Leewood Healthcare Center



Serving you from our heart

November 23, 2018

Mr. Paul Wade, LTC Supervisor

Office of Licensure and Certification

Division of Long Term Care Services

9960 Mayland Drive, Suite 401

Richmond, VA 23233

Re: Leewood Healthcare Center (Provider Number 495337)

Dear Mr. Wade,

Enclosed for your review, please find our plan of correction for survey ending November 8th, 2018. We submit this plan of correction as Leewood's allegation of compliance. Please contact me directly if you have any questions or require additional information.

Sincerely,

Terrence Kee

Administrator

PRINTED: 11/15/2018 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/08/2018	
LEEWOO	ROVIDER OR SUPPLIER D HEALTHCARE CENTE		71 A	REET ADDRESS, CITY, STATE, ZIP CODE 20 BRADDOCK ROAD NNANDALE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	
E 000		ergency Preparedness	E 000	Plan of Correction Leewood Healthcare, 11/201	8	
F 000	The facility was in sub	d 11/6/18 through 11/8/18. estantial compliance with 42 quirement for Long-Term	F 000	This Plan of Correction is sub- as required under State and F law. The facility's submission Plan of Correction does	ederal of the	
	survey was conducted Corrections are requir			constitute an admission on the of the facility that the findings are accurate, that the findings constitute a deficiency, or the scope and severity determinate correct. Because the facility is	s cited addings at the tion is	
F 607	117 at the time of the consisted of 34 reside Develop/Implement A	ouse/Neglect Policies	F 607	no such admissions, the state made in the Plan of Corr cannot be used against the fa	ments ection acility	
33-0	§483.12(b) The facility			in any subsequent administrat civil proceeding.	ive or	
	§483.12(b)(1) Prohibit neglect, and exploitati misappropriation of re	on of residents and		F 607 Development/Imple Abuse/Neglect Policies Compliance Date: 11/30/2018	ement	
	to investigate any suc					
	by: Based on observation interviews, facility doc	is not met as evidenced is, family interviews, staff umentation review, and the facility staff failed to				

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

minto ater

(X6) DATE

11/23/18

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING		44/09/2049	
	PROVIDER OR SUPPLIER D HEALTHCARE CENTE SUMMARY ST	TATEMENT OF DEFICIENCIES	7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECT	11/08/2018	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETION	
F 607	choking incident and	e 1 nd procedures regarding a a bruise of unknown origin dent #82, #78) in a sample of	F 607	Immediate action taken resident found to have affected include: Resident # 82 was evaluated 10/16/2018 by a Licensed I	e been ated on	
 For Resident #82, the facility staff failed to investigate a choking incident. For Resident #78, the facility staff failed to investigate a bruise of unknown origin. 		incident. the facility staff failed to		Nurse, Vital signs were normal limits. Afebrile. Ri room when incident occurr and Speech therapist made On 10/17, resident's die	within P in the ed. MD aware. et was	
		the facility staff failed to		downgraded to pureed textunectar thickened liquids. No action required.		
	include dysphagia an	year old female was y on 11/16/17. Diagnoses		Resident # 78 was evaluated licensed practical nurse on a head to toe skin instrumentation completed. No new skin all noted. Resident remains stab	11/8/18, spection teration	
	Data Set (MDS) had a Date (ARD) of 08/09/0 coded with a Brief Into	an Assessment Reference 2018. Resident #82 was not erview of Mental Status nitive skills for daily decision		Identification of other re		
	Functional status for e requiring extensive as	eating was coded as		All residents have the pote be affected.	ential to	
	Resident was awake was elevated approximately oxygen on at 2 liters/r On 11/06/18 at approximately nurse's notes were re-	vith family at bedside. The and the head of the head mately 60 degrees. She had minute via nasal cannula.		All nurses notes were reviet the DON and the Nurse Mar 11/8/2018, no new incide choking or injury of u origin identified. No other rewere identified to be afferthis practice.	ngers on nces of nknown esidents	

An entry dated 10/16/18 at 2:02 PM documented,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING	1	11/08/2018
		ER .	7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003	11100/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	N
F 607	started choking. Upo pieces of watermelor in stable condition. Vnormal limits. MD an aware." A nurse's note dated "Resident observed congestion" "O2SAT order received (sic) fand done, result received mouth daily for pneuradministered for cought administered for cought may be a silver of the physician's ordered dated 01/09/"Mechanical soft diet. An order dated 10/17 downgrade Pt to pure liquids." An order dated 10/24 clarification order: 5X 5 weeks to continue to tolerance with moder dysphagia." An order dated 10/29	resident lunch, when she in suctioning resident, small in were brought up. Patient is fitals monitored and within dispeech therapy made. 10/24/18 documented, with coughing nad (sic) 89-90%", "MD made aware for chest xray order placed eived (sic) Impression Right Pleural effusion, MD made if (sic) for Levaquin 250mg by monia" "PRN Robitussingh with effective result" It were reviewed. An a documented, with thin liquids." 1/18 documented, with nectar thick liquids." 1/18 documented, "ST to be solid with nectar thick liquids." 1/18 documented, "ST to be solid with nectar thick liquids." 1/18 documented, "ST to be solid with nectar thick liquids."	F 607	A head to toe skin inspection	into uture was urses the e on the eport uding njury eleted e for vices
	liquids." Speech therapy note:	s were reviewed.		The Director of Nursing/Desi will review the Nurses Notes of	

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CLIVILI	O I ON WEDICANE &	WEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
LEEWOO	D HEALTHCARE CENTER		7	120 BRADDOCK ROAD	
LEEWOO	D HEALTHCARE CENTE	X		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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	coughing on thin liquincluded "mild residue solids" with a diet reconsoft textures and nect An entry dated 10/10/ reported he was conconectar thick liquids, ploof nectar thick liquids, side of bed, reporting liquids from the room. An entry dated 10/15/ educated staff of diet liquids in the room an (sic) pt meds with thin An entry dated 10/17/ reportedly choked last to puree. Pt with prolomastication, needing and prolonged AP tranappropriate for pureed and edentulous status. An entry dated 10/18/ thin liquids at bedside room and informing numbers.	18 documented, "Pt. h therapy) by nursing for ds." Assessment summary e in oral cavity, pocketing of ommendation of mechanical ar thick liquids. 18 documented, "Pt's son erned that pt would refuse with no resistance to intake " "ST finding thin liquids at to nursing and removing " 18 documented, "ST restrictions after finding thin d nurse attempting to get liquids." 17 documented, "Pt e night, ST downgrading pt nged and disorganized cues to initiate swallowing hsit. Pt additionally more I diet to level of alertness ." 18 documented, "ST finding AGAIN, clearing from ursing of problem." 18 documented, "ST finding AGAIN left by family in the	F 607	residents daily for two weekly for four weeks and for two months to en incidents of choking, it unknown origin and provinvestigation is implement completed. The Director of Nursing/I will present the results of retthe Quality A Performance Improcommittee for review and recommendations. Assurance Performance Improvement Team Include: Administrator, Director of Services, Director of Director of Housekeeping, of Maintenance, Nurse Minimum Data Set Cool Medical Director, Director of Services, and Pharmacy Col If issues are identified	monthly sure all ajury of tocol on ated and decembers rector of elopment Social Dietary, Director tanagers, rdinator, of Rehab insultant. It, then will be a of the made to
1	An entry dated 10/23/	18 documented, "ST finding		_	

thin liquids in pt's room AGAIN. ST in process of

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495337	B. WING_		11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R	*	STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 607	to families (sic) nonce restrictions after educe on 11/07/18 at 8:40 A observed awake in be elevated approximate oxygen on at 2 liters/On 11/7/18 at 9:00 Al was interviewed. Emfacility used a dietary System. He provided 10/16/18 (the day of the menu for 10/16/18 die Employee A provided included fruit as the semployee A stated the for the facility. When for the last time the face Employee A stated the every week. When as delivered whole or preserved.	st medical advice) form due ompliance with diet cation about purpose." AM, the Resident was ed with the head of bed ely 60 degrees. She had minute via nasal cannula. M, Employee A, dietary staff, uployee A explained that the program called TrayCard It tray cards for Resident de the menus for Tuesday the choking incident). The dinot list watermelon. a snack schedule that	F€	507	
	type of fruit served on 2:00 p.m. snack Empl keep record. He state watermelon or cantaloutility was delivered on day, Employee A state				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING	3	
		495337	B. WING		11/08/2018
	PROVIDER OR SUPPLIER D HEALTHCARE CENT	TER		STREET ADDRESS, CITY, STATE, ZIP COI 7120 BRADDOCK ROAD ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 607	interviewed. LPN A anything about Res She did not remem She did not comple On 11/7/18 at 9:45 LPN B stated that the Resident. LPN B stated that the Resident. LPN B stated that the Resident A (CNA A #82 was choking. LPN D responded. Suctioned the reside pieces of watermelot the watermelon pieces of watermelot watermelon was or if the family broughter-in-law were When asked about daughter-in-law statit happened but her other son) was then occurred. When asked	A was asked if she knew sident #82's choking incident. ber the details of the incident. te an incident report. AM, LPN B was interviewed the son had been feeding the stated that Certified Nursing notified her that Resident LPN B stated that LPN D sent. LPN B stated that LPN D tent. LPN B stated that LPN D tent. LPN B stated that 2-3 on were removed. She stated ces were long and skinny, LPN B could not remember if a served by the facility that day got in the fruit. A PM, the Resident's son and re at the Resident's bedside the choking incident, the ted they were not there when brother-in-law (Resident's e when the choking incident ked if her brother-in-law may	F 60		
	"never brings in food On 11/7/18 at 1:45 pagain to describe he was prepared to see provided an exampl was a tall, cylindrica filled the container he fruit was cut in cube He provided an exa for the survey team.	o.m., Employee A was asked ow the Tuesday fruit snack and to the unit. Employee A e of the container he used. It al container. He stated that he nalf full. He stated that the es less than an inch in size, mple of the cut up watermelon			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		i i i i i i i i i i i i i i i i i i i	A. BUILDI	NG	OOM ELIEB
		495337	B. WING		11/08/2018
NAME OF F	PROVIDER OR SUPPLIER		_	STREET ADDRESS, CITY, STAT	
				7120 BRADDOCK ROAD	
LEEWOO	D HEALTHCARE CENT	FER		ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT) CROSS-REFERENC	VLAN OF CORRECTION (X5) VIVE ACTION SHOULD BE COMPLETION SED TO THE APPROPRIATE DATE FICIENCY)
F 607	serve the fruit. Emsend applesauce for the fruit. Emsend applesauce for the send applesauce for the send applesauce for the send applesauce for the send at the send applesauce for the send at the send at the send applesauce for the send applesauc	e nursing staff would use to aployee A stated he would or residents on puree diet. D PM, the Resident's younger d. When asked about the e son stated he arrived when feeding his mom in the dining e CNA was crushing large fon with a fork before feeding it in was shown the example of provided by Employee A and like what the CNA was ag to his mom that day. He CNA left the dining room and mom back to her room and ther bed. While his mom was ed she appeared to be	F	607	
	CNA A stated that a dining room and sa dining room table. Sidining room feeding does not know who Resident was taken Resident's son. On 11/08/18 at 9:00 interviewed. When state the choking inciden much about it." Whe the Resident water daughter-in-law gav	noking, and notified the nurse. Ifterwards, she went into the w the Resident's tray on the She stated she was not in the I the Resident that day and was. CNA A also stated the I back to her room by the I AM, the DON was asked what she knew about t, she stated "I don't know en asked if she knew who fed melon that day, she said the te her watermelon. She stated rings in food from home.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495337	B. WING			11/08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COD 7120 BRADDOCK ROAD ANNANDALE, VA 22003	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B APPROPRIA		
	she didn't have an in sometimes residents while they are being Resident couldn't brown and death situation. It when asked about the stated she was feed room that day but do food was. She also she sident's son came on 11/08/18 at 9:30 When asked about the states he was called the Resident was in clammy, and gaspin suction was in the restated the son was in usually not here') and LPN D stated he lood couldn't see anything results and then such big piece of watermed again and a smaller picture to depict what said the first piece who said the first piece who said the first piece who said the son. He also ston gave his mom 'to on 11/08/18 at 11:15 wanted to share who choking incident. He investigation. He sta	an incident report, she stated incident report. She stated incident report. She stated is with dysphagia will cough fed. She then stated if the eathe, that would be a "life" She also stated she didn't needed to be suctioned. AM, CNA B was interviewed, the choking incident, CNA B ing the Resident in the dining present remember what the stated she remembers the entitle into the dining room. AM, LPN D was interviewed, the choking incident, LPN D into the dining room. AM, LPN D was interviewed, the choking incident, LPN D in the room by LPN B. He states the bed sweating, pale, gright for breath. He states soom on the crash cart. LPN D in the room ('the one that is disaid his mom was choking ked in Resident's mouth and gright He suctioned her without tioned deeper. He stated a relion came out, then suctioned piece came out. He drew a lat the pieces looked like. He as large, "about a 3-inch he did not see any food in atted that LPN B told him the	F	507			

STATEMENT OF DEI AND PLAN OF CORI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495337	B. WING _		11/08/2018
NAME OF PROVID	ER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE COMPLÉTION THE APPROPRIATE DATE
but Adm feed Res stat Adm to a asking stat thick water the stat stat. The inverse was accident for a contract of the stat stat stat stat stat stat stat sta	ninistrator stateding the Reside dident back to held he also spole ininistrator at the lert LPN B and ad for his assisted the son told kened liquids be remelon out. The son was asked and 'we don't bried 'we condents or incide stigating and residents or incide st	g the Resident. The d CNA B told him the son was nt and then brought the er room. The Administrator ke with CNA A. CNA A told the et time of the incident, she went saw LPN D in the hall and tance also. The Administrator LPN B the son gave his mom ut LPN D suctioned ne Administrator stated when if he brought in food, the son ng in fruit' and another time	F 6	07	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495337	B_WING_			11/08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	the choking incider speech therapist w give the Resident I liquid. There are conchoking incident sucame from (facility consistency the ware Resident ate it, and the Resident. Sever incident, the physic progress notes that aspiration pneumon cough medicine, and investigation contains and identify risks, correst improve the health of 11/08/18 at app. Administrator and the concerns and they 2. For Resident # administrator and the concerns and they 2. For Resident # administrator and the concerns and they Resident # 78, an 8 admitted to the facilinclude anemia, hydepression, Parkins disease. Resident # 78's most Data Set (MDS) had Date (ARD) of 10/0 coded with a Brief I (BIMS) score but concerns and the concerns and the coded with a Brief I (BIMS) score but concerns and the coded with a Brief I (BIMS) score but concerns are concerns and the coded with a Brief I (BIMS) score but coded with a Br	vitnessed a nurse attempting to ther medications with a thin conflicting reports about the cuch as where the watermelon versus family), what size and atermelon was when the d who fed the watermelon to the days after the choking cian documented in the t Resident had possible nia, ordered labs, chest x-ray, and antibiotics. There was not inducted by the facility staff and	Fé	607			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION		DATE SURVEY COMPLETED
		495337	B. WING				11/08/2018
	PROVIDER OR SUPPLIER D HEALTHCARE CENT	ER		7120	ET ADDRESS, CITY, STATE, ZIP CODE BRADDOCK ROAD ANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x I	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	dressing, and person requiring extensive On 11/06/18 at 01:5 observed sitting in the Resident had a and anterior to here inch diameter. On 11/07/18 at app Resident was observed in the stand lunch with stands on her right are libow with approximal on the afternoon of 4 months for this Resident was 109/28/18 for a cut of the following interverse evaluation of wound observation of skin skin evaluation weed.	r bed mobility, transfers, anal hygiene was coded as	F	607			
	assistant (CNA) C v the bruise on this R not aware the Resid	AM, certified nursing was asked about the origin of esident's arm. The CNA was lent had bruise on her right served the bruise as the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			((X3) DATE SURVEY COMPLETED	
		495337	B. WING_			11/08	8/2018
	PROVIDER OR SUPPLIER D HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 607	CNA stated 'it's an oryellowish in the central Licensed practical numbers and stated the not remember how the but stated she 'wrote on 11/08/2018 at 10 about Resident #78's requested from the Enew bruise" so the inwritten yet. On 11/08/18 at 10:30 E was conducted. Lecheck on Resident # bruise (on the right at 10 to yellow).	In the day room and the d bruise'. The bruise was er and purplish on the edges. Urse (LPN) E was standing at it was an old bruise but did ne Resident acquired bruise it up'. In 5 AM, an incident report is bruise on her right arm was pond and she stated "that's a cident report has not been AM, an interview with LPN in E stated she did a skin room Tuesday and that rm) was not there. She went	F	507			
	walking her mom out returned and showed back of the Resident bruise on the Reside from yesterday." On 11/08/18 at appropresented an incident the right arm. It was and documented, "Property of the right) arm of the right arm of the right) upper arm of the return of the right) upper arm of the return of the	sident's daughter was side yesterday and then I the staff a bump on the is head. LPN E stated the int's arm was a "new bruise eximately 2:45 PM, the DON the report about the bruise on dated 11/08/18 at 9:30 AM is noted with intact bruise to close to the elbow. RP					
	both arm (sic) by the side (sic) the building dark-red puplish (sic) color that measures (In summary, a bruise #78's right arm above	cknowledged holding pt on elbow during ambulation out yesterday. Intact bruise with edges and slight greenish in 6x5x0." was observed on Resident to her elbow on 11/06/18 by the re was no evidence the staff				4	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING	
		495337	B. WING		11/08/2018
	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	:	STREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA	
IAO			IAG	DEFICIENCY)	
F 607	Continued From pag was aware of the bru assessment, started findings, or initiated	uise, conducted an an investigation, reported	F 607		
F 609 SS=D	Administrator and Do and they offered no Reporting of Alleged CFR(s): 483.12(c)(1	Violations	F 609	F 609 Reporting of Al Violations Compliance Date: 11/30/18	lleged 11/30/18
	§483.12(c)(1) Ensurinvolving abuse, neg mistreatment, includ source and misappro are reported immedi	e that all alleged violations lect, exploitation or ing injuries of unknown opriation of resident property, ately, but not later than 2 ation is made, if the events		Immediate action taken for resident found to have affected include:	
	that cause the allega serious bodily injury, the events that caus abuse and do not re- the administrator of to officials (including to adult protective serv for jurisdiction in long accordance with Sta procedures.	ation involve abuse or result in or not later than 24 hours if the the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ces where state law provides geterm care facilities) in the law through established		Resident # 82 was evaluate 10/16/2018 by a Licensed Pra Nurse, Vital signs were wormed limits. Afebrile. RP room when incident occurred and Speech therapist made at On 10/17, resident's diet downgraded to pureed texture nectar thickened liquids.	actical within in the l. MD aware. was
	designated represen accordance with Star Survey Agency, with incident, and if the al	the results of all administrator or his or her tative and to other officials in the law, including to the State in 5 working days of the leged violation is verified e action must be taken.		Resident # 78 was evaluated licensed practical nurse on 11 a head to toe skin inspecompleted. No new skin alternoted. Resident remains stable	/8/18, ection ration

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(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 (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 609	by: Based on observation interviews, facility does clinical record review investigate a choking unknown origin for 2 #78) in a sample of 3 1. For Resident #82, investigate a choking	is not met as evidenced ns, family interviews, staff cumentation review, and the facility staff failed to incident and a bruise of residents (Resident #82, 4 residents. the facility staff failed to incident.	F 60	Identification of other rechaving the potential of affected. All residents have the potential be affected. All nurses notes were review the DON and the Nurse Mangal 11/8/2018, no new inciden	ntial to wed by gers on	
	The findings include:	the facility staff failed to		choking or injury of un origin identified. No other re were identified to be affecthis practice.	known sidents	
2	Resident #82's most and Data Set (MDS) had a Date (ARD) of 08/09/2 coded with a Brief Into (BIMS) score but cog making were coded a Functional status for a requiring extensive as On 11/06/18 at 1:25 F observed in her bed was elevated approximations.	on 11/16/17. Diagnoses didementia. recent quarterly Minimum an Assessment Reference 2018. Resident #82 was not erview of Mental Status nitive skills for daily decision is severely impaired. eating was coded as sisistance.		A head to toe skin inspection conducted on all resident 11/8/2018 by the Wound Nur Unit Mangers to ensure no in unknown origin is observed required an investigation. No residents were identified affected by this practice.	nts on se, and jury of ved or other	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED	
		495337	B. WING	The second secon	11/08/2018
LEEWOO		R ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	71 Al	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
F 609	nurse's notes were re An entry dated 10/16 "Family was feeding of started choking. Upon pieces of watermelon in stable condition. Volume normal limits. MD and aware." A nurse's note dated "Resident observed vongestion" "O2SAT order received (sic) for and done, result received aware order received mouth daily for pneur	ximately 3:00 PM, the	F 609	Actions taken/systems put place to reduce the risk of occurrence. Education, in-service program conducted for all licensed was initiated on 11/7/18 because the facility policy on incident procedures, reporting requirement and investigation of incident choking and injury of uniorigin to be completed by 11/3. Any staff member unavailable education will receive in-seprior to their return to work.	m was nurses by the ee on report ements ces of known 30/18.
	An order dated 10/17 downgrade Pt to pure liquids." An order dated 10/24 clarification order: 5X 5 weeks to continue tolerance with modera dysphagia."	18 documented, with thin liquids." /18 documented, with nectar thick liquids." /18 documented, "ST to be solid with nectar thick /18 documented, "ST /WK (five times a week) for o monitor pts (patient's) diet ate oropharyngeal		How the corrective action (see monitored to ensure practice will not recur: The administrator and or D of nursing will review all in reports on choking and injuried unknown origin to assure the for investigation and report followed as required for chokinjuries of unknown origin datwo weeks, three times a we two weeks, weekly for 4 week monthly for 2 months.	irector acident ries of policy ing is ting or aily for eek for
	An order dated 10/29	/18 documented,			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B, WING		11/08/2018
LEEWOOI	O HEALTHCARE CENTER		7 A	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	liquids." Speech therapy notes An entry dated 10/09/ referred to ST (speech coughing on thin liquifincluded "mild residue solids" with a diet recesoft textures and nech extra thick liquids, professed to bed, reporting liquids from the room. An entry dated 10/15/ educated staff of diet liquids in the room and (sic) pt meds with thir entry dated 10/17/ reportedly choked last to puree. Pt with professed and prolonged AP train appropriate for pureed and edentulous status. An entry dated 10/18/ thin liquids at bedside room and informing in entry dated 10/19/ An entry dated 10/19/	s were reviewed. 18 documented, "Pt. h therapy) by nursing for ds." Assessment summary e in oral cavity, pocketing of commendation of mechanical far thick liquids. 18 documented, "Pt's son ferned that pt would refuse e with no resistance to intake ""ST finding thin liquids at to nursing and removing" 18 documented, "ST restrictions after finding thin d nurse attempting to get in liquids." 17 documented, "Pt t night, ST downgrading pt finged and disorganized cues to initiate swallowing finsit. Pt additionally more d diet to level of alertness is." 18 documented, "ST finding final documented, "ST	F 609	include: Administrator, Director Nursing, Staff Develor Coordinator, Director of	to the mance review ations. mance embers etor of opment Social bietary, irector nagers, inator, Rehab ultant. then I be of the

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495337	B. WING_			11/	08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CEN			STREET ADDRESS, 7120 BRADDOCK I ANNANDALE, VA			00/2010
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 609	thin liquids in pt's pursuing AMA (ag to families (sic) no restrictions after e On 11/07/18 at 8:4 observed awake is elevated approximoxygen on at 2 lite. On 11/7/18 at 9:00 was interviewed, facility used a diet System. He provi #82. He also provi 10/16/18 (the day menu for 10/16/18 Employee A provicincluded fruit as the Employee A stated for the facility. Who for the last time the Employee A stated every week. Whe delivered whole of watermelon was watermelon.	/23/18 documented, "ST finding room AGAIN. ST in process of ainst medical advice) form due incompliance with diet ducation about purpose." 40 AM, the Resident was in bed with the head of bed hately 60 degrees. She had ers/minute via nasal cannula. O AM, Employee A, dietary staff, Employee A explained that the eary program called TrayCard ded tray cards for Resident wided the menus for Tuesday of the choking incident). The did not list watermelon. Ded a snack schedule that he snack for Tuesdays. If that he does the food ordering hen asked to provide the invoice he facility ordered watermelon, asked if the watermelon was precut, Employee A stated the whole and the facility cut up the	Fe	09			
	type of fruit served 2:00 p.m. snack E keep record. He s watermelon or car fruit was delivered day, Employee A s	re was documentation of the for Tuesday 10/16/18 for the imployee A sated that he did not stated that it could have been intaloupe. When asked how the on the units for Tuesday snack stated that he sent large pans of e staff portioned the fruit into					i i

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 609	Licensed Practical interviewed. LPN anything about Resident of the New York of the Watermelon was a subject to the Watermelon was a subject to the Watermelon was about an inch long the watermelon was the family brown in the family brown in the water of the family brown in the water of the family brown in the family brown in the water of the family brown in the f	D a.m., the Unit Manager, I Nurse A (LPN A), was A was asked if she knew esident #82's choking incident. Inher the details of the incident. Idete an incident report. D AM, LPN B was interviewed. Ithe son had been feeding the stated that Certified Nursing A) notified her that Resident LPN B stated that LPN D Ident. LPN B stated that LPN D Ident. LPN B stated that 2-3 Inlended by the facility that day ing. LPN B could not remember if it as served by the facility that day ing the Resident's son and itere at the Resident's bedside. If the choking incident, the itere when the choking incident is sere when the choking incident is sked if her brother-in-law may and from home, she stated he	Fé	509	Y)
	On 11/7/18 at 1:4: again to describe was prepared to s provided an exam- was a tall, cylindri filled the containe	5 p.m., Employee A was asked how the Tuesday fruit snack end to the unit. Employee A ple of the container he used. It cal container. He stated that he r half full. He stated that the pes less than an inch in size.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		405227	B. WING		
		495337	B. WING		11/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
LEEWOOL	D HEALTHCARE CENTE	R		7120 BRADDOCK ROAD	
LEEWOOI	D HEALINGARE CENTE			ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
E 600	Continued From pag	10.18	F 6	200	
1 003			го	509	
		nple of the cut up watermelon			
	for the survey team.				
		inch cubes. Employee A			
		plastic cups and a serving			
		nursing staff would use to			
		ployee A stated he would			
	send applesauce for	residents on puree diet.			
	On 11/07/18 at 3:50	PM, the Resident's younger			y.
		. When asked about the			:
		son stated he arrived when			
	_	eeding his mom in the dining			
		CNA was crushing large			
		on with a fork before feeding it			
		was shown the example of			
		rovided by Employee A and			H.
		ke what the CNA was			Ĭ.
		to his mom that day. He			
	_				2
		CNA left the dining room and			1
	•	om back to her room and ner bed. While his mom was			
		d she appeared to be			
	choking so he called	• •			
	Choking so he called	for the hurse.			i.
	On 11/08/18 at 8:45	AM, CNA A was interviewed:			
		day the Resident choked,			
		and she entered the room,			
		oking, and notified the nurse.			
		terwards, she went into the			
		the Resident's tray on the			
		he stated she was not in the	i i	ļ.	
		the Resident that day and			1
	_	was. CNA A also stated the	0	Š.	
		back to her room by the			
	Resident's son.	Duck to her found by the			
	On 11/08/18 at 9:00	•			
		sked what she knew about			
	the choking incident.	she stated "I don't know	10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495337	B WING_	· · · · · · · · · · · · · · · · · · ·	11/08/2	2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP COI 7120 BRADDOCK ROAD ANNANDALE, VA 22003	DE	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE CO E APPROPRIATE	(X5) DMPLETION DATE
F 609	the Resident watermed aughter-in-law gave the family usually brir When asked about as she didn't have an independent of the property of the pr	asked if she knew who fed elon that day, she said the her watermelon. She stated ags in food from home. In incident report, she stated with dysphagia will cough fed. She then stated if the athe, that would be a "life She also stated she didn't seded to be suctioned. AM, CNA B was interviewed. He choking incident, CNA B ag the Resident in the dining sen't remember what the tated she remembers the into the dining room. AM, LPN D was interviewed, he choking incident, LPN D to room by LPN B. He states the bed sweating, pale, for breath. He states om on the crash cart. LPN D the room ('the one that is a said his mom was choking. He suctioned her without soned deeper. He stated a lon came out, then suctioned diece came out. He drew a the pieces looked like, He as large, "about a 3-inch ne did not see any food in sted that LPN B told him the	F 6	09		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION IE APPROPRIATE DATE
F 609	choking incident. He investigation. He state she told him she was but was not feeding to Administrator stated of feeding the Resident Resident back to her stated he also spoke Administrator at the tot alert LPN B and sate asked for his assistant stated the son told Letthickened liquids but watermelon out. The the son was asked if stated 'we don't bring stated 'we don't bring stated 'we don't bring stated 'we don't bring the son was asked if stated 'we don't bring stated 'we don	the learned about the apologized for not having an ed he spoke with CNA B and in the dining room that day he Resident. The CNA B told him the son was and then brought the room. The Administrator with CNA A. CNA A told the ime of the incident, she went low LPN D in the hall and ince also. The Administrator PN B the son gave his mom LPN D suctioned Administrator stated when the brought in food, the son in fruit' and another time ther food.' Avised 10/01/2017) for corting accidents/incidents involving residents, rendors, etc., occurring at investigated and reported to Section 2.1 under General ne policy states an incident eted for all reported	F 6	09	

STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R	7120	EET ADDRESS, CITY, STATE, ZIP CODE D BRADDOCK ROAD NANDALE, VA 22003	11700/2010
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 609	Continued From page	e 21	F 609		
	soft nectar thick liquic incident occurred on the choking incident or speech therapist with give the Resident her liquid. There are confunctional confunctional incident such came from (facility veconsistency the water Resident aterit, and with the Resident Seven incident, the physicial progress notes that Fraspiration pneumonial cough medicine, and an investigation conduction an incident report was Investigations and residentify risks, correct improve the health and Concerns and they of the Concerns and they of the Resident #78, an 83 admitted to the facility include anemia, hyper depression, Parkinson disease. Resident #78's most	Resident had possible a, ordered labs, chest x-ray, antibiotics. There was not lucted by the facility staff and s not completed. porting assist facilities to broken processes, and and safety of their residents. eximately 3:00, the e DON were notified of fered no further information. B, the facility staff failed to of unknown origin. eyear old female, was y on 10/05/2012. Diagnoses ertension, diabetes,			

NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED 11/08/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 22 Date (ARD) of 10/01/2018. Resident #78 was not			495337	B. WING		11/08/2018
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 22 Date (ARD) of 10/01/2018. Resident #78 was not			R	7120	BRADDOCK ROAD	1 11/00/2010
Date (ARD) of 10/01/2018. Resident #78 was not	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHORE) CROSS-REFERENCED TO THE APP	OULD BE COMPLETIC
(BIMS) score but cognitive skills for daily decision-making was coded as severely impaired. Functional status for bed mobility, transfers, dressing, and personal hygiene was coded as requiring extensive assistance. On 11/06/18 at 01:52 PM, the Resident was observed sitting in the day room, fully clothed. The Resident had a bruise on her right arm above and anterior to her elbow with approximately a 3-inch diameter. On 11/07/18 at approximately 12:45 PM, the Resident was observed sitting in the day area, eating lunch with staff assistance. She had a bruise on her right arm above and anterior to her elbow with approximately a 3- inch diameter. On the afternoon of 11/07/18, fall records for last 4 months for this Resident were requested from the DON. On 11/08/18, the DON stated there were no fall records for past four months for Resident #78. The care plan was reviewed. An entry dated 09/28/18 for a cut on Resident's finger included the following interventions: "I need a weekly evaluation of wound healing. I need a daily observation of skin with routine care. I need a full skin evaluation weekly with bath/shower." Nurse's notes for September - November 2018 were reviewed. The bruise on the right arm was not addressed. On 11/08/18 at 8:40 AM, certified nursing	F 609	Date (ARD) of 10/01/coded with a Brief Int (BIMS) score but cog decision-making was Functional status for dressing, and person requiring extensive at On 11/06/18 at 01:52 observed sitting in the The Resident had a band anterior to her elinch diameter. On 11/07/18 at approximate the ap	2018. Resident #78 was not derview of Mental Status shitive skills for daily coded as severely impaired, bed mobility, transfers, all hygiene was coded as sesistance. PM, the Resident was eday room, fully clothed, bruise on her right arm above abow with approximately a 3-eximately 12:45 PM, the ed sitting in the day area, if assistance. She had a mabove and anterior to her ately a 3- inch diameter. 11/07/18, fall records for last sident were requested from N stated there were no fall months for Resident #78. Eviewed. An entry dated Resident's finger included ations: "I need a weekly healing. I need a daily gith routine care. I need a full by with bath/shower."	F 609		

PRINTED: 11/15/2018 FORM APPROVED

OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495337	B. WING_		1	1/08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI; TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	the bruise on this Renot aware the Residelbow. The CNA observation Resident was seated CNA stated 'it's an open yellowish in the cent Licensed practical in nearby and stated throat remember how the but stated she 'wroted Con 11/08/2018 at 10 about Resident #78' requested from the Innew bruise' so the inwritten yet. On 11/08/18 at 10:30 E was conducted. Licensed on Resident # bruise (on the right a on to say that the Rewalking her momour returned and showed back of the Resident bruise on the Resident	vas asked about the origin of esident's arm. The CNA was ent had bruise on her right served the bruise as the din the day room and the old bruise'. The bruise was ter and purplish on the edges. The bruise but did the Resident acquired bruise et it up'. 2:15 AM, an incident report is bruise on her right arm was DON and she stated "that's a notident report has not been O AM, an interview with LPN PN E stated she did a skin for a skin was not there. She went esident's daughter was taide yesterday and then did the staff a bump on the t's head. LPN E stated the ent's arm was a "new bruise on dated 11/08/18 at 9:30 AM of the is noted with intact bruise to close to the elbow. RP tecknowledged holding pt on the elbow during ambulation out greenish in estates as the contract of the elbow and slight greenish in	F	509			

PRINTED: 11/15/2018 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/08/2018	
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD 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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 656 SS=E	was reviewed. The fa accidents or incidents employees, visitors, vour facilities must be inthe Administrator." In Guidelines part 1B, the report must be completed accidents or incidents investigating and report the safety of all reside "into the cause of any order to improve care occurrences." In summary, a bruise #78's right arm above this surveyor and there was aware of the bruit assessment, started a findings, or initiated a COn 11/08/18 at approximation of the complement of CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faction of the complement a comprehe care plan for each resident rights set for §483.10(c)(3), that incobjectives and timefra	rised 10/01/2017) for prining accidents/incidents cility policy states that "All involving residents, endors, etc., occurring at investigated and reported to Section 2.1 under General e policy states an incident eted for all reported" The purpose of prining incidents is to "ensure ents" and investigations incident will be tracked in and to prevent future was observed on Resident ther elbow on 11/06/18 by the was no evidence the staff se, conducted an an investigation, reported treatment plan. eximately 2:45 PM, the N were notified of concerns on their information. comprehensive Care Plans cility must develop and ensive person-centered cident, consistent with the hat §483.10(c)(2) and	F 6	F 656 Develop/Imp Comprehensive Care Plan Compliance Date: 11/12/201 Immediate action taken	8 11/12/18	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	(EACH DEFICIENC	R ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	71	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 656	assessment. The cordescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483 provided due to the nunder §483.10, including treatment under §483. (iii) Any specialized significant and the resident and the resident and the resident and the resident's represental (iv) In consultation with resident's prefuture discharge. Fact whether the resident's prefuture discharge plans is plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on observation documentation review the facility staff failed comprehensive persentations.	ited in the comprehensive in prehensive care plan must of a care to be furnished to attain ent's highest practicable of psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required .25 or §483.40 but are not esident's exercise of rights ding the right to refuse 8.10(c)(6). Betwices or specialized as the nursing facility will PASARR as facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and reference and potential for dilities must document as desire to return to the seed and any referrals to s and/or other appropriate	F 656	1. A comprehensive care p dementia care that describ addresses behaviors was devand implemented for Reside by the MDS Coordinator Manager and Interdisciplinar including the resident's sis 11/9/2018. 2. A comprehensive care p dementia care that describ addresses behaviors was devand implemented for Reside by the MDS Coordinator Manger and Interdisciplinary including resident's so 11/9/2018. 3. Resident # 59's care pl reviewed and updated on 11/the MDS coordinator, Unit I and Interdisciplinary team address his dementia need behaviors requiring us psychotropic medications.	es and veloped nt # 43 c; Unit y Team ster on veloped ent #20 c; Unit y Team n on an was 9/18 by Manger n to ds and

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OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	₹	1 7	STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 656	care plan for demention 2. Resident #20 did in care plan for demention 3. Resident #59's care address, his demention The findings included 1. Resident #43 did in care plan for demention Resident #43 was address. Dementia, muscular depressure. Resident #43's Minimal assessment protocoly. Reference Date of 9-7 with severe cognitive completed as a significant assessment as the resident was incontined the seven day lookback. Review of the Hospice revealed: "Patient is in the resident was incontined the seven day lookback."	e survey sample. not have a comprehensive a care. not have a comprehensive a care. e plan did not describe, nor a needs, or behaviors. not have a comprehensive a care. not have a comprehensive acare. not have a care. not have a care.	F 656	The facility has determined the residents with a dementia diagnate the potential to be affected. A review of the care plan of the residents with a dementia diagnate was conducted on 11/12/18 to Director of Nursing and	nat all gnosis ed. For all gnosis by the MDS dents' iewed ldress

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 495337 B. WING 11/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD LEEWOOD HEALTHCARE CENTER ANNANDALE, VA 22003 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) 1D COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Actions taken/systems put into F 656 Continued From page 27 F 656 place to reduce the risk of future On 11/08/18 at 10:02 AM, A phone interview with occurrence. Other A (Hospice nurse) regarding Resident #43's Education was done with the MDS use of Haldol was conducted. The Hospice nurse Coordinators, Unit Managers, stated, "She has been discharged from Hospice a month ago." She also stated the Haldol was Social Services Director, and started because of increased screaming and Activities Director by the Director yelling that would not subside and that it worked of Nursing on 11/8/18 regarding the for her. She said Ativan did not work well, and development and implementation of the family did not want it used. comprehensive care plan. 11/08/18 at 11:23 AM, a review of the clinical Education was done for all licensed record including MAR's (medication administration record) revealed the resident nurses starting on 11/8/18 by the started on 8-27-18 with Haldol 0.5 mg Director of Nursing/Designee on (milligrams) every day at bedtime for restlessness policy and procedure of behavior and agitation for 14 days. On 8-28-18, the order management and documentation on for Haldol was changed to give 0.5 mg every 4 hours as needed for restlessness and agitation residents with dementia. for 14 days. None was given in September and it was discontinued after 14 days. On 9-14-18 the Haldol was increased to 0.5 mg twice daily. How the corrective action(s) will Review of Resident #43's care plan dated be monitored to ensure the 9-14-18 contained the following: "I am at risk for practice will not recur: side effects from antipsychotic drug use for restlessness and agitation." The interventions The Director of Nursing or designee included: will review care plans for residents with a diagnosis of dementia to

assistance

physician

monthly

* Monitor my behavior

* Administer my medication as ordered by

* Pharmacy consultant review of my medication

* Keep call light within arm's length of me and

teach me how to use call light to request

There were no targeted behaviors, non

* Observe me for adverse side effects

ensure a comprehensive care is

implemented that describes and

addresses behaviors, weekly for 4

The Administrator/Designee will

present the results of reviews to the

Quality Assurance Performance

Improvement Committee for review

weeks then monthly for 2 months.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
		495337	B. WING	11/08/2018
	(EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP COD 7120 BRADDOCK ROAD ANNANDALE, VA 22003 ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE	RRECTION (X5) I SHOULD BE COMPLETION
	Continued From page 28 pharmacological interventions to address behaviors or to address dementia care. The facility presented a form named "Behavior Management". For yelling behaviors it included: "Give the person something to eat or suck on (hard candy). Distract the resident by talking or getting the resident involved in a favorite activity. Provide comfort such as touch (holding hands), music, or comfort objects (dolls or stuffed animals). If cause is overstimulation, move the person to a quieter environment. If cause is too little stimulation, give more chances for human contact. On 11/08/18 at 12:41 PM, an interview was conducted with LPN (licensed practical nurse) H. LPN (H) stated, "For dementia care, I will usually put that part in and will care plan with the behaviors." LPN (H) stated, It is not on the care plan" (interventions to address behaviors due to dementia).		F 656 Quality Assurance Improvement Team include: Administrator	r, Director of Development r of Social of Dietary, bing, Director se Managers, Coordinator, ector of Rehab by Consultant. ntified, then n will be cation of the ll be made to
	Resident #20 was 2-10-18. Diagnos Dementia, hyperte Resident #20's Mi assessment proto Reference Date o with severe cognit completed as a quesident required (activities of daily	admitted to the facility on es included, but not limited to, ension and prostate cancer. nimum Data Set (MDS, an col) with an Assessment f 8-9-18 coded Resident #20 ive impairment. The MDS was parterly assessment. The extensive care with all ADL's living such as bed mobility and aff members. The resident was		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
			A SOLESINO		
		495337	B WING		11/08/2018
NAME OF P	ROVIDER OR SUPPLIER	-1		STREET ADDRESS, CITY, STATE, ZIP C	
LEEWOO	D HEALTHCARE CENTE	. D		7120 BRADDOCK ROAD	
LEEWOO	D REALIRCARE CENTE	:K		ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ION SHOULD BE COMPLÉTION THE APPROPRIATE DATE
F 656	Continued From pag	e 29 and bladder. The resident	F	656	#
	such as hitting 1-3 da	ring behaviors 4-6 days			
	Review of the care p the following regarding	lan dated 8-13-18 revealed ng behaviors:			
1. "Resident sleep (sic) on the floor difficult to redirect at time (sic). Interventions included not to argue with resident, Talk in a calm voice, redirect to sleep on the bed."					
	wheeling the suitcase redirect resident in a as needed, medication	of facility to go home e. Interventions included calm manner, psych consult ons as needed and assist to ident is actively exit seeking.			
	(Licensed practical n conducted regarding She stated he disrob physically abusive.	PM, an interview with LPN urse) H- care planner was behaviors of Resident #20 . es, is resistant to care and is the was not sure if he has			
	code (will alarm if res stated you never can behaviors. LPN (H) w of job the resident ha	the doors are secured by ident goes out). LPN (H) tell what causes his vas unsure what kind of kind d done in the past. The LPN aviors were not addressed			
	was given to the surv nursing) included bel The form included su minimizing day time r	for Management form that reyor by the DON (director of naviors such as wandering. ch interventions as napping, and that "exercise e," For a resident exposing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495337	B WING	a la la company	11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER SUMMARY STATEMENT OF DESICIENCIES				STREET ADDRESS, CITY, STATE, ZIP O 7120 BRADDOCK ROAD ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 656	He may simply need Catastrophic reactions such as crying or you when residents hat usually in response overwhelmed." Into calmly and slowly for but firm tone of voice their feelings. Guidencessary. If you are and you need to pror leave the room in the calmly and slowly for the calmly and you need to pror leave the room in the calmly simple statement.	e reason behind the behavior. d to go to the bathroom." ons are "emotional outbursts elling, hitting or screaming. ve a catastrophic reaction it is	F	656	
	address, his demer which the Resident medications. Resident #59 was a 4-25-18. Diagnose to; unspecified dem disturbance, Alzhei dysphagia, history cognitive communic Resident #59's mos (an assessment pro assessment with an of 10-17-18 coded	care plan did not describe, nor nitia needs, nor behaviors, for received 5 psychotropic admitted to the facility on s included but were not limited nentia, without behavioral mer dementia, femur fracture, of falling, cardiac disease, and cation deficit. St recent Minimum Data Set potocol) was a quarterly a Assessment Reference Date Resident #59 with a BIMS nental status) score of "99", or			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING_		11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETION
F 656	unable to complete, due to cognitive impairment. Resident #59 required extensive assistance for his ADL's (activities of daily living such as bed mobility and toileting) of one to two staff members. The resident was incontinent of bowel & bladder. On 11-7-18 at 10:30 a.m., Resident #59 was observed in the back of the main dining/living room area of the locked Alzheimer's unit. The Resident was sitting in a high back wheel chair at a dining table alone. The Resident was against the wall to his left, and had a short "knee" wall behind him. The Resident was staring down at the table, and nothing was on the table. The surveyor approached the Resident his name, and other questions, the Resident did not look up or		F	556	
:	observed in the back room area of the locker Resident was sitting in a dining table alone. The wall to his left, and behind him. The Resident wastaring down at the tall approached the Resident his questions, the Resident Review of the physicial	of the main dining/living ed Alzheimer's unit. The in a high back wheel chair at The Resident was against if had a short "knee" wall dent was staring down at paper was on the table was not looking at it, but was ble. The surveyor lent and said "hello", and is name, and other int did not look up or speak.			
1	record revealed the re receiving the following	sident was currently			

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AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495337	B. WING		11/08/2018		
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER SLIMMADY STATEMENT OF DEFICIENCIES				DDE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE		
F 656	Continued From pag	e 32	F6	56			
	3. Razadyne for dem 4. Namenda for dem 5. Seroquel for deme Review of the curren revealed only 4 care could be related to d developed on 5-3-18 6-20-18. Those follo	nown/no medical need given nentia entia entia entia entia with agitation t care plan dated 5-3-18, planned problem areas that ementia. three were and the last was added on w with their goals and					
	refuses care, attemp difficult to redirect." residents and staff w injury to others thru r The "INTERVENTIO resident with cayusid	e resident is easily upset, he ts to hit staff, and very The "GOAL". "safety of ith no incident reports of nrst (sic) review." NS/approaches". "approach on (sic), try to redirect eeds as quickly as possible,					
	from antidepressant The "GOAL". "I will he medication usage/sid The "INTERVENTIO" "administer my medical physician, observe medicument and report consultant review of	nave no injury related to de effects thru next review." NS/approaches". cation as ordered by the for adverse side effects, at to physician, pharmacy my medication monthly."					
	from antipsychotic dr The "GOAL", "I will h	am at risk for side effects rug use." nave no serious injury related /side effects thru next		7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING_		11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER				DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 656	The "INTERVENTIC" administer my med physician, observe document and repobehavior." 4. dated 6-20-18 "Feedision making ski Alzheimer's disease assessments for conthe "GOAL". "Resistaff/significant other appropriate thru new The "INTERVENTIC each activity/care pobserve for changed daily routine with reeach decision made when presenting deto resident, give resoverwhelming". Review of physician geriatric psychiatric only "behavior" documes refusal of care, pursued or insisted resident refused. The were completed, (R. Seroquel in August worsening of the Records (MAR's/TA revealed an area fo "behaviors" were changed in the presenting of the Records (MAR's/TA revealed an area fo "behaviors" were changles of Septembra and the physician area for "behaviors" were changles of the provided and the provided and the physician area for "behaviors" were changles of the physician area for "behaviors" wer	DNS/approaches". lication as ordered by me for adverse side effects, rt to physician, monitor my PROBLEM". "Impaired Ills related to diagnosis of e as evidenced by staff gnition." dent will accept judgement of er regarding plan of care as ext review date." DNS/approaches". "explain rocedure prior to beginning it, is in cognitive status, establish sident, praise resident for e, give resident two choices cisions, offer simple choices cident no choice that will be a progress notes, to include evaluations revealed that the umented in the clinical record and agitation when staff on giving care when the wo gradual dose reductions azadyne in June 2018, and 2018), with success, as no esident's refusal of care	F	556	

OLIVILIA	O I OIT MILDIONITE O	WEDIONID GENTIGES					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		NSTRUCTION		TE SURVEY MPLETED
		495337	B. WING				1/08/2018
NAME OF P	ROVIDER OR SUPPLIER	100001		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		170072010
IVAIVIL OF T	NOVIDEN ON OUT FIELD				BRADDOCK ROAD		
LEEWOOD HEALTHCARE CENTER				ANDALE, VA 22003			
	OLIMAN DV. OT	ATEMENT OF DEFICIENCIES		- 11111		ION	(%5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	Continued From page	2.34	_	656			
1 000			'	030			
		d in a 4 month period, which on, and no nursing note					
	describes what that e						
	Review of nursing pro	ogress notes revealed no		- 1			
	aggressive behaviors						
	"behavior" document						
		igitation when staff pursued					
	or insisted on giving refused.	care when the resident					
	reiusea.						
	There were no target						
	the plan of care, nor		0:				
	pharmacological inte						
	Resident's refusal of						
		is no indication that the staff					
		ssible reason for the refusal					
		re any plans to mitigate the		- 9			
		xpressed by the Resident. lat and blunted, lethargic					
		or observations, and did not					
		estioning, nor did he interact					
		. The Resident appeared as					
	_	the table, with no reaction to		E			
	verbal stimuli						
	On 11-8-18, an inten	riew was conducted with LPN					
		esident's care giver, and					
		yes, I take care of him every					
		hat the Resident never					
	•	ents, he was just upset					
	sometimes with staff	when they tried to change		1			
		th. She further stated that					
		e little area by the wall, and					
		e liked, and if staff gave it to					
	•	etly and was no problem at					
		nanager approached and					
		e any problem with him					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 656	Continued From page	e 35	F 6	· 556	
	agitated, but the med was asked why he was asked why he was asked to planning was comple she stated "It can be included or not, but if we care plan it." She the care plan was to needed for this partic asked to review Resime what his behavior doing for them. LPN and will hit staff, and was asked what do s She reviewed the care know." She was asked triggered the refusals know." She was asked sychotropic medicat and she stated "yes." The Facility policy en Management" was retraining was given to care, catastrophic rea and interventions that	icine helps with this." LPN A as not allowed to refuse, and the doesn't know what is best of his dementia." D.m., an interview was are plan coordinator LPN H. tell surveyors how care ted for dementia residents, done with behaviors the resident has behaviors stated that the purpose of instruct staff on the care ular resident. She was dent #59's care plan and tell is were, and what they were H stated "he refuses care, is difficult to redirect." She taff do when this happens? te plan, and stated "I don't ted if she knew what i, and she stated "I don't ted if he received the tions for these behaviors, titled "Behavior viewed and revealed staff in regard to resisting tections, agitation, redirection, to would be appropriate in stances. Most were not			
	On 11-8-19 at 1:00 p. Director of Nursing (E the findings. At the ti	m., the Administrator and DON) were made aware of me of exit the DON stated information available to			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A, BUILDING	CONSTRUCTION (X3) DATE COMP	SURVEY
		495337	B, WING	11/	08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003		
(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Care Plan Timing and CFR(s): 483.21(b)(2)((i)-(iii)	F 657	F 657 Care Plan Timing and Revision Compliance Date: 11/7/18	11/7/18
	§483.21(b)(2) A comp be-	orehensive care plan must 7 days after completion of		Immediate action taken for the resident found to have been affected include:	
	(ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practive resident and the ran explanation must be medical record if the pand their resident report practicable for the resident's care plan.	terdisciplinary team, that bited to vsician. e with responsibility for the responsibility for the I and nutrition services staff. cticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined		Resident # 23's orders were reviewed. A clarification order was written on 11/7/18 by licensed nurse to discontinue the order for angled utensils. The care plan was updated on 11/7/18 by the MDS Coordinator to reflect the change. Identification of other residents having the potential to be	
2	disciplines as determined or as requested by the control of the co	ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the		The facility has determined that residents with adaptive utensil use have the potential to be affected. All residents with orders for adaptive utensil were reviewed by the MDS Coordinator, Dietitian and Rehab Director on 11/7/18 to ensure residents orders were current and are accurately reflected on the care	
	1. For Resident #82, discontinue the use of	the facility did not f adaptive utensils on the		plan. No other residents identified to be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R	7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 657	facility on 4/17/17. It is clerosis, dysphagia hypertension, diabeted disease. The most reassessment was sign with an assessment. The resident was confuncted Status score cognitive impairment assistance with active On 11/7/18, Resident	plan. d: ear old, was admitted to the biagnoses included multiple paralytic syndrome, es and chronic kidney ecent Minimum Data Set inficant change assessment reference date of 8/14/18. Inded with a Brief Interview of of 9 indicating moderate and required extensive ities of daily living.	F 657	Actions taken/systems place to reduce the risk of occurrence. An in-service education was conducted on 11/7/18 Rehab Director to the tregarding writing disorders on adaptive utensils reflect discontinuance of or Manual Conducted by the Di Nursing/Designee to the	program 8 by the cherapists scontinue timely to oders.
	nobserved to use regumeals. Resident #23's compreviewed. The care "Resident requires a to enable her to help (multiple sclerosis)". dated 9/17/18 read of the end of day me Administrator and Dinotified that Residen without her adaptive On 11/8/18 at 8:30 a the following Occupated 4/25/17, "pt (patient) up handles on utens	in her room. She was ular utensils during both prehensive care plan was plan dated 3/24/18 read, ingled utensils at every meal feed herself due to MS The comments section continue with plan of care setting on 11/7/18, the rector of Nursing were t #23 was observed eating utensils. Im., the Administrator provide stional Therapy note dated does not want to use build ils." The Administrator stated should have been taken off		nurses on the monitoring at adaptive utensils initia 11/8/18. How the corrective actions be monitored to ensure practice will not recur: The Director of Nursing at managers will review phorders daily during the clinical meeting to identify discontinued adaptive utensito determine if care pupdated with interventions and orders are carried out.	nd use of ated on on on(s) will ure the ond/or unit mysician's morning y new or sil orders lans are

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LEEWOO	D HEALTHCARE CENTE	0	1 7	7120 BRADDOCK ROAD	
LLLWOO	D HEALINGARE CENTE		4	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
	diagnosed with deme appropriate treatment maintain his or her his mental, and psychose This REQUIREMENT	ent who displays or is ntia, receives the and services to attain or ghest practicable physical,	F 744	The Director of Nursing or will audit the residents wit for adaptive utensil use daweeks, 3 times a week weeks then weekly for 4 vassure adaptive utensil us place and is accurately planned.	th orders ily for 2 for two weeks to se is in
	record review, and clifacility staff failed to pand services for four (Resident #59, #43, #sample of 34 Resident 1. Resident #59 receimedications without rinterventions, and wawith none described of than refusing care, and when they did not affect an antipsychotic. 3. Resident #43 did not for treatment of her dan antipsychotic. 3. Resident #20 did not treat his demential two types of antipsychotic. 4. For Resident #82, assess for triggers, indevelop non-pharmater.	ved 5 psychotropic ion-pharmacological is medicated for "behaviors", or care planned for, other and attempting to hit staff ord him his right to refuse. ot receive care and services ementia and was placed on ot receive care and services Instead the resident was on notics simultaneously.		Performance Improcement Committee for review and recommendations. Assurance Performance P	audits to assurance rovement d further Quality formance Members rector of elopment f Social Dietary, Director Managers, ordinator, of Rehab onsultant. ed, then will be m of the made to

The findings included:

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO	0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495337	B. WING		11/	08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	Continued From page	∋ 39	F 744	Dementia		11/12/18
	medications without r interventions, and wa with none described than refusing care, an	Resident #59 received 5 psychotropic nedications without non-pharmacological nterventions, and was medicated for "behaviors", with none described or care planned for, other han refusing care, and attempting to hit staff		Compliance Date: 11/12/2018 Immediate action taken f resident found to have affected include:	or the	, 12, 10
	Resident #59 was ad 4-25-18. Diagnoses to; unspecified demendisturbance, Alzheim dysphagia, history of cognitive communica. Resident #59's most (an assessment protoassessment with an Assessment with a As	recent Minimum Data Set ocol) was a quarterly Assessment Reference Date		1. Resident # 59's care plate reviewed and updated on 11/9 the MDS coordinator, Unit Mand Interdisciplinary team address his dementia need behaviors with pharmacological intervention approaches in addition to the of psychotropic medications.	9/18 by Manger n to ds and non- ns and he use	
	(brief interview of me unable to complete, of Resident #59 require his ADL's (activities of mobility and toileting)	esident #59 with a BIMS ntal status) score of "99", or lue to cognitive impairment. d extensive assistance for f daily living such as bed of one to two staff ent was incontinent of bowel		2. A comprehensive care p dementia care that describe addresses behaviors with pharmacological intervention approaches was developed implemented for Resident #	es and non-ns and d and 43 by	
	observed in the back room area of the lock Resident was sitting i a dining table alone. the wall to his left, an behind him. The Res the table, and nothing surveyor approached	a.m., Resident #59 was of the main dining/living ed Alzheimer's unit. The n a high back wheel chair at The Resident was against d had a short "knee" wall sident was staring down at g was on the table. The the Resident his name, and		the MDS Coordinator, Manager and Interdisciplinar including the resident's sis 11/9/2018.	•	

other questions, the Resident did not look up or

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495337 B. WING 11/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD LEEWOOD HEALTHCARE CENTER ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 3. A comprehensive care plan for F 744 | Continued From page 40 F 744 dementia care that describes and addresses behaviors with non-On 11-8-18 at 11:00 a.m., during a second pharmacological interventions and observation of Resident #59, the Resident was approaches was developed and observed in the back of the main dining/living implemented for Resident #20 by room area of the locked Alzheimer's unit. The Resident was sitting in a high back wheel chair at the MDS Coordinator, Unit Manger a dining table alone. The Resident was against and Interdisciplinary Team the wall to his left, and had a short "knee" wall including resident's behind him. The Resident was staring down at son on the table, and a newspaper was on the table 11/9/2018. folded, the Resident was not looking at it, but was staring down at the table. The surveyor approached the Resident and said "hello", and 4. Resident # 82's medication list asked the Resident his name, and other questions, the Resident did not look up or speak. care plan reviewed by licensed 11/9/2018 nurse. Review of the physician's orders in the clinical Seroquel was discontinued by the record revealed the resident was currently physician on 11/9/2018. Care plan receiving the following 5 psychotropic medications, and melatonin for sleep at night; for psychotropic drug use was resolved on 11/9/2018 by the Unit 1. Wellbutrin for depression No further action Manager. 2. Depakote for unknown/no medical need given required, resident is not receiving 3. Razadyne for dementia 4. Namenda for dementia any psychotropic medication. 5. Seroquel for dementia with agitation Review of the current care plan dated 5-3-18, revealed only 4 care planned problem areas that could be related to dementia. three were developed on 5-3-18, and the last was added on 6-20-18. Those follow with their goals and interventions to be used: 1. "PROBLEM". "The resident is easily upset, he refuses care, attempts to hit staff, and very difficult to redirect." The "GOAL". "safety of

residents and staff with no incident reports of injury to others thru nrst (sic) review."

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENT	ER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD INNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTION
F 744	resident with cayusi	DNS/approaches". "approach on (sic), try to redirect	F 744	Identification of other rehaving the potential affected. The facility has determined	to be
	resident, attend to needs as quickly as possible, continue full assist in care, ADL care". 2. "PROBLEM". "I am at risk for side effects from antidepressant medication use." The "GOAL". "I will have no injury related to medication usage/side effects thru next review." The "INTERVENTIONS/approaches". "administer my medication as ordered by physician, observe me for adverse side effects, document and report to physician, pharmacy consultant review of my medication monthly." 3. "PROBLEM". "I am at risk for side effects from antipsychotic drug use."			residents receiving psych medications have the potent affected. A review of the care plus behavior management log residents with a dementia d was conducted on 11/12/18 Director of Nursing and coordinators. Two redementia care plans were redemental care plans were redemedications.	hotropic ial to be lan and for all iagnosis B by the la MDS esidents' eviewed
	The "GOAL". "I will to medication usage review." The "INTERVENTIC" administer my med physician, observe	have no serious injury related e/side effects thru next		and updated to describe and behaviors with pharmacological approach interventions on 11/12/18 MDS Coordinator, Unit Mar Interdisciplinary Team.	non- es and by the
	decision making ski Alzheimer's disease assessments for co The "GOAL". "Resi staff/significant othe appropriate thru nex The "INTERVENTIC each activity/care probserve for changes daily routine with re- each decision made	dent will accept judgement of r regarding plan of care as			

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/	08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODI 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 744	Review of physician geriatric psychiatric conly "behavior" docu was refusal of care, a pursued or insisted or resident refused. Tw. were completed, (Ra Seroquel in August 2 worsening of the Resoccurred afterward. Physician orders were that Occupational The continued 3 times per 11-1-18, and Physician continued 3 times per beginning 10-25-18. Resident did follow directed and redirect been appropriate to the Medication, and Records (MAR's/TAF revealed an area for "behaviors" were charmonths of September 2018. For August 20 behavior documenter was 8-30-18 at 3:00 describes what that experience of the serious process of the serious proces	progress notes, to include evaluations revealed that the mented in the clinical record and agitation when staff in giving care when the ro gradual dose reductions zadyne in June 2018, and 018), with success, as no sident's refusal of care The reviewed and documented erapy was ordered to be revek for 1 week on all therapy was ordered to be revek for 6 weeks This indicated that the irrections and was able to be end or therapy would not have order. Treatment Administration R's) were reviewed and "Behavior charting". No arted as ever occurring in the rr, October, nor November 118, only one time was d in a 4 month period, which p.m., and no nursing note	F	utilizing the behavior tool to ensure dement receive care and servi dementia was given to nursing staff starting on Education was done with Coordinators, Unit Social Services Director by of Nursing on 11/8/18 redevelopment and imple comprehensive care pladocumentation	on program Director of policy and management of non- nterventions monitoring tia residents ces to treat the licensed 11/9/2018. ith the MDS Managers, rector, and the Director regarding the mentation of an to include f non- roaches to	
		s toward peers. The only				1

refusal of care, and agitation when staff pursued or insisted on giving care when the resident

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	(EACH DEFICIENC	R ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROVIDER'S DEFICIENCY)	D BE COMPLETION
F 744	staff is refusal of care that is refused. Ther behaviors addressed were there any non princluded for the Resiagitation during refusindication that the stapossible reason for the there any plans to mile expressed by the Reflat and blunted, lethobservations, and did questioning, nor did surroundings. The stupor, staring at the verbal stimuli. On 11-8-18, an intended by the Restated when asked, day." LPN E stated to bothered other Resident liked the that he had a book him, he would sit qui all. LPN A, the unit restated, "we don't have except for incontinent agitated, but the med was asked why he were asked why he were asked why he were asked with a staff of the stated of the resident liked the stated, "we don't have except for incontinent agitated, but the med was asked why he were asked why he	ocumented or described by e, and agitation during care e were no targeted on the plan of care, nor charmacological interventions dent's refusal of care or sed care. There is no aff ever identified the ne refusal of care, nor were trigate the agitation and upset sident. The Resident had a largic affect on both surveyor do not respond to direct ne interact with his desident appeared as in a stable, with no reaction to the view was conducted with LPN esident's care giver, and lyes, I take care of him every that the Resident never tents, he was just upset when they tried to change with. She further stated that the little area by the wall, and the liked, and if staff gave it to eatly and was no problem at manager approached and the any problem with this." LPN A as not allowed to refuse, and the doesn't know what is best	F 744	How the corrective action be monitored to ensure practice will not recur: The Director of Nursing an managers will review monitoring tool for all utilizing psychotropic meduring the morning clinical to ensure that non pharmacinterventions are utilized residents manifesting inapposed behaviors or mood and is addocumented on the calincluding approaches, five tweek for 2 weeks, then 3 week for two weeks therefor 4 weeks.	d/or unit behavior residents edication meeting cological red for propriate ccurately re plan times per times a

On 11-8-18 at 12:20 p_rm_{ri} an interview was

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

Facility ID: VA0142

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/1	08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003		00/2016	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 744	LPN H was asked to planning was compleshe stated "It can be included or not, but if we care plan it." She the care plan was to needed for this partic asked to review Resime what his behavior doing for them. LPN and will hit staff, and was asked what do so the reviewed the care know." She was asked triggered the refusals know." She was asked psychotropic medicate and she stated "yes." The Facility policy en Management" was retraining was given to care, catastrophic retained interventions that treating these circum used in Resident # 50. On 11-8-19 at 1:00 p Director of Nursing (It there was no further submit to surveyors.	tell surveyors how care sted for dementia residents, done with behaviors the resident has behaviors stated that the purpose of instruct staff on the care sular resident. She was dent #59's care plan and tell rs were, and what they were H stated "he refuses care, is difficult to redirect," She staff do when this happens? The plan, and stated "I don't ed if she knew what so, and she stated "I don't ed if he received the stions for these behaviors, withtled "Behavior eviewed and revealed staff in regard to resisting actions, agitation, redirection, it would be appropriate in stances. Most were not 9's care plan. Im., the Administrator and DON) were made aware of time of exit the DON stated information available to	F 7	the Quality Performance In Committee for review recommendations. Assurance P Improvement Team include: Administrator, Nursing, Staff D Coordinator, Director	Assurance approvement and further Quality reformance Members Director of evelopment of Social f Dietary, ag, Director Managers, Coordinator, or of Rehab Consultant. fied, then will be tion of the be made to		
	placed on an antipsy						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 744	Continued From page	ge 45	F 7	744	
	10/31/17. Diagnose	dmitted to the facility on es included, but not limited to, r dystrophy and high blood			
	assessment protoco Reference Date of S with severe cognitive completed as a sign assessment as the Hospice. The reside with all ADL's (active mobility and toileting resident was incontractions.)	mum Data Set (MDS, an ol) with an Assessment 9-7-18 coded Resident #43 e impairment. The MDS was nificant change in status resident had completed ent required extensive care ities of daily living such as bed g) of two staff members. The inent of bowel and bladder. oded with no behaviors during back.			
		a clinical record review as initiated 6-5-18 for senile nuscular dystrophy.			
	intakes for Septemb 2018 revealed the r meals 3 times in Se October, and had e	10 AM, a review of the meal oper, October and November, esident had eaten 0% for optember, and 8 times in aten only 25 % 17 times in as in October and 14 times in			
	other A (Hospice nu use of Haldol was c stated, "She has be month ago." She als started because of i yelling that would no	M, a phone interview with arse) regarding Resident #20's conducted. The Hospice nurse en discharged from Hospice a so stated the Haldol was increased screaming and cot subside and that it worked the hospice work well, and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING_		11/08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	ER .	STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE	
F 744	record including MAI resident was taking I every day at bedtime agitation for 14 days given for Haldol give needed for restlessn days. None was gividiscontinued after 14 On 7-11-18, a pharm addressed prn (as ne place for more than declined the recommattempt to schedule (symptoms). Patient On 9-14-18 the Hald twice daily and had be survey. Saunders Nursing Diestless to 560, classified used to treat schizop is a black box warnin "Increased risk of modementia related psy Review of Resident #9-14-18 contained the	M Review of the clinical R's revealed 8-27-18, the Haldol 0.5 mg (milligrams) at for restlessness and and a distance of the control of the co	F 7			
	restlessness and agi included:	tation." The interventions				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION JE APPROPRIATE DATE
F 744	monthly * Keep call light withit teach me how to use assistance There were no yelling pharmacological intervices to treat his cresident was on two simultaneously. Resident #20 was ac 2-10-18. Diagnoses Dementia, hypertens Resident #20's Mining assessment protocological materials. Resident #20's Mining assessment protocological ma	nt review of my medication n arm's length of me and call light to request g behaviors or non rventions in the care plan. not receive care and dementia. Instead the types of antipsychotics dmitted to the facility on included, but not limited to, sion and prostate cancer. num Data Set (MDS, an) with an Assessment -9-18 coded Resident #20 e impairment. The MDS was terly assessment. The tensive care with all ADL's ng such as bed mobility and members. The resident was and bladder. The resident aviors not affecting others ays during the 7 day ring behaviors 4-6 days period. 9 AM, an interview was tent's son on the phone. The teard from the nurses that he that he had "violent"	F7	44	

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OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ISTRUCTION		ATE SURVEY DMPLETED
		495337	B. WING				11/08/2018
	ROVIDER OR SUPPLIER DHEALTHCARE CENTE	R		7120 E	ET ADDRESS, CITY, STATE, ZIP CODE BRADDOCK ROAD ANDALE, VA 22003	·	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 744	nurse) G, stated the room wearing only bredirect him and he hout of it completely because he was tryingood, does not eat at Will not wake him up On 11/07/18 at 1:03 Robserved sitting on si Would visibly flinch we drilling into wall next would get louder next woul	PM LPN (licensed practical resident had come out of his ief and T shirt, tried to it aide in the face. He was had to lock myself in rooming to get at me." Appetite a usual times, give snacks, as he gets very agitated. PM the resident was ide of bed, eating lunch, when construction worker door. Cursed when noise to door. PM an interview was ON (director of nursing) The DON stated he wanders to exit seeking, can come out did been awhile since he has	F7	'44			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495337	B WING			11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENT	ER		STREET ADDRESS, CITY, STATE, 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	NN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 744	Continued From pa	ge 49	F	744		
	record including MA administration record the resident was starng (milligrams) ever The resident also had tivan (antianxiety) needed for agitation 10-17-18 (greater the given during Septer received Ativan on On 10-16-18, the astenewed for 14 more making a visit to the received Ativan twice 10-30-18. The resident for delusions. On 9 increased to 50 mg Seroquel dose was daily. The resident every 6 hours. On 10-30-18, the Administration of the control of	d), behavior records revealed arted on 8-1-18 on Haldol 2 ry 6 hours for psychosis. ad an order dated 9-24-18 for 0.5 mg every 4 hours as 1, which was discontinued on 1 han 14 days). No Ativan was 1 hoer. In October, the resident 10-4-18, 10-15-18, 10-16-18. Is needed order for Ativan was 1 e days without a physician 1 eresident 10-25-18 and once on 10-25-18 and once on 10-18 dent was also taking Seroquel 1 hed on 7-16-18 at once daily 1 he seroquel was 1 twice daily. On 11-6-18, the 1 increased to 100 mg twice 1 continued on Haldol 2 mg				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION NG	_ (X	(X3) DATE SURVEY COMPLETED		
		495337	B WING_			11/08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R	STREET ADDRESS, CITY, STATE, ZIP CO 7120 BRADDOCK ROAD ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 744	10-31-18 revealed the be very lethargic todal visit again." The psy practitioner) also note contact psych if it per Review of the care plus the following regarding. 1. "Resident sleep (stredirect at time (sic), to argue with resident redirect to sleep on the secure unit when resident in a as needed, medicatic secure unit when resident conducted regarding. She stated he disrob physically abusive. Stated you never can behaviors. LPN (H) word job the resident had did state that the behavior that it is a grain conducted staff, gets agitated. Stated significant conducted staff, gets agitated.	the psychiatric note dated be following: "Patient noted to be and hard to wake up for chiatric NP (nurse ed; "Watch lethargy and sists or worsens." an dated 8-13-18 revealed ag behaviors: sic) on the floor difficult to Interventions included not to the floor difficult to Interventions included not to the floor difficult to Interventions included not to the floor difficult to Interventions included calm manner, psych consult ons as needed and assist to dident is actively exit seeking. PM, an interview with LPN curse in the care planner was behaviors of Resident #20 ces, is resistant to care and is the was not sure if he has the doors are secured by dident goes out). LPN (H) tell what causes his was unsure what kind of kind done in the past. The LPN aviors were not addressed An interview with the DON in the flesh described agitation and kick." She stated	F	744			

PRINTED: 11/15/2018 FORM APPROVED

FORM APPROVED
OMB NO. 0938-0391

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION LAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495337	B. WING	10 Page 1	11/08/2018	
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER		ER	712	REET ADDRESS, CITY, STATE, ZIP CODE 0 BRADDOCK ROAD NANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 744	Continued From pa	ge 51	F 744			
	dementia. When as antipsychotic medic	n's, to control behaviors for sked about overuse of cations, the DON stated, "You cally restrain or decrease the				
	558 to 560, classified used to treat schizo is a black box warning	Orug Handbook 2011, pages ed Haldol as an antipsychotic, ophrenia and Tourette's. There ing for this drug which states, nortality in elderly patients with sychosis."				
	984-986 classified sused to treat schizo episodes of bipolar box warning in the e	Drug Handbook, 2011, pages Seroquel as an antipsychotic, ophrenia, acute manic disorder. It also has a black elderly with dementia related creased risk of death.				
	was given to the sunursing) included be The form included siminimizing day time is good, let them pahimself, "look for the He may simply need Catastrophic reactions such as crying or you When residents have usually in response overwhelmed." Intecalmly and slowly frout firm tone of voice their feelings. Guid necessary. If you a	erventions include: "Approach rom the front, using a gentle ce. Do not argue, validate				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED		
		495337	B. WING				11/08/2018	
	ROVIDER OR SUPPLIER DHEALTHCARE CENTE	R		7120	EET ADDRESS, CITY, STATE, ZIP CODE D BRADDOCK ROAD NANDALE, VA 22003			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 744	Continued From pag	e 52	F	744				
		kimately 2:30 PM, the DN were notified of above						
	assess for triggers, id develop non-pharma	, the facility staff failed to dentify behaviors, and cological interventions to ecific dementia care and						
	Resident #82, an 88 admitted to the facilit include dysphagia ar	y on 11/16/17. Diagnoses						
	Data Set (MDS) had Date (ARD) of 08/09 coded with a Brief In (BIMS) score but cog making were coded a Functional status for	recent quarterly Minimum an Assessment Reference /2018. Resident #82 was not terview of Mental Status gnitive skills for daily decision as severely impaired. bed mobility, dressing, hygiene was coded as assistance.						
	observed in her bed Resident was awake head was elevated a	PM, the Resident was with family at bedside. The c, calm, and the head of the pproximately 60 degrees. at 2 liters/minute via nasal						
	observed awake in b	AM, the Resident was ed, quiet, with the head of imately 60 degrees. She had /minute via nasal cannula.						

Facility ID: VA0142

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

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLÉTED		
		495337	B. WING				11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R		7120 BRAI	DDRESS, CITY, STATE, ZIP CODE DDOCK ROAD DALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 744	dated 11/16/17 docu Podiatric, Opthamolo services may be obta indicated." An order dated 11/16 "Quetiapine fumarate by mouth at bedtime An order dated 11/16 and document mood The Medication Reg dates ranging from 1 reviewed. The page pharmacist signature entries on 12/6/17, 1 and 6/8/18, the box 1 noted irregularities a selected. For monthl 7/11/18, 8/13/18, 9/1 labeled "NI (no irreg There was no other The MAR (medication October and Novem Quetiapine was sign daily as scheduled. I "monitor and docum shift", there were sta behaviors document Resident notes were November 2018. As 8/10/18 at 2:23 PM of and cooperative with behaviors have been	rs were reviewed. An order mented, "Dental, Psych, ogical and Audiological ained for the resident as a solution of the residen	F	744			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENTE	R	S1 71 A		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 744	Continued From page	e 54	F 744		
	group for medication	management."			i
	A nurse's note dated documented, "no abn observed."	8/24/18 at 10:20 PM ormal behavior/distress			
	documented, "No mo documented. Resider mood and Melatonin	e dated 10/11/18 at 8:00 PM od alteration has been nt continues on Seroquel for for sleep. Resident is t has a habit of grabbing or			
	dated 10/16/18 at 2:4 "Receives psychotrop	am meeting/MDS note 3 PM documented, sic medications for insomnia o adverse side effects noted			
		10/20/18 documented, erbally responsive. Pleasant			
!		nt unable to comprehend ken to but would smile at			
	dated 11/29/17 docume ffects from antipsych Interventions included as ordered by physici side effects, documer physician. Monitor my targeted behaviors lis	behavior." There were no ted on the care plan or interventions associated obing or pinching as			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/0	8/2018
	ROVIDER OR SUPPLIER D HEALTHCARE CENT	ER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD INNANDALE, VA 22003	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 744	Continued From page	ge 55	F 744	F 755 Pharmacy Services Compliance Date: 11/8/2018	0	11/8/18
	care plan the Reside develop and implementation behavior management of dementia and Reand expressions. On 11/08/18 at 11:4 asked about behavious he stated she has	nce in the nurse's notes or ent has been assessed to nent Resident-specific ent associated with diagnosis sident's personal preference 5 AM, when LPN B was ors exhibited by Resident #82, o't seen any behaviors in went on to say Resident #82 is		Immediate action taken resident found to have affected include: Resident #29 was evaluated 11/9/18 by Unit Manage complaints of pain or sign symptoms of GI discommendation reflux noted. MD and Raware. No further action required to have a sign of the sign of	for the e been atted on ger, no gns and nfort or P made	
	nurse was asked wifor residents with decan have demential behaviors." When a care plan for a reside behaviors and she swas unable to elaborate of the properties of the properties of the process of the	roximately 2:45 PM, the ION were notified of concerns further information. occdures/Pharmacist/Records o)(1)-(3) Services ovide routine and emergency Is to its residents, or obtain	F 755	Identification of other rehaving the potential affected. The facility has determined residents have the potential affected. 100% audit of resident channels of the non-covered menotifications were conducted in the conduction of the physician medications have been protected this practice.	to be I that all al to be narts for edication cted on agers to eve been a and all vided to residents	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	((X3) DATE : COMPL	
		495337	B. WING _			11/0	08/2018
LEEWOOI		TATEMENT OF DEFICIENCIES	JD DDEEL	7120 BRADDOCK F ANNANDALE, VA	A 22003 OVIDER'S PLAN OF CORRECTION	BF	(X5) COMPLETION
PREFIX TAG	Continued From page §483.45(a) Procedur pharmaceutical servi that assure the accur dispensing, and adm biologicals) to meet t §483.45(b) Service Comust employ or obtain pharmacist who- §483.45(b)(1) Provid aspects of the provisithe facility. §483.45(b)(2) Establination and service and disposition sufficient detail to entreconciliation; and service and that an act is maintained and perform the service and clinical record represident (Resident #29 the medication ordered be substitute until the medication funds: Resident #29, a 69 years and service and service and that and the physician.	e 56 es. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and he needs of each resident. Consultation. The facility in the services of a licensed es consultation on all ion of pharmacy services in shes a system of records of an of all controlled drugs in able an accurate nines that drug records are in count of all controlled drugs riodically reconciled. T is not met as evidenced riew, facility documentation view the facility failed for 1 records as ordered by a facility failed to obtain the physician or obtain redication was available.	ID PREFIT TAG	Actions place to occurren An in-set was conde Nursing/I nurses in ensuring recomment completed the phy medication ordered. ensuring or of pharmace available. How the be mon practice v The Direct managers recomment morning of recomment timely administer per week a week for	taken/systems pureduce the risk of ace. ervice education producted by the Direct Designee to all limitiated on 11/9/20 phandations are revided and addressed time system and that ons are administer Emphasis made availability of medicular therapy if the corrective action (state of Nursing and/owill review phandations during clinical meeting to adations are carried and medications red as ordered; five for 2 weeks, then 3 or two weeks then we retain the product of the p	t into future rogram etor of censed 18 on armacy iewed, ely by t all red as e on ication chative f not s) will the the continuity of the assure dout are times times	(X5) COMPLETION DATE
	the facility on 10/10/2	2016 with diagnoses	Ŷ.	for 4 weel	KS.		

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OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ B. WING 495337 11/08/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7120 BRADDOCK ROAD LEEWOOD HEALTHCARE CENTER ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) The Director of Nursing/Designee F 755 Continued From page 57 F 755 will present the results of audits to including but not limited to Dysphagia, Muscular the **Ouality** Assurance weakness, Aphasia (inability to talk), Parkinson's Performance Improvement disease, and Hemiplegia. The most recent Committee for review and further (Minimum Data Set) MDS with an (Assessment Reference Date) ARD of 02/19/2018 coded the recommendations. **Ouality** Resident as having a (Brief Interview of Mental Performance Assurance Status) of 15 indicating no cognitive impairment. Team Members Improvement include: Administrator, Director of On 11/7/2018 during clinical record review it was noted that Resident had order for Protonix Nursing. Staff Development Suspension 40 (milligrams) mg (by mouth) PO Coordinator, Director of Social every day for (Gastro Esophageal Reflux Services, Director of Dietary, Disease). The medication had been originally Director of Housekeeping, Director ordered on 10/13/2017. of Maintenance, Nurse Managers, On review of the (Medication Administration Minimum Data Set Coordinator, Record) it was noted that the Resident missed 11 Medical Director, Director of Rehab doses of the medication in October. Services, and Pharmacy Consultant. 10/05/2018 at 6:00 AM If issues are identified. 10/10/2018 at 6:00 AM education additional will he 10/11/2018 at 6:00 AM provided and modification of the 10/13/2018 at 6:00 AM 10/14/2018 at 6:00 AM Plan of Correction will be made to 10/15/2018 at 6:00 AM address the deficient practice 10/16/2018 at 6:00 AM 10/17/2018 at 6:00 AM 10/18/2018 at 6:00 AM 10/19/2018 at 6:00 AM 10/20/2018 at 6:00 AM On 11/8/2018 an interview was conducted with the DON who stated "Well the insurance refused to pay for the liquid Protonix anymore and this Resident cannot swallow pills and he needs the liquid." She went on to say they used to cover it

but then stopped paying for the liquid and the Pharmacy tried to get the doctor to substitute but

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

DENTIFICATION NUMBER:		1.	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495337	B. WING		11/08/2018
PREFIX (EACH DEFICI		71	REET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
Pharmacy Recommendations Medication" - one the second one withird was dated 1 were marked as " The DON stated the Protonix with saw the insurance "Dexilant DR 60 r Swallowing- may content onto apply do not chew." The Administrato and no further inf F 758 Free from Unnect SS=D CFR(s): 483.45(c)(3) A paffects brain active processes and be but are not limited categories: (i) Anti-psychotic; (ii) Anti-depressation (iii) Anti-anxiety; (iv) Hypnotic	Inot sign, he refused the immendations." d three pharmacy is titled "Urgent - Non -Covered inotification was dated 07/25/18 was dated 08/28/2018 and the 0/1/2018 all of the documents (DENIED - Severe Dysphagia". that the doctor finally substituted another medication when he is would not cover it. an order on 10/21/2018 for mig by mouth once daily, open capsule and sprinkle it is sauce to be swallowed whole or was made aware on 11/6/2018 formation was provided. Psychotropic Meds/PRN Use (S)(3)(e)(1)-(5) motropic Drugs. Desychotropic drug is any drug that writies associated with mental enavior. These drugs include, dient;	F 758	F 758 Free of Unner Psychotropic Meds/PRN us Compliance Date: 11/21/201 Immediate action taken fresident found to have affected include: Resident #4 was assessed psychiatric Nurse Practitio 11/21/2018, to review Tem use, gradual dose reduction, due to patient's requestion on the continue with therapy. Moreontinue with the physician on 11/9/2018 by the Manager. No further required.	for the been by the oner on azepam on not quest to elatonin on list licensed ontinued 18. Care use was

Facility ID: VA0142

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			D. MINIO		
		495337	B, WING	TOTAL ADDRESS CITY STATE ZID CODE	11/08/2018
NAME OF PE	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
LEEWOO	HEALTHCARE CENTE	R		NNANDALE, VA 22003	
0/40 ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TON (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	Continued From page	e 59	F 758	Identification of other r having the potential	residents to be
				affected.	
	psychotropic drugs a unless the medication specific condition as in the clinical record;	ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented		The facility has determined residents receiving psyc medications have the potent affected.	hoactive
	drugs receive gradua behavioral intervention	ents who use psychotropic al dose reductions, and ons, unless clinically n effort to discontinue these		100% audit on all resident psychoactive medications initiated on 11/9/2018 Director of Nursing ar	s were by the nd Unit
	unless that medication diagnosed specific of in the clinical record;	ursuant to a PRN order on is necessary to treat a condition that is documented and		Managers to ensure to psychoactive medications attempted gradual dose reduplace. No other resident is to have been affected practice.	uction in dentified
	sare limited to 14 days §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he	RN order to be extended or she should document their ent's medical record and		100% audit on all resident psychoactive medications initiated on 11/9/2018 Director of Nursing at Managers to ensure that that are taking antip	s were by the nd Unit residents osychotic
	drugs are limited to renewed unless the apprescribing practition the appropriateness This REQUIREMEN' by: Based on staff internand clinical record re	orders for anti-psychotic 14 days and cannot be attending physician or her evaluates the resident for of that medication. T is not met as evidenced view, facility documentation eview the facility failed to ents (Resident #4 and #82) in		medications have an ap diagnosis which excludes of No other resident identified been affected by this practic	lementia. d to have

a survey sample of 34 Residents were free from

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED		
		495337	B, WING		11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		7	STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003 ID PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DATE
F 758	gradual dose reduction Temazepam for a year 2. For Resident #82, ensure she was free medication Seroquel residents with a diagram. The findings included Resident #4, a 76 year.	ne facility failed to attempt on of Psychotropic Drug ar. the facility staff failed to from the psychotropic which is not indicated for nosis of dementia.	F 758	Actions taken/systems proplace to reduce the risk of occurrence. An in-service education ensuring GDR's are done times to residents with psychological director on 11/21 the Psychiatric services to ensure GDR's are done times pharmacy recommendation state guidelines. An in-service education was	on on mely for moactive by the /018 to eam to ely per as and
	not limited to Diabete Fibrillation, and Depre On 11/06/2018 during noted that Resident # Temazepam 15 (millimouth at bedtime and 5/7/2017 he also had 75 mg. (an antidepre On 11/08/2018 at 11: conducted with the D Resident was on Tem "Temazepam is a Hyysleep." When asked stated "The Wellbutri Upon further investig the Resident has had	g clinical record review it was 44 had orders for gram) mg 1 capsule by 3 that order started on an order for Wellbutrin ER ssant) twice daily. OO AM an interview was ON and she was asked why nazepam she stated protic he takes it to help him about the Wellbutrin she in is an Antidepressant."		on 11/21/2018 by the M Director to the Psychiatric S team on ensuring apprediagnosis is provided f antipsychotic drug use. How the corrective action be monitored to ensure practice will not recur: The Director of Nursing and managers will review phrecommendations monthly requests for GDR and ensure through by attending physical designs a provided to the practice will not recure through by attending physical designs are provided to the provi	Medical dervices ropriate for all (s) will re the Mor unit harmacy y for e follow

On 11/08/2018 during end of day meeting with

OLIVILLI	OT ON MILDIONINE O	MEDIO/ IID OLIVIOLO			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495337	B. WING		11/08/2018
	ROVIDER OR SUPPLIER HEALTHCARE CENT	ER	7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 758	only Psychoactive M Zyprexa needed a G On 11/08/2018 durin noted that according	was my understanding that Medications like Seroquel and BDR." In g clinical record review it was g to the MDS from past year BDR for the Psychotropic	F 758	The Director of Nursing Designee will review to orders daily during morning meeting to ensure appediagnosis is used for patient psychotropic medications, done daily for 2 weeks, three a week for 2 weeks, month months.	clinical propriate staking To be times
	Annual - 10/31/2017 Resident #4 was condended According to (Gradual Dose Reduction was left blace attempted GDR-NCD physician document NONE Quarterly MDS-01/3 Medications- Residereceived Antidepresidays a week. According to the question was left attempted GDR-NCD physician document NONE	Section N- Medicationsded as having received well as Hypnotics 7 days a section N-0450- Has GDR action) been attempted the ank. Section C - Last DNE. Section E- Date clinically contraindicated - 30/18 - Section N-ent #4 was coded as having sants as well as Hypnotics 7 ding to section N-0450- Has a Reduction) been attempted it blank. Section C - Last DNE. Section E- Date clinically contraindicated -		Performance Improcement Committee for review and recommendations. Assurance Performance Performance Improvement Team Minclude: Administrator, Director, Director of Services, Director of Director of Housekeeping, of Maintenance, Nurse Minimum Data Set Cook Medical Director, Director of Medical Director of	eviews to ssurance rovement d further Quality formance Members rector of elopment Social Dietary, Director fanagers, rdinator, of Rehab
	Resident #4 was co Antidepressants as week. According to (Gradual Dose Redi question was left bla attempted GDR-NO	8 -Section N- Medications- ded as having received well as Hypnotics 7 days a section N-0450- Has GDR uction) been attempted the ank. Section C - Last NE. Section E- Date clinically contraindicated -		Services, and Pharmacy Collificational education was provided and modification Plan of Correction will be address the deficient practic	d, then will be of the made to

		WEDIGAID SERVICES	T	LICTURE COLUMN	(V2) DATE SUBVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
			A. BUILDING		
		495337	B. WING		11/08/2018
NAME OF PR	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
. =========	NUMBER OF STREET	· n	7120	BRADDOCK ROAD	
LEEWOOL	HEALTHCARE CENTE	:K	ANN	ANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 758	Continued From pag	e 62	F 758		
1 730	NONE	0.02	1 730		
	NONE				
	Ouarterly - 07/30/20	18- Section N- Medications-			
	•	ded as having received			
		well as Hypnotics 7 days a			
		section N-0450- Has GDR			
	,	iction) been attempted the			
	question was left blank. Section C - Last attempted GDR- NONE. Section E- Date physician document clinically contraindicated -				
	NONE	cliffically contraindicated -			
	NONE				
	Administrator was no	otified of lack of GDR on			
	11/08/2018 no furthe	er information was provided.			
	2 For Resident #82	, the facility staff failed to			
		from the psychotropic			
		I which is not indicated for			
	residents with a diag				
			1.		
	Resident #82, an 88				
	include dysphagia a	ty on 11/16/17. Diagnoses			
	illiciude dyspilagia a	nd dementia.			
	Resident #82's most	t recent quarterly Minimum			
		an Assessment Reference			
		0/2018. Resident #82 was not			
		terview of Mental Status			
	, ,	gnitive skills for daily decision			
		as severely impaired.			
		bed mobility, dressing, I hygiene was coded as			
	requiring extensive				
	On 11/06/18 at 1:25	PM, the Resident was			
		with family at bedside. The			
		e, calm, and the head of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495337	B. WING			11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER		ER		7120	ET ADDRESS, CITY, STATE, ZIP CODE BRADDOCK ROAD ANDALE, VA 22003	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	1D PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 758	She had oxygen on cannula.	approximately 60 degrees. at 2 liters/minute via nasal	F	758		
	observed awake in l	AM, the Resident was bed, quiet, with the head of ximately 60 degrees. She had s/minute via nasal cannula.				
	dated 11/16/17 docu Podiatric, Opthamol	ers were reviewed. An order umented, "Dental, Psych, ogical and Audiological tained for the resident as				
	An order dated 11/1 "Quetiapine fumarate by mouth at bedtime	te 25 mg tab. Give one tablet				
		6/17 documented, "Monitor d and behavior every shift."				
	dates ranging from reviewed. The page signatures and date 12/6/17, 1/8/18, 2/7, 6/8/18, the box labe irregularities and/or selected. For month 7/11/18, 8/13/18, 9/1 labeled "NI (no irreg	gime Review document with 12/6/17 to 10/9/18 was contains monthly pharmacist d. For monthly entries on /18, 3/8/18, 4/9/18, and led "see report for any noted recommendations" is saly entries dated 5/4/18, 12/18, and 10/9/18, the box gularities)" is selected. There nentation on the form.				
	October and Novem Quetiapine was sign daily as scheduled.	on administration record) for aber 2018 was reviewed. ned off as being administered Under behavior charting, nent mood and behavior every				

NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
LEEWOOD HEALTHCARE CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 64 shift", there were staff initials daily and "0" behaviors documented daily. Resident notes were reviewed ranging August - November 2018. Asocial service entry dated 8/10/18 at 2:23 PM documented. "She is pleasant and cooperative with care and no moods or behaviors have been documented. Resident is on Seroquel for mood and is being followed by psych group for medication management." A nurse's note dated 8/24/18 at 10:20 PM documented, "no abnormal behavior/distress observed." A social services note dated 10/11/18 at 8:00 PM documented. Resident continues on Seroquel for mood and Melatonin for sleep. Resident is			495337	B. WING_			11/08/2018	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 758 Continued From page 64 shift", there were staff initials daily and "0" behaviors documented daily. Resident notes were reviewed ranging August - November 2018. Asocial service entry dated 8/10/18 at 2:23 PM documented, "She is pleasant and cooperative with care and no moods or behaviors have been documented. Resident is on Seroquel for mood and is being followed by psych group for medication management." A nurse's note dated 8/24/18 at 10:20 PM documented, "no abnormal behavior/distress observed." A social services note dated 10/11/18 at 8:00 PM documented, "No mood alteration has been documented. Resident toon Seroquel for mood and Melatonin for sleep. Resident is					7120 BRADDOCK ROAD	CODE		
shift", there were staff initials daily and "0" behaviors documented daily. Resident notes were reviewed ranging August - November 2018. Asocial service entry dated 8/10/18 at 2:23 PM documented, "She is pleasant and cooperative with care and no moods or behaviors have been documented. Resident is on Seroquel for mood and is being followed by psych group for medication management." A nurse's note dated 8/24/18 at 10:20 PM documented, "no abnormal behavior/distress observed." A social services note dated 10/11/18 at 8:00 PM documented, "No mood alteration has been documented. Resident continues on Seroquel for mood and Melatonin for sleep. Resident is	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
pinching at times." An interdisciplinary team meeting/MDS note dated 10/16/18 at 2:43 PM documented, "Receives psychotropic medications for insomnia and mood disorder no adverse side effects noted at this time." A nurse's note dated 10/20/18 documented, "Resident alert and verbally responsive. Pleasant and cooperative." A nurse's note dated 11/8/18 at 3:33 AM documented, "Resident unable to comprehend commands when spoken to but would smile at staff speaking to her." The care plan was reviewed. A problem onset dated 11/29/17 documented, "I am at risk for side	F 758	shift", there were s behaviors docume. Resident notes we November 2018. A 8/10/18 at 2:23 PM and cooperative with behaviors have be Seroquel for mood group for medication. A nurse's note date documented, "no a observed." A social services in documented, "No a documented, "No a documented, "No a documented. Resimple and Melaton generally pleasant pinching at times." An interdisciplinary dated 10/16/18 at "Receives psychot and mood disorder at this time." A nurse's note date "Resident alert and and cooperative." A nurse's note date documented, "Resident alert and and cooperative." A nurse's note date documented, "Resident alert and and sylvanial staff speaking to here."	taff initials daily and "0" inted daily. The reviewed ranging August - Isocial service entry dated in documented, "She is pleasant with care and no moods or en documented. Resident is on and is being followed by psychion management." The destance of the date of the da	F	758			

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495337	B. WING		11/08/2018
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 7120 BRADDOCK ROAD ANNANDALE, VA 22003	E
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F.759 O. thousand France and	05	F 7	50	
Interventions include as ordered by physician. Monitor in targeted behaviors in non-pharmacological with behaviors of gradocumented in the state of	chotic drug use due to mood." ed, "Administer my medication cian. Observe me for adverse ent and report to my my behavior." There were no isted on the care plan or al interventions associated abbing or pinching as social services note. Ince in the nurse's notes or ent has been assessed to ment Resident-specific ent associated with diagnosis sident's personal preference 5 AM, when LPN B was ors exhibited by Resident #82, n't seen any behaviors in went on to say Resident #82 is roximately 1:10 PM, the DON on thipsychotics and she stated of see antipsychotics ents with bipolar, rette syndrome, and and when asked why a notial is prescribed and the stated they are used a lot for ential and behavior problems. They don't want to chemically	F 75	58	

Facility ID: VA0142

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/08/2018	
	ROVIDER OR SUPPLIER D HEALTHCARE CENT		7 [.]	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003	NAL OVE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 761	dementia-related por risk of death from C (Nursing 2018 Drug Label/Store Drugs	ch as Seroquel is elderly patients with sychosis because of increased by disease or infection." Handbook, 2018, p. 1274). and Biologicals	F 758	F 761 Label/Store Drug Biologicals Compliance Date: 11/7/2018 Immediate action taken fresident found to have affected include:	11/7/18 Cor the	
SS=D	Drugs and biological labeled in accordar professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the		The medications were refrom the wall cabinet by the Manager on 11/7/18 and disposed of according to policy. Unit does not have wandering patients at the transition incident. No further action residuals.	ne Unit d was facility ve any ime of	
	§483.45(h)(1) In act Federal laws, the fabiologicals in locked temperature control personnel to have a §483.45(h)(2) The locked, permanently storage of controlled the Comprehensive Control Act of 1976	cordance with State and acility must store all drugs and dicompartments under proper ls, and permit only authorized access to the keys. facility must provide separately y affixed compartments for didrugs listed in Schedule II of a Drug Abuse Prevention and and other drugs subject to the facility uses single unit		All unit wall cabinets and careas searched for unlocked unsecured medications 11/7/2018 by the Direct Nursing and Unit Manage other unit was identified affected by this practice. Identification of other rehaving the potential affected.	on to be	
	package drug distri quantity stored is n be readily detected This REQUIREMED by:	bution systems in which the ninimal and a missing dose can NT is not met as evidenced		The facility has determined residents have the potentia affected. All unit wall cabinets and c	l to be	
	Record Review, the	tion, staff Interview, and facility e facility staff failed to ensure ere not in an unlocked area,		areas searched for unlock unsecured medications		

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

Facility ID: VA0142

PRINTED: 11/15/2018 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & I		ONID NO. 0936-038	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495337	B. WING	11/08/2018

NAME OF PROVIDER OR SUPPLIER

LEEWOOD HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

7120 BRADDOCK ROAD ANNANDALE, VA 22003

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 761 Continued From page 67 and available to residents.

A wall cabinet on the Azalea unit was open, unlocked, and could be easily accessed by wandering Residents. The cabinet contained 2 open gallon sized zip lock bags of various medications, on the bottom shelf, closest to the counter top.

The findings include:

On 11-17-18 at 9:17 a.m., The wall cabinet directly over the nursing station counter top, was opened by surveyors from the hallway. The cabinet contained 2 large gallon size zip lock bags full of open, and unopened medications. No nursing staff were in the nursing station, and Residents were wandering the halls freely. Some residents were noted to be in wheel chairs, and some were ambulatory.

On 11-17-18 at 9:30 a.m., A Licensed Practical Nurse returned to the nursing station (LPN F), and surveyors pointed to the medications from the cabinet at that time, and asked her why the medications were there unlocked. LPN F stated "We put them in the cabinet waiting to destroy them." LPN F then started to leave the nursing station, and was asked if she planned to leave the medications there, and she stated "I am waiting for the DON" (Director of Nursing). She then exited the nursing station again leaving the medications unattended. Surveyors then removed the medications from the cabinet and began documenting what was found in the bags.

On 11-17-18 at 9:36 a.m., the nurse and DON arrived on the unit and spoke with surveyors.

F 761 Nursing and Unit Managers. No other unit was identified to be affected by this practice.

Actions taken/systems put into place to reduce the risk of future occurrence.

An in-service education program was conducted by the Director of Nursing/Designee on 11/7/2018 to all licensed nurses regarding medication storage and disposal policy.

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

The Director of Nursing or designee will perform inspections on all unit wall cabinets and common areas for unsecured and unlocked medications daily for two weeks, three times a week for two weeks, weekly for two weeks and monthly for two months to ensure all medications are stored according to policy and remains out of access to residents.

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495337	B. WING		11/08/2018
NAME OF PI	ROVIDER OR SUPPLIER		10.	STREET ADDRESS, CITY, STATE, ZIP CODE	
LEEWOOL	HEALTHCARE CENTE	R		7120 BRADDOCK ROAD	
				ANNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION	J (Y5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
			31	The Director of Nursing/De	
F 761	Continued From pag		F 76	Problem 1	
	unlocked and unatter stated "no." A third surveyor obse	I if medications should be left nded in the cabinet, and she erved the locked medication PN F stated that room was		Performance Improve Committee for review and recommendations.	
	where medications s to a large bin which s medications were pla pharmacy". Those n and unopened, but w (controlled) drugs. L drugs had to be dest pharmacy would not	chould be stored, and pointed she stated was "where aced to return to the medications were opened, were not scheduledPN F stated "all controlled troyed by 2 nurses, the take them back, one of the estroy controlled medications		Improvement Team Me include: Administrator, Direct Nursing, Staff Development Coordinator, Director of	embers etor of opment Social Dietary, virector nagers,
	were reviewed by 2 some new medication not expired, some open date, so expirate some open with an owere expired. The bottles of those medication	nd in the unlocked cabinet surveyors, and found to be; ons that were unopened and beened medications with no ution could not be known, and open date on the bottle, and loags contained multiple ications listed below, some ned. The items were as		Medical Director, Director of Services, and Pharmacy Con If issues are identified additional education with provided and modification Plan of Correction will be a address the deficient practice	sultant. , then ill be of the made to
	unopened Sodium chloride tabl unopened	d, and unopened ed 500 mg opened, and			

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	COMPLETED		
		495337	B WING		11/08/20	18	
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COM	(X5) MPLETION DATE	
F 808	medication storage with She stated that "Facilitate opened on their the medication has be medications must be unavailable to reside. On 11-17-18, and 11 debriefs the facility Anotified of the above. Therapeutic Diet Pre CFR(s): 483.60(e)(1) \$483.60(e)(1) Therapeutic by the att. §483.60(e)(1) Therapeutic by the att. §483.60(e)(2) The adelegate to a registe task of prescribing a therapeutic diet, to the law. This REQUIREMEN' by: Based on staff internand clinical record refersure that 1 Resideresidents was provided.	d pened ened on my opened acy policy and procedure for was discussed with the DON. Allity staff should record the medication container when been opened, and all stored in a locked area ants." -18-18, at the end of day dministrator and DON were findings. scribed by Physician (2) utic Diets peutic diets must be ending physician. Attending physician may red or licensed dietitian the resident's diet, including a ne extent allowed by State T is not met as evidenced wiew, facility documentation eview the facility failed to ent (Resident #55) of 34 leed the therapeutic diet as	F 761	F 808 Therapeutic Prescribed by Physician Compliance Date: 11/7/2014 Immediate action taken resident found to hav affected include:	for the re been estriction 1/7/2018 licensed mount of erved by and was eal ticket er action residents to be d that all a fluid	./7/18	
SS=D	§483.60(e) Theraped §483.60(e)(1) Theraped prescribed by the att §483.60(e)(2) The adelegate to a registe task of prescribing a therapeutic diet, to the law. This REQUIREMEN by: Based on staff internand clinical record refersure that 1 Reside	utic Diets peutic diets must be ending physician. Ittending physician may red or licensed dietitian the resident's diet, including a ne extent allowed by State T is not met as evidenced View, facility documentation eview the facility failed to ent (Resident #55) of 34 led the therapeutic diet as		having the potential affected. The facility has determined residents who are on restriction have the potential	to be d that all a fluid		

Facility ID: VA0142

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495337	B. WING		11/08/2018	
15 LEEWOOD HEALTHCARE CENTER		TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE	
F 808	Resident was give on his fluid restrict on his fluid restrict. The findings include Resident #55 a 75 the facility with dia Stage Renal Diseau Dialysis, Dysphag Staphylococcus A Inserted Central li On 11/7/2018 it were wise with the Residence of the Renal Disease. To 10/23/2018 that resident in the findilliliters of the Remain Dietary." The ord	the facility failed to ensure en the correct amount of fluids ed Renal Diet.	F 808	Director of Nursing and Mangers on 11/7/2018 to en fluid restriction orders and tickets are accurate and residuate receiving correct amount fluid based on their restriction other resident was identified to been affected by this practice. Actions taken/systems put place to reduce the risk of function of the reservice education prowas initiated on 11/7/2018 because initiated on 11/7/2018 because of Nursing/Designeer Registered Dietitian, dietary and nursing personnel on ensaccuracy of fluid amount proto residents with fluid restrictions.	the Unit asure meal dents ts of a. No have into ature egram y the to the staff suring vided ons.	
	supposed to be. orders was an order	Further down on the list of ler dated 10/19/18 that read 1.5 ml in 24 hours."		How the corrective action(s) be monitored to ensure practice will not recur:	will the	
ě	on 11/8/2018 Em Dietary Tickets fo ticket showed Flu Breakfast states of Water and milk Under that statem	ployee A was asked to pull the r Resident #55. The dietary id Restriction 1400 mł / day. 620 ml, he was given 8 oz. each and 4 oz. of orange juice. NR. The Resident gets milk		The Director of Nursing designee will review physicorders and telephone orders for two weeks, then 3 times a for two weeks then weekly weeks to ensure adequate accurate amounts of fluid provided to residents with a restriction.	cians daily week for 4 and are	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/15/2018 FORM APPROVED OMB NO. 0938-0391

	TO F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495337	B, WING		11/08/2018	
NAME OF PROVIDER OR SUPPLIER LEEWOOD HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD 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 CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION	
F 808	which is mentioned u 240 ml of his allotted The DON was notified orders vs. Dietary tick not sure why the Diet /day fluid restriction a /day. The DON came back that she had spoken that it should have be to be given by nursing ml by Dietary. The DON also stated Resident's family to fare as resident is nor The Administrator was	nder dislikes and is using up 1500 ml of fluids. d of the discrepancy in kets. DON stated she was ary orders stated 1400 ml and the chart stated 1500 ml later that day and stated to the doctor and clarified been 1500 ml /day and 300 ml g staff the remaining 1200 she would check with the ind out what the preferences	F 808	Performance Imp Committee for review an recommendations. Assurance Per Improvement Team include: Administrator, D Nursing, Staff Dev Coordinator, Director of Services, Director of Director of Housekeeping of Maintenance, Nurse I Minimum Data Set Co Medical Director, Director Services, and Pharmacy C If issues are identifi	audits to Assurance rovement ad further Quality formance Members irector of relopment of Social Dietary, Director Managers, ordinator, of Rehab consultant. ed, then will be on of the	

Facility ID: VA0142