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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING B. WING	C 10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

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

F 000 INITIAL COMMENTS

F 000

An unannounced Medicare/Medicaid abbreviated survey was conducted 10/22/19 through 10/23/19. One complaint was investigated during survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 222 bed certified facility was 210 at the time of the survey. The survey sample consisted of 4 current resident reviews (Residents #2 through #5) and 1 closed record reviews (Resident #1).

F 842 Resident Records - Identifiable Information
SS=D CFR(s): 483.20(l)(5), 483.70(i)(1)-(5)

F 842

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented:
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records,

F000 – The statements made in the following plan of correction are not admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

11/20/2019

1. Resident #1 was discharged from the facility on 9/26/2019
2. An audit of all new admissions with wounds within the last 30days will be conducted to ensure that all wounds were assessed and documented. Unit Managers or shift supervisors will assess all new admission within 24 to 48 hours to ensure that all wounds were assessed and findings were document in the clinical record, to ensure accurate and complete documentation.

VERIFIED

RECEIVED

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

Senior Executive Director 11/8/19

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

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regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law:
(ii) Required by Law:
(iii) For treatment. payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes. research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medic at record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law. or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identi(y the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided:
(iv) The results of anypreadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

3. ADON or designee will educate all Licensed nurses on assessing all new admissions with wounds, then document their findings in the clinical record to ensure complete and accurate documentation. ADON or designee will educate all Unit Managers and shift supervisors on assessing all new admissions with wounds within 24 to 48 hours then document in the clinical record to ensure accurate and complete documentation.
4. Facility will conduct weekly audits for three weeks, then monthly for two months to ensure that all new admissions with wounds are assessed by License nurse on admission and shift supervisors or unit managers within 24 to 48 hours and the findings are documented in the clinical records to ensure complete and accurate documentation. All findings will be reported to QAPI committee to ensure substantial compliance and the need for further intervention.
5. Completion date 11/20/2019

11/20/2019

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professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to ensure complete and accurate documentation of a right anterior leg wound upon admission and throughout Resident #1's facility stay.

The findings included:

Resident #1 was admitted to the facility on 8/24/19 and readmitted on 9/24/19 with diagnoses that included but were not limited to fracture of the right tibia, and anxiety disorder. Resident #1's most recent comprehensive MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 8/31/19. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #1 was coded in Section M (Skin Conditions) as having two advanced pressure ulcers.*

Review of Resident #1's hospital discharge instructions dated 8/24/19 documented that Resident #1 had three wounds. The following wounds were documented: "R (right) dorsum foot wound, Sacrum Wound, R buttock wound..."

Review of Resident #1's wound care notes by the wound care physician dated 8/27/19, addressed wounds to the Right hip (Stage 4 pressure ulcer) and Sacrum (Stage 4 pressure ulcer). There was no documentation of a right foot or leg wound.

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Review of Resident #1's OT (Occupational Therapy) notes revealed the following OT note was documented on 9/5/19: "Pt (patient) unwilling to participate in session 2' (secondary) fear of R knee wound opening up and catheter leaking."

There was no evidence in Resident #1's entire clinical record that Resident #1 had a right knee wound.

Further review of Resident #1's nursing notes revealed that he had complained of increased pain to his right knee on 9/9/19. The following nursing note was documented: "Resident refuses AM care writer and CNA (certified nursing assistant) in room to do care. C/O (complaints) of pain and discomfort to right knee stated he will all (sic) 911. After PT (Physical Therapy) did ROM (range of motion) to legs maybe PT dislocated his knee. NP (Nurse Practitioner) notified stat x-ray order. Pain medication offered resident refused. Director of Rehab was notified."

The next note dated 9/9/19 documented the following: "X-ray result of right knee came conclusion: Fracture distal femur of uncertain age Tibia/Fibula of right fracture proximal tibia/fibula of uncertain age...previous fracture. no acute change...Doctor (Name of doctor) notified Physician asked to send resident to ER (emergency room) ...at 11:40 (PM) writer left facility."

Review of Resident #1's emergency room records dated 9/9/19 documented the following: "49 year old male with history of paraplegia, diabetes who presents with wound over previously fractured right tibia/fibula. Small

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amount of purulent discharge without warmth...Pt reports manipulation of fracture at SNF (skilled nursing facility). Wound probes to bone...pain from possible infection."

Review of Resident #1's history and physical dated 9/10/19 documented the following: "Active diagnosis: Osteomyelitis...recent tib/fib fracture 2/2 from fall who presents with increased pain from right leg with purulent wound at right anterior shin who is scheduled for a OR (operating room) with Ortho for I & D (incision and drainage) ...Right leg wound: 0.8 cm in diameter would with some purulence with no significant erythema (redness)..."

Further review of Resident #1's clinical record revealed he was admitted back to the facility on 9/24/19.

On 10/22/19 at 2:59 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the wound care nurse. When asked about Resident #1's wounds upon admission to the facility on 8/24/19, LPN #1 stated that Resident #1 had arrived to the facility with two stage 4 wounds. When asked where these wounds were located, LPN #1 stated that his wounds were located on his sacral area and right hip. When asked if Resident #1 was admitted with any additional wounds, LPN #1 stated that she could not recall. LPN #1 stated that Resident #1 frequently refused skin assessments and wound care treatments. LPN #1 also stated that Resident #1 refused to be turned and repositioned. LPN #1 stated his wounds did not really improve due to his non-compliance. When asked if he obtained any additional wounds while at the facility, LPN #1 stated that she didn't think

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so. When asked if he ever had an open area to his right leg, LPN #1 stated that she could not recall. When asked if she could recall Resident #1 having concerns that therapy had re-opened a wound, LPN #1 stated that she could not recall.

On 10/22/19 at 4:02 p.m., an interview was conducted with RN (Registered Nurse) #1, the unit manager. When asked what she could recall regarding Resident #1's wounds, RN #1 could not tell this writer the location of any wounds. When asked if she could recall Resident #1 having concerns that therapy had re-opened a wound to his right leg, RN #1 stated that she thought Resident #1 was admitted to the facility with a wound to his right knee/leg on 8/24/19. When asked if she would expect her staff to document the wound on an admission skin assessment, RN #1 stated that she would expect her staff to document the wound, but that Resident #1 frequently refused assessments. When asked if she would still expect staff to document that the resident had a wound to the right leg and is refusing an assessment, RN #1 stated that she would.

On 10/22/19 at 4:23 p.m., an interview was conducted with ASM (administrative staff member) #4, the wound care physician. ASM #4 stated that he has worked with Resident #1 at other nursing facilities. When asked if he could recall Resident #1 having a right leg wound, ASM #4 stated that Resident #1 has had the right leg wound in the past with a history of osteomyelitis to that right leg. ASM #4 stated that he did not recall seeing a right leg wound during his stay at this facility. ASM #4 stated that he saw Resident #1 2-3 times before the Resident was sent to the hospital on 9/9/19. ASM #4 stated that he usually

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came to the facility once a week to assess wounds. ASM #4 stated he was treating the stage 4 pressure ulcers to Resident #1's sacral area and right hip.

On 10/22/19 at 3:40 p.m., an interview was conducted with OSM #6, the physical therapy director. OSM #6 stated that she decided to go down to see Resident #1 on 9/9/19 due to his frequent refusals with other therapists. OSM #6 stated that she had noticed a dressing to his right leg. OSM #6 stated that Resident #1 would not allow her to touch him and stated that his right knee had hurt, that his wound and knee had popped during a therapy session. OSM #6 stated that the therapy department had no recollection of this happening. OSM #6 stated that she was told by the resident that an X-ray was performed that day. OSM #6 stated that did not touch Resident #1 that day, she only instructed him on ways to off-load pressure off his sacral wound.

On 10/22/19 at 4:24 p.m., an interview was conducted with OSM (other staff member) #5, the OT assistant who worked with Resident #1. OSM #5 stated that she attempted to do therapy with Resident #1 on 9/5/19. OSM #5 stated that the resident told her that his wound to his right leg had busted earlier that day or the day before. OSM #5 stated, "He said his knee exploded." ASM #5 stated that there was a dressing on the leg that appeared to be clean.

On 10/23/19 at 9:33 a.m., an interview was conducted with ASM #2, the DON (director of nursing). When asked what she could recall about his right leg wound, ASM #2 stated that she could not recall anything about a wound. When asked if she could recall his right leg wound

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"exploding" during a therapy session, ASM #2 stated that she didn't know of any explosions. ASM #2 stated that an incident such as a wound opening, during therapy or care etc. would always be documented in the clinical record. When asked how Resident #1 had a wound to his right leg upon admission to the ER on 9/9/19, if he did not obtain a wound at the facility, ASM #2 stated, "Unless he originally came here with a dressing." ASM #2 stated that she wasn't sure if Resident #1 was admitted to the facility on 8/24/19 with a wound to his right leg. When asked if she expected all skin areas to be documented/reflected upon admission to the facility, ASM #2 stated that did.

On 10/23/19 at 10:30 a.m., an interview was conducted with LPN #2, a nurse who frequently worked with Resident #1. When asked the process when residents arrive to the facility with skin areas, such as pressure ulcers and other wounds, LPN #2 stated that nurses will do a full head to toe assessment and document the location, size and description of the wound. When asked if Resident #1 had wounds upon arrival to the facility, LPN #2 stated that Resident #1 had a sacral wound and right hip wound. LPN #2 stated that Resident #1 refused his initial skin assessment but then allowed the wound care physician to assess his wounds on 8/27/19. When asked if Resident #1 had a wound to his right leg (near the knee), LPN #2 stated that Resident #1 had arrived to the facility with a bandage to his right knee. LPN #2 stated that the resident would not allow staff to touch this area, that according to Resident #1, Ortho was going to take care of it. LPN #2 stated that Resident #1 did not have any Ortho appointments during his short stay at the facility. When asked if she

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documented that Resident #1 had this area to his right leg in the clinical record, LPN #2 stated that she thought she had documented a note. When asked if this area should have been reflected on his weekly skin assessments along with his other wounds even if the resident refused care, LPN #2 stated that it should. When asked if every attempt to look at a resident's wound should be documented in the clinical record, LPN #2 stated that it should. This writer asked LPN #2 to present anything she could find that showed Resident #1 had this right leg wound upon admission.

On 10/23/19 at 10:50 a.m., LPN #2 presented a note dated 9/6/19 that documented the following: "Late entering for 8/26/19: Writer/wound care nurse in resident assist with wound care. Wound nurse offered and encouraged to open his Rt leg. Resident stated, "No one touch/open my leg it's done by my orthopedic" MD (medical doctor), resident is his on (sic) RP (responsible party). incoming nurse made aware noted."

When asked LPN #2 what "encouraged to open right leg" meant, LPN #2 stated that that sentence was referring to removing the dressing to look at the right leg wound. LPN #2 stated again that Resident #1 would not allow staff to look at that wound his entire stay at the facility. LPN #2 also stated that Resident #1 wore a soft brace to his right knee that covered the wound. LPN #2 stated that this maybe the reason why other staff could not recall a wound to his right leg. LPN #2 stated again that she should have documented every refusal and attempt to assess and dress Resident #1's right leg wound. LPN #2 stated that Resident #1 was care planned for refusing treatments.

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Resident #1's comprehensive care plan dated 8/27/19 and revised on 9/9/19 documented in part, the following: "(Name of Resident #1) exhibits the following maladaptive behaviors: Refusal of prescribed diet, medications, medical treatments, assessments, ADL support, weight, wound care, frequent conflicts with roommate in attempt to get private room,. He prefers to have his room untidy with items on the bed, does not allow staff to put away belongings. He prefers to have his food very hot ... (Name of Resident #26) sabotages his own medical care."

Further review of Resident #1's skin integrity care plan dated 8/27/19 documented the following: "(Name of Resident #1) has pressure ulcer or potential for pressure ulcer development to his sacrum and right hip r/t (related to) Disease process, Hx (history of ulcer), Immobility." This care plan did not address the wound to his right lower leg.

On 10/23/19 at approximately 10:52 a.m., ASM #2, the DON presented more information (documents) from Resident #1's hospital stay prior to his admission to the facility on 8/24/19. The following documents revealed that Resident #1 had an anterior wound to his right leg prior to admission into the facility. The following was documented on 8/23/19 in the hospital: "Right tibia Fx (fracture)...well padded soft splint in place, monitor anterior wounds, healing appropriately." There was no evidence of discharge orders from the hospital for this right anterior wound.

On 10/23/19 at 10:55 a.m., further interview was conducted with LPN #1, the wound care nurse. LPN #1 stated that now she could recall that

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Resident #1 did have a right leg wound when he was admitted to the facility. LPN #1 stated that he never allowed her or other staff to look at the wound and that he always had it covered up. LPN #1 stated that she thought the wound was always covered with an ACE bandage. When asked if Resident #1 had orders to treat his right wound from the hospital, LPN #1 stated that she didn't think so, but that the facility usually changes treatment orders after a skin assessment anyway.

*A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

(1) Stage 4 Pressure Ulcer- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable. This information was

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