April 13, 2019

VIA FAX AND OVERNIGHT MAIL

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

APR 1 6 2019 VDH/OLC

Dear Mrs. Weigel-Delano:

RE: Belvoir Woods Health Care Center at The Fairfax Provider Number 495197

Please find the Plan of Correction (POC) for Belvoir Woods Health Care Center at the Fairfax. The unannounced survey conducted by the Department of Health's Office of Licensure and Certification ended on March 28, 2019.

The POC addresses each of the alleged deficiencies cited in the Statement of Deficiencies, which accompanied your letter dated April 4, 2019. Belvoir Woods Health Care Center at the Fairfax has taken specific measures to ensure that the alleged deficiencies have been addressed and that measures have been enacted to ensure that such circumstances do not occur.

Accordingly, this letter constitutes our credible allegation of compliance with Medicare and Medicaid program requirements. Belvoir Woods Health Care Center at The Fairfax will complete implementation of the enclosed POC as of May 10th, 2019.

Thank you for your support of Belvoir Woods Health Care Center at the Fairfax. The professionalism and courtesy shown by the surveyors during our recent survey was recognized by my team and very much appreciated. Please extend my appreciation on behalf of the residents, families and team members.

Should you need to contact me, please do so via email Christine.Piracci@sunriseseniorliving.com or by calling 703-781-2402.

Respectfully,

Christine Piracci, MSW, LNHA

Administrator

PRINTED: 04/04/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495197	B. WNG		C 03/28/2019
	ROVIDER OR SUPPLIER	E CENTER AT THE FAIRFAX	9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 000	An unannounced Esurvey was conduct 03/28/19. The facilic compliance with 42 Requirement for Lo INITIAL COMMENT An unannounced Marvey was conduct 03/28/19. Three conduct 03/28/19. Three conduct 03/28/19 is a the time of the survey with 42 Term Care requireman survey/report will for the census in this 5 at the time of the survey.	ng-Term Care Facilities. S dedicare/Medicaid standard ed 03/26/19 through emplaints were investigated Corrections are required for CFR Part 483 Federal Long ments. The Life Safety Code	F 000		
F 623 SS=D	closed record review Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility transident, the facility (i) Notify the resident representative(s) of the reasons for the language and mann facility must send a representative of the Long-Term Care On (ii) Record the reasons discharge in the rest accordance with parand	es Before Transfer/Discharge b)-(6)(8) be before transfer. sfers or discharges a must- at and the resident's the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a e Office of the State	F 623	With respect to the specific observation cite On 3/28/19, the Administrator (ASM #1) pro evidence that the Ombudsman was notified 3/27/19 of resident #13's transfer to the hos On 3/28/19, ASM #1, Administrator provide evidence that the Ombudsman was notified 3/27/19 of resident #19's transfer to the hos RECEIVED APR 16 2019 VDH/OLC	ovided I on spital. d

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

TITLE

(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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICAR	E & MEDICAID SERVICES	*	OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			C
	495197	B WNG	02/20/2010

•	495197	B. WING		03/28/2019
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
(c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be repetited by the safety of inches and this section; (B) The health of inches endangered, und this section; (C) The resident's heallow a more immedunder paragraph (c) (D) An immediate the required by the resident has redays. §483.15(c)(5) Contention of the effective data (iii) The effective data (iii) The location to the transferred or disches (iv) A statement of the including the name, and telephone number the province of the control of	this section. Ig of the notice. Ig of the notice of transfer or under this section must be at least 30 days before the least as soon as practicable is charge when-dividuals in the facility would ler paragraph (c)(1)(i)(C) of least the improves sufficiently to diate transfer or discharge, Ig of this section; Ig of this section; Ig of this section; Ig of the notice. The written learning the notice. The written learning the notice of transfer or discharge; Ig of trans	F 623	With respect to how the facility will identify reside with the potential for the identified concern and to corrective action: An audit of transfers and discharges for resident transferred or discharged from the facility during 30 days prior to the end of the survey will be conducted by May 10, 2019 by the Health Inform Coordinator or designee. Issues identified will be resolved: a notice will be to a representative of the Office of the State Lon Term Care Ombudsman by the Health Informatic Coordinator or designee. With respect to what systemic measures have be put in place to address the stated concern: Refresher training conducted by the Administrat Notice Requirements Before Transfer/Discharge commenced. Training of admissions staff, nurse social worker(s) and the health information office be completed by the Administrator or designee of 5/10/19. Over the next three months, transfers/discharges will be audited by the Health Informatic Coordinator or designee to confirm that resident the resident's representative(s) are notified of the transfer or discharge and the reasons for the min writing and in a language and manner they understand. The Audit will include confirmation that the facilities ent a copy of the notice to a representative of the Office of the State Long Term Care Ombudsman The Audit will include confirmation that the residence of the State Long Term Care Ombudsman The Audit will include a record of the reasons the transfer or discharge. The findings of the audits will be reviewed at Que Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the timonths, the QAPI committee will re-evaluate an initiate necessary action or extend the review permitted in the review permitted will review permitted revie	s the nation sent gon 5/10/2019 or on e has er will by stion s and e bye, the n. ent's for nality nree nd

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completing the form and submitting the appeal

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CENTER	S FOR WEDICARE	& MEDICAID SERVICES				. 0000-000
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION		SURVEY LETED
		495197	B. WING			28/2019
	PROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	91	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIE	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	(X5) COMPLETION DATE
F 623	hearing request; (v) The name, addr telephone number of Long-Term Care Or (vi) For nursing fact and developmental disabilities, the mai telephone number of the protection and a developmental disa C of the Developmental and Bill of Rights Ac codified at 42 U.S.C (vii) For nursing fact disorder or related email address and agency responsible advocacy of individ established under to for Mentally III Indivi- §483.15(c)(6) Chart If the information in effecting the transfer must update the recast practicable once becomes available. §483.15(c)(8) Notice In the case of facilit the administrator of written notification p to the State Survey State Long-Term Ca the facility, and the well as the plan for	less (mailing and email) and of the Office of the State inbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with abilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, C. 15001 et seq.); and illity residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy iduals Act.	F 623	With respect to how the plan of corrective will be monitored: The Executive Director and/or Administrat responsible for confirming implementation ongoing compliance with the components Plan of Correction, addressing, and resolv variances that may occur. The Executive Director and/or Administrat responsible for confirming the status of this of Correction is reviewed and discussed a meetings and action initiated if required.	or are and of this ring or are s Plan	5/10/2019

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Facility ID: VA0028

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STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495197	B. WING		03/28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160	ET ADDRESS, CITY, STATE, ZIP CODE BELVOIR WOODS PKWY T BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
F 623	This REQUIREME by: Based on staff int review, and clinical determined that far written notification the ombudsman, to resident's represe the survey sample 1. The facility staff ombudsman and president's represe the resident was to 02/09/19. 2. The facility staff when Resident # 16 hospital on 02/02/ The findings include 1. The facility staff ombudsman and president's represe the resident was to 02/09/19. Resident # 13 was 07/20/15 and a re- diagnoses that income	enterview, facility document all record review, it was acility staff failed to provide a of a facility initiated transfer to the resident and/or the intative for two of 30 residents in a Residents # 13 and # 19. If failed to notify the provide Resident # 13 or the intative written notification when ransferred to the hospital on the intative written are failed to notify the orbidation when ransferred to the hospital on the intative written in the intative wr	F 623		
	set), a quarterly as (assessment refer Resident # 13 as s	ost recent MDS (minimum data assessment with an ARD ence date) of 01/22/19, coded scoring a 4 (four) on the brief al status (BIMS) of a score of 0			

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495197	B. WING		03/28/2019
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			910	REET ADDRESS, CITY, STATE, ZIP CODE 50 BELVOIR WOODS PKWY DRT BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICE (CROSS-REFERENCE)	D BE COMPLETION
F 623	- 15, 4 (four) - beil cognition for maki 13 was coded as	page 4 Ing severely impaired of any daily decisions. Resident # being totally dependent of one activities of daily living.	F 623		
	for Resident # 13 around 6:45 pm (p came to writer that pass urine in the F writer assessed pr some distension in pain when abdom suprapubic cath (c BPH (benign prosidector) made awa ER (emergency re via (by) non-emergand came pickup	ress Notes," dated 02/09/2019 at 10:40 p.m. documented, "At p.m.) after dinner, resident wife ther husband has not [sic] Foley bag since breakfast. This total (patient), abdomen is big with noted. Pt c/o (complained of) en been palpated, pt has catheter) for dx (diagnosis) of tatic hyperplasia). MD (medical re, new order to transfer pt to pom) to eval (evaluate) and treat gence. (Name of Transport) call resident at about 8:45 PM wen to ER nurse (Name of			
	for Resident # 13 documented, "Resident (2:00 a.m.) from (I (French) pubic cather centimeters) balloothis hour. Resident distress observed cefixime 400 mg ((capsule) po (by not tract infection) x (the discontinue Trimet cefixime and result therapy. Denies p	ress Notes," dated 02/10/2019 at 02:31 (2:31 a.m.) sident returned to unit at 0200 Name of Hospital) with an 18 From theter with 10cc (cubic on in place and draining well at an appears comfortable with no at this hour. New order for milligrams) 1 (one) cap mouth) daily for UTI (urinary imes) 10 days and to thoprim while resident is [sic] no me post ABT (antibiotic) atin, no distress observed.			
	The facility's "Tran	sfer / Discharge Summary -V2"			45 me 31

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495197	B. WING		03/28/2019		
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE		
F 623	form for Resident # 02/09/2019 22:25 (Signature/Acknowle below indicates that reviewed with me in my questions answ medication list or phave been notified dispensed in contain Review of the head Receiving Instruction Resident/Guest" and they were left blank On 03/27/19 at appoint the end of the day in (administrative staff a request was mad ombudsman was not ransfer to the hospital of the mospital of the mospit	in 13 with the "Effective Date: 10:58 p.m.)" documented, "F. edgement. My signature it Discharge Instructions were in a language I understand and ered. I have received the rescriptions identified and of any medication(s) inters that are not child-proof." lings "1. Signature of Person ons, 2. Relationship to old 3."Date Signed" revealed in the signed of the signed	F 623				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OND NO. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A TOTAL CONTRACTOR AND	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495197	B. WING		03/28/2019
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			9160	EET ADDRESS, CITY, STATE, ZIP CODE BELVOIR WOODS PKWY RT BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 623	ASM # 1 stated, "It i form." After reviewing Summary -V2" form "Effective Date: 02/0 ASM # 1 was asked complete. ASM # 1 there was evidence resident's responsible transfer on 02/09/19. The facility's policy 'Hold Notices' docur services coordinator following steps beford discharges a resident a. Notify the resident member or legal repetite transfer or discharges a resident a. Notify the resident move, in writing, in a understand." On 03/28/19 at appreciation of the formation o	s documented on the transfering the "Transfer / Discharge for Resident # 13 with the 19/2019 22:25 (10:58 p.m.)" if section "F" of the form was stated no. When asked if that, the resident or the leparty was notified of the party was notified as a language will complete the party that and, if known, a family presentative of the resident of the party was not the party was not party was not party was not party was provided prior to exit. In plegia, Palsy, Paraplegia, party was provided prior to exit. In plegia, Palsy, Paraplegia, party was provided prior to exit. In plegia, Palsy, Paraplegia, party was provided prior to exit. In plegia, Palsy, Paraplegia, party was provided prior to exit. In plegia, Palsy, Paraplegia, party was provided prior to exit. In plegia, Palsy, Paraplegia, party was provided prior to exit. In plegia, Palsy, Paraplegia, party was party was provided prior to exit. In plegia, Palsy, Paraplegia, party was party w	F 623		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495197	B. WING _			C 3/28/2019	
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060					
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	(2) An enlarged p obtained from the https://www.nlm.n statebph.html. (3) Low iron. This the website: https://www.nlm.n obtained from the https://www.nlm.n essure.html. (4) High blood preobtained from the https://www.nlm.n essure.html. 2. The facility staf when Resident # 19 wa 03/16/16 and a rediagnoses that inchemiplegia (1), pedepressive disord (4). Resident # 19's m set), a 5-day asse (assessment reference Resident # 19 as interview for mention 15, 15 - being or decisions. Reside extensive assistal activities of daily in the nurse's "Prog 03:25 (3:25 a.m.)	rostate. This information was website: hih.gov/medlineplus/enlargedpro information was obtained from hih.gov/medlineplus/anemia.html essure. This information was website: hih.gov/medlineplus/highbloodpr If failed to notify the ombudsman 19 was transferred to the 19. Is admitted to the facility on e-admission on 02/05/19 with cluded but were not limited to: eripheral vascular disease (2), ler (3) and syncope and collapse host recent MDS (minimum data essment with an ARD rence date) of 02/12/19, coded scoring a 15 on the brief tal status (BIMS) of a score of 0 orgitively intact for making daily ent # 19 was coded as requiring nce of one staff member for	Fé	523			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY PLETED	
		495197	B. WING			C /28/2019	
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	pressure applied to applied to open ar send to ER (emento (Name of Hospobservation and The nurse's "Prog 21:45 (9:45 p.m.) (Resident # 19) ar via ambulance fro accompanied by home of the day (administrative states a request was man ombudsman was transfer to the hose of the day (March 27, 2019 at conducted RN (redirector of nursing (administrative states who is responsible at the time of a reserval on 103/28/19 at approvided a copy of the seconducted RN (redirector of nursing (administrative states who is responsible at the time of a reserval on 103/28/19 at approvided a copy of the seconducted RN (redirector of nursing (administrative states who is responsible at the time of a reserval on 103/28/19 at approvided a copy of the seconducted RN (redirector of nursing (administrative states) and the day before the day before the company of the seconducted RN (redirector of nursing (administrative states) and the day before the company of the seconducted RN (redirector of nursing (administrative states) and the day before the company of the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN (redirector of nursing (administrative states) and the seconducted RN	o bleeding site and dry dressing rea on back. Order obtained to gency room) and resident sent stall via (by) 911 for further ex (treatment)." Tress Notes," dated 02/05/19 at documented, "Resident Arrived: rived 2/5/19 at 4:15 pm (p.m.) m (Name of Hospital). He was assis wife." Proximately 5:25 p.m., during remeeting with ASM off member) # 1, administrator, de for evidence that the notified of Resident # 19's epital on 02/02/19. Proximately 8:30 a.m., ASM # 1 f a facsimile to the ombudsman dated "MAR -27 0827 PM at 8:27 p.m.)." 51 a.m., an interview was gistered nurse) # 2, acting and the administrator, ASM off member) # 1. When asked the for notifying the ombudsman sident's transfer to the hospital, the nurses or designee." When acsimile to the ombudsman for ed 3/27/19, ASM # 1 stated that sent after the request was	F 623				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495197	B. WING			C 3/28/2019	
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			STREET ADDRESS, CITY, STATE, ZIP O 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		0/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	References: (1) Also called: He Quadriplegia. Pair function in part of something goes we pass between you can be complete to both sides of your one area, or it carrinformation was on https://medlineplu. (2) The vascular shood vessels. It in capillaries that carries can beconcalled atherosclerivessels and block Weakened blood bleeding inside the obtained from the https://www.nlm.n. ases.html. (3) Depression mablue, unhappy, mit Most of us feel this short periods. Clindisorder in which for frustration interior more. This inforwebsite: https://medlineplu.	emiplegia, Palsy, Paraplegia, ralysis is the loss of muscle your body. It happens when were an and muscles. Paralysis or partial. It can occur on one or body. It can also occur in just a be widespread This betained from the website: s.gov/paralysis.html. Tystem is the body's network of includes the arteries, veins and try blood to and from the heart. The thick and stiff, a problem to be body. It can stiff, a problem to be seen and try blood to the heart or brain. The vessels can burst, causing the body.) This information was	F 62	23			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7410 0410		495197	A. BUILDING _ B. WING _		C 03/28/2019	
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	S 9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060	03/20/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
F 623 F 625 SS=D	https://www.nlm.nih 003092.htm. Notice of Bed Hold CFR(s): 483.15(d)(Policy Before/Upon Trnsfr	F 623	The Administrator or designee will send writte communication to residents #19 and #20 or the responsible parties informing them of the Bed	en neir Hold	
	§483.15(d)(1) Notice nursing facility transite resident goes on nursing facility must the resident or resident or resident or resident or the resident or resident or the duration of the any, during which the return and resume facility; (ii) The reserve beginn, under § 447.4 (iii) The nursing factors and periods, we paragraph (e)(1) of resident to return; as	ce before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the st provide written information to dent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing dipayment policy in the state 40 of this chapter, if any; cility's policies regarding which must be consistent with this section, permitting a		Policy before/Upon transfer as of their dates of transfer. With respect to how the facility will identify reswith the potential to be affected by the identification and take corrective action: An audit of residents transferred from the facility during the 30 days prior to the survey end dath be conducted by 5/10/19 by the Health Inform Coordinator or designee to confirm residents or responsible parties were informed of the Bed policy before/upon transfer as of their dates of transfer. Issues identified will be resolved for current rethe Bed Hold Policy will be sent to current resident their responsible parties	sidents 5/10/2019 ity e will action or their Hold f	
	§483.15(d)(2) Bed- the time of transfer hospitalization or tr facility must provide resident representa specifies the durati- described in paragr This REQUIREMED by: Based on resident facility document re-	hold notice upon transfer. At of a resident for nerapeutic leave, a nursing to to the resident and the ative written notice which on of the bed-hold policy raph (d)(1) of this section. NT is not met as evidenced interview, staff interview, eview, and clinical record ramined that facility staff failed		With respect to what systemic measures have put in place to address the stated concern: Refresher training on Bed Hold Policy Before. Transfer for admissions staff, nurses, social wand the health information officer has comme and will be completed by the Administrator or designee by 5/10/19. Over the next three months, transfers and be notifications will be audited by the Health Info Coordinator or designee. The findings from the will be reviewed at the Quality Assurance / Performance Improvement (QAPI) meetings. During and at the conclusion of the three mor the QAPI committee will re-evaluate and initial necessary action or extend the review period.	/Upon worker(s) inced d hold rmation ne audits	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING _			C
	495197	B. WING			28/2019
	RE CENTER AT THE FAIRFAX	91	60 BELVOIR WOODS PKWY	DE	
(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
to provide a bed heresident's represent hospital for two of sample, Residents 1. The facility staff 19 or the resident's notification of the bresident was trans 02/02/19. 2. The facility staff bed hold policy to at the time of trans The findings included the findings included the staff 19 or the resident's notification of the bresident was trans 02/02/19. Resident # 19 was 03/16/16 and a readiagnoses that inchemiplegia (1), per depressive disorder collapse (4). Resident # 19's meset), a 5-day asses (assessment references interview for mental staff and the series of	old policy to the resident or the intative upon transfer to the 30 residents in the survey is # 19 and # 20. If failed to provide Resident # is representative written bed hold policy when the ferred to the hospital on failed to send a copy of the the hospital with Resident #20, is fer on 01/16/2019. It failed to provide Resident # is representative written bed hold policy when the ferred to the hospital on failed to the hospital on is admitted to the hospital on admitted to the facility on admitted on 02/05/19, with luded but were not limited to: ripheral vascular disease (2), is recent MDS (minimum data is sment with an ARD ence date) of 02/12/19, coded acoring a 15 on the briefical status (BIMS) of a score of 0	F 625	With respect to how the plan of c will be monitored: The Executive Director and/or Ac responsible for confirming implem ongoing compliance with the com Plan of Correction, addressing, a variances that may occur. The Executive Director and/or Ac responsible for confirming the state Correction is reviewed and discussions.	orrective measures Iministrator are nentation and oponents of this nd resolving Iministrator are tutus of this Plan of ssed at QAPI	5/10/2019
	ROVIDER OR SUPPLIER WOODS HEALTH CA SUMMARY (EACH DEFICIE REGULATORY) Continued From p to provide a bed h resident's represel hospital for two of sample, Residents 1. The facility staff 19 or the resident' notification of the h resident was trans 02/02/19. 2. The facility staff bed hold policy to at the time of trans The findings include 1. The facility staff 19 or the resident's notification of the h resident was trans 02/02/19. Resident # 19 was 03/16/16 and a rea diagnoses that inchemiplegia (1), per depressive disorder collapse (4). Resident # 19's me set), a 5-day asses (assessment references) Resident # 19 as s interview for mental - 15, 15 - being col decisions. Reside extensive assistant	A95197 ROVIDER OR SUPPLIER WOODS HEALTH CARE CENTER AT THE FAIRFAX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 to provide a bed hold policy to the resident or the resident's representative upon transfer to the hospital for two of 30 residents in the survey sample, Residents # 19 and # 20. 1. The facility staff failed to provide Resident # 19 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 02/02/19. 2. The facility staff failed to send a copy of the bed hold policy to the hospital with Resident #20, at the time of transfer on 01/16/2019. The findings include: 1. The facility staff failed to provide Resident # 19 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 02/02/19. Resident # 19 was admitted to provide Resident # 19 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 02/02/19. Resident # 19 was admitted to the facility on 03/16/16 and a readmitted on 02/05/19, with diagnoses that included but were not limited to: hemiplegia (1), peripheral vascular disease (2), depressive disorder (3), and syncope and	CORRECTION (X1) PROVIDER SUPPLIER (X2) MULTIPLE A BUILDING B. WING B.	ASTRECT ADDRESS, CITY, STATE, ZIP COUNTING BELLOING ROWIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 to provide a bed hold policy to the resident or the resident's representative upon transfer to the hospital for two of 30 residents in the survey sample, Resident's 19 and # 20. 1. The facility staff failed to provide Resident # 19 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 02/02/19. 2. The facility staff failed to send a copy of the bed hold policy to the hospital with Resident #20, at the time of transfer on 01/16/2019. The findings include: 1. The facility staff failed to provide Resident # 19 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 02/02/19. Resident # 19 was admitted to the facility on 03/16/16 and a readmitted on 02/05/19, with diagnoses that included but were not limited to: hermiplegia (1), peripheral vascular disease (2), depressive disorder (3), and syncope and collapse (4). Resident # 19's most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 02/12/19, coded Resident # 19 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 19 was coded as requiring extensive assistance of one staff member for	DESCRICENCIES CORRECTION (X1) PROVIDER SUPPLIER (X2) MULTIPLE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, 2IP CODE 9169 BELVOIR WOODS PRWY FORT BELVOIR, VIA 23660 SUMMARY STATEMENT OF DESTORMOIS REGULATORY OR LS CIENTEYING INFORMATION) Continued From page 11 to provide a bed hold policy to the resident or the resident's representative upon transfer to the hospital for two of 30 residents in the survey sample, Resident #1 9 and #2 0. 1. The facility staff failed to provide Resident #1 19 or the resident vas transferred to the hospital on C07/207/19. 2. The facility staff failed to send a copy of the bed hold policy to the hospital on C07/207/19. The findings include: 1. The facility staff failed to provide Resident #1 19 or the resident was transferred to the hospital on C07/207/19. The findings include: 1. The facility staff failed to provide Resident #1 19 or the resident was transferred to the hospital on C07/207/19. The findings include: 1. The facility staff failed to provide Resident #1 19 or the resident was transferred to the hospital on C07/207/19. The findings include: 1. The facility staff failed to provide Resident #1 19 or the resident was transferred to the hospital on C07/207/19. Resident #1 9 was admitted on C07/207/19, with diagnoses that included but were not limited to hemiplegia (1), peripheral vascular disease (2), depressive disorder (3), and synoope and collapse (4). Resident #19's most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of C07/12/19, coded Resident #19 as scoring a 15 on the biref interview for mental status (BIMS) of a score of 0 -15, 15 - being cognitively intact for making daily decisions. Resident #19 was coded as requiring extensive assistance of one staff member for

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		495197	B. WNG			3/28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CO 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		0/20/20 10
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 625	O3:25 (3:25 a.m.) of Action/Intervention pressure applied to applied to open are send to ER (emerge to (Name of Hospirobservation and Transfer to (Passident # 19) and via ambulance from accompanied by hose to the clinification of the clinif	ress Notes," dated 02/02/19 at documented, "Event: Fall. Resident was assessed, be bleeding site and dry dressing ea on back. Order obtained to gency room) and resident sent tal) via (by) 911 for further of (treatment)." Ress Notes," dated 02/05/19 at documented, "Resident Arrived: rived 2/5/19 at 4:15 pm (p.m.) m (Name of Hospital). He was its wife." Cal record for Resident # 19 documentation that a bed hold do to the resident or the entative upon transfer to the lip. If a.m., an interview was gistered nurse) # 2, acting and the administrator, ASM off member) # 1. When asked locess for providing a copy of bold policy at the time of a lated, ""It is the responsibility of and if they are not available the to a designee, which may be asked if a bed hold policy was ent # 19 or their representative after on 02/02/19, ASM # 1	F 62	5		
	Hold Notices" doc	"Transfer, Discharge & Bed umented, "3. The SSC (social pr)/designee will provide written				

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		495197	B. WING		C 03/28/2019	
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160	EET ADDRESS, CITY, STATE, ZIP CODE BELVOIR WOODS PKWY T BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM	(X5) MPLETION DATE
F 625	information to the legal representative of a hospital or for a Discharge, Transtat includes: a. Toolicy under the Sthe resident is per residence in the copayment policy in community's policibed-hold." On 03/28/19 at approximation (administrative standard administrative	resident, family member or we before transfer of a resident of the therapeutic leave, consisting of asfer & Bed Hold Notice Policy the duration of the bed-hold state plan, if any, during which mitted to return and resume community. B. The reserve bed the state plan, if any, c. The ites on the duration of the approximately 3:00 p.m. ASM aff member) # 1, the amade aware of the findings. Attion was provided prior to exit. The interpretation of the amade aware of the findings. The interpretation of the amade aware of the findings. The interpretation of the amade aware of the findings. The interpretation of the amade aware of the findings. The interpretation of the amade aware of the findings. The interpretation of the amade aware of the findings. The interpretation of the state of the interpretation of the website: The widespread. This interpretation of the interpretation of the website: The system is the body's network of includes the arteries, veins and the interpretation of the heart. The system is the body's network of includes the arteries, veins and the interpretation of the heart. The system is the body's network of includes the arteries, veins and the interpretation of the heart. The interpretation of the heart of brain. The interpretation of the bed interpretation of the heart of brain. The interpretation of the bed interpretation of the heart of brain. The interpretation of the bed interpretation of the heart of brain. The interpretation of the bed interpretation of the interpretation of the interpretation of the bed interpretati	F 625			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY MPLETED
		495197	B. WING		0	3/28/2019
1. 4.16	ROVIDER OR SUPPLIER WOODS HEALTH CAR	RE CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CO 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 625	https://www.nlm.nihases.html. (3) Depression may blue, unhappy, mis Most of us feel this short periods. Clinidisorder in which feor frustration interfeor more. This inforwebsite: https://medlineplus (4) Fainting. This in the website: https://medlineplus (4) Fainting. This in the website: https://www.nlm.nih003092.htm. 2. The facility staff bed hold policy to that the time of transfer the time of the time of transfer the t	n.gov/medlineplus/vasculardise y be described as feeling sad, erable, or down in the dumps. way at one time or another for ical depression is a mood eelings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the .gov/ency/article/003213.htm. information was obtained from in.gov/medlineplus/ency/article/ failed to send a copy of the the hospital with Resident #20, fer on 01/16/2019. admitted to the facility on ost recent readmission to the	F 62	25		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	STRE 9160	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 625	4:34a.m: "Transfer/Discharg Reason for Transfer resident need(s) the alert and verbally laying on her left is Bedside table also Upon assessment noted with c/o (con ROM (range of months checks initiated. Months (responsible party resident was transfer NAME)) for evaluate attempts to meet the attempted interver Resident transfer meet resident need Discharge Plan increceiving facility: [Family/Physician receiving facility: [Family/Physician receiv	ge - Unable to Meet Needs er/Discharge indicate specific nat cannot be met: Resident is responsive to care, was noted ide on the floor calling for help. on floor partially over resident. , deformity of the right leg was mplaint of) pain and limited otion). Neuro (neurological) ID (medical doctor) and RP) notified. 911 called and efferred to ER. ([HOSPITAL tition and Tx (treatment). Facility the resident need(s) - include all ntions: Neuro checks initiated. ed to Hospital due to unable to ds at this time clude services available at HOSPITAL NAME] notification and new orders: on call [MD NAME] Additional	F 625		

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SIAIEMENT OF DEFICIENCIES IXI FROMDER/SOFFEIE/OCEA		(X3) DATE SURVEY COMPLETED			
		495197	B. WNG		C 03/28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	91	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICI	Y 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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 625	the responsibility f be the nurse." Wh was provided to R representative at t 01/16/2019, ASM	falls to a designee, which may nen asked if a bed hold policy esident #20 or their the time of transfer on #1 stated, "No."	F 625		
F 656 SS=D	S483.21(b) Composition S483.21(b) (1) The implement a composite plan for each resident rights set	rehensive Care Plans facility must develop and brehensive person-centered resident, consistent with the forth at §483.10(c)(2) and	F 656	With respect to the specific observation cited Resident # 146 transferred to the hospital on 3/17/18 and did not return to the facility	
	objectives and timmedical, nursing, needs that are ide assessment. The describe the follow (i) The services the or maintain the resphysical, mental, a required under §48(ii) Any services the under §483.24, §4 provided due to the under §483.10, increatment under §4(iii) Any specialize rehabilitative services are a result recommendations findings of the PAS rationale in the reseiv) In consultation resident's represeit	at are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and att would otherwise be required 83.25 or §483.40 but are not be resident's exercise of rights cluding the right to refuse 483.10(c)(6). If a services or specialized ces the nursing facility will be of PASARR. If a facility disagrees with the SARR, it must indicate its sident's medical record. With the resident and the intative(s)-goals for admission and		With respect to how the facility will identify re with the potential to be affected by the identificancem and take corrective action: An audit was initiated by the Acting DNS of rwith PRN (as needed) pain medications to clonfirm orders. Issues identified were addressed and resolve Nursing Team. The care plans for Residents experiencing pand/or Resident experiencing falls will be auby the DNS or designee to confirm the care paddressed pain, including individualized interlessues identified will be resolved: care plans updated and communicated to the Nursing Tthrough daily communication venues.	residents arify and ed by the ain dited plans rventions. will be

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		(X3) DATE :				
		495197	B. WNG		03/2	28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	(B) The resident's future discharge. I whether the reside community was as local contact agerentities, for this put (C) Discharge plan plan, as appropriate requirements set is section. This REQUIREMED by: Based on staff intreview, and clinicate course of a comple determined that the implement the corof 30 residents in 146. The facility staff far #146's compreher administration of a medication for corresident's fall with The findings included the second contact of the contact of t	preference and potential for Facilities must document ent's desire to return to the assessed and any referrals to notice and/or other appropriate urpose. In the comprehensive care ate, in accordance with the forth in paragraph (c) of this sent in the accordance with the forth in paragraph (c) of this sent in accordance with the forth in paragraph (c) of this sent in paragraph (d) of this sent in the accordance with the accordance with the forth in paragraph (d) of this sent in paragraph (e) of this sent in paragraph (c) of this sent in the accordance with the factor of the accordance with the sent in the sent i	F 656	With respect to what systemic measures had place to address the stated concern. Refresher training for nursing staff on deve implementing comprehensive care plans, for administration of a PRN (as needed) pain in for complaints of pain, has commenced. To completed by the Director of Nursing or her 5/10/19. Over the next three months, care plans for of PRN (as needed) pain medication, and for pain, will be audited by the Director of Notice confirm that pain is addressed. The findings from the audits will be reviewed Assurance / Performance Improvement (Quering and at the conclusion of the three measurance in the review period. With respect to how the plan of corrective monitored: The findings from the audits will be reviewed Assurance / Performance Improvement (Quering and at the conclusion of the three in QAPI committee will re-evaluate and initiate action or extend the review period. The Executive Director and/or Administrate for confirming implementation and ongoing the components of this Plan of Correction, resolving variances that may occur. The Executive Director and/or Administrate for confirming the status of this Plan of Correviewed and discussed at QAPI meetings initiated if required.	loping and or the medication, raining will be r designee by the administration or complaints ursing or designee ad at the Quality API) meetings. It is a sample of the the Quality API) meetings are sample or are responsible or are responsible rection is	

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Event ID: HHHN1

Facility ID: VA002

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		E SURVEY IPLETED
		495197	B. WING		03	C 8/28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Resident # 146's " 03/17/2018 docum Person and Place. The POS (physicia 146 dated "03/01/2 the following: - "Aspirin EC (ente [5] Tablet Delayed Give 1 (one) table: pain. Start Date: (0 - "Gabapentin [6] () (Three) capsules to Start Date: 03/13/2 - "Oxycontin ER (e) MG. Give 1 tablet Order Date: 03/13/2 - "Tylenol [8] Extra (Acetaminophen). three times a day: 03/13/2018. Start - "Oxycodone [7] To tablet by mouth ev pain. May take 1-2 Date: 03/13/2018. The eMAR (electrorecord) for Resider 2018 documented Review of the eMA Resident # 146 recomedications on 03 a.m., Oxycontin 20 Tylenol 1000 mg amg at 3:47 a.m. ar of the eMAR revea	Post Fall Assessment" dated hented, "Alert. Orientated to " an's order sheet) for Resident # 2018 - 03/31/2-18" documented eric coated) [delayed release] Release 81 MG (milligram). It by mouth one time a day for 03/13/2018." Capsule 300 MG. Give 3 by mouth at bedtime for pain.	F 656			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION		TE SURVEY MPLETED
		495197	B. WNG			3/28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	91	REET ADDRESS, CITY, STATE, ZIP CO 60 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	The comprehensidated 03/14/2018 resident has chron 03/14/2018. Undedocumented, "Adi (medical doctor) of shift. Date Initiated The facility's "Safe Resident Evaluati dated 03/1/3/18 dispersive weight on bears weight of the facility's "Fall Resident # 146 da documented, "Act Under "Resident I like voiding before balance and fell." immediately after assessed for pain to always call for I The nurse's "Prograted 03/17/2018 "Writer was on the screaming for help the floor on her rignoted skin tear to (0.1 length by 0.1 0.5 (lower). Rang extremities. Residelbow and hip are aware of resident after falling order."	ve care plan for Resident # 146 , documented, "Focus: The nic pain. Date Initiated er "Interventions" it minister medication per MD orders, pain assessment every ed: 03/14/2018." Resident Movement Program on Form" for Resident # 146 ocumented, "Gait Belt. Resident ooth legs and sits independently. ansfers with physical assistance or "Comments" it documented, est (assistance)." Investigation Worksheet" for ated 03/17/18 at 1:15 p.m., ivity: "Unassisted transfer." interview:" it documented, "I felt et therapy, I think I could it, lost Under "Interventions fall" it documented, "Resident treatment done to skin. Advise	F 656			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		TE SURVEY MPLETED
		495197	B. WING		0	C 3/28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Resident left facili stretcher alert and accompanied by of the facility's "PT (Treatment Note" with member) # 7, phy 03/17/2018 document on the floor in the having been seen for proper safety signature (transfer). Pt had help from staff, us standing at the sir OT had been award advised pt against PTA (physical their with with the with	ty at 1720 (5:20 p.m.) via (by) I oriented x (times) 3 (three),	F 656			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI	NSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/28/2019	
		495197	B. WING			
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160	ET ADDRESS, CITY, STATE, ZIP COL BELVOIR WOODS PKWY T BELVOIR, VA 22060	DE.	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLI	LETION
F 656	Resident # 146 ar fall, RN # 4 stated on scheduled pair above documented did not receive the 6:00 a.m., before An attempt to intermember) # 7, phy unsuccessful due longer employed of the conducted with RI When asked about resident has a fall they are having a stated, "I would git the physician's or medication. It shourse's progress of a resident with LF regarding care plate the purpose of a resident." When a documented on the LPN # 3 stated, "No comprehensive care documents to adn and a PRN pain in when a resident should be a paid and a paid a	ny pain medication following the I, "No because she was already in medication." (*Note the MAR and Resident #146 refused and a scheduled pain medication at ther fall). Inview OSM (other staff sical therapy assistant was to the fact that he was no with the facility. OS p.m., an interview was N # 2, acting director of nursing. In the process staff follow if a land is cognitively intact stating then out of ten for pain, RN # 2 we pain medication based on ders for prn (as needed) pain build be documented in the	F 656			

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TION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		MPLETED C	
	495197	B. WING			3/28/2019	
OR SUPPLIER		9	160 BELVOIR WOODS PKWY		30/20/20	
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
ther informative intermediate the amount ation was oblive www.nlm.nih.4.htm. I condition in was poortion on the condition the body and	ion was provided prior to exit. cy se in which the body cannot at of sugar in the blood. This tained from the website: a.gov/medlineplus/ency/article/ which the heart is no longer able the blood to the rest of the body uses symptoms to occur y. This information was website: a.gov/ency/article/000158.htm. seure. This information was website:	F 656				
hould. This in absite: /medlineplus. escription aspoms of rheun alling of the liarthritis (arthring of the join of	agov/chronickidneydisease.htm Dirin is used to relieve the matoid arthritis (arthritis caused ning of the joints), itis caused by breakdown of the light of the					
	SUMMARY (EACH DEFICIE REGULATORY O ued From particle information in the information was obtained in the information in the in	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) LUCE From page 22 Istrator was made aware of the findings. There information was provided prior to exit. Laint deficiency Linces: Chronic disease in which the body cannot te the amount of sugar in the blood. This ation was obtained from the website: Lywww.nlm.nih.gov/medlineplus/ency/article/4.htm. Londition in which the heart is no longer able to poxygen-rich blood to the rest of the body ntly. This causes symptoms to occur hout the body. This information was the from the website: Lymedlineplus.gov/ency/article/000158.htm. Line blood pressure. This information was the from the website: Lywww.nlm.nih.gov/medlineplus/highbloodpres.html. Lineys are damaged and can't filter blood, as mould. This information was obtained from	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Lucd From page 22 Instrator was made aware of the findings. Ither information was provided prior to exit. In aint deficiency In an amount of sugar in the blood. This ation was obtained from the website: In a was obtained from the website: In a was obtained from the subsite: In a was obtained from the subsite: In a was obtained from the body cannot the tent amount of sugar in the blood. This ation was obtained from the website: In a was obtained from the website: In a was obtained from the subsite: In a was obtained from the subsite: In a was obtained from the subsite: In a was obtained from the website: In a w	STREET ADDRESS, CITY, STATE, ZIP 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA. 22060 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) USE FROM THE FROM THE FAIRFAX TAG PREFIX TAG F 656 F	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELLVOIR WOODS PKWY FORT BELLVOIR, VA 22060 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) LID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELLVOIR WOODS PKWY FORT BELLVOIR, VA 22060 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 F 656 STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELLVOIR WOODS PKWY FORT BELLVOIR, VA 22060 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 F 656 F 656 F 656 F 656 F 656 F 657 F 658 F	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495197	B. WING			C 3/28/2019
	ROVIDER OR SUPPLIER WOODS HEALTH CAR	E CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	pain and swelling) a rheumatologic condimmune system att. Nonprescription as and to relieve mild headaches, menstr toothaches, and maspirin is also used people who have angina (of the heart does not expected by the he		F 656			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING			С
		495197	B. WING		0:	3/28/2019
	ROVIDER OR SUPPLIER	ARE CENTER AT THE FAIRFAX	9160	ET ADDRESS, CITY, STATE, ZIP CODE BELVOIR WOODS PKWY T BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	discomfort in the I the legs, especial lying down). Gaba medications calle treats seizures by excitement in the pain of PHN by cl senses pain. It is gabapentin works This information whittps://medlineplu tml. (7) Oxycodone is severe pain. This the website: https://medlineplu tml. (8) Acetaminophe moderate pain fro menstrual periods toothaches, back vaccinations (sho Acetaminophen is analgesics (pain reducers). It work senses pain and information was of	legs and a strong urge to move ly at night and when sitting or apentin is in a class of d anticonvulsants. Gabapentin decreasing abnormal brain. Gabapentin relieves the hanging the way the body not known exactly how to treat restless legs syndrome. Was obtained from the website: Us.gov/druginfo/meds/a694007.h used to relieve moderate to sinformation was obtained from us.gov/druginfo/meds/a682132.h en is used to relieve mild to om headaches, muscle aches, s, colds and sore throats, aches, and reactions to ots), and to reduce fever. In a class of medications called relievers) and antipyretics (fever its by changing the way the body by cooling the body. This obtained from the website: us.gov/druginfo/meds/a681004.h	F 656			
	for children to he pain. Now the so	originally created with children lp them communicate about their cale is used around the world 3 and older, facilitating				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		
AND PLAN OF	CORRECTION					00/2040
NAME OF PE	ROVIDER OR SUPPLIER	495197	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	28/2019
BELVOIR	WOODS HEALTH CA	RE CENTER AT THE FAIRFAX		160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	communication an pain management information was of https://wongbaker	d improving assessment so can be addressed. This otained from the website: faces.org/.	F 656			
The second second	CFR(s): 483.21(b)		F 658	With respect to the specific observation cited: Resident # 146 transferred to the hospital on 3/17/did not return to the facility.	18 and	5/10/2019
	The services provi as outlined by the must- (i) Meet profession This REQUIREME by: Based on staff intreview, and clinical determined that the professional standaresidents in the sur The facility staff far physician orders for (1) and oxycodone	prehensive Care Plans ded or arranged by the facility, comprehensive care plan, and standards of quality. ENT is not met as evidenced erview, facility document all record review, it was e facility staff failed to follow ards of practice for one of 30 rvey sample, Resident #22. illed to clarify Resident #22's or pain medications of tramadol e (2) to determine which and should be administered based meters.		With respect to how the facility will identify residents with the potential to be affected by the identified concern and take corrective action: An audit is being initiated of current residents with PRN (as needed) pain medications by the Nursing Team. Orders containing PRN (as needed) pain medications are being reviewed with the medical provider by a Nurse and clarified to determine which medication and when medication should be administered based on pain level parameters. The care plans for residents experiencing pain were audited by the Resident Assessment Coordinator (RAC) or designee to confirm the care plans address pain, including individualized interventions. Issues identified are being resolved: care plans are being were updated and communicated to the Nursing Team through daily communication venues.		5/10/2019
	on 2/5/19 with a m 2/11/2019, with dia not limited to: Oste hypertension (5). Resident #22's mo set) an admission (assessment refere the resident as soo	initially admitted to the facility ost recent readmission on agnoses that included but were coarthritis (3), anemia (4), and st recent MDS (minimum dada assessment with an ARD ence date) of 2/18/19 coded oring a 15 on the brief interview BIMS) out of a score of zero		With respect to what systemic measures have been place to address the stated concern: Refresher training on following medication administ standards for administration of PRN pain medication commenced for nursing staff. Training will be computed by the Director of Nursing or designee by 5/10/19. Over the next three months, audits will be conducted DNS or designee of physician orders for PRN pain medications to confirm there is clarification regarding medication and when medication should be administated upon pain level parameters. Issues identified resolved, if needed. The findings from the audits will be reviewed at the Assurance / Performance Improvement (QAPI) medical puring and at the conclusion of the three months, the committee will re-evaluate and initiate necessary and extend the review period.	tration ons has pleted by the ong which stered of will be Quality etings.	5/10/2019

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(V2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		COMPLETED		
7 202		0	;	
B. WING		03/2	28/2019	
S	TREET ADDRESS, CITY, STATE, ZIP CODE			
F	A STATE OF THE STA			
PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
F 658	With respect to how the plan of corrective measur monitored: The Executive Director and/or Administrator are refor confirming implementation and ongoing complithe components of this Plan of Correction, address resolving variances that may occur. The Executive Director and/or Administrator are refor confirming the status of this Plan of Correction	esponsible ance with sing, and esponsible is reviewed	5/10/2019	
	A. BUILDING _ B. WING S 9 F ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) F 658 With respect to how the plan of corrective measure monitored: The Executive Director and/or Administrator are refor confirming implementation and ongoing complithe components of this Plan of Correction, address resolving variances that may occur. The Executive Director and/or Administrator are refor confirming the status of this Plan of Correction and discussed at QAPI meetings and action initiat	A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 658 With respect to how the plan of corrective measures will be monitored: The Executive Director and/or Administrator are responsible for confirming implementation and ongoing compliance with the components of this Plan of Correction, addressing, and resolving variances that may occur. The Executive Director and/or Administrator are responsible for confirming the status of this Plan of Correction is reviewed and discussed at QAPI meetings and action initiated	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495197 NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			(X2) MULTIPLE C	ONSTRUCTION		TE SURVEY MPLETED	
		495197	B. WING			03/28/2019	
			916	REET ADDRESS, CITY, STATE, ZIP O 0 BELVOIR WOODS PKWY RT BELVOIR, VA 22060	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	5mg 1 tablet pain On 2/13/19 [08:5mg 1 tablet for bout 10 On 2/13/19 [11:5mg 1 tablet left if On 2/13/19 [21:5mg 1 tablet left if On 2/13/19 [22:5mg 1 tablet left if On 2/16/19 [17:mg 1 tablet given On 2/17/19 [21:mg 1 tablet given On 2/14/19 [21:mg 1 tablet given On 3/20/19 [04:mg 1 tablet given On 3/20/19 [04:mg one tablet for scale five out of 1 On 3/27/19 at apinterview was cor #2, regarding the residents compla ask the resident fen, the pain local before I give then asked about the fadministering PR #2 stated, "I look determine what porder for before I asked how the stadminister if a residents order should be rated of parameters indicated the resident added the res	level was zero out 10 244] 8:44 a.m., oxycodone HCI oth legs pain for pain level five 331] 11:31 a.m., oxycodone HCI nip pain level zero out of 10 200] 9:00 p.m.; oxycodone HCI nip pain for pain level five out 10 253] 10:53 p.m., oxycodone HCI nip pain for pain level five out 10 254] 5.54 p.m., Tramadol HCI 50 for pain level zero out 10 254] 9:31 p.m., Tramadol HCI 50 pain level zero out 10 258] 9:48 p.m., Tramadol HCI 50 pain level zero out 10 267] 4:07 a.m.; tramadol HCI 50 general discomfort with a pain	F 658				

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			CIVID IVO. COCC CCC.	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D IMPIC		C	
		495197	B. WING	OSST ADDRESS SITY STATE TIP CODE	03/28/2019	
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 50 BELVOIR WOODS PKWY		
BELVOIR	WOODS HEALTH CAI	RE CENTER AT THE FAIRFAX		ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 658	cognitively intact repain medication the Resident #22's as should have param RN # 2 stated, "I we the order parameter medication." On 3/27/19 at 4:49 conducted with AS #2, regional director regarding the proceadministering as new #2 stated, "The ordex ample for mild parablet or for pain letablets." After revier orders for as needed documented above Resident #22's as and Tramadol order ASM #2 stated, "Ye the orders should he #22's case there we administer tramado On 3/28/19 at 8:52 conducted with RN #22's orders should stated, "Yes, the orders and the order should stated, "Yes, the order should	PRN #2 continued to state, "A esident will tell the nurse what ey desire." When asked if needed pain medication orders neters, RN #2 stated, "Yes." ill call the physician to clarify ers before giving the pain p.m., an interview was M (administrator staff member) or of resident care, RN, ess staff follows for eeded pain medications. ASM der should be written as an ain from one to five give one evel from five to ten give two ewing Resident #22's physician ed pain medication (as e), ASM #2 was asked if needed OxyContin Tablet ER ers should have parameter and have a parameter. In Resident as no distinction when to	F 658	DEFICIENCY)		
	procedures manual	the facility policies and ." eximately 10:30 a.m., the				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495197	B. WING		C 03/28/2019	
	ROVIDER OR SUPPLIER	E CENTER AT THE FAIRFAX	9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	03/13/18 with diagram not limited to: diabet (2), hypertension (3) (4). Review of the clinical comprehensive MDS Resident # 146 coull her discharge from the Resident # 146's "Pour 17/2018 docume Person and Place." The POS (physician 146 dated "03/01/20 the following: - "Aspirin EC (entering 15] Tablet Delayed Regive 1 (one) tablet the pain. Start Date: 03-13/20-10 "Gabapentin [6] Cate (Three) capsules by Start Date: 03/13/20-10 "Tylenol [8] Extra Start Date: 03/13/20-10 (Acetaminophen). Othere times a day for 03/13/2018. Start D-10 (Tablet by mouth ever 18 (Tablet by mouth ever 18 (Tablet by mouth ever 19 (Tabl	admitted to the facility on oses that included but were the mellitus (1), heart failure of and chronic kidney disease all record revealed a so (minimum data set) for do not be completed before the facility on 03/17/18. The facility on 03/17/18 oses Fall Assessment' dated anted, "Alert. Orientated to the original of the facility on 03/17/18 oses Fall Assessment' dated anted, "Alert. Orientated to the original of the original	F 697	With respect to what systemic measures have be place to address the stated concern: Refresher training regarding adhering to pain measures has commenced for nursing staff and completed by the Director of Nursing or her desis 5/10/19. Over the next three months, audits will be conducted by the Director of Nursing or her desis 5/10/19. Over the next three months, audits will be conducted by the Director and orders for pain medetermine which and when medication should be administered based upon pain level parameters. The findings from the audits will be reviewed at the Assurance / Performance Improvement (QAPI) the During and at the conclusion of the three months committee will re-evaluate and initiate necessary extend the review period. With respect to how the plan of corrective measurements of this Plan of Correction, addressed in the components of this Plan of Correction, addressed in the status of this Plan of Correction and discussed at QAPI meetings and action initial frequired.	edication d will be gnee by locted by the edications to e the Quality meetings. In action or location	5/10/2019

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		TE SURVEY MPLETED
		495197	B. WNG			C 3/28/2019
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX		ARE CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 697	2018 documented Review of the eM. Resident # 146 re medications on 03 a.m., Oxycontin 2 Tylenol 1000 mg at 3:47 a.m. at of the eMAR revereceive any more medication for the The comprehensidated 03/14/2018 resident has chror 03/14/2018. Under documented, "Adr (medical doctor) oshift. Date Initiate The facility's "Safe Resident Evaluation at the facility's "Safe Resident Evaluation at the facility's "Fall Resident # 146 dad documented, "Acti Under "Resident I like voiding before balance and fell." immediately after it is series of 1 (and the facility's "Fall Resident # 146 dad documented, "Acti Under "Resident I like voiding before balance and fell." immediately after it is series of 1 (and the facility's "Fall Resident I like voiding before balance and fell." immediately after it is series of 1 (and the facility's "Fall Resident I like voiding before balance and fell." immediately after it is series of 1 (and the facility's "Fall Resident I like voiding before balance and fell." immediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is mediately after it is series of 1 (and the facility is is series of 1 (and the facility is is series of 1 (and the fa	ent # 146 dated "Mar (March) If, the above medication orders. AR dated March 2018 revealed received scheduled pain 3/17 18: Aspirin 81 mg at 11:00 0 mg refused at 6:00 a.m., at 11:00 a.m., and Oxycodone 5 and at 11:02 a.m. Further review alled that Resident # 146 did not PRN (as needed) pain a remainder of the day. We care plan for Resident # 146 documented, "Focus: The nic pain. Date Initiated: ar "Interventions" it minister medication per MD arders, pain assessment every ad: 03/14/2018." Be Resident Movement Program on Form" for Resident # 146 accumented, "Gail Belt. Resident oth legs and sits independently. ansfers with physical assistance of "Comments" it documented, as (assistance)." Investigation Worksheet" for ated 03/17/18 at 1:15 p.m., aivity: "Unassisted transfer." arterview:" it documented, "I felt at therapy, I think I could it, lost Under "Interventions fall" it documented, "Resident treatment done to skin. Advise	F 697			
	The nurse's "Prog	ress Notes" for Resident # 146				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495197		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/28/2019	
	PROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 697	dated 03/17/2018 "Writer was on the screaming for help the floor on her rig noted skin tear to (0.1 length by 0.1 o.5 (lower). Range extremities. Residelbow and hip area aware of resident after falling order to (emergency depar Resident left facility stretcher alert and accompanied by downward to the floor in the fl	17:34 (5:34 p.m.) documented, hallway heard resident on the side. Resident assessed right forearm area 0.1 x 0.1 cm width centimeters) (upper) 0.5 x e of motion done able to move lent complaining of pain to right a. (Name of Physician) made complaining of pain to right hip to transfer resident to ED transfer resident to ED transfer to for further evaluation. by at 1720 (5:20 p.m.) via (by) oriented x (times) 3 (three),	F 697		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495197	B. WING		03/28/2019
NAME OF PROVIDER OR SUPPLIER BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPL HE APPROPRIATE DATE
F 697	POA (power of attemped of the member) # 7, phy unsuccessful due longer employed. On 03/27/19 at an interview was con asked if he compl resident falls, RN falls we do a pain pain assessment RN #4 stated "Yes 146 was yelling on RN # 4 stated, "N Resident # 146 ar fall, RN # 4 stated on scheduled pair above documents."	in (RN # 7). (RN # 7) called torney)." Priview OSM (other staff resical therapy assistant was to the fact that he was no with the facility. Proximately 12:23 p.m., an adducted with RN # 4. When retes a pain assessment when a # 4 stated, "Any time someone assessment." When asked if a rescreaming in pain after the fall, o." When asked if he gave reprivatively pain medication following the late, "No because she was already in medication." (*Note the MAR and Resident #146 refused and rescheduled pain medication at	F 697		
	conducted with RI When asked to de follow for an unwit do an assessmen injuries, suspected of consciousness, directions and ver and stopping it if i move their arms a they cannot do the possible fractures then you transfer Call the doctor if the	05 p.m., an interview was N # 2, acting director of nursing. escribe the procedure staff tnessed fall, RN # 2 stated, "We t, head to toe, checking for any d fractures and skin tears, level alertness, being able to follow bally communicate, bleeding t occurs. We ask the patient to and leg, squeeze our hand and if eses it may be indications of . If they are able to move them, them to the bed or a wheelchair, here is an injury or if there is not am know the resident fell. If we			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		DATE SURVEY COMPLETED
		495197	B. WING			C 03/28/2019
	ROVIDER OR SUPPLIER WOODS HEALTH CA	RE CENTER AT THE FAIRFAX	9160	ET ADDRESS, CITY, STATE, ZIP CO BELVOIR WOODS PKWY T BELVOIR, VA 22060	DDE	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 697	911 and keep the pasked about pain, assess for pain whassessment by using zero being no pain and the location of as well." RN #2 who check vitals signs a documented. RN # the first 15 minutes minutes for an hour hours, then every fevery eight hours are is documented on the When asked if a rest they state they are pain, RN # 2 stated based on the physical needed) pain medicumented in the Con 03/28/19 at 1:1 conducted with RN When asked if Resoffered a pain med 2 stated "Yes." RN was documentation was offered and or 2 re-reviewed the finurse's notes for Rourse's notes for Rourse	we don't move them, we call patient comfortable." When RN # 2 stated, "We also alle doing the head to toe ing the pain scale zero to 10, and 10 being extreme pain the pain. We check vital signs as asked how often staff would and where they would be 2 stated, "They are taken for 3, for one hour, then, 30 r, then every hour for four our hours for 48 hours, then every shift for three days and it the neurological assessment." sident is cognitively intact and having a ten out of ten for d, "I would give pain medication cian's orders for prn (as cation. It should be nurse's progress notes." 3 p.m., an interview was # 2, acting director of nursing, ident # 146 should have been intat the prn pain medication if the resident refused it, RN # all assessment, eMAR and esident #146 and stated, "No. as done and the monitoring didn't manage her pain."	F 697			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING	
		495197	B. WING		C 03/28/2019
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160	ET ADDRESS, CITY, STATE, ZIP CODE BELVOIR WOODS PKWY T BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICI	Y 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 697	Continued From p		F 697		
	regulate the amount information was of https://www.nlm.ni 001214.htm. (2) A condition in was on the pump oxygen-risefficiently. This can throughout the borobtained from the https://medlineplus. (3) High blood presobtained from the https://www.nlm.ni essure.html. (4) Kidneys are dat they should. This is the website: https://medlineplus.l. (5) Prescription as symptoms of rheur by swelling of the losteoarthritis (arthithe lining of the joinerythematosus (continuous line).	s.gov/ency/article/000158.htm. ssure. This information was website: h.gov/medlineplus/highbloodpr maged and can't filter blood, as nformation was obtained from s.gov/chronickidneydisease.htm pirin is used to relieve the matoid arthritis (arthritis caused ining of the joints), ritis caused by breakdown of ints), systemic lupus ndition in which the immune i joints and organs and causes			
	rheumatologic con immune system at	ditions (conditions in which the tacks parts of the body).			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/28/2019
	ROVIDER OR SUPPLIER WOODS HEALTH CAR	RE CENTER AT THE FAIRFAX	STRE 9160	ET ADDRESS, CITY, STATE, ZIP CODE BELVOIR WOODS PKWY T BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 697	and to relieve mild headaches, menstr toothaches, and mi aspirin is also used people who have he who have angina (or the heart does not Nonprescription as risk of death in people who have recently Nonprescription as ischemic strokes (stode blood clot blocks the mini-strokes (stroke blood to the brain is people who have hemorrhagic stroke in the brain). Aspiricalled salicylates. It production of certaic cause fever, pain, sinformation was obhttps://medlineplus.tml. (6) Used to help coin people who have capsules, tablets, at to relieve the pain of (PHN; the burning, may last for months shingles). Gabaper (Horizant) are used syndrome (RLS; a discomfort in the letthe legs, especially lying down). Gabap	to moderate pain from rual periods, arthritis, colds, uscle aches. Nonprescription I to prevent heart attacks in ad a heart attack in the past or chest pain that occurs when get enough oxygen). pirin is also used to reduce the ple who are experiencing or experienced a heart attack. pirin is also used to prevent trokes that occur when a le flow of blood to the brain) or es that occur when the flow of s blocked for a short time) in ad this type of stroke or last. Aspirin will not prevent les (strokes caused by bleeding in is in a group of medications to works by stopping the in natural substances that swelling, and blood clots. This tained from the website: gov/druginfo/meds/a682878.h Introl certain types of seizures expellepsy. Gabapentin and oral solution are also used of postherpetic neuralgia stabbing pain or aches that so or years after an attack of litin extended-release tablets I to treat restless legs condition that causes ge and a strong urge to move at night and when sitting or lentin is in a class of lanticonvulsants. Gabapentin	F 697		

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495197	B. WING		03/28/2019	
	ROVIDER OR SUPPLIER	ARE CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		03/20/2013	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR 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 697	treats seizures by excitement in the pain of PHN by channels by excitement in the pain of PHN by channels by chann	decreasing abnormal brain. Gabapentin relieves the hanging the way the body not known exactly how to treat restless legs syndrome. Was obtained from the website: s.gov/druginfo/meds/a694007.h hand to relieve moderate to information was obtained from s.gov/druginfo/meds/a682132.h hand is used to relieve mild to m headaches, muscle aches, c.gods and sore throats, aches, and reactions to take, and to reduce fever. The lining of the joints). The in a class of medications called elievers) and antipyretics (fever is by changing the way the body by cooling the body. This brained from the website: s.gov/druginfo/meds/a681004.h hand originally created with children of them communicate about their ale is used around the world and improving assessment so it can be addressed. This brained from the website:	F 697			

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STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	
		495197	B. WING		03/2	28/2019
	ROVIDER OR SUPPLIER WOODS HEALTH CAR	RE CENTER AT THE FAIRFAX	91	REET ADDRESS, CITY, STATE, ZIP CODE 60 BELVOIR WOODS PKWY DRT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC 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 761 SS=D	CFR(s): 483.45(g)(§483.45(g) Labeling Drugs and biological labeled in accordar professional principal propriate accessinstructions, and the	h)(1)(2) g of Drugs and Biologicals als used in the facility must be nce with currently accepted oles, and include the	F 761	With respect to the specific observation cited: LPN # 2 received refresher training conducted Administrator or Acting DNS on securing and st medications in a safe manner. With respect to how the facility will identify residue to potential to be affected by the identified contake corrective action:	dents with	5/10/2019
	§483.45(h)(1) In act Federal laws, the fabiologicals in locked temperature control personnel to have a §483.45(h)(2) The folioted, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distriquantity stored is more readily detected. This REQUIREMED by: Based on medication staff interview, facilical record reviet facility staff failed to manner for one of 4 hallway. On 3/27/19, during observation on the	facility must provide separately y affixed compartments for and drugs listed in Schedule II of a Drug Abuse Prevention and a and other drugs subject to an the facility uses single unit bution systems in which the aninimal and a missing dose can		By 5/10/19, the DNS or designee will conduct repass observations and cart audits to confirm mare secured appropriately. Issues identified will be resolved and "in the mare fresher training will be initiated if needed. With respect to what systemic measures have to place to address the stated concern: Refresher training on securing and storing Drug Biologicals has commenced for nursing staff. To be completed by the Director of Nursing or desistation of the confluence of the confirmition of the confirmition passes and med cart audits conducted by the DNS or designee monthly for to confirm that medications are secured. The findings from medication pass observations cart audits will be reviewed at the Quality Assur Performance Improvement (QAPI) meetings. Duting the conclusion of the three months, the QAPI will re-evaluate and initiate necessary action or review period.	peen put in gs and raining will gnee by swill be 3 months and med rance / buring and committee	5/10/2019

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		ON PROMESTICATED	OVER THE TIPLE	CONSTRUCTION	(V3) DATE	SI IDVEV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7. DOLDING_				
		495197	B. WING			28/2019	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DELVOIR	WOODS HEALTH CA	DE CENTED AT THE EAIDEAY	91	60 BELVOIR WOODS PKWY			
BELVOIR	WOODS HEALTH CA	RE CENTER AT THE FAIRFAX	F	ORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 761	Continued From p	age 40	F 761	With respect to how the plan of correct	tive measures will be	5/10/2019	
		cart unsecured and the		monitored:			
		as out of LPN #2's the line of		The Executive Director and/or Adminis	trator are responsible		
	sight.	as out of El 14 #25 the line of		for confirming implementation and ongoing compliance with the components of this Plan of Correction, addressing, and resolving variances that may occur.			
	The findings include	de:		The Executive Director and/or Administration for confirming the status of this Plan of reviewed and discussed at QAPI meet	Correction is		
	Resident #41 was	admitted to the facility on		initiated if required.			
	11/29/13, with diag	gnoses that include but are not					
	_	od pressure, peripheral					
		arrhythmia, abdominal aortic					
		ctive uropathy, chronic kidney					
	A STATE OF THE PARTY OF THE PAR	osis, benign prostatic					
		ortic valve disorder. The most					
		num Data Set) was a quarterly					
		an ARD (Assessment of 3/1/19. The resident was					
		ely intact in ability to make daily					
	life decisions.	in ability to make daily					
		a.m., LPN #2 (Licensed					
		as observed preparing and					
		lications to Resident #41. The					
	following medication administered:	ons were prepared and					
	Norvasc (1) 5 mg	(milligrams), 1 tab (tablet)					
	Aspirin (2) 81 mg,						
	Flexeril (3) 5 mg, 1						
	Colace (4) 100 mg						
		0 mcg (micrograms), 1 spray					
	each nostril						
		laritin (6) 10 mg, 1 tab etoprolol (7) 50 mg, 1 tab hera Multivitamin (8) 400 mcg, 1 tab iralax (9) 17 gm (gram), 1 cap full					
	Ivilialax (9) 17 gm	(grain), I cap iuii					
	On 3/27/19 at 8:11	a.m., LPN #2 went into the					
		aving all the medication packs					
		n top of cart unsupervised.					

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		495197	B. WING		03/28/2019		
	WOODS HEALTH CA	RE CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			03/26/2019	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 761	On 3/27/19 at 8:12 to get the Dymistal back in room, leave top of cart, unsuper by the cart. The condorway of the room halfway closed, can be out of line of sign back at the cart from addition, LPN #2 who point washing her completely out of 10 on 3/27/19 at 8:15 #2, she stated that medications unsuper medication cart, and her part. A review of the fact Preparation and M documented, "3.9 medications or check on 3/27/19 at 5:30 Staff Member, the aware of the finding provided by the enterprovided by the enterprovided by the enterprovided in provided in the provided in provided in the p	a.m., LPN #2 returned to cart in asal spray, and then went ing all the medication packs on ervised. A staff member passed art was mainly in front of the om, however the door was ausing the majority of the cart to ght; and LPN #2 never looked om the resident's bedside. In was also in the bathroom at one hands, wherein the cart was ine of sight. It is a.m., in an interview with LPN to she should not leave bervised on top of the and that it was an oversight on the indication Administration. Facility staff should not leave emicals unattended. In PM, ASM #1 (Administrative Administrator) was made gs. No further information was ad of the survey.	F 761				

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DISTRUCTION	(X3) DATE SURVEY COMPLETED C
	495197	B. WING		03/28/2019
ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160	BELVOIR WOODS PKWY	
(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
attacks in people of the past or who had of death in people have recently experienced by the prevent ischemic speople who have it mini-stroke in the property in the property is the property in the property in the property is the property in the property in the property is the property in the property in the property is the property in the property in the property is the property in the property in the property in the property is the property in the property in the property in the property is the property in the property	who have had a heart attack in ave anginato reduce the risk who are experiencing or who erienced a heart attackto strokesor mini-strokesin had this type of stroke or past." ed from s.gov/druginfo/meds/a682878.h ax muscles and relieve pain used by strains, sprains, and es. ed from s.gov/druginfo/meds/a682514.h to relieve constipation ed from s.gov/druginfo/meds/a601113.ht If to treat allergy symptoms ed from s.gov/druginfo/meds/a697014.h s.gov/druginfo/meds/a695002.h to treat allergy symptoms ed from s.gov/druginfo/meds/a695002.h to treat allergy symptoms ed from s.gov/druginfo/meds/a697038.h	F 761		
Information obtained	ed from			
	Continued From p attacks in people who have recently experience in the people who have in mini-stroke in the proposed in the people who have in mini-stroke in the people who have in mini-stroke in the proposed in the people who have in mini-stroke in the people who have in mini-stroke in the people who have in mini-stroke in the proposed in the people who have in mini-stroke in the people who have in mini-stroke in the proposed in the people who have in mini-stroke in the proposed in the people who have in mini-stroke in the people who have in	ROVIDER OR SUPPLIER WOODS HEALTH CARE CENTER AT THE FAIRFAX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 attacks in people who have had a heart attack in the past or who have anginato reduce the risk of death in people who are experiencing or who have recently experienced a heart attackto prevent ischemic strokesor mini-strokesin people who have had this type of stroke or mini-stroke in the past." Information obtained from https://medlineplus.gov/druginfo/meds/a682878.h tml (3) Flexeril - to relax muscles and relieve pain and discomfort caused by strains, sprains, and other muscle injuries. Information obtained from https://medlineplus.gov/druginfo/meds/a682514.h tml (4) Colace - Used to relieve constipation Information obtained from https://medlineplus.gov/druginfo/meds/a601113.ht ml (5) Dymista - Used to treat allergy symptoms Information obtained from https://medlineplus.gov/druginfo/meds/a697014.h tml and from https://medlineplus.gov/druginfo/meds/a695002.h tml (6) Claritin - Used to treat allergy symptoms Information obtained from https://medlineplus.gov/druginfo/meds/a697038.h	DE DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER (X2) MULTIPLE CC A BUILDING B. WING	DE DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER 495197 ROMDER OR SUPPLIER WOODS HEALTH CARE CENTER AT THE FAIRFAX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 42 attacks in people who have had a heart attack in the past or who have anginato reduce the risk of death in people who have had a heart attackto prevent ischemic strokesor mini-strokesin people who have had this type of stroke or mini-stroke in the past." Information obtained from https://medlineplus.gov/druginfo/meds/a682878.h tml (3) Flexeril - to relax muscles and relieve pain and discomfort caused by strains, sprains, and other muscle injuries. Information obtained from https://medlineplus.gov/druginfo/meds/a682514.h tml (4) Colace - Used to relieve constipation Information obtained from https://medlineplus.gov/druginfo/meds/a687011.3.ht ml (5) Dymista - Used to treat allergy symptoms Information obtained from https://medlineplus.gov/druginfo/meds/a697014.h tml (6) Claritin - Used to treat allergy symptoms Information obtained from https://medlineplus.gov/druginfo/meds/a697014.h tml (7) Metoprolol - Used to treat tile blood pressure Information obtained from https://medlineplus.gov/druginfo/meds/a697038.h tml

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	Lancing Co.	Ol	MB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	120 120 1	LE CONSTRUCTION (X	COMPLETED
	ROVIDER OR SUPPLIER	ARE CENTER AT THE FAIRFAX	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	03/28/2019
(X4) ID PREFIX TAG	(EACH DEFIC	Y 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	tml (8) Thera Multivita combination of manormally found in sources. Multivita vitamins that are Multivitamins are deficiencies (lack pregnancy, poor and many other conformation obtain https://www.drugs	amin - Multivitamins are a any different vitamins that are foods and other natural amins are used to provide not taken in through the diet. also used to treat vitamin of vitamins) caused by illness, nutrition, digestive disorders, onditions. and from a com/mtm/multivitamins.html	F 76		
F 812 SS=E	tml Food Procuremer CFR(s): 483.60(i)	afety requirements.	F 81:	With respect to the specific observation cited: Dining and Nursing Staff received refresher training of serving food in a safe manner, including hand washin serving of plates, and food safety. The refresher training was conducted by the Certified Dietary Manager (CDM).	ng.
	§483.60(i)(1) - Pro approved or cons state or local auth (i) This may include from local product and local laws or (ii) This provision facilities from usin gardens, subject to safe growing and (iii) This provision from consuming for	ocure food from sources idered satisfactory by federal, orities. de food items obtained directly ers, subject to applicable State		With respect to how the facility will identify residents the potential to be affected by the identified concern a take corrective action: Following the findings, meals were observed by the Cor designee to confirm food was served in a sanitary manner. *In the moment* refresher training was conducted with members by the CDM, as needed.	CDM

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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	
		495197	B. WING		03/2	8/2019	
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	91	REET ADDRESS, CITY, STATE, ZIP CODE 60 BELVOIR WOODS PKWY DRT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICI	Y 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 & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 812	standards for food This REQUIREME by: Based on observe document review, facility staff failed manner for one of dining room. 1. OSM (other stat touching food serve fingers. OSM #2 a also were observe residents' plates w residents the lunch 2. OSM (other stat failed to keep his failed	ardance with professional service safety. ENT is not met as evidenced ation, staff interview, and facility it was determined that the to serve food in a sanitary one dining rooms; the main If member) #2 was observed and to residents with bare and RN (registered nurse) #3 and touching the food surface of while assisting and serving an meal in the main dining room. If member) #6, dietary aide fingers from touching the food while serving the resident's	F 812	With respect to what systemic measures have be place to address the stated concern: Refresher training on the serving of food in a saf has commenced. Training will be completed by or designee by 5/10/19. Weekly during the next three months, meals will observed by the CDM or designee to confirm foo served in a sanitary manner. The findings from meal observations will be revie the Quality Assurance / Performance Improveme (QAPI) meetings. During and at the conclusion of three months, the QAPI committee will re-evalual initiate necessary action or extend the review performance in the plan of corrective measurements of this Plan of Correction, address resolving variances that may occur. The Executive Director and/or Administrator are in for confirming implementation and ongoing complete components of this Plan of Correction, address resolving variances that may occur. The Executive Director and/or Administrator are in for confirming the status of this Plan of Correction reviewed and discussed at QAPI meetings and administrated if required.	be dis be	5/10/2019	
	touching food serve fingers. OSM #2 a also were observe residents' plates w residents the lunch On 3/26/19 between observation of service was condumember) #2 was oplates on the table OSM #2 was observations.	ff member) #2 was observed red to residents with bare and RN (registered nurse) #3 do touching the food surface of while assisting and serving an meal in the main dining room. The number of the main dining room meal and the main dining room meal acted. OSM (other staff observed placing a tray of as as she served each table. The number of the plates from the top of the rim of the plates					

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STATEMENT (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		495197	B. WING		C 03/28/2019	
	ROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160 FOR		1, 100	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 812	with her bare finger in front of the resid her hands before g bare fingers touchin plates and serving On 3/26/19 at 12:4 bringing a tray of proom. OSM #2 the plate on the tray wi it on a resident's plate on the tray wi it on a resident's plate fingers or use On 3/26/19 at 12:4 #3 was observed s and was asked to fable. RN #3 did nafter leaving the tatte new table to fee brought a tray of plate in front of the plate with the plate in front of began feeding the sanitize her hands her bare fingers touplate and feeding the On 03/27/19 at apprinterview was conditioned.	rs and then placed the plates ents. OSM #2 did not sanitize rabbing each plate with her not the top of the rim of the the plates to each resident. 2 p.m., OSM #2 was observed lates to a table in the dining in grabbed a crab cake off a the her bare fingers and placed late. OSM #2 did not sanitize rabbing the crab cake with her a utensil such as tongs. 2 p.m., RN (registered nurse) litting at a table with residents leed a resident at a different of wash or sanitize her hands lole she was at before going to led the resident. OSM #2 lates to the table in the dining ling the residents but not the last going to assist with eating. Led grabbing the resident's plate led; she touched the top of the last placed late resident. RN #3 then resident. RN #3 did not before grabbing the plate with laching the top of the rim of the late resident. All the plates with lates and placed lates to the lates and placed lates and pla	F 812			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495197	B. WING		C 03/28/2019	
	PROVIDER OR SUPPLIER	RE CENTER AT THE FAIRFAX	9160	ET ADDRESS, CITY, STATE, ZIP COD BELVOIR WOODS PKWY T BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION	
F 812	conducted with RN feeding a resident stated, "I am new feed a resident. So needs assistance whole time and the When asked to de #2 brought the resistated, "I was then the food." When a plate, RN #3 state put it in front of he not on it the server RN #3 demonstrate holding the plastic top of the rim of the okay for bare finges the plate, RN #3 swere the food is at have her bare fing plate, RN #3 said, Review of facility's documented, "Poli encouraged to reconstruct whenever possible promptly assisted of plates should not clothing or hands. handled on the out forks, and spoons handles." On 3/27/19 at app (administrative stated Administrator and (Director of Nursin electric whenever of Nursin electric whenever of Nursin electric stated and instrator and (Director of Nursin electric whole with the plate should not be out forks, and spoons handles."	33 a.m., an interview was 1 #3. When asked about in the dining room, RN #3 here and I was asked to help the is on a pureed diet and with eating. I was not there the ey pulled me to help feed her." scribe her actions when OSM ident's plate to the table, RN #3 e when she (OSM #2) brought asked how she handled the d, "I lifted from the bottom and r (the resident), the cover was r (OSM #2) lifted the cover." red using a plastic plate by plate with her thumbs on the e plate. When asked if it was ers to touch the top of the rim of aid, "I did not have my thumb to the top of the rim of the "No." To policy, "Dining Room Service" cy Residents should be eive dining room service be served with dignity and Procedure Eating surfaces of come in contact with staff Cups and glasses should be taide of the containers, Knives, should be handled by the	F 812			

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No.		495197	B. WING			03/28/2019
	ROVIDER OR SUPPLIER WOODS HEALTH CAR	RE CENTER AT THE FAIRFAX	916	REET ADDRESS, CITY, STATE, ZIP CODE 60 BELVOIR WOODS PKWY 0RT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 812	failed to keep his firsurface of plates we lunch in the dining. On 03/26/19 at approbservation of lunch was conducted in the Observations during OSM (other staff medianer plates contained one resident receivations covering owe up the plate from the thumbs on the food and bowl he served On 03/27/19 at apprinterview was condimember) # 6, dietadescribe his responserve the residents resident's orders for the lid off the plate, place it in front of the places his fingers we the resident, OSM and on the edge." We observation on 03/20 OSM # 6 stated, "It hurry."	rey. If member) #6, dietary aide rigers from touching the food hile serving the resident's room. It is a served to the residents he facility's dining room. If it is a served to the residents he facility's dining room. If it is a service revealed lember) #6, dietary aide served lunch. Four residents received ining several food items and red a bowl of fruit and a bowl of lurther observation of OSM # It is a that after removing the ler each plate, OSM # 6 picked lies serving tray by placing his I surface portion of each plate	F 812			
		ucted with OSM (other staff v manager. When asked how				

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STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495197	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	co	TE SURVEY MPLETED C 03/28/2019	
	ROVIDER OR SUPPLIER WOODS HEALTH CAR	E CENTER AT THE FAIRFAX	916	REET ADDRESS, CITY, STATE, ZIP CODI 50 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		1 00/20/2010	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 812	it is served, OSM # fingers should not b plate." On 03/27/19 at appr (administrative staff was made aware of	food should be handled when 1 stated, "The hands and e on the eating surface of the roximately 5:25 p.m., ASM member) # 1, administrator,	F 812				

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