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	495171	A. BUILDING _____ B. WING _____	C 11/20/2019

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GOODWIN HOUSE BAILEY'S CROSSROADS	3440 S JEFFERSON STREET FALLS CHURCH, VA 22041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 11/19/19 through 11/20/19. One complaint [VA00047821- substantiated with deficiency] was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 73 certified bed facility was 59 at the time of the survey. The survey sample consisted of three current Residents reviews (Residents #3 through #5 and #7) and three closed record review (Residents #1, #2 and #6).	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan. The facility staff failed to administer the physician Lasix (medication used to treat fluid retention) 40	F 684	1) Resident #6 was discharged to the hospital for an in-patient stay on October 6, 2019 and therefore we were unable to administer the Lasix. When the resident returned to the facility on October 14, 2019 her Lasix order was verified with her physician and was administered as ordered until discharge. 2) All residents admitted to the Health	1/4/20

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

Electronically Signed | 12/10/2019

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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F 684	Continued From page 1 mg (milligram) tablet as ordered on 10/6/2019. The Lasix was available for administration in the facility's stock medication supply. The findings include: Resident #6 was admitted to the facility on 11/21/2014, with a readmission on 10/4/2019 with diagnoses that included but were not limited to dysphagia (1), lymphedema (2) and low back pain. Resident #6's most recent MDS (minimum data set), was not due at the time of the survey. The facility's nursing admission assessment dated 10/04/2019, coded Resident #6 as being oriented times three, "Oriented to time, place, person." Resident #6 was coded as requiring the assistance of two persons with transfers and as requiring assistance with ADL's (activities of daily living). The Baseline care plan "Lymphedema to BLE (bilateral lower extremities)" documented in part, "Administer diuretic (medication for fluid retention) as ordered. Monitor response and report adverse reactions to MD (medical doctor). Start 10/04/2019." Review of the clinical record for Resident #6 revealed "Interdisciplinary Notes" which documented in part, "10/05/19 23:18:46 (11:18 p.m.) ...Daughter wanted to check medication list and found out no order for Lasix 40 mg, which resident has been taking; MD notified by supervisor to get order ..." Review of the POS (physician order summary) for	F 684	Care Center are at risk for this deficient practice. 3)All licensed nurses will be re-educated and newly hired licensed nurses will receive education upon hire on the Medication Shortages/ Unavailable Medications policy to include medications available in the Stat Box on the Health Care Center and when it should be accessed. 4) All new admission charts will be audited for compliance for 14 days post education, then 50% will be audited for compliance for 30 days, then 10% monitored monthly for compliance ongoing and reported at QAPI quarterly. 5) All education will be completed by January 4th, 2020.	

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Resident #6 documented the following "Lasix 40 mg tablet [Furosemide] (generic name for Lasix) - 40 mg by mouth once daily for CHF (congestive heart failure) (3); [Name of Physician] Order Date 10/05/19, Start Date 10/06/19."

Review of the MAR (Medication Administration Record) for Resident #6 for "Oct (October) 2019" documented the medication as listed above. In the area on the MAR for 10/6/19 "AM 7a-11a (7:00 a.m. - 11:00 a.m.)" it documented "(N) (med not administered)." The MAR "Comment/Notes" documented, "10/06/19 08:00 Med [medication] Not Administered; medication not here."

On 11/19/19 at 5:00 p.m., an interview was conducted with RN (registered nurse) #4. When asked about the Lasix orders on admission for Resident #6, RN #4 stated Resident #6's daughter came in and asked to see the medication list on 10/5/19 and found that there was no Lasix on it. RN #4 stated that Resident #6's daughter texted the physician to get the order and then she went to the supervisor who obtained an order for the Lasix. When asked if Resident #6's daughter brought any medication in from home, RN #4 stated that she brought medication in plastic bags. RN #4 stated that they do not accept medications from home unlabeled in plastic bags that they should have been sent back home with the family. When asked about the process for getting medications for residents, RN #4 stated that the order is faxed to the pharmacy and the delivery is during the night or the next morning. When asked about the Lasix, RN #4 stated Lasix is in the stat [immediate] box [emergency supply of medications], and could be pulled for the resident if it did not come in from the pharmacy. RN #4

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stated that Resident #6's daughter specifically requested that Resident #6 not receive the Lasix on 10/5/19 afternoon, so that she would not be up to the bathroom during the night and requested that she receive it on Sunday morning 10/6/19.

On 11/20/19 at 9:00 a.m., an interview was conducted with RN (registered nurse) #6. When asked about the Lasix ordered on 10/5/19 for Resident #6, RN #6 stated that the medication was not available from the pharmacy for the 10/6/19 dosage. RN #6 stated that Resident #6's daughter brought medications in from home in a plastic bag but they could not give them because they did not have an order. RN #6 stated that Lasix is kept in the stat box at the facility. RN #6 stated that she was new at the time and was not aware that there was a stat box in the facility. RN #6 stated that her supervisor told her later after her shift that the facility had a stat box and that the medication was available and that it could have been obtained from there.

On 11/20/19 at 11:08 a.m., an interview was conducted with ASM (administrative staff member) #2, director of nursing. When asked about the Lasix for Resident #6, ASM #2 stated that Resident #6 was admitted on a Friday night and staff had to get orders for the medications when she got here. ASM #2 stated that the physician did not initially order the Lasix on 10/4/19. ASM #2 stated that on Saturday, Resident #6's daughter came in and brought plastic bags with medications for Sunday in them. ASM #2 stated that the medications were not in the original containers and the facility cannot accept medications that are packaged that way, so the nurse working on Sunday could not administer them to Resident #6. ASM #2 stated

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that the day nurse contacted the pharmacy when the Lasix was not available to give on Sunday morning to arrange to have it delivered later that day. ASM #2 stated that the nurse had access to the stat box that had Lasix in it but, was a fairly - new staff member and thought that calling the pharmacy was the right thing to do. ASM #2 stated that the day nurse did not let the supervisor know so that the medication could be obtained from the stat box in the building. ASM #2 stated that afterwards the nurse was educated on the stat box, the contents of the box and the process to access it.

The facility internal investigation notes regarding Resident #6 by ASM #2 dated "10-6-2019" documented in part, "On Saturday, October 5, 2019, between 4:00 pm-4:30 pm, [Name of RN #4], noted that resident was without her Oxygen and was confused. Oxygen was placed on resident and resident was monitored. Resident's daughter arrived and was concerned that resident was confused ... Resident's daughter requested review of medication list given resident's worsening mental status. On review, [Name of Resident #6's daughter] noted that Lasix had been left off original medication list signed by [Name of Physician]. [Name of Physician] was contacted by Supervisor, [Name of supervisor] and new order for Lasix was obtained. [Name of Physician] asked that Lasix be held 10/5/2019 so that Resident would be able to sleep and be restarted 10/6/2019 in the AM (morning) ..."

It further documented "Resident's daughter asked to review medication list 10/5/2019 with [Name of RN #4]. On review, she noted that several medications were missing. These included Lasix, Vitamin B, and Allegra. Resident's daughter went

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home and provided missing medications in [Brand name] bags, which were accepted by [Name of supervisor]. On 10/6/2019 in the morning, the day nurse [Name of RN #6] did not administer the medications supplied from home because they were in [Brand name] bags with hand written instructions. She correctly opted to not administer medications because they were not in the originally labeled containers. [Name of RN #6] contacted the pharmacy to determine when the medications would be delivered. She was told on the afternoon delivery, which is generally around 3 pm. The medications were in fact delivered at 2:45 pm as the resident was going out to the hospital. In reviewing this event, the resident did not receive her Lasix on 10/5/2019 and 10/6/2019 due to physician orders. When the error was noticed, [Name of Physician] ordered that the medication be restarted 10/6/2019. The nurse who was to administer the AM (morning) dose did not notify the Nursing Supervisor and was unaware she could access the STAT (emergency) box to obtain medications in instances when there could be a delay due to pharmacy delivery. The nurse was educated that the procedure when medications were unavailable or delayed that she was to notify the supervisor so that the STAT box could be utilized. A reminder was sent to all nursing staff to ensure that all staff were aware of the existing protocol and that medications should only be accepted in appropriately labeled containers."

The facility provided stock list of medications contained in the "Stat box". The list documented the following, "Furosemide 20mg Tab (tablet); Lasix; QTY (Quantity) 5 (five); Location Tray 1, Row 3."

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On 11/20/19 at approximately 2:00 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy regarding medication administration and unavailable medications.

The facility policy "Medication shortages/unavailable medications, 12/01/07" documented in part "If a medication shortage is discovered during normal pharmacy hours: Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. If the next available delivery causes delay or a missed dose in the resident's medication scheduled, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose ..."

On 11/20/19 at 3:45 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

Complaint Deficiency

References:

1. Dysphagia - A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

2. Lymphedema - is the name of a type of swelling. It happens when lymph builds up in your body's soft tissues. Lymph is a fluid that contains

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F 684	Continued From page 7 white blood cells that defend against germs. It can build up when the lymph system is damaged or blocked. It usually happens in the arms or legs. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=lymphedema&_ga=2.224074523.1499032817.1574364629-1838772440.1562936034 3. CHF (congestive heart failure) - is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to store oxygen in a safe manner for one of seven residents in the survey sample,	F 695	1) The freestanding oxygen cylinder for Resident #7 was immediately secured in an approved portable stand. 2) All residents receiving oxygen therapy on the Health Care Center are at risk for	1/4/20

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Resident #7. Resident # 7's oxygen cylinder was freestanding next to the dining room table and not secured.

The findings include:

Resident #7 was admitted to the facility 06/07/2010 with a readmission on 11/19/2019 with diagnoses that included but were not limited to cardiac arrhythmia (1), dementia (2), and acute respiratory failure (3).

Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/16/2019, coded Resident #7 as scoring a 10 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 10- being moderately impaired for making daily decisions. Section O of the MDS failed to evidence documentation of Resident #7 receiving oxygen therapy during the MDS assessment period.

On 11/20/19 at 7:50 a.m., Resident # 7 was observed sitting in a wheelchair in the [Name of unit] dining room at a table eating breakfast. Further observation of Resident # 7 revealed she was receiving oxygen by a nasal cannula which was connected to a portable oxygen cylinder. Observation of the oxygen cylinder revealed it was freestanding next to the dining room table.

The order summary report dated 11/20/2019 documented, "Oxygen at 2 (two) liters via nasal cannula qshift (every shift) PRN (as needed) to keep pulse ox (oximetry) (oxygen level) > (greater than) 92%- Every shift as needed; [Name of

this deficient practice.
3) All licensed nurses and certified nursing assistants will be re-educated, and newly hired licensed nurses and certified nursing assistants will receive education upon hire on the policy for Oxygen Administration & Safety on the Health Care Center.
4) All residents receiving oxygen will be audited for compliance for 14 days post education, then 50% will be audited for compliance for 30 days, then 10% monitored monthly for compliance ongoing and reported at QAPI quarterly
5) All education will be completed by January 4th, 2020.

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Physician]; Order Date: 11/20/19; Start Date: 05/22/2019."

On 11/20/19 at 8:41 a.m., an interview was conducted with RN [registered nurse] # 1 regarding the above observation of Resident # 7's oxygen cylinder. RN # 1 stated, "The CNA (certified nursing assistant) brought [Resident # 7] to the dining room for breakfast and I told her I would meet her in the dining room with the oxygen. I put the nasal cannula on [Resident # 7] and turned on the cylinder." When asked if the oxygen cylinder was placed in a stand, RN # 1 stated, "No it was not." When asked if an oxygen cylinder should be left free standing, RN # 1, stated, "No, I know that now."

The facility's policy "Oxygen Administration & Safety" documented in part, "Procedure: 7. Oxygen cylinders may not be left free standing. They must be secured at all times or placed in green oxygen boxes."

On 11/20/19 at approximately 3:45 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

Reference:

1. Cardiac arrythmia is a problem with the rate or rhythm of your heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/arrhythmia.html.

2. Dementia is a loss of brain function that

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occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. Acute respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems. When you breathe, your lungs take in oxygen. The oxygen passes into your blood, which carries it to your organs. Your organs, such as your heart and brain, need this oxygen-rich blood to work well. Another part of breathing is removing the carbon dioxide from the blood and breathing it out. Having too much carbon dioxide in your blood can harm your organs. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=respiratory+failure&_ga=2.10765815.252353412.1572267082-1838772440.1562936034

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