HOLLOW HEALTHCARE CENTER ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID (XS) MPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COM REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 656 Continued From page 52 F 656 on the locked unit." The MDS Director was unable to provide documentation that Resident #162's comprehensive person-centered care plan initiated on 6/30/17 and revised on 7/7/17 include the risk of elopement. The MDS Director stated. "We did care plan her for an elopement risk after her elopement on 8/18/17." Resident #162's Progress Notes were reviewed and are documented in part, as follows: 8/19/17 17:21 (5:21 P.M.) Incident Note: Resident was last seen by staff at about 10:30 A.M., at 10:45 A.M. was not on unit, facility and grounds check initiated, law enforcement, md/rp (medical doctor/responsible party) notifies. Resident found at 12:11 P.M. by facility staff. 8/19/17 17:49 (5:49 P.M.) Nurses Note: writer first saw resident this morning at 6:30 am in bed sleeping, when giving her room mate medication. staff assist resident with ADL (activities of daily living) at 7:45 am, initially refuses her 9 am meds but she took it close to 10 am, was last seen by staff at about 10:30 am, pacing in the hallway, staff noticed that resident was missing at 10:45 am, facility and grounds search was initiated, law enforcement was notified at 10:59 am. MD was notified at 11:01 am. Resident was found at 12.11 pm by the facility staff on gallows road and masonville road. resident is stable at this time no distress noted. 8/19/17 23:30 (11:30 P.M.) Care Plan Note: resident was placed on 1:1 monitoring from 12:50

pm to 4pm. Window secured at 4pm and 1:1

During the survey Resident #162 was observed

monitoring was discontinued.

		& MEDICAID SERVICES				OMB NO. 0938-0391		
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F 656	wanderguard brack room was also instructed shut. On 8/22/18 at 5:00 conducted with the of Nursing were the discussed. The suif a resident is place and if Resident #16 since admission. To be secured for the supervision. Yes, I placed on the locked surveyor then asked unit should have be Administrator state #162's) window has broken and become The facility policy to last reviewed 4/20/follows: Definition: Elopem resident/patient lead area without authors supervision and platharm or injury. Policy: The facility	r the locked dementia unit with elet in place. Resident #162's pected and the windows were P.M. an interview was Administrator and the Director eleabove elopement was prevent asked what determines seed on the locked dementia unit 62 had resided on that unit 62 had resided on that unit 63 had resided on that unit 64 had resided on that unit 65 had resided on that unit 65 had resided on that unit 66 had resided on that unit 67 had resident who exit seek, need to it safety and require Name (Resident #162) was ed unit upon admission." The elect of the windows on the locked een secured. The elect of the windows on the locked een secured. The elect of the windows on the locked een secured. The elect of the windows on the locked een secured. The elect of the windows on the locked een secured but it had elect on the locked elect of the windows on the locked een secured. The elect of the windows on the locked een secured but it had elect on the locked elect of the windows on the locked ele	F6	56				
	resident/patient elo supporting resident mobility. The focus resident/patient to a highest practicable	pement, while promoting and //patient independence and						

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family/responsible party 6. Initiate individualized elopement risk factors. 7. Communicate individualized the caregiving staff, resi family/responsible party On 8/23/18 at 1:31 PM a conducted with the Adm Nursing, Cooperate Clin Executive Officer, and A where the above informatic residualization of faction of the communication of the communica	admitted who is I can self-ambulate is Intrisk until determined Itert: Elopement In with input from the Ind the resident/patient and Interventions to address Itualized interventions to Ident/patient and/or Intervention to of Iterative intervention to Intervention was shared. Prior to Intervention was shared. Intervention was	F 689	1. For resident #241, #47 and #28 smoking materials were secured by Executive Director outside of the designated smoking area on 8/22/18. 2. All residents have the potential to be affected. Smoking materials for all current residents were secured by Executive Director on 8/22/18. For all new smokers their smoking materials will be secured per policy. 3. All staff will be educated on the smoking policy by the Assistant Director of Nursing or designee on or before 09/26/18.	d	09/26/18	

STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X3) DATE SURVEY COMPLETED C 08/23/2018	
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F 689 Continued From page 55 staff interviews, and facility document review the facility staff failed to maintain an environment as free as possible of accident hazards for 3 of 42 Residents in the survey sample (Residents #241, #47, and #28). 1. For Resident #241, who required supervision with smoking, the facility staff failed to ensure that his smoking materials were secured outside of the designated smoking activity. 2. For Resident #47, the facility staff failed to ensure that his smoking materials were secured outside of the designated smoking activity. 3. For Resident #28 the facility staff failed to ensure that his smoking materials were secured outside of the designated smoking activity. The findings included: 1. Resident #241 was observed to have smoking materials which included cigarettee and a lighter. Resident #241 was re-admitted to the facility on 1/11/18 with diagnoses of renal disease, muscle weakness, neurogenic bladder, and hypertension. Resident #241 had a Biref Interview for Mental Status Score of 14. Resident 241 was assessed in area of Activities of Daily Living as 1/1 for transfer and mobility. This resident did not require staff eassistant in the area of personal hygiene, bathing or eating. A Care Plan with a revision date of 4/24/18 indicated: Problem- Resident is resistive to care refusing medication.	09/26/18	

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE A BUILDING		TIPLE CONSTRUCTION	OMB NO	M APPROVE 0. 0938-039		
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	cognitive impairme behavior verbal alte Anticipate and mee as necessary to proothers. Resident #2 a supervised smoking assessme annually and with country the ability to smoke during smoking. Ed regarding center's s	age 56 ent. History of combative ercation. Intervention_ et resident's needs. Intervene otect the rights and safety of 241 is a smoker- assessed as er. Intervention- complete ent. Reassess quarterly, change of condition that affects b. Monitor resident safety lucate resident and family smoking policy, designated distorage of smoking	F 68	19		
	observed with a a p person. During the c resident was observed out a pack of ci- justing his own cigating his front right poor smoking in the designed Resident was observed on 8/2	P.M. Resident #241 was each of cigarettes on his 6:00 P.M. smoking hour this wed to reach into his shirt and igarettes. The resident began arette with a lighter that he had exet. Resident was observed ignated smoking areas. Inved during the 1:P.M. 21/18 with cigarettes and a is observed to light his in smoking.				
	and ask where did h cigarettes. This resi	to approach Resident #241 ne get the lighter and ident responded back to staff, iness and leave me alone."				
	Resident uses cigar	Assessment indicated: rettes. Resident can light his dent needs supervision for				

A Facility Smoking Policy dated 4/01/2016 indicated: 5. Smokers will be permitted to smoke

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495155 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 689 Continued From page 57 F 689 only in designated smoking areas. 9. All smoking materials will be maintained by the facility staff and provided to the resident/patient on request. 9-C. Smoking materials will be returned to the facility staff upon completion of smoking. Facility staff failed to ensure safe smoking material management. 2. For Resident #47, the facility staff failed to ensure that his smoking materials were secured outside of designated smoking activity. Resident #47 was a 76 year old who was admitted to the facility on 7/27/16 . Resident #47's diagnoses included Left Eye Cataract. Abnormalities of Gait and Mobility, Wheezing, Type 2 Diabetes Mellitus. Chronic Obstructive kidney Disease with Exacerbation, Muscle Weakness-Generalized, and Hypertension. The Minimum Data Set, which was an Annual Assessment with an assessment reference date of 6/1/18, coded Resident #47 as having a Brief Interview of Mental Status Score of 14. A score of 14 indicated intact cognition. On 8/20/18 at 6:00 P.M., an observation was conducted of Resident #47 entering the designated smoking area. He already had a pack

smoking materials.

of cigarettes and a lighter in his possession. He lit and smoked a cigarette. Afterwards, he did not give the cigarettes and lighter to the staff member to place in the lock box with the other resident's

On 8/20/18 at 6:10 P.M., an interview was conducted with the staff nurse who was supervising the smoking activity (Registered

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	smoking materials is supposed to carry to supposed to carry to the facility. Resident the door which indicate oxygen was one roommate, who was one commate, who was one of the conducted with RN attempt to get the recigarettes and lighter find the cigarettes and lighter. He left with in the cigarettes are cigarette. He refuse lighter. He left with in the cigarettes are cigarette. He refuse lighter. He left with in the cigarette or the finding of the had been assess smoke independent facility smoking polic contained a Smoking dated 6/25/18 that we con 8/22/18 the Direct the findings. No furth the findings. No furth out smoking on the finding of t	d that Resident #47 had his with him, and that he was not hem around on his person. P.M., a tour was conducted of t #47's room had a label on rated that oxygen was in use. dered for Resident #47's son a leave of absence. A.M. a 2nd interview was 2. When asked about her esident to give her his er. "I asked him where did he and lighter. He said, 'This is my ed to give me the pack and it. I told my supervisor." I was conducted of Resident His care plan indicated that ed as having been able to thy, as long as he followed the cy. Resident #47's record g Acknowledgement Form was signed by him on 6/25/18. Ictor of Nursing was notified of her information was received. Det smoking paraphernalia er) in his room to use when facility patio three times a dimitted to the nursing facility noses that included stroke lence.	F 64	89			
	The most recent Min	nimum Data Set (MDS)					

Event ID: 4E4011

Facility ID. VA0227

If continuation sheet Page 59 of 77



CENTE	RS FOR MEDICARI	AND HUMAN SERVICES & MEDICAID SERVICES				FORI	D: 09/04/2018 M APPROVED D: 0938-039
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F 689	coded the resident Mental Status (BIM possible score of 1 was cognitively inta decision making. Trequired limited assactivities of daily liv assessed to require The resident was n walk or transition for position. The resident used a mobility. The care plan dated The resident used a mobility. The care plan dated The resident used a mobility. The care plan dated The resident used a mobility. The care plan dated The resident used a sassessed smoker. The goal swas that they would independence to sa approaches the stating goal included to assessment per the the resident for unsattempts to obtain soutside sources, if a sasure smoking mato resident leaving a resident in position ashtray and review resident and or the required smoking mator are when both independent are Resident #28's mos	quarterly dated 5/24/18 and on the Brief Interview for IS) with a score of 14 out of a 5 which indicated the resident act in the skills for daily he resident was coded to sistance from one staff for all ing (ADL). The resident was a supervision only for bathing of independently steady to om a seated to a standing ant was impaired in range of in upper and lower extremity. A cane/crutch or wheelchair for the safe and an independent at by the staff for the resident I maintain the resident's afely smoke. Some of the fif would take to accomplish	F	889			

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 09/04/2016 MAPPROVED D: 0938-039	
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	ATE SURVEY EMPLETED	
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	PROVIDER OR SUPPLIER HOLLOW HEALTHCA	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 6700 COLUMBIA PIKE ANNANDALE, VA 22003	DE	08/23/2018	
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	was aware of the risproblems, no dexte times a day and recafternoon and even cigarette, had no sy of choking, had no lappropriately disposed on 8/21/18 at 10:00 that Resident #28 w patio smoking cigar notice staff giving reas she was handing the patio. The surve supervisor, Register how the resident reclighter. Nurse superresident didn't come lighter because he also stated that he windependent smoke allowed to self carry. On 8/21/18 at 1:30 phis smoking materia station. He stated hasking the nurse for designated smoking and 6:00 p.m. On 8/22/18 at 11:00 conducted with the fasked of the social we provided the smokin returned with four smoking material with four smoking signed by the understanding of the	/e Alzheimer's or dementia, sks of Nicotine, had no vision rity problems, smoked 2-5 juested to smoke morning ing, was safe to light a vallowing problems, no history hand tremors, and can	F 68	9			

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

PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495155 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE			& MEDICAID SERVICES			CIVID IT	O. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE				A. BUILD	ING		
SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE	NAME OF	PROVIDER OR SUPPLIED	100.00			0	8/23/2018
A THE PARTY OF THE			ARE CENTER			DE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM- TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI)	(EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE
F 689 Continued From page 61 social worker stated the significance of the smoking assessment was to determine the needs of the smoker, whether they were independent and their level of supervision, whether they needed a smoking apron, cigarette holder, assistancs to light the cigarette, cognition and vision ability. She stated regardless of the assessment, for safety purposes, smoking materials were to be kept locked at the nurse's station and not kept on the resident or in their rooms. On 8/23/18 at 1:35 p.m., a debriefing was held with the Administrator and the Director of Nursing (DON). They stated they expected the staff and residents to abide by the facility's safety policy on smoking that included securing smoking materials at the nurse's station to issue at the designated smoking times. F 689 SS=D CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, a Resident Interview, staff interviews, and facility document review the facility staff failed to ensure a dialysis Resident received the necessary care and services to include assessment of an Arteriovenous (AV) fistula hemodialysis access sile for bruit and thrill for 1 of 42 Residents in the survey sample, Resident #67.	F 698	social worker state smoking assessment of the smoker, whe and their level of su needed a smoking assistance to light to vision ability. She sassessment, for sa materials were to be station and not kep rooms. On 8/23/18 at 1:35 with the Administrat (DON). They state residents to abide the smoking that include materials at the nur designated smoking Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must enrequire dialysis receivith professional stromprehensive per the residents' goals This REQUIREMENT by: Based on observat Resident Interview, document review the dialysis Resident and services to include Arteriovenous (AV) site for bruit and thr	d the significance of the ent was to determine the needs of the ent was to determine the needs of the ent was to determine the needs of the they were independent upervision, whether they apron, cigarette holder, the cigarette, cognition and stated regardless of the fety purposes, smoking e kept locked at the nurse's ton the resident or in their p.m., a debriefing was held for and the Director of Nursing of they expected the staff and by the facility's safety policy on led securing smoking se's station to issue at the gradient of practice, the son-centered care plan, and and preferences. It is not met as evidenced ions, medical record review, a staff interviews, and facility e facility staff failed to ensure received the necessary care ude assessment of an fistula hemodialysis access ill for 1 of 42 Residents in the		1. LPN #1 and Unit Manager RN #1 educated on ho assess arteriove (AV) fistula hemodialysis ac site for bruit an on hemodialysis resident #67. 2. All residents receiving dialy have the pote to be affected licensed nursit staff will be educated on h to assess arteriovenous fistula hemodi access site for and thrill on al hemodialysis	were w to enous cess d thrill s rsis ntial All ng ow (AV) alysis bruit	09/26/18

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	0: 09/04/2018 APPROVED
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NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 06	/23/2018
SLEEPY	HOLLOW HEALTHCA	ARE CENTER		67	700 COLUMBIA PIKE NNANDALE, VA 22003		
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F 698	Continued From page	no 60			3. Assistant Director of		,
. 000	Continued From pa	ge 62	F 69	98	Nursing or designee		
	The Facility staff fail	led to ensure that Resident			will continue to		
	site was adequately	fistula hemodialysis access assessed for bruit and thrill.			educate newly hired		
	Vieter on	accepted for bruit and timil.		-	licensed nursing staff		
	Description from	com/treatment-services/dialysi			on orientation and		
	s/vascular-access-y	our-lifeline-to-hemodialysis:			annually.		
	Learn the feel of the	"thrill" or vibration of blood access and check it several			4. Random observations		
	times a day. Call you	ur dialysis care team			will be done by Unit		'
	immediately if the flo	ow stops or changes. This			Managers on licensed		
	clots can be dissolve	clot. With quick action, many			nursing staff assessing		
	Learn to listen with a	stethoscope to the sound			arteriovenous (AV)		
	(called "bruit") of blo	od flowing ("whooshing") If the sound of the bruit					-
	changes to a higher	pitch, like a whistle, it could			fistula hemodialysis		
	be an indication that	blood vessels are narrowing may slow or stop blood flow		-	access site for bruit and		
	through your access	I may slow or stop blood flow is. If you do not hear the bruit			thrill weekly x3 and		
	at all, or only your pu	ilse, you may have a blood			then monthly. Any		
	you notice any change	Call your dialysis care team if			deviation will be		
					forwarded to the		
	The findings include	d:			Director of Nursing or		
	Resident #67 was a	61 year old admitted to the		- Contraction	designee and QAPI		
	facility on 4/24/17 wi	th diagnoses to include (1.)			(Quality Assurance		
	Dependence on Ren	ase, Stage 3, and (2.)		The second second	Performance		
				-	Improvement)		
	Set (MDS) assessment	nprehensive Minimum Data ent was an Annual with an			committee for		
	Assessment Referen	nce Date (ARD) of 5/3/18.		-	recommendations for		
	The Brief Interview for	or Mental Status (BIMS) was			monthly x 3 and	4.5	
	Resident #67 cogniti	e 15 which indicated that vely intact and capable of			ongoing.		
	daily decision making	g. Under Section O Special			ongoing.		

Event ID: 4E4011

Facility ID: VA0227

If continuation sheet Page 63 of 77



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING 495155 **B. WING** 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6700 COLUMBIA PIKE** SLEEPY HOLLOW HEALTHCARE CENTER ANNANDALE, VA 22003 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) MPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 698 Continued From page 63 F 698 Treatments, Procedures, and Programs, Date of compliance 09/26/18 Resident #67 was coded as receiving Dialysis 09/26/18 while a resident. Resident #67's Comprehensive Care Plan last revised 5/19/2018 was reviewed and is documented in part, as follows: Focus: (Name) Resident #67 has Alteration in Kidney Function Related to ESRD (end stage renal disease) with Hemodialysis Tuesday, Thursday, and Saturday and at risk from bleeding from dialysis access. Intervention: Monitor thrill and bruit daily in left arm and document findings:report abnormal findings to Physician. Resident #67's current Physician Orders were reviewed and are documented in part, as follows: Order: Monitor AV (Arteriovenous Fistula) on left arm for bruit and thrill every shift. Status: Active Start Date: 3/25/2018 On 08/22/18 at 09:25 AM an interview was conducted with Resident #67. Resident #67 was asked if the nurse's assess his left arm dialysis fistula when he returns from dialysis on Tuesdays, Thursdays, and Saturdays. Resident #67 stated, "No, they don't check it here only at dialysis." On 08/22/18 09:35 AM LPN (Licensed Practical

Nurse) #1 who was assigned to Resident #67 for the day was asked if she would walk with the

IAIEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(20)		OMB N	M APPROVE O. 0938-039		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) D	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		-	STREET ADDRESS CITY OFFI	01	8/23/2018		
SLEEPY	HOLLOW HEALTHC	ARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE ANNANDALE, VA 22003				
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	the resident's room over the resident's room over the resident's lid lifeel the vibration." all you do to check it task completed. LP you do for bruit and ever obtained or use. On 8/22/18 at 9:45 ARN (Registered Nursestation when LPN #1 Resident #67's room surveyor how to check esident with a Arterit. LPN #1's right arm abover the lower end and you will feel the vibrathat is all you do to che task completed. You so." No stethosused to check bruit. On 8/22/18 at 10:30 Aregarding bruit and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Region of RN #1 was share fursing and the Rught was sha	Resident #67's his left arm ruit and thrill. LPN #1 entered and placed her right hand eft arm and stated, "It's good, Surveyor then asked if that is bruit and thrill and was the N #1 stated, "Yes, that is all thrill." No stethoscope was ed to check bruit. A.M. the Wing 2 Unit Manager se) #1 was at the nurse's I and I returned from I she was asked to show the ck bruit and thrill on a ovenous Fistula. RN #1 held and placed her right hand and stated, "You feel here and atton." Surveyor then asked if heck bruit and thrill and was RN #1 stated, "Yes, that's all cope was ever obtained or A.M. the above information arrill assessment by LPN #1 and with the Director of onal Nurse Consultant and all they have expected from ector of Nursing stated, "For stethoscope to listen for the ethrill." The Regional ted, "The RN didn't use a eneed to start training now."	F 698					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG PREFIX TAG DEFICIENCY) F 698 Continued From page 65 F 698 Definitions: Bruit: the "swishing" sound heard over the site of anastomosis using a stethoscope; the sound is due to the large volume and high pressure of blood passing through the site. Thrill: The vibration felt by the flow of blood at the anastomosis; thrills are not audible but must be felt with a light touch and indicate good blood flow. Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents Procedures: III. Signs and Symptoms to monitor: I. Lack of bruit heard or thrill palpated at the site of the anastomosis. VI. General Vascular Access Device care and Precautions: b. Thrill: normal sensation felt at site of anastomosis for grafts and fistulas. c. Bruit: normal sensation heard with stethoscope as swishing sound at site of anastomosis for grafts and fistulas. Thrills and bruits are normal with grafts and fistulas sue to high velocity of blood through the vein at the anastomosis site. VIII. Post-Dialysis b. Nurse to complete the poet-dialysis evaluation upon return from dialysis center to include but not

limited to:

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE 4D (X5) COMPLETION TAG PREFIX TAG DEFICIENCY) F 698 Continued From page 66 F 726 F 698 Thrill absence or presence. 1. LPN #1 and Unit ii. Bruit absence or presence 09/26/18 Manager RN #1 were On 8/23/18 at 1:31 PM a pre-exit conference was educated on how to conducted with the Administrator, Director of assess arteriovenous Nursing, Cooperate Clinical Nurse, Chief Executive Officer, and Assistant Administrator (AV) fistula where the above information was shared. Prior to hemodialysis access exit no further information was shared. site for bruit and thrill F 726 **Competent Nursing Staff** F 726 CFR(s): 483.35(a)(3)(4)(c) SS=D on hemodialysis resident #67. §483.35 Nursing Services The facility must have sufficient nursing staff with 2. All residents receiving the appropriate competencies and skills sets to dialysis have the provide nursing and related services to assure potential to be resident safety and attain or maintain the highest practicable physical, mental, and psychosocial affected. All licensed well-being of each resident, as determined by nursing staff will be resident assessments and individual plans of care educated on how to and considering the number, acuity and diagnoses of the facility's resident population in assess arteriovenous accordance with the facility assessment required (AV) fistula at §483.70(e). hemodialysis access §483.35(a)(3) The facility must ensure that site for bruit and thrill licensed nurses have the specific competencies on all hemodialysis and skill sets necessary to care for residents' needs, as identified through resident residents. assessments, and described in the plan of care. 3. Assistant Director of Nursing or designee will §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and continue to educate implementing resident care plans and responding newly hired licensed

to resident's needs.

§483.35(c) Proficiency of nurse aides.

The facility must ensure that nurse aides are able

nursing staff on

orientation and

annually.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** 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 495155 B WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE TAG **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 726 Continued From page 67 4. Observations will be F 726 to demonstrate competency in skills and done by Unit Managers techniques necessary to care for residents' needs, as identified through resident 3 times a week on assessments, and described in the plan of care. licensed nursing staff This REQUIREMENT is not met as evidenced bv: assessing Based on observations, medical record review, a Resident Interview, staff interviews, and facility arteriovenous (AV) document review, the facility staff failed to ensure fistula hemodialysis competency in assessing an Arteriovenous access site for brill and Fistula hemodialysis access for bruit and thrill for 1 (Resident thrill weekly x3 and #67) of 42 residents in the survey sample. then monthly. Any The facility staff failed to ensure that Resident deviation will be #67's Arteriovenous Fistula hemodialysis access forwarded to the was adequately assessed for *bruit and **thrill. Director of Nursing or The findings included: designee and QAPI Resident #67 was a 61 year old admitted to the (Quality Assurance facility on 4/24/17 with diagnoses to include (1.) Performance Chronic Kidney Disease, Stage 3, and (2.) Dependence on Renal Dialysis. Improvement) committee for The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an recommendations for Assessment Reference Date (ARD) of 5/3/18. The Brief Interview for Mental Status (BIMS) was monthly x 3 and a 15 out of a possible 15 which indicated that ongoing. Resident #67 cognitively intact and capable of daily decision making. Under Section O Special 5. Date of compliance Treatments, Procedures, and Programs, 09/26/18 Resident #67 was coded as receiving Dialysis 09/26/18

in part, as follows:

while a resident.

Resident #67's Comprehensive Care Plan last revised 5/19/2018 was reviewed and documented

DEPAR	TMENT OF HEALT	HAND HUMAN SERVICES				PRINTE	D: 09/04/2018
ISTATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T			OMB N	M APPROVED O. 0938-0391
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F 726	Continued From pa	age 68	F 7	26			
	runction Related to disease) with Hemo and Saturday and a dialysis access. Intervention: Monitor thrill and brid document findings; Physician. Resident #67's currereviewed and are do Order: Monitor A/V arm for bruit and thristatus: Active Start Date: 3/25/201 On 08/22/18 at 09:2:	8 5 AM an interview was					
1	conducted with Resi asked if the nurse's listula when he retur Tuesdays, Thursday	dent #67. Resident #67 was					
t c	Nurse) #1 who was a the day was asked if surveyor to assess R dialysis fistula for bru the resident's room a pover the resident's le feel the vibration."	AM LPN (Licensed Practical assigned to Resident #67 for she would walk with the desident #67's his left arm lit and thrill. LPN #1 entered and placed her right hand ft arm and stated, "It's good, Surveyor then asked if that is ruit and thrill and was the N #1 stated, "Yes, that is all		entretentremannententremannententremannententremannententremannententremannententremannententremannententreman			

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Facility ID: VA0227

If continuation sheet Page 69 of 77

Event ID: 4E4011

FORM CMS-2567(02-99) Previous Versions Obsolete

VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 69 F 726 you do for bruit and thrill." No stethoscope was ever obtained or used to check bruit. On 8/22/18 at 9:45 A.M. the Wing 2 Unit Manager RN (Registered Nurse) #1 was at the nurse's station when LPN #1 and I returned from Resident #67's room she was asked to show the surveyor how to check bruit and thrill on a resident with a Arteriovenous Fistula. RN #1 held LPN #1's right arm and placed her right hand over the lower end and stated, "You feel here and you will feel the vibration." Surveyor then asked if that is all you do to check bruit and thrill and was the task completed. RN #1 stated, "Yes, that's all you so." No stethoscope was ever obtained or used to check bruit. On 8/22/18 at 10:30 A.M. the above information regarding bruit and thrill assessment by LPN #1 and RN #1 was shared with the Director of Nursing and the Regional Nurse Consultant and were asked what would they have expected from their nurses. The Director of Nursing stated, "For them to have used a stethoscope to listen for the bruit and to feel for the thrill." The Regional Nurse Consultant stated, "The RN didn't use a stethoscope either we need to start training now." The surveyor replied, "No." The facility policy titled "Hemodialysis Monitoring" last revised 3/23/18 was reviewed and is documented in part, as follows: Definitions: *Bruit: the "swishing" sound heard over the site of anastomosis using a stethoscope; the sound is due to the large volume and high pressure of blood passing through the site.

STATEMEN	T OF DEFICIENCIES	E & MEDICAID SERVICES				OMB N	M APPROVI 0. 0938-03
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		495155	B. WING		1	C 08/23/2018 ZIP CODE	
	PROVIDER OR SUPPLIER HOLLOW HEALTHC			67	TREET ADDRESS, CITY, STATE, ZIP CODE 700 COLUMBIA PIKE NNANDALE, VA 22003		
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F 726	Continued From pa	ige 70	F 7	26			
	the anastomosis: th	on felt by the flow of blood at rills are not audible but must buch and indicate good blood					5
and the second s	Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents.		(44)				
	Procedures: III. Signs and Symp I. Lack of bruit hear of the anastomosis.	otoms to monitor: d or thrili palpated at the site		The second second second second second			
	Precautions: b. Thrill: normal ser anastomosis for gra- c. Bruit: normal ser stethoscope as swis anastomosis for grai bruits are normal wit	nsation felt at site of fits and fistulas. Insation heard with hing sound at site of fits and fistulas. Thrills and h grafts and fistulas sue to d through the vein at the		And the second s			
	VIII. Post-Dialysis b. Nurse to complete upon return from dial imited to: . Thrill absence or p i. Bruit absence or p	e the poet-dialysis evaluation lysis center to include but not resence.					
0	On 8/23/16 at 1:31 Properties of the Allersing, Cooperate (M a pre-exit conference was dministrator, Director of Clinical Nurse, Chief d Assistant Administrator					

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

PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	LE CONSTRUCTION	(X3) DA	O. 0938-039 TE SURVEY MPLETED
	495155	B. WING			С
NAME OF PROVIDER OR SUPPLIER SLEEPY HOLLOW HEALTHC		6	TREET ADDRESS, CITY, STATE, 2 700 COLUMBIA PIKE NNANDALE, VA 22003	3/23/2018	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 842 Resident Records CFR(s): 483.20(f)(s) §483.20(f)(s) Resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use of except to the extent to do so. §483.70(i) Medical signal standards are a must maintain medit that are- (i) Complete; (ii) Accurately docur (iii) Readily accessil (iv) Systematically of \$483.70(i)(2) The far all information contaregardless of the for records, except when (i) To the individual, representative when (ii) Required by Law (iii) For treatment, properations, as permit with 45 CFR 164.50(iv) For public health	Information was shared. Prior to the mation was shared. Identifiable Information Identifiable Information. Ident-identifiable information. It release information that is It to the public. In release information that is It to an agent only in Identifiable information that is Identifiable infor	F 726	1. Resident #44 discharged 6/ Resident #24 discharged 5/ 2. All residents potential to be affected. Mee Records depa will ensure the records are concurate, systematicall organized, and accessible from acquisition — per policy. 3. Assistant Dire Nursing or de educate med records staff complete, accessible med records per policy. 3. Assistant Dire Nursing or de educate med records staff complete, accessible med records per policy.	/1/17. 0 was /30/17. have the be dical artment hat medical complete, tematically had readily om date of 5/1/17 ector of esignee will lical on having curate, y had readily edical policy on or	

SIAIEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
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	HOLLOW HEALTHCA	RE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 COLUMBIA PIKE ANNANDALE, VA 22003	, ,	<u> </u>	
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	law enforcement pur purposes, research medical examiners, a serious threat to h by and in compliance §483.70(i)(3) The fair record information a unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 ye legal age under State §483.70(i)(5) The medical formation of the resident information of the resident review experience of the resident review experience in the resident review and factorized in the resident review and factorized review and factorized clinical record record review and factorized clinical record reco	rposes, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or all records must be retained a required by State law; or need at e of discharge when eart in State law; or ars after a resident reaches e law. cidical record must containion to identify the resident; sident's assessments; we plan of care and services or preadmission screening valuations and acted by the State; 's, and other licensed	F 84	4. Assistant Executive Director or designee will audit 10% of discharges weekly x3 and then monthly. And deviation will be forwarded to the Director of Nursing of designee and QAPI (Quality Assurance Performance Improvement) committee for recommendations for monthly x 3 and ongoing. 5. Date of compliance 09/26/18.	s ny r	09/26/18	

1. The facility staff failed to ensure the clinical

Event ID: 4E4011

Facility ID: VA0227

If continuation sheet Page 73 of 77



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES **FORM APPROVED** STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX ID PREFIX (X5) COMPLETION TAG TAG DATE DEFICIENCY) F 842 | Continued From page 73 F 842 record was accurate for Resident #440; a progress note indicated resident was a status post right hip fracture with staples when in fact was not 2. The facility staff failed to retain Resident #240's clinical record after new management took over the facility. The findings included: 1. Resident #440 was admitted to the facility on 3/1/17. Diagnosis for Resident #440 included but not limited to *Dementia with behavioral disturbance. *Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia. https://www.ncbi.nlm.nih.gov/pubmed/22644311 The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 5/30/17 coded the resident with a 01 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. In addition, the MDS coded Resident #440 total dependence of one with bathing, extensive assistance of one with dressing, limited assistance of one with bed mobility, toilet use and personal hygiene for Activities of Daily Living care. The care plan dated as initiated on 03/01/17 did not indicate a recent right hip fracture with surgical interventions.

The resident's progress note dated 04/28/17,

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE, ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG DEFICIENCY) F 842 Continued From page 74 F 842 include the following under musculoskeletal system: staples to right hip status post fracture (s/p). The assessment and plan: s/p hip fracture of right hip, going today to have staples removed. The review of Resident #440's clinical notes from admission on 3/1/17 through 6/1/18 did not reveal a right hip fracture with surgical interventions. An interview was conducted on 8/22/18 at approximately 1:25 p.m., with the Director of Nursing (DON) who stated, "I was unable to locate where Resident #440 had a recent right hip fracture with surgical interventions." The facility administration was informed of the findings during a briefing on 08/23/18 at approximately 2:00 p.m. The facility did not present any further information about the findings. 2. Resident #240 was admitted to the facility on 8/26/16 with diagnoses which included: Cardiovascular Accident with Aphasia, Renal disease with dialysis, chronic kidney disease. hypothyroidism, hypertension, depression. Type II diabetes mellitus with hyperglycemia, and hyperlipidemia. The facility staff failed to have clinical records available. During the investigation of a complaint that Resident #240 was out of the facility for over 6 hours on a medical appointment without food or any change of her depends. The Administrator was asked for the clinical records of Resident

#240. The Administrator stated, "The facility came under new management in May of 2017 and there were no means to obtain the past medical

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 09/04/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING 495155 B. WING NAME OF PROVIDER OR SUPPLIER 08/23/2018 STREET ADDRESS, CITY, STATE ZIP CODE SLEEPY HOLLOW HEALTHCARE CENTER 6700 COLUMBIA PIKE ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID ID **PREFIX** PROVIDER'S PLAN OF CORRECTION PREFIX TAG EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 842 | Continued From page 75 F 842 records of Resident #240. F 925 09/26/18 No medical records were made available to The following rooms confirm that Resident #24 was out of the facility were inspected and on 3/17/17. Nor were medical records made available to review for the care and treatment of treated by Bay city pest Resident #240. management on F 925 Maintains Effective Pest Control Program F 925 9/10/2018 - #308, SS=E CFR(s): 483.90(i)(4) #309, # 311, # 114 and §483.90(i)(4) Maintain an effective pest control offices # 324, #328 program so that the facility is free of pests and #329. The following rodents. This REQUIREMENT is not met as evidenced room were inspected and treated by Bay city Based on observations, record review group interview and staff interview, the facility staff failed pest management on to maintain an effective Pest Control Program. 9/12/2018 - # 112, #106, #204, #305, #9, The findings included: #213, and south dining During the Group Interview on 8/22/18 residents room. No additional complained of mice being in their rooms. The residents stated mice droppings were observed in evidence of pest found rooms 106, 204 and 305. in the rooms. The Microwave oven was A review of the Pest Control Log for the North Unit indicated: On 8/15/18 a mice (sic) was removed from the East sighted in room 9. Unit on 08/23/18. Holes in walls were A review of the Pest Control Log for the South Unit indicated: On 2/21/18 mice were sighted in sealed on 09/12/18. the dining room. Trees were trimmed away from the building

room 213.

A review of the Pest Control Log for the West 1

Unit indicated: On 8/21/18 mice were sighted in

on or before 09/26/18.

South Kitchen sink was cleaned on 08/23/18.

ND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A BUILDING	PLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
HADAT OF		495155	B. WING			C	
SLEEPY	PROVIDER OR SUPPLIER HOLLOW HEALTHC	ARE CENTER		STREET ADDRESS, CITY, STATE, ZI 8700 COLUMBIA PIKE ANNANDALE, VA 22003	PCODE	08/23/2018	
(X4) ID PREFIX TAG	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE	
	A review of the Pes indicated: On 2/13/ following rooms, #308, #309, #311, (log indicated: Need away from building. A review of the Pes indicated: On 5/30/1 the microwave over sighted in room 112 sighted in room 114 A Pest Assessment Kitchen: Serviced m West 1 and 2: Baite East Unit: Baited for South Unit: Kitchen: Emerald Court Unit: HVAC Units in hallwown and the policy During an interview of Regional Director of 11:30 A.M. the Admin was being aggressive acidity. The Regional Direct of 11:30 A.M. the Admin M.M. t	at Control Log for the 300 Unit 18 mice were sighted in the 20ffice, #324, #328, #329. The to seal holes in walls/trim tree at Control Log for the East Unit 18 roaches were observed by 1. On 8/19/18 mice were 2. On 8/20/18 mice were 3. On 8/20/18	F 925	2. All residents have t	the ed. For all control rooms of t if raff will in the ting eds. A coprocess t done hen k pest ensure sted in book d by		
				ongoing. 5. Date of compliar 09/26/18	nce	09/26/18	

Event ID: 4E4011

Facility ID: VA0227

If continuation sheet Page 77 of 77





COMMONWEALTH of VIRGINIA

M. Norman Oliver, MD, MA State Health Commissioner

Department of Health Office of Licensure and Certification

TYY 7-1-1 OP 1-800-828-1120 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Fax (804) 527-4502

September 4, 2018

Mr. Ezedube Eze, Administrator Sleepy Hollow Healthcare Center 6700 Columbia Pike Annandale, VA 22003

RE:

Sleepy Hollow Healthcare Center

Provider Number 495155

Dear Mr Eze:

An unannounced licensure, standard and complaint survey, ending August 23, 2018, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Six complaints were investigated during the survey. One complaints was substantiated, with deficiencies. Two complaints were substantiated, with no deficiencies. Three complaints were unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested

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Mr. Ezedube Eze, Administrator September 4, 2018 Page 2

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached

Plan of Correction (PoC): Please cross reference the attatched licensure deficiencies to your federal deficiencies.

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Laura Veuhoff, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

2. Address how the facility will identify other residents having the potential to be affected by the

3. Address what measures will be put into place or systemic changes made to ensure that the

4. Indicate how the facility plans to monitor its performance to make sure that solutions are

5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through Resolution Process, http://www.vdh.virginia.gov/licensure-and-certification/the-division-of-long-term-care/. may accessed

Mr. Ezedube Eze, Administrator September 4, 2018 Page 3

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State

- Pursuant to §488.408(c)
 - Directed Plan of Correction (PoC) (§488.424).

State monitoring (§488.422).

- Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
 - Denial of payment for new admissions (§488.417).

Denial of payment for all individuals - (§488.418).

- Civil Money Penalty, \$50 \$3,000 per day (§488.430, §488.438), effective on the survey
- Civil money penalties of \$1,000 \$10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Mr. Ezedube Eze, Administrator September 4, 2018 Page 4

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf. We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Laura S. Veuhoff, LTC Supervisor

Division of Long Term Care

Lawa Spacuse Vernoff

Enclosure

cc: Joani Latimer, State Ombudsman

Bertha Ventura, Dmas (Sent Electronically)

SEP 2 4 2018
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