PRINTED: 02/21/2019 FORM APPROVED OMB NO. 0938-0391

1 *	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	ı	495337	B, WING				C 13/2019
	PROVIDER OR SUPPLIER DD HEALTHCARE CEI	NTER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION DATE
F 000 F 641 SS=D	survey was conduct Complaint was inve Corrections are req following 42 CFR P. Care requirements. The census in this 1 123 at the time of the consisted of 1 curres #1). Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment me	fedicare/Medicaid abbreviated and 2/13/19. One stigated during the survey. Ulred for compliance with the art 483 Federal Long Term 132 certified bed facility was be survey. The survey sample and resident reviews (Resident ments		3641	This Plan of Correction is subnas required under State and Felaw. The facility's submission of Plan of Correction does constitute an admission on the of the facility that the findings are accurate, that the finconstitute a deficiency, or the scope and severity determination correct. Because the facility no such admissions, the statemade in the Plan of Correctannot be used against the fain any subsequent administraticivil proceeding.	ederal of the not e part cited dings at the on is nakes nents ction cility	3/4/19
	by: Based on observat interview, clinical re documentation reviews taff failed to ensure Data Assessments resulted in a fire in the facility staff failed Resident #1's MDS and 10/2/18 to incluin a fire in the resident #1 was a Stothe facility on 8/14 Muscle Weakness,	ed to ensure the accuracy of assessments on 1/17/19, de tobacco use that resulted ent's bed on 2/5/19.			F 641 Accuracy of Assessment Compliance Date: 3/4//19 Immediate action taken for resident found to have affected include: Resident #1's MDS assessment updated on 2/13/19 to include tobacco use. Identification of other residence having the potential to affected. No other residents have potential to be affected as residual to the affected as residents.	the been was clude lents be the ident	(X6) DATE

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495337	100		- 1	C
NAME OF	PROVIDER OR SUPPLIER	=======================================	10	STREET ADDRESS, CITY, STATE, ZIP (13/2019
LEEWO(OD HEALTHCARE CE	NTER		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	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 641	Peripheral Vascula with Diabetic Neuro Disorder. The Minimum Data Assessment with a of 1/17/19 was revihaving a Brief Inter 15, indicating that haddition, Resident physical assistance dressing. In Section incorrectly coded a	Data Set, which was an Annual th an Assessment Reference Date reviewed. It coded Resident #1 as interview of Mental Status Score of that he was cognitively intact. In the ent #1 was coded as requiring the sance of 1 person for eating and ction J, Resident #1 was eat as having no tobacco use. In the content was required to ensure the content to the content was required to ensure the content to reduce the risk of future occurrence. Education, in-service program was conducted for MDS nurses by Administrator on 3/4/19 regarding properly coding tobacco use on MDS assessments.				
	10/2/18, Section J, his tobacco use. On 2/13/19, at 1:45 made of Resident # He was not being s was in his wheelchabed and grabbled the then pulled hims wheelchair. He had that had the top hal the tips of his finger old, worn and soiled.	P.M. an observation was It who was alone in his room. Upervised by facility staff. He air, and reached up over his ne metal triangle apparatus. Self into bed from his cotton gloves on both hands of gloves cut off, exposing as. The gloves appeared to be d with debris. Resident #1 the gloves all of the time		practice will not recur: The Director of Nursin will review MDS assess residents who use tobacce the assessment accurate resident's status, week weeks then monthly for 2	esiments for to to ensure ely reflects kly for 4	
	bed. He stated that facility, he smoked breaks at 8 A.M., 12 stated that staff sor apron on him. Whe night of the fire on 2 "They didn't give me	sked how the fire started in his since his admission to the during scheduled smoking 2 Noon, 4 P.M., and 8 P.M. He netimes didn't put a smoking n asked specifically about the 2/5/19, Resident #1 stated, a smoking apron that night, would not have had the fire	- 1860 1880	•		***

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		495337	B. WING		C	T I
NAME OF	PROVIDER OR SUPPLIER		1,000	STREET ADDRESS, CITY, STATE, ZIP CODE	02/1	3/2019
LEEWO	DD HEALTHCARE CE	NTER		7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 641	The embers got on wheelchair. I always chest, legs and feet got in bed and went bed was on fire." On 2/13/19, a reviet documentation, revincident dated 2/5/12019 at approximat observed coming fropened the door an originating from res resident from room, fire was put out by sire department arr. [Resident #1] was a injuries or concerns was not necessary liphysicians agreemed grandfathered and is smoking privileges. 8:30 pm where he was and feet and f	my blanket covering my shave 2 blankets covering my and a shave 2 blankets covering my and a share 2 blankets a share 2 blank	F 641	will present the results of reviets the Quality Assi Performance Improve Committee for review and for recommendations. Assurance Performance Performance	ews to urance rement further Quality mance embers etor of pment Social pietary, irector nagers, inator, Rehab cultant. then l be of the ade to	
	by the staff who sme Certified Nursing As extinguished the fire Nursing (Employee the staff person who supervising Resider break just prior to the not contain any infor- regarding the smoki statement in the inve	ntation contained statements elled the smoke, and by the sistant (Employee B), who e. The facility Director of A) identified Employee B as a was responsible for at #1 during his smoking e fire. The investigation did mation from Employee B no break. There was no estigation from Employee B noking apron on Resident #1 s no statement from	2 2-192			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
			A, BOILE	1110			
		495337	B. WING		4	02/13/2019	
	PROVIDER OR SUPPLIER OD HEALTHCARE CE	NTER		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 SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE / CROSS-REFERENCED)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	SHOULD BE COMPLE	
F 641	Employee B that he ensuring that Resid smoldering embers blankets prior to Recourtyard and putting the Employee B submit statements (2 writtenstatement dated 2/when I was doing in smoke coming from immediately rushed that the whole room from the mattress of followed the facility. Employee B's second telephone intervied 2/13/19 at 3:30 P.N. what happened the got the cigarettes a medication cart. I phas blankets on hir After he smoked 2 and blanket and mablanket." When ask Employee E hesitaring we use to feed resion that day, it's brospecifically described B stated again, "It's to feed that resident	dent #1 did not have any strom cigarette use on his desident #1 leaving the mg himself in bed. Itted three conflicting en, and 1 verbal). The first 5/19 read, "Around 10:50 pm my initial rounds, I notice in [Resident's room] and id into the room and realized in was covered with smoke and blankets. I immediately protocol." Indicate the fire, he stated, "I and lighter from the nurse and the bib on him. He normally in because it's cold outside. Cigarettes, I took off the bib ade sure nothing was in the ked to describe the "bib", ted, then stated, "It's the bib dents. That's the one I used with the brown bib we always use its." Employee E was unable to	F	641			
9-1	Nursing (Employee protectors on the unresident, and that the	•			1	T h	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING			02	/13/2019
70	PROVIDER OR SUPPLIER OD HEALTHCARE CI		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003			. 7572010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC DENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 641	stated that Reside apron that had bee manufacturer's ins protector read, "Acheavy domestic te blend." The clothir retardant. Employee B's third email at the reque (Employee C), who during the survey. 2/14/19. It read, "C took (Resident #1) courtyard so he cacigarettes. As usual over him first as I sinished the first wit trashed into the cig second one too. A and blankets were him into his room a him clean. I have been working the survey working the survey.	#1's smoking apron. The DON nt #1 had a gray smoking en discarded. The structions for the brown clothing dult Clothing Protector. Made of the first cloth. 50/50 cotton polyester ag protector was not fire the facility Administrator of was not present in the facility. The third statement was dated on 2/5/19 at around 8:30 pm, I have his routine smoke of all I put on his smoking apronistand and watch. After he hich I gave, the half was garette (ashtray) and so for the salways sure that the apronitation and put him in his bed and get	F	641			
29 m	am very conversar facility's policy with On 2/13/19, I recei working for the Stame some question took placed on 2/5 Dogwood evening about the type and [Resident # 1] whe the above mention	nt with smoking routine and the	2.e			s a	e sa cida e sa cida

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI ND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUL A, BUILD	LTIPLE CONSTRUCTION DING	C (X3) DATE SURVEY	
		495337	B, WING			13/2019
	PROVIDER OR SUPPLIER DD HEALTHCARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP COE 7120 BRADDOCK ROAD ANNANDALE, VA 22003	Æ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 641	#1's clinical record, Activities care plan buys cigarettes, alcoutings and refuses hold items. He hide gloves and become staff request to lock Resident #1's care safety again until at on 2/5/19. The curr brought some ashe some parts of his b for cigarettes and li on one sitter provid progress notes, Re supervision until 2/6 documentation in th on one supervision	w was conducted of Resident revealing a 4 year old dated 7/8/15. It read, "Often who and lighters when on so to allow the activity aide to selighters and cigarettes in his as aggressive when facility them up for his safety." plan did not address smoking fiter the fire in his bed occurred ent care plan read, "Resident est to the room and burned ed. Monitoring and searches ghter. Verbal reminders. One led." According to the sident #1 had one on one 8/19. There was no ne progress notes that the one had been discontinued. The occument the discontinuance of	F6	641		
	signed physician's of with staff 2 times in evening." Resident #1's clinic	sident # 1 had the following orders, "Resident may smoke morning and 2 times in the all record contained only one				
*** #	read, "Apply Šmoki The facility Smokin "Residents will not l the direct supervision member or volunted provided throughou	ds Assessment dated 1/3/19. It ng Apron". g Policy, dated 10/3/17 réad, be permitted to smoke without on of a responsible staff er. Direct supervision must be at the entire smoking period. All ke will be assessed upon			en e	4") 1.7 4.4

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	1.	COMPLETED	
		495337	B. WING		02/13/2019
	(EACH DEFICIENC)	NTER ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	71	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
F 641	conditions warrants Examples of equipand assistive devic On 2/13/19 at 3:45 was informed of the	ly, and PRN (as needed) as so for safety equipment needs. ment include smoking apronses. P.M. the Director of Nursing	F 641	F 656 Develop/Impleme Comprehensive Care Plan Compliance Date: 3/8/19 Immediate action taken for the resident found to have be affected include:	3/8/19
F 656 SS=D	S483.21 (b) Compre §483.21 (b) (1) The implement a compre care plan for each resident rights set it §483.10(c)(3), that objectives and time medical, nursing, a needs that are ident assessment. The odescribe the follow (i) The services that or maintain the resphysical, mental, arequired under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incitreatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations findings of the PAS rationale in the resi	chensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable eframes to meet a resident's and mental and psychosocial attified in the comprehensive comprehensive care plan must ing - at are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required as.25 or §483.40 but are not are resident's exercise of rights and the right to refuse 83.10(c)(6). It services or specialized ares the nursing facility will of PASARR aff a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the	F 656	affected.	the be the ent the was ers /19 ing for

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TELEGRATION AND INTERES.		X2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF			S 7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD NNANDALE, VA 22003	1 021	13/2019	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 656	(A) The resident's desired outcomes. (B) The resident's future discharge. If whether the reside community was as local contact agenentities, for this purities, for this REQUIREMED by: Based on observation interview, clinical redocumentation revistaff failed to devert to prevent a fire in the facility staff fare (who had a document and cigarette in his Safety care plan to bed on 2/5/19.	goals for admission and preference and potential for facilities must document ent's desire to return to the esessed and any referrals to cies and/or other appropriate rpose. In the comprehensive care te, in accordance with the borth in paragraph (c) of this entition, resident interview, staff ecord review, and facility liew, for Resident #1, the facility lop a Smoking Safety care plan the resident's bed. Illed to ensure that Resident #1 ented history of hiding lighters is gloves), had a Smoking in prevent a fire in the resident's	Fe	956	How the corrective action(s) be monitored to ensure practice will not recur: The Director of Nursing/Desi will review care plans for residuho are allowed to smoke at facility to ensure a comprehencare plan is implemented, we for 4 weeks then monthly funonths. The Administrator/Designee present the results of reviews to Quality Assurance Perform Improvement Committee for reand further recommendat Quality Assurance Perform Improvement Team Meninclude: Administrator, Director Nursing, Staff Develop Coordinator, Director of Services, Director of Director of Housekeeping, Director of Maintenance, Nurse Mana Minimum Data Set Coordinator	gnee dents t the nsive ekly or 2 will o the ance view ions. ance bers or of ment ocial etary, ector gers,		
	to the facility on 8/ Muscle Weakness Peripheral Vascula	ded: 90 year old who was admitted 14/14. His diagnoses included , Other Lack of Coordination, r Disease, Type 2 Diabetes opathy, Depression and Anxiety	ā		Minimum Data Set Coordir Medical Director, Director of R Services, and Pharmacy Consu If issues are identified, additional education will provided and modification of Plan of Correction will be made	ehab Itant. then be the		
	Assessment with a	Set, which was an Annual n Assessment Reference Date lewed. It coded Resident #1 as			address the deficient practice		**	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A, BUILC		.F. CONSTRUCTION	COMPLETED			
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	PROVIDER OR SUPPLIER DD HEALTHCARE CE	NTER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 120 BRADDOCK ROAD ANNANDALE, VA 22003				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		D BE	(X5) COMPLETION DATE			
F 656	15, indicating that haddition, Resident aphysical assistance dressing. In Section incorrectly coded a addition, in the Qui 10/2/18, Section J, his tobacco use. On 2/13/19, at 1:45 made of Resident He was not being swas in his wheelchair He had that had the top had the tips of his finge old, worn and soiler	view of Mental Status Score of the was cognitively intact. In #1 was coded as requiring the e of 1 person for eating and in J, Resident #1 was is having no tobacco use. In arterly Assessment dated the facility failed to document. P.M. an observation was #1 who was alone in his room. upervised by facility staff. He air, and reached up over his ne metal triangle apparatus. Self into bed from his cotton gloves on both hands for gloves cut off, exposing ris. The gloves appeared to be divith debris. Resident #1 the gloves all of the time	F	356					
	bed. He stated that facility, he smoked breaks at 8 A.M., 1 stated that staff sor apron on him. Whe night of the fire on 2 "They didn't give milf I had that apron I The embers got on wheelchair. I always chest, legs and fee got in bed and wended, was on fire."	sked how the fire started in his since his admission to the during scheduled smoking 2 Noon, 4 P.M., and 8 P.M. He netimes didn't put a smoking n asked specifically about the 2/5/19, Resident #1 stated, e a smoking apron that night, would not have had the fire. my blanket covering my shave 2 blankets covering my t. After smoking that night, I to sleep. I didn't know my		5. C	a saba	e de	and the sales had		
7	On 2/13/19, a revie	w was conducted of facility		we .	187				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILD	NG	COMPLETED			
	j	495337	B. WING		02/1	3/2019	
	PROVIDER OR SUPPLIER DD HEALTHCARE CE	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003				
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F 656	documentation, rev Incident dated 2/5/1 2019 at approximat observed coming from responding fro	ealing a Facility Reported 19. It read, "On February 5, ely 10:40 p.m., smoke was om [Resident #1's] room. Staff and saw smoke and fire idents' bed. Staff evacuated and fire alarm was sounded, and staff using fire extinguisher. ived and reviewed situation. assessed by staff and EMS; no anoted, transfer to the hospital based on assessment and ent. [Resident #1] was as the only resident with His last smoke break was at was supervised by staff. Order as obtained and patch was	F6	= + + + + + + + + + + + + + + + + + + +			
#2	not contain any info regarding the smok statement in the inv that he had put a sr on 2/5/19. There wa Employee B that he ensuring that Resid smoldering embers	rmation from Employee B ing break. There was no restigation from Employee B moking apron on Resident #1 as no statement from provided supervision by ent #1 did not have any from cigarette use on his sident #1 leaving the	47 17				
				4/			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495337	B. WING			C 02/13/2019	
	PROVIDER OR SUPPLIER DD HEALTHCARE CE	NTER		71	REET ADDRESS, CITY, STATE, ZIP CODE 20 BRADDOCK ROAD NNANDALE, VA 22003	1 021	13/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE
F 656	Employee B submi statements (2 writte statement dated 2/4 when I was doing in smoke coming from immediately rushed that the whole room from the mattress a followed the facility Employee B's seco a telephone intervie 2/13/19 at 3:30 P.N what happened the got the cigarettes a medication cart. I p has blankets on hin After he smoked 2 and blanket and mablanket." When ask Employee E hesital we use to feed resion that day, it's browspecifically describe B stated again, "It's to feed that resident describe a smoking. The surveyor confir Nursing (Employee protectors on the unresident, and that the facility staff was surveyor Resident as stated that Resident apron that had been	atted three conflicting en, and 1 verbal). The first 5/19 read, "Around 10:50 pm my initial rounds, I notice n [Resident's room] and I into the room and realized n was covered with smoke and blankets. I immediately protocol." Ind statement was received via the with this Surveyor on I. When asked to describe night of the fire, he staled, "I and lighter from the nurse and the bib on him. He normally in because it's cold outside. Cigarettes, I took off the bib ade sure nothing was in the ted to describe the "bib", ed, then stated, "It's the bib dents. That's the one I used wn." When asked again to the item he used, Employee the brown bib we always use ts." Employee E was unable to apron. med with the Director of A) that the brown clothing nit were used for every ney were not smoking aprons. Is not able to show the It's smoking apron. The DON the that a gray smoking in discarded. The	F	556	DEFICIENCY)		
	protector read, "Adu	ructions for the brown clothing ult Clothing Protector. Made of y cloth. 50/50 cotton polyester					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDIN	NG		(X3) DATE SURVEY COMPLETED	
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1 50	PROVIDER OR SUPPLIER OD HEALTHCARE CE	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003			
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F 656	blend." The clothing retardant. Employee B's third email at the reques (Employee C), who during the survey. 2/14/19. It read, "O took (Resident #1) courtyard so he car cigarettes. As usua over him first as I s finished the first wh trashed into the cig second one too. As and blankets were him into his room a him clean. I have been working am very conversant facility's policy with On 2/13/19, I receiv working for the Stateme some questions took placed on 2/5/Dogwood evening sabout the type and [Resident # 1] when the above mentione smoking apron that was not sure about	statement was submitted via t of the Facility Administrator was not present in the facility. The third statement was dated in 2/5/19 at around 8:30 pm, I of room 170 out in the inhave his routine smoke of I put on his smoking apronated and watch. After he ich I gave, the half was arette (ashtray) and so for the always sure that the apronated on of him before taking and put him in his bed and get gwith him for three years and twith smoking routine and the regards that. Yed a call from somebody the board and wanted to ask about the fire accident that 19 whilst I was working at shift. I was asked specifically color apron I used on all took him out to smoke on addate, and my reply was, his he usually use for smoking, the color."	F 65			
4.1 °	On 2/13/19 a review #1's clinical record, Activities care plan buys cigarettes, alc	v was conducted of Resident revealing a 4 year old dated 7/8/15. It read, "Often ohol and lighters when on to allow the activity aide to			Arian	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	A. BUILD		CONSTRUCTION	CON	MPLETED	
		495337	B. WING				C /13/2019	
!	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)		SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E		(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 656	gloves and become staff request to local Resident #1's care safety again until at on 2/5/19. The curr brought some ashes some parts of his befor cigarettes and light on one sitter provide progress notes, Resupervision until 2/d documentation in the one one supervision care plan did not do one on one supervision. Prior to the fire, Resigned physician's	es lighters and cigarettes in his es aggressive when facility to them up for his safety." plan did not address smoking feer the fire in his bed occurred ent care plan read, "Resident es to the room and burned ed. Monitoring and searches ghter. Verbal reminders. One led." According to the sident #1 had one on one 8/19. There was no ne progress notes that the one had been discontinued. The ocument the discontinuance of	F	656		2		
G. State	Resident #1's clinic Safe Smoking Nee read, "Apply Smokin The facility Smokin "Residents will not the direct supervisimember or volunte provided throughouresidents who smoadmission, quarterl conditions warrants Examples of equipand assistive devices	g Policy, dated 10/3/17 read, be permitted to smoke without on of a responsible staff er. Direct supervision must be at the entire smoking period. All ke will be assessed upon y, and PRN (as needed) as a for safety equipment needs, ment include smoking aprons es.						
	On 2/13/19 at 3:45	P.M. the Director of Nursing		3	27			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	T	495337	B. WING		C 02/13/2019
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/13/2019
LEEWOO	DD HEALTHCARE CE	NTER	1	120 BRADDOCK ROAD NNANDALE, VA 22003	*** *****
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 656	Continued From pa was informed of the		F 656	F 689 Free of Acci Hazards/Supervision/Devices	dent
F 689		azards/Supervision/Devices	F 689	Compliance Date: 3/22/19	3/22/19
SS=D	CFR(s): 483.25(d)(§483.25(d) Acciden The facility must en	ts. sure that -		Immediate action taken for resident found to have affected include:	3 1
		resident environment remains hazards as is possible; and		Resident #1 was given a Nice patch and is no longer smo	
	supervision and ass accidents.	resident receives adequate sistance devices to prevent		cigarettes.	
ř	by: Based on observat	IT is not met as evidenced ion, resident interview, staff cord review, and facility		Identification of other residence having the potential to affected.	ents be
	documentation revides staff failed to provide	ew, for Resident #1, the facility le adequate supervision and nt a fire in the resident's bed.		No other residents have potential to be affected as resident was the only smoker in	dent
		ed to ensure that Resident #1 on used during a smoking 3:00 P.M.		facility.	
	The Findings includ	ed:		Actions taken/systems put place to reduce the risk of fu	
	to the facility on 8/1	90 year old who was admitted 4/14. His diagnoses included Other Lack of Coordination,		occurrence.	
	Peripheral Vascular	Disease, Type 2 Diabetes pathy, Depression and Anxiety	90	Education was initiated with nursing staff regarding importance of the proper smo	the
9	Assessment with an of 1/17/19 was review	Set, which was an Annual a Assessment Reference Date ewed. It coded Resident #1 as view of Mental Status Score of	at .	apron being used.	
	naving a Difer interv	mew or Merical Status Score of	24		**

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495337	B. WING	P - 700	C	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/13/2019	
LEEWOOD HEALTHCARE CENTER			7	7120 BRADDOCK ROAD 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPORTION OF T	D BE COMPLETION	
F 689	15, indicating that addition, Resident physical assistance dressing. In Sectic incorrectly coded addition, in the Quadition, at 1:4 made of Resident He was not being was in his wheeled bed and grabbled. He then pulled him wheelchair. He had that had the top had the tips of his finge old, worn and soile stated that he worn because they supplied the stated that he worn because they supplied that the stated that facility, he smoked breaks at 8 A.M., stated that staff so apron on him. When ight of the fire on "They didn't give mit I had that apron The embers got or wheelchair. I alway chest, legs and feet addition, in the side of the stated that apron the embers got or wheelchair. I alway chest, legs and feet addition, in the control of the fire on the control of the fire of the	#1 was coded as requiring the e of 1 person for eating and on J, Resident #1 was as having no tobacco use. In uarterly Assessment dated, the facility failed to document 5 P.M. an observation was #1 who was alone in his room, supervised by facility staff. He hair, and reached up over his the metal triangle apparatus. In the metal triangle apparatus. In self into bed from his dicotton gloves on both hands all of gloves cut off, exposing ers. The gloves appeared to be ed with debris. Resident #1 to the gloves all of the time	F 689	How the corrective action(s) be monitored to ensure practice will not recur: The Director of Nursing/Deswill review smoking apron u all smoking residents; weekly weeks then monthly for 2 mon The Administrator/Designee present the results of reviews to Quality Assurance Perform Improvement Committee for reand further recommendate Quality Assurance Perform	signee se for for 4 sths. will to the mance eview tions. mance mbers or of oment Social etary, rector agers, mator, tehab altant. then be f the	
	bed was on fire."	ew was conducted of facility				
		realing a Facility Reported				

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COM	E SURVEY IPLETED
		495337	B. WING			C 13/2019
	PROVIDER OR SUPPLIER DD HEALTHCARE CE		712	BEET ADDRESS, CITY, STATE, ZIP CODE O BRADDOCK ROAD NANDALE, VA 22003	1 02/	13/2019
(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	(X5) COMPLETION DATE
F 689	Incident dated 2/5/2019 at approxima observed coming for opened the door a originating from resident from room fire was put out by Fire department ar [Resident #1] was injuries or concern was not necessary physicians agreem grandfathered and smoking privileges 8:30 pm where he	19. It read, "On February 5, tely 10:40 p.m., smoke was rom [Resident #1's] room. Staff nd saw smoke and fire sidents' bed. Staff evacuated a, fire alarm was sounded, and staff using fire extinguisher. rived and reviewed situation. assessed by staff and EMS; no s noted, transfer to the hospital based on assessment and ent. [Resident #1] was is the only resident with. His last smoke break was at was supervised by staff. Order was obtained and patch was	F 689			
	by the staff who son Certified Nursing A extinguished the fin Nursing (Employee the staff person wh supervising Reside break just prior to to not contain any inforcegarding the smol statement in the introduced that he had put a son 2/5/19. There we Employee B that he ensuring that Resides smoldering embers	entation contained statements nelled the smoke, and by the ssistant (Employee B), who re. The facility Director of e A) identified Employee B as no was responsible for ent #1 during his smoking he fire. The investigation didormation from Employee B king break. There was no vestigation from Employee B moking apron on Resident #1 as no statement from e provided supervision by dent #1 did not have any sfrom cigarette use on his esident #1 leaving the ng himself in bed.		de d	ar or his ran	
	Employee B submi	tted three conflicting				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILO	[· · · · ·		COM	DATE SURVEY COMPLETED	
		495337	B. WING			- 1	13/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP OF THE TRANSPORT OF THE TRANS								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	HOULD BE COMPLET		
F 689	statements (2 writte statement dated 2/5 when I was doing m smoke coming from	on, and 1 verbal). The first 5/19 read, "Around 10:50 pm ny initial rounds, I notice n [Resident's room] and	F	589				
(a)	that the whole room	I into the room and realized in was covered with smoke and blankets. I immediately protocol."						
	a telephone intervie 2/13/19 at 3:30 P.N what happened the got the cigarettes a medication cart. I p has blankets on hin After he smoked 2 and blanket and ma blanket." When ask Employee E hesitat we use to feed resi- on that day, it's bro- specifically describe B stated again, "It's	and statement was received via the with this Surveyor on I. When asked to describe night of the fire, he stated, "I and lighter from the nurse and ut the bib on him. He normally in because it's cold outside. digarettes, I took off the bib ade sure nothing was in the ade sure nothing was in the ade sure nothing was in the ade to describe the "bib", and, then stated, "It's the bib dents. That's the one I used win." When asked again to the item he used, Employee the brown bib we always use tts." Employee E was unable to papron.						
e (8)	Nursing (Émployee protectors on the ui resident, and that the The facility staff was urveyor Resident is stated that Residen apron that had bee manufacturer's inst protector read, "Adheavy domestic term."	med with the Director of A) that the brown clothing nit were used for every ney were not smoking aprons. s not able to show the #1's smoking apron. The DON at #1 had a gray smoking In discarded. The ructions for the brown clothing full Clothing Protector. Made of try cloth. 50/50 cotton polyester g protector was not fire					1 m/m 14*	

4	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495337	B, WING	. WING		02/1	 3/2019
NAME OF F	PROVIDER OR SUPPLIER	100007			TREET ADDRESS, CITY, STATE, ZIP CODE	1 02/	13/2019
LEEWOOD HEALTHCARE CENTER					120 BRADDOCK ROAD NNANDALE, VA 22003	- 1900	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 17	F	689	Λ	11	
	email at the reques (Employee C), who during the survey. I 2/14/19. It read, "Or took (Resident #1) courtyard so he car cigarettes. As usua over him first as I si finished the first wh trashed into the cigsecond one too. As and blankets were	statement was submitted via t of the Facility Administrator was not present in the facility The third statement was dated in 2/5/19 at around 8:30 pm, I of room 170 out in the in have his routine smoke of I I put on his smoking apronated and watch. After he ich I gave, the half was arette (ashtray) and so for the always sure that the apronated put him in his bed and get			i v	y v	
		g with him for three years and t with smoking routine and the regards that.					
	working for the Stal me some questions took placed on 2/5/ Dogwood evening s about the type and [Resident # 1] when the above mentions	yed a call from somebody the board and wanted to ask a about the fire accident that 19 whilst I was working at shift. I was asked specifically color apron I used on 1 took him out to smoke on ed date, and my reply was, his the usually use for smoking, the color."					
	#1's clinical record, Activities care plan buys cigarettes, alc outings and refuses	w was conducted of Resident revealing a 4 year old dated 7/8/15. It read, "Often ohol and lighters when on to allow the activity aide to selighters and cigarettes in his	,				* ************************************

	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		495337	B. WING		02	/13/2019
	PROVIDER OR SUPPLIER OD HEALTHCARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003		
(X4) ID PREFIX TAG			ID PREFIX TAG		ULD 8E	(X5) COMPLETION DATE
F 689	gloves and become staff request to lock Resident #1's care safety again until af on 2/5/19. The curr brought some ashe some parts of his b for cigarettes and li on one sitter provid progress notes, Resupervision until 2/8 documentation in the on one supervision	es aggressive when facility them up for his safety." plan did not address smoking iter the fire in his bed occurred ent care plan read, "Resident is to the room and burned ed. Monitoring and searches ghter. Verbal reminders. One ed." According to the sident #1 had one on one 8/19. There was no be progress notes that the one had been discontinued. The occument the discontinuance of	F6	889		
	signed physician's of with staff 2 times in evening." Resident #1's clinic Safe Smoking Need read, "Apply Smoking The facility Smoking Inc.	g Policy, dated 10/3/17 read,				
	the direct supervision member or volunted provided throughou residents who smol admission, quarterly conditions warrants Examples of equipment and assistive devices	P.M. the Director of Nursing	- 40 - 27			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I CONTROL OF THE PROPERTY OF T		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495337				C 02/13/2019	
	PROVIDER OR SUPPLIER DD HEALTHCARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7120 BRADDOCK ROAD ANNANDALE, VA 22003			
(X4) ID PREFIX TAG	REFIX LEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX LEACH CORRECTIVE ACTION SHOULD			JLD BE	(X5) COMPLETION DATE		
		en de la companya de				of the	
4.		3 Ta	*1-	444		- · ·	