PRINTED: 08/17/2021 FORM APPROVED OMB NO: 0938-0391

NAME OF PMOVIDER OR SUPPLER  BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX  STREET ADDRESS, CITY, STATE, DP CODE 9100 BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX  PREPARATE PROVIDER OR SUMMARY STATEMENT OF DEPOISONESS PREPER PROVIDER OR SUMMARY STATEMENT OF DEPOISONESS TAG  CROWN THE PROVIDER OR SUMMARY STATEMENT OF DEPOISONESS TAG  PREPER PROVIDER OR SUMMARY STATEMENT OF DEPOISONESS TAG  REQULATORY OR LSC EXEMPTITING INFORMATION)  E 000  Initial Comments  E 000  Initial Comments  E 000  Initial Comments  E 000  An unannounced Emergency Preparedness survey was conducted 08/10/2021 through 19/11/2021. The facility was in substantial compliance with 42 CFR Part 483-73? Requirement for Long-Term Care Facilities.  F 000  Initial Comments  An unannounced Medicare/Medicaid standard, licensure and complaints survey was conducted 8/10/21 through 9/11/21. Two complaints (V/A000511/6-Substantiated) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483-6feral Long Term Care requirements. The Life Safety Code survey/report will follow.  The cansus in this 56 bed Medicare certified facility was 37 at the time of the survey. The survey sample included wenty-five current and closed record reviews.  F 558 Resonable Accommodations Needs/Preferences Sexper when to do so would endanger the health or safety of the resident or other residents.  This REQUIREMENT is not met as evidenced by:  This REQUIREMENT is not met as evidenced by:  Sabad on staff interview, resident interview, facility document review and chinical record review.  Based on staff interview, residents in the record review, it was determined the facility staff failed to ansure resident rights by accommodating the needs of ori on 2/25 Seidents in the survey  ABORATION SUBJECT THE ADDRESS SCIANTINES SIGNATURE  TITLE  Administrator  SABORATION SUBJECT STATE AND CORRECTION SON PROVIDENCE PROVIDENCE PREPRESESTATIVES SIGNATURE  THE ADDRESS SUAN OR CORRECTION SON PROVIDENCE PREPRESESTATIVES SIGNATURE  THE ADDRESS SUAN OR CO	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING				3) DATE SURVEY COMPLETED	
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	_ABORATORY I	DIRECTOR'S OR PROVIDER!S	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 30 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 40 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
						С	
		495197	B. WNG _			08/	11/2021
NAME OF PI	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE		
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY			
DELIGIA	WOODO HEAEIN OAKE	OEMERA METAMA		F	ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 558	Continued From page 1 sample, Resident #9.  The facility staff failed to ensure accommodation of Resident #9's need for a thick wheelchair cushion.		F 5	558	Facility's social worker interviewed all residents (three residents) who were re hospitalized and re-admitted to ask the		8/24/21
į					any appropriate equipment and supplie they need. There were no equipment a supplies need voiced by the residents.	s	
	The findings include:  Resident #9 was admitted to the facility on				C. Address what measures will be put place or systemic changes made to en that the deficient practice will not recur	sure	
•	6/10/21 with diagnose limited to: acute resp heart and lungs to ma gas exchange) (1), di insulin to function nor the left knee amputati of the limb-below the	es that include but are not iratory failure (inability of the intain an adequate level of abetes mellitus (inability of mally in the body) (2), below fon [LBKA] (surgical removal left knee) (3) and tion of the lungs usually			Director of Nursing Services (DNS) and designee will provide education for the Interdisciplinary Team and nursing staregarding admission/re-admission recording process for equipment, supplies, medicand treatment plans to meet resident's and maintain continuity of care.	ff onciliation cations	9/10/21
	set) assessment, a fix assessment, with an a of 6/17/21, coded the	cent MDS (minimum data re day Medicare assessment reference date resident as scoring 15 out ief interview for mental			Facility's DNS and Rehab Director will education for nursing staff and rehab s regarding reporting structure if a reside not have the correct equipment.	taff	9/10/21
	status) score, indicati cognitively intact. MD Status: coded the res assistance with bed n locomotion and super and bathing. Walking MDS Section H- Bow	ng the resident was S Section G- Functional ident as extensive nobility, transfers, dressing, vision for eating, hygiene did not occur. A review of el and Bladder: coded the continent for bowel and as			IDT will add a question regarding whet not they have all the equipment and su they need during care plan meetings.  D. Indicate how the facility plans to more performance to make sure that solution sustained:	ipplies	8/27/21
	On 8/10/21 at 8:45 Al observations, Resider He had a wheelchair one-inch cushions in	M, during the initial resident nt #9 was observed in bed. with two approximately the seat of the wheelchair. In room and Resident #9			DNS and/or designee will conduct wee audits for one re-admission (if any) begweek of 08/23/21 for three months to me-admission reconciliation process.	jinning	8/27/21

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Event ID: TEJD11

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PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495197	B. WING		C 08/11/2021	
BELVOIR	<u></u>	CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 558	asked how often he g stated, "Since I came about one week ago, occupational therapy. hospital, I had a black wheelchair and I could wheelchair. When I c someone had taken the those cushions for lon hurts my coccyx." Re "We've asked for the c someone else needed bed because he is not Resident #9 was hosp 8/3/21 with Pneumoni A review of the physic and 8/3/21, document pressure relief cushion A review of the compressure relief cushion A review of the compressure relief cushion A review of the compressident #9 dated 8/4 documented in part, "I risk for falls related to and muscle weakness INTERVENTIONS-An resident's needs daily wheelchair, positioning A review of Resident a living) form for August "Locomotion on Unit-t person physical assist (8/4/21, 8/5/21, 8/6/21	rviewed at this time. When of out of bed, Resident #9 back from the hospital I get up for physical and Before I went to the thick cushion in the I tolerate being up in the ame back from the hospital, he black cushion and given yellow ones. I can't sit on g period of time because it sident #9's wife stated, cushion back, and were told I it. He doesn't get out of the comfortable."  bitalized from 8/1/21 to a.  ian's orders dated 6/10/21 ed in part, "Wheelchair in."  ehensive care plan for 1/21 and revised 8/7/21, FOCUS- The resident is at left BKA, diabetes mellitus is.  ticipate and meet the check and ensure that g equipment are in use."  #9's ADL (activities of daily 2021, documented in part, otal dependence with one if for five of eight days , 8/7/21, 8/11/21). A documented for three of	F 558	DNS and/or designee will report results audits at the Quality Assurance and Pe Improvement (QAPI) Committee for the 3 months.  During and at the conclusion of the 3 m the QAPI Committee will re-evaluate ar the necessary action or extend the review The Administrator and/or designee is responsible for confirming implementationgoing compliance with the componenthe Plan of Correction and addressing a resolving variances that may occur.	rformance next onths, ad initiate ew period.	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
				-		С	
		495197	B. WING			08/	11/2021
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		_	(X5) COMPLETION DATE
F 558	AM with OSM (other soccupational therapis she had worked with stated, "Yes, I used to went to the hospital. days and putting on hwith a little assistance cushion in his wheeld was gone. I have not return from the hospit can't find the cushion from supply."  An interview was cone AM with OSM #3, the asked if she had work #3 stated, "Yes, I did. the wheelchair. I did anymore. He should don't want him to have because he doesn't had interview was cone AM with Resident #9. used to get up into the stated, "Yes, I used to had the thick black cubefore I went to the hito OT and PT becaus by coccyx. They told	ducted on 8/11/21 at 9:10 staff member) #2, the t assistant. When asked if Resident #9, OSM #2 o work with him before he He was out of bed most is pants (sweat like pants) e. He had a thick black hair. I did not know that it worked with him since his al. I will look for it and if I , I will order another one  ducted on 8/11/21 at 9:22 physical therapist. When ted with Resident #9, OSM He had a black cushion in not realize he did not have it be getting up more, but I	F	558	DEFICIENCY)		
	got up yesterday for F On 8/11/21 at 11:15 A bringing a black cushi	or another resident. I only PT/OT in the afternoon."  M, OSM #2 was observed fon into Resident #9's room. Yes, that is it! I'm so glad					

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PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495197	B. WING_			C 08/11/2021	
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		9/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 558	you found it."  On 8/11/21 at 1:08 Pl member) #1, the adm director of nursing we on 8/11/21 at 2:00 Pl observed out of bed it how he was feeling, If good sitting up in this had a cheeseburger for sitting to did not want to get up have the correct cush. On 8/11/21 at 3:00 Pl observed sitting in which participating with the PM was observed parcocktail hour.  ASM #2 provided the "Care Standards" dat documented in part, "directs in accordance standards of clinical pof this policy, the Clin follows standards as practice/program/procorders. Perry & Potte Procedures."	M, ASM (administrative staff inistrator and ASM #2, the pre informed of the concern.  M, Resident #9 was an wheelchair. When asked Resident #9 stated, "It feels chair with this cushion. I for lunch. It is going well."  M, an interview was (certified nursing assistant) at the N/A mean on the ADL d, "It can mean that the dothe activity. Resident #9 a because the chair did not sion in it."  M, Resident #9 was neelchair in main lobby area singing activity and at 4:00 articipating in the facility  team with the facility policy red 2/29/16, which the Director of Nursing with care and services oractice. For the purposes ical Operations Department outlined in the predures and physician are: Clinical Nursing Skills & Potter, which documents in	F	558			

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Event ID: TEJD11

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PRINTED: 08/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		496197	B. WNG _	R WING		С	
NAME OF P	ROVIDER OR SUPPLIER	430107	I B. VIIIVO _	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	/11/2021	
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 656 SS=D	assessment including Ultimately the feature must match a patient."  A review of the facility "Exhibit 7- Resident F 10/25/2018, which do shall inform the reside in his or her treatmen resident in this right. include an assessment and needs."  No further information References: (1) Barron's Dictionar Non-Medical Reader, Chapman, page 502. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 160. (3) Barron's Dictionar Non-Medical Reader, Chapman, page 29. (4) Perry & Potter Clinedition, Ostendorf, Election, Ostendorf, Electio	individual needs. s of the support surface s unique needs." (4)  It's admission packet, Rights (Federal)" dated cuments in part, "The facility ent of the right to participate t and shall support the The planning process must: int of the resident's strengths  It was provided prior to exit.  It of Medical Terms for the The edition, Rothenberg and It of Medical Terms for the The dition, Rothenberg and It of Medical Terms for the The dition, Rothenberg and It of Medical Terms for the The dition, Rothenberg and It of Medical Terms for the The dition, Rothenberg and It is of Medical Terms for th	F 5	A. Address how correction action w accomplished for those residents for been affected by the deficient pract.  Upon receipt of the concern by surving 08/11/21, resident #17's floor maplaced on both sides while in bed prand care plan.	und to have ce: ey team it was	8/11/21	

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Event ID: TEJO11

Facility ID: VA0028





	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		С	
		495197	B. WING	_		08/	11/2021
NAME OF P	RÖVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX	9160 BELVOIR WOODS PKWY				
DELVOIR	WOODS HEALIN SAKE	CENTERAL THE FAIRTAX		F	ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	needs that are identificances assessment. The complete describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483.	ied in the comprehensive inprehensive care plan must it - ire to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not	F	656	Resident #21's wound treatment sched e-TAR was also immediately updated p MD order.  B. Address how the facility will identify the residents having the potential to be affect the same deficient practice:	other	8/11/21
	provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).  (iii) Any specialized services or specialized rehabilitative services the nursing facility will				Facility's Administrator and/or designee conducted 100% audit for residents who floor mats to confirm the compliance wi order and care plan.	o need	8/25/21
	findings of the PASAF rationale in the reside	a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-			Facility's DNS and/or designee will conditional 100% audit for residents who need wou to confirm the compliance with MD order care plan.	ınd care	9/10/21
	future discharge. Faci whether the resident's	s desire to return to the			C. Address what measures will be put in place or systemic changes made to enset the deficient practice will not recur:		
	local contact agencies entities, for this purpo (C) Discharge plans in	n the comprehensive care			DNS and/or designee will provide educa nurses regarding accurate order verifica and transcription to e-TAR.		9/10/21
	requirements set forth section. This REQUIREMENT by: Based on observation document review and was determined that timplement the compre	in accordance with the in paragraph (c) of this is not met as evidenced ins, staff interview, facility clinical record review, it the facility staff failed to be ensive care plan for the ise of 25 residents in the			DNS and/or designee will provide educaterified nursing aides (CNAs) regarding following MD order and care plan for flo	g	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495197	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	100101		STREET ADDRESS, CITY, STATE, ZIP CODE		/11/2021
				9160 BELVOIR WOODS PKWY		
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	Continued From page	<del>2</del> 7	F 65	6 D. Indicate how the facility plans	s to monitor its	
	survey sample, Resid	ent # 17; and for the		performance to make sure that	solutions are	
	provision of pressure ulcer treatment per		i	sustained:		i
	physician orders for o	ne of 25 residents in the				
	survey sample, Resident # 21. Administrator and/or designee will conduct		vill conduct	8/27/21		
				random weekly audits for floor r		
	The findings include:			beginning week of 08/23/21 for	•	
				to confirm the compliance with p		
		led to implement Resident #				
		care plan for the use of fall	İ	Administrator and/or designee v	vill report	1
	mats while in bed.			results of the audits at the Quali	*	
	Pecident # 17 was ad	Imitted to the facility with		and Performance Improvement	-	
		ed but were not limited to:		Committee for the next 3 month		
	_	ture of the right Ilium [2] and				
	muscle weakness.	and of the right manifest and		During and at the conclusion of	the 3 months.	
				the QAPI Committee will re-eva		
	Resident # 17's most	recent MDS (minimum data		initiate the necessary action or e	extend the	
		e date) of 06/23/2021,		review period.		
		as scoring a 15 on the brief		The Administrator and/or design	iee is	
		tatus (BIMS) of a score of 0		responsible for confirming imple		
		tively intact for making daily		ongoing compliance with the co		
		# 17 was coded as requiring		the Plan of Correction and addre	•	
		of one staff member for		resolving variances that may oc	_	
	activities of daily living	g.				
		n.m., an observation of ed the resident lying in their				
		tion revealed one fall mat				
	on the floor to the res	ident's right side of the bed.				
	1	or to the resident's left side				
	failed to evidence a fa	all mat on the floor.				
	Observation of Reside	ent # 17's room revealed				
		observed leaning against the				
	wall at the foot of the	bed.				
	On 08/11/21 at 7:40 a	.m., an observation of				
		ed the resident lying in their				
	bed. Further observa	tion revealed one fall mat				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, , ,	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		495197	B. WNG_			C 08/11/2021	
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		08/11/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 656	Observation of the flof failed to evidence a fice observation of Reside another fall mat was at the foot of the bed.  The care plan for Reside documented in part, had more than one at multiple falls, and is a impaired mobility, del lumbar and sacrum with Use of Antidepressar Halo bar to improve poly 1/17/21 with no appa 09/21/2020." Under documented in part, bed. Date Initiated: 0 On 08/10/2021 at 7:4 conducted with Reside about the placement 17 stated that both fadown when they are in the conducted with LPN   6. After observing the 17's bed, LPN #6 was LPN #6 stated that the floor next to Resident stated, "There should on each side of the both 10/2021 at 10:46	dident's right side of the bed. For to the resident's left side all mat on the floor. In the floor revealed deaning against the wall at sident # 17 dated 09/21/2020 Focus. The resident has ctual fall with h/o [history of] at risk for falls r/t [related to] with the use of back brace. In the use of back brace. In the use of back brace. In the risk for side effects. In terventions it floor when in 1/17/2021."  2 a.m., an interview was lent # 17. When asked of the fall mats, Resident # Il mats were supposed to be in bed.  In an interview and ent # 17's room was flicensed practical nurse] # If the foor around Resident # If saked about the fall mats. In the rewer was one fall mat on the interview and the fall mats one was one fall mat on the interview and the fall mats. In the rewer was one fall mat on the interview was one fall mat on the interview fall mats down, one was a.m., an interview with LPN a.m., an interview with LPN a.m., an interview with LPN	F	356			
	# 6. LPN #6 reviewer comprehensive care	d Resident # 17's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` `	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495197	B. WNG			C 08/11/2021	
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	Ē	1 00/	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 656	completing the review comprehensive care passed on the observa stated, "Not as it shot fall mat down and the On 08/11/2021 at app (administrative staff nadministrator and ASI were made aware of No further information References: [1] High blood pressu obtained from the well https://www.nlm.nih.gessure.html.  [2] The broad, dorsal, three principal bones pelvis. This information website: https://www.merriam-2. The facility staff facomprehensive care provide pressure ulce Provide pressure ulce Resident #21 was addiagnoses that includ diabetes (2), heart faid disease (4). Resident (minimum data set) a assessment with an Adate) of 7/25/2021 coscoring a 15 on the Bernatal status), 15-bernaking daily decision	y, LPN # 6 was asked if the colan was being followed ations above. LPN # 6 and be. There was only one are should be two."  Proximately 1:08 p.m. ASM member) # 1, the M # 2, director of nursing, the above findings.  In was provided prior to exit.  This information was besite:  Ov/medlineplus/highbloodpr  upper, and largest of the composing either half of the control was obtained from the webster.com/dictionary/ilium illed to implement the colan for Resident #21 to are treatment as ordered.  In the dot were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (3) and end stage renal to the facility with ed but were not limited to lure (4) and lure (4) and lure (4) and lure (4)	F6	556			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495197	B. WING			C 08/11/2021	
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		91	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060	1 00/	11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	one person for bed m persons for transfers. #21 having one unstawas present on admisted was personal was p	section M coded Resident ageable pressure ulcer that sision.  The ensive care plan dated a in part, "I have an ound. Date Initiated: re plan further documented, stageable pressure ulcer sure ulcer development r/t rocess, immobility. Date "Under "Interventions" it Adhere to the resident's prevention/treatment of ed Initiated: 08/08/2021. In and treatments as ordered iveness. Date Initiated:  Oximately 10:45 a.m., an atted with Resident #21. That the facility staff applied a their buttocks. Resident urses changed the dressing ad seen the wound doctor rior to them getting out of the summary for Resident #21 are following: "Cleanse e bilateral buttocks with dry, apply soothe and coolery day and evening shift er gauze until resolved.	F	656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	ľ	(X3) DATE SURVEY COMPLETED	
		495197	B. WING			C <b>08/11/2021</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	00/11/2021	
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCED)			
F 656	Continued From page	: 11	F	956			
	Time Code 0700-1500 Start on: 8/4/2021 Da	0 (7:00 a.m3:00 p.m.); y 7-3"					
	treatment orders as d unstageable pressure was completed on Da a.m3:00 p.m.) each 8/10/2021. The eTAR evidence documentat treatment being comp as ordered by the phy The "Surgical Note" for 7/27/2021 documente Location: Sacrum; Eti Wound Stage: Unstage	ocumented the physician ocumented above, to the ulcer and documented it y shift (between 7:00 day from 8/4/2021 through a for Resident #21 failed to ion of the pressure ulcer eleted on the evening shift esician.  or Resident #21 dated in part, " Wound ology: Pressure injury/ulcer-peable pressure cm [centimeter]) 6.0, Width of UTD [unable to rea (cm2) 90; Wound					
	The "Surgical Note" for 8/10/2021 documenter Sacrum; Etiology: Pre Stage: Unstageable processed (cm) 7.0, Width (cm) 100 Wound Area (cm2) 730 Wound has decreased doing well. We will contreatment for now. I week. The goal will be On 8/11/2021 at approinterview was conducted practical nurse) #6. Liplan gave everyone a	or Resident #21 dated d in part, "Wound Location: ssure injury/ulcer- Wound ressure injurySize: Length 10.5, Depth (cm) 0.3, 1.5; Wound progress: d in sizeHis wounds are					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE COMP	SURVEY
		495197	B. WING _			C 11/2021
	ROVIDER OR SUPPLIER 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 DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)		(X5) COMPLETION DATE
F 656	ulcers and skin care very care plan. LPN #6 streatments were docuthe eTAR (electronic record). LPN #6 reviewed: #21 which documents include bilateral butto pat dry, apply soothe every day and evenin boarder gauze until re 08/03/2021. Start Dathat the eTAR should completed on the day LPN #6 reviewed the stated that there was treatment being comp. #6 stated that the trea on the eTAR for the enot aware that it was LPN #6 stated that th implemented if the treperformed as ordered.  On 8/11/2021 at apprinterview was conducted as ordered. On 8/11/2021 at apprinterview was conducted as ordered. Was stated that the order was scheduled only and was not beir ASM #2 stated that un with a schedule of danot show on the eTAR the evening shift treat they would change the	were documented on the ated that pressure ulcer umented as completed on treatment administration ewed the order for Resident ed, "Cleanse unstageable to ocks with wound cleanser, and cool mix with calazime ag shift and cover with esolved. Order Date: ate: 08/04/2021" and stated reflect the treatment being y shift and the evening shift. eTAR for Resident #21 and only documentation of the pleted on the day shift. LPN atment was not scheduled evening shift so they were to be done twice a day. The care plan was not being the care plan was not being the coximately 12:55 p.m., an exted with ASM (administrative exterect of nursing. ASM	F6	656		

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 _				C 11/2021
	ROVIDER OR SUPPLIER WOODS HEALTH CARE	CENTER AT THE FAIRFAX		9	STREET ADDRESS, CITY, STATE, ZIP CODE 1160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	stated that the care plimplemented for treat were not completing the evening shift.  On 8/11/2021 at appropries a special shift.  On 8/11/2021 at appropries a special shift.  On 8/11/2021 at appropries a special shift policy of plan.  The facility policy "Ind 2/29/16 documented (interdisciplinary team care plan addressing problems. The comprinclude: a. Services the attain or maintain the practicable physical, resultable physical physi	lan was not being ments as ordered if staff the treatment on day and oximately 1:00 p.m., a ASM #1, the administrator on implementing the care dividualized Care Plan" dated in part, " The IDT of the resident's most acute the resident's most acute the resident's highest mental, and psychosocial oximately 10:48 a.m., ASM member) #2 stated that the & Potter as their nursing tials for Practice, 6th edition, 107, pages 119-127), was a ms. "A nursing care plan is a coordinating nursing care, of care and listing outcome the evaluation of nursing the plan communicates are plan also identifies and as used to deliver nursing	F	356			
	easy to continue care another"	nulated care plan makes it from one nurse to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495197	B. WING		C 08/11/2021	
	ROVIDER OR SUPPLIER WOODS HEALTH CARE	CENTER AT THE FAIRFAX	9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060	00.1112021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION	
F 656	Continued From page	÷ 14	F 656			
	#1, the administrator nursing were made a	oximately 1:15 p.m., ASM and ASM #2, the director of ware of the concerns.			65	
	References:					
	down when somethin against the skin. Prethe severity of symptomstage. Stage IV is the painful area on the skin when pressed. This is forming. The skin most. Stage II: The sk sore. The area around irritated. Stage III: Thopen, sunken hole cabelow the skin is dam see body fat in the crapressure ulcer has be damage to the muscle to tendons and joints. obtained from the well-	come so deep that there is e and bone, and sometimes This information was				
	cannot regulate the a This information was	c disease in which the body mount of sugar in the blood. obtained from the website: ov/medlineplus/ency/article/				
	no longer able to pum	ndition in which the heart is p oxygen-rich blood to the entry. This causes symptoms				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		495197	B. WING_			C 9/11/2021
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656	Continued From page to occur throughout the	e 15 ne body. This information	F6	556		
		e website: ov/ency/article/000158.htm. disease: The last stage of				
	chronic kidney diseas can no longer support information was obtain	e. This is when your kidneys your body's needs. This				Si .
F 658 SS≃D	CFR(s): 483.21(b)(3)( §483.21(b)(3) Compre	ehensive Care Plans	F6	A. Address how correction action accomplished for those residen have been affected by the deficit	ts found to	
!	as outlined by the con must- (i) Meet professional s			Upon receipt of the concern by resident #17's order on e-MAR immediately based on MD orde	was corrected	8/11/21
	by: Based on staff intervi and clinical record rev the facility staff failed standards of practice	is not met as evidenced  ew, facility document review riew, it was determined that to follow professional for the administration of 25 residents in the survey		For resident #21, the wound tre schedule on e-TAR was immed per MD order and care plan was accordingly.	iately corrected	8/11/21 d
	sample, Resident # 17 professional standard	7; and failed to follow for the provision of ent per physician's orders		B. Address how the facility will in residents having the potential to by the same deficient practice:	•	
	The findings include:  1. The facility staff fail the physician's order or	ed to accurately transcribe of metoprolol [1] for		DNS and/or designee will perform of e-MAR and e-TAR for all new 8/1/21 to 8/27/21 to confirm according transcription of MD orders.	orders from	9/10/21
	Resident # 17.  Resident # 17 was ad diagnoses that include	mitted to the facility with ed but were not limited to: ure of the right Ilium [3] and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE  AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING							
		495197	B. WING_			08/	11/2021
NAME OF PI	ROVIDER OR SUPPLIER			\$	TREET ADDRESS, CITY, STATE, ZIP CODE		
DELVOID	WOODS HEALTH CARE	OPNIED AT THE FAIREAY		91	160 BELVOIR WOODS PKWY		
BELVOIR	WOODS REALIR CARE	CENTER AT THE FAIRFAX		F	ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	± 16	Fe	358	C. Address what measures will be put i	nto	
	muscle weakness				place or systemic changes made to en		
	muscic weakiess.				that the deficient practice will not recur:		
o.	set), a quarterly asses (assessment reference coded Resident # 17 interview for mental st	recent MDS (minimum data ssment with an ARD se date) of 06/23/2021, as scoring a 15 on the brief tatus (BIMS) of a score of 0 tively intact for making daily			DNS and/or designee will provide educ all nurses regarding accurate order tran and order review process by night shift	ation for	9/10/21
	decisions. Resident a extensive assistance activities of daily living	t 17 was coded as requiring of one staff member for 3.			D. Indicate how the facility plans to more performance to make sure that solution sustained:		
		ent # 17 documented, etoprolol] to 50mg QD [every ess than] 110 or < 60 pulse.			DNS and/or designee will perform weel audits of e-MAR and e-TAR of random 5 residents with new telephone orders week of 08/23/21 for for 3 months to co compliance with MD orders.	beginning	8/27/21
	Extended Release 24 Give 1 [one] tablet by HTN [hypertension]. pressure] less than 11	olol Succinate ER Tablet Hour 50 MG [milligram]. mouth one time a day for Hold for SBP [systolic blood I0 and pulse less than 60.			DNS and/or designee will report results audits at the Quality Assurance and Performance Improvement (QAPI) Confor the next 3 months.		
	records] for Resident through August 11, 20 "Metoprolol Succinate Release 24 Hour 50 M tablet by mouth one ti [hypertension]. Hold pressure] less than 11 Order Date: 9/25/2020	ic medication administration # 17 dated January 2021 221 documented in part, ER Tablet Extended MG [milligram]. Give 1 [one] me a day for HTN for SBP [systolic blood 10 and pulse less than 60. 0."			During and at the conclusion of the 3 m the QAPI Committee will re-evaluate ar initiate the necessary action or extend the review period.  The Administrator and/or designee is responsible for confirming implementationgoing compliance with the componer Plan of Correction and addressing and variances that may occur.	nd the ion and nts of the	
	interview was conduc	oximately 12:10 p.m., an ted with ASM [administrative director of pursing. After					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G		LETED
	¥0	495197	B. WING			C 11/2021
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658	reviewing the eMARs through August 11, 20 copy of the physician' 09/25/2020 for Reside that the orders on the transcribed correctly telephone order.  On 8/11/2021 at apprinterview was conducted that the massing orders from the physical on the telephone order that the nursing staff sheet to transcribe that ASM #2 stated that exchecked every chart frand compared them to that they were transcribed to provide necessist each resident they were transcribed to prov	dated January 2021 021, ASM # 2 provided a stelephone order dated ent # 17. ASM # 2 stated eMARs were not from the physician's  eximately 2:40 p.m., an ted with ASM (administrative director of nursing. ASM a staff received telephone cian and documented them er sheet. ASM #2 stated used the telephone order er order into the computer. Very night the nurse for new telephone orders to the computer to ensure ribed correctly.  Eare Standards" documented ment: It is the policy of the essary care and services to a attain or maintain his/her vel of physical, mental and ag in accordance with emprehensive assessment re is documented in the ordance with State and  eroximately 1:08 p.m. ASM member) # 1, the M # 2, director of nursing,	F 65	58		

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			C 98/11/2021	
	ROVIDER OR SUPPLIER 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 DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 658	medications to treat hinformation was obtain https://medlineplus.gottml.  [2] High blood pressure obtained from the well https://www.nlm.nih.gotsure.html.  [3] The broad, dorsal, three principal bones pelvis. This information website: https://www.merriam-2. The facility staff fa a physician's order in record for Resident # admitted to the facility readmission on 8/3/20 pressure ulcer (1) on physician's orders for ulcer documented the completed on day and facility staff transcribes the treatment as day Resident #21 receiving day.  Resident #21 was addiagnoses that includ diabetes (2), heart fail disease (4). Resident (minimum data set) a assessment with an Adate) of 7/25/2021 co	ombination with other igh blood pressure. This ned from the website: by/druginfo/meds/a682864.h are. This information was osite: by/medlineplus/highbloodpr upper, and largest of the composing either half of the on was obtained from the webster.com/dictionary/ilium illed to accurately transcribe to the electronic medical 21. Resident #21 was on 7/8/2021 with a 021, with an unstageable the sacrum/buttocks. The treatment to the pressure of the treatment was to be devening shift however, the did the scheduled times for shift only resulting in gother treatment only once a mitted to the facility with ed but were not limited to lure (3) and end stage renal at #21's most recent MDS ssessment, a 5 day uRD (assessment reference	F 65	58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_			С
		495197	B. WING	_		08/	11/2021
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY CORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	making daily decision Resident #21 requirin one persons for bed may persons for transfers. #21 having one unstated was present on admisted Resident #21's comparts and manageable sacral was 08/03/2021 documented unstageable sacral was 108/03/2021." The confurther documented, "unstageable pressure pressure ulcer develod disease process, immo 108/08/2021." Under "documented in part, "treatment plan for the skin breakdown. Date Administer medication and monitor for effect 08/08/2021"  On 8/10/2021 at approximate of the sore on #21 stated that the nuevery day and they have arlier that morning pubed.  The physician's order	sing cognitively intact for s. Section G coded g extensive assistance of obility and toileting and two Section M coded Resident geable pressure ulcer that ssion.  The resident has a ulcer and potential for a prehensive care plan are ulcer and potential for a prehensive care plan are ulcer and potential for a prehensive to the resident are ulcer and potential for a prehensive to the resident's preventions it and treatment of and treatments as ordered a linitiated: 08/08/2021. In and treatments as order	F	658			
	documented in part the unstageable to include wound cleanser, part of mix with calazime even	ne following: "Cleanse e bilateral buttocks with dry, apply soothe and cool ery day and evening shift					

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_			1	C 11/2021
	ROVIDER OR SUPPLIER WOODS HEALTH CARE	CENTER AT THE FAIRFAX	•	STREET ADDRESS, CITY, STATE, ZIP COI 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	Œ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI E APPROPRIA		(X5) COMPLETION DATE
F 658	Order Date: 08/03/20 08/04/2021" Under the order it document every day shift, Scher Time Code 0700-150 Start on: 8/4/2021 Date of the eTAR for Reside: 8/1/2021-8/31/2021 direatment orders as dunstageable pressure was completed on Date: a.m3:00 p.m.) each 8/10/2021. The eTAR evidence documentate treatment being compas ordered by the phy.  The "Surgical Note" for 7/27/2021 documented Location: Sacrum; Eti Wound Stage: UnstaginjurySize: Length (Depth (cm) UTD, Woprogress: Undeterminate The "Surgical Note" for 8/10/2021 documented Sacrum; Etiology: Pressure Stage: Unstageable progress: Unstageable progres	21. Start Date:  "the "Scheduling Details" of ed in part, "Frequency: dule Type: Everyday; Facility 0 (7:00 a.m3:00 p.m.); y 7-3"  Int #21 dated ocumented the physician ocumented above, to the e ulcer and documented it hy shift (between 7:00 day from 8/4/2021 through R for Resident #21 failed to hion of the pressure ulcer bleted on the evening shift yrician.  Or Resident #21 dated ed in part, " Wound ology: Pressure injury/ulcer- geable pressure cm) 6.0, Width (cm) 15.0, und Area (cm2) 90; Wound hed: First Visit."  Or Resident #21 dated ed in part, "Wound Location: essure injury/ulcer- Wound oressure injury/ulcer- Wound oressure injury/ Size: Length 10.5, Depth (cm) 0.3, 3.5; Wound progress: d in size His wounds are	F 6	558			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495197	B. WING			C
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX	1	STREET ADDRESS, CITY, STATE, ZI 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	P CODE	08/11/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIA	
F 658	practical nurse) #6. Les wound physician came to see residents. LPN provided the pressure physician was not in that pressure ulcer treas completed on the dadministration record order for Resident #2 "Cleanse unstageable with wound cleanser, cool mix with calazim shift and cover with border Date: 08/03/20 and stated that the est treatment being compthe evening shift. LPN Resident #21 and stadocumentation of the on the day shift. LPN was not scheduled or shift so they were not done twice a day.  On 8/11/2021 at apprinterview was conducted that Reside pressure ulcer treatment being completed that the order as was scheduled to be and was not being do ASM #2 stated that unwith a schedule of danot show on the eTAF it. ASM #2 stated that	PN #6 stated that the e to the facility once a week I #6 stated that the nurses culcer care when the wound the facility. LPN #6 stated the fac	F	658		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		P. 1822.47	(X3) DATE SURVEY COMPLETED	
						(	
		495197	B. WING			08/	11/2021
	ROVIDER OR SUPPLIER WOODS HEALTH CARE	CENTER AT THE FAIRFAX		9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	interview was conduct staff member) #2, the #2 stated that nursing orders from the physic on the telephone order that the nursing staff is sheet to transcribe the ASM #2 stated that exchecked every chart if and compared them to that they were transcribe the ASM #1/2021 at appropriate the facility policy of orders.  The facility policy "Phauthorization and Corpharmacy" dated 12/0"Facility staff should Physician/Prescriber agent to ensure accur "sound alike" medicate that the person receiving in the order, the Physician/Prescriber, person recording the should be recorded by On 8/10/2021 at appropriate the should be recorded by On 8/10/2021 at appropriate the should be recorded by the	eximately 2:40 p.m., an a ted with ASM (administrative director of nursing. ASM a staff received telephone coan and documented them are sheet. ASM #2 stated used the telephone order are order into the computer. It is a computer to ensure	F	358			

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

Event ID: TEJD11

Facility ID: VA0028

If continuation sheet Page 23 of 47



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495197	B WING			08/	11/2021
NAME OF PI	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
BEI VOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		9	160 BELVOIR WOODS PKWY		
DELVOIR	WOODO NEAEIN OAKE	OBITERAL THE TAIN AX		F	FORT BELVOIR, VA 22060		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
IAG	1,2000		170		DEFICIENCY)		
F 658	Continued From page	23	F	658			
	According to Basic Nu	ursing, Essentials for					
		Potter and Perry, 2007,					
	pages 349-360) "A mo	edication order is required					
		any medication to a patient.					
		I process a medication,					
		or health care provider's					
		appropriate medication					
		MAR includes the patient's					
	· · ·	number, as well as the					
	administration for eac	uencies, and routes of					
	transcribing orders, e						
	_	s, routes, and times are					
		ecks all orders for accuracy					
		/hen orders are transcribed,					
		needs to be checked again				,	
	by the nurse. It is ess	sential that you verify the					
	accuracy of every me	dication you give to the					
		nt's orders. To ensure safe				]	
		ation, be aware of the six					
	*	dministration. 1. The right					
	_	ht dose 3. The right patient					
	_	The right time 6. The right					
	documentation"						
	On 8/11/2021 at appre	oximately 1:15 p.m., ASM					
		and ASM #2, the director of				-	
	nursing were made av						
	5						
	No further information	was presented prior to exit.					
	References:						
	Pressure ulcer						
	A pressure sore is an	area of the skin that breaks					
	down when something	g keeps rubbing or pressing					
		ssure sores are grouped by					
		oms. Stage I is the mildest					
	stage. Stage IV is the	worst. Stage I: A reddened.					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495197	B. WING			C	
NAME OF PE	ROVIDER OR SUPPLIER	483197	0. 1110	S	TREET ADDRESS, CITY, STATE, ZIP CODE	08/	11/2021
	172 11				160 BELVOIR WOODS PKWY		
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		F	ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	when pressed. This is is forming. The skin m soft. Stage II: The sk sore. The area around irritated. Stage III: The open, sunken hole cabelow the skin is dam see body fat in the crapressure ulcer has be damage to the muscle to tendons and joints. obtained from the wel https://medlineplus.go.00740.htm.  2. Diabetes mellitus A chronic disease in v regulate the amount of information was obtain https://www.nlm.nih.go.01214.htm.  3. Heart failure A condition in which the pump oxygen-rich bloefficiently. This cause throughout the body. obtained from the well https://medlineplus.go.4. End-stage kidney of the last stage of chrowhen your kidneys cabody's needs. This in from the website:	in that does not turn white is a sign that a pressure ulcer hay be warm or cool, firm or in blisters or forms an open do the sore may be red and he skin now develops an alled a crater. The tissue aged. You may be able to ater. Stage IV: The become so deep that there is an and bone, and sometimes. This information was besite:  by/ency/patientinstructions/0  which the body cannot of sugar in the blood. This ned from the website:  by/ency/article/  the heart is no longer able to do to the rest of the body is symptoms to occur. This information was besite:  by/ency/article/000158.htm.	F	658			
F 686 SS=E	Treatment/Svcs to Pro	event/Heal Pressure Ulcer	F	686			

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

Event ID: TEJD11

Facility ID: VA0028

If continuation sheet Page 25 of 47



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495197	B. WING		C 08/11/2021
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	00/11/2021
PELVOIR	WOODS HEALTH CADE	CENTER AT THE FAIRFAX	•	9160 BELVOIR WOODS PKWY	
BELYOIK	HOODS HEALTH CARE	CENTER AT THE FAIRFAX		FORT BELVOIR, VA 22060	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 686	CFR(s): 483.25(b)(1)(1)( §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indiv demonstrates that the (ii) A resident with pre necessary treatment a with professional stan promote healing, prev new ulcers from deve This REQUIREMENT by: Based on resident int facility document revie review, it was determine	rity re ulcers. hensive assessment of a just ensure that- a care, consistent with s of practice, to prevent does not develop pressure vidual's clinical condition by were unavoidable; and ssure ulcers receives and services, consistent dards of practice, to yent infection and prevent loping. is not met as evidenced derview, staff interview, yew and clinical record ined that the facility staff	F 68	A. Address how correction action will be accomplished for those residents found been affected by the deficient practice:  Upon receipt of the concern by survey t resident #21's wound treatment schedu e-TAR was immediately corrected per M and care plan was updated accordingly Resident #21 did not have any worsening condition per wound MD.  B. Address how the facility will identify the same deficient practice:  Facility's DNS and/or designee will concern to confirm compliance with MD ordicare plan.	to have eam, le on ID order og skin other cted by duct I wound
	physician to promote for one of 25 residents (Resident #21).  Resident #21 was addr/8/2021 with a readmunstageable pressure sacrum/buttocks. The treatment to the press treatment was to be devening shift however the scheduled time for only resulting in Resident and the scheduled time for only resulting in Resident and the scheduled time for only resulting in Resident and the scheduled time for only resulting in Resident and the scheduled time for only resulting in Resident and the scheduled time for only once and the scheduled time for only once and the scheduled time for only resulting in Resident and the scheduled time for only once and the scheduled time for only resulting in Resident time for only once and the scheduled time for only resulting time for only once and the scheduled time for only resulting time for only re	e physician's orders for sure ulcer documented the ompleted on day and r, the facility staff transcribed r the treatment as day shift		C. Address what measures will be put in or systemic changes made to ensure the deficient practice will not recur:  DNS and/or designee will provide educated all nurses regarding accurate order transland order review process by night shift	at the ation for 9/10/21 scription

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE: COMPI	
		495197	B. WNG			00%	
NAME OF D	ROVIDER OR SUPPLIER		1	-	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>U8/</u>	11/2021
NAME OF F	ROVIDER OR SUPPLIER						
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX			160 BELVOIR WOODS PKWY		
				F	ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page The findings include:	<del>2</del> 6	F6	86	D. Indicate how the facility plans to mor performance to make sure that solutions sustained:	- 1	
	diagnoses that include diabetes (2), heart fail disease (4). Resident (minimum data set) at assessment with an Adate) of 7/25/2021 conscoring a 15 on the Billiamental status), 15-bet making daily decision Resident #21 requiring one persons for bed minimum persons for transfers. #21 having one unstal was present on admission 8/10/2021 at appresentation and the sore on #21 stated that the nule every day and they have assessed to the sore on #21 stated that the nule every day and they have assessed to the sore on #21 stated that the nule every day and they have assessed to the sore on #21 stated that the nule every day and they have assessed to the sore on #21 stated that the nule every day and they have assessed to the sore on #21 stated that the nule every day and they have assessed to the sore on #21 stated that the nule every day and they have assessed to the sore of t	ARD (assessment reference ded Resident #21 as IMS (brief interview for eing cognitively intact for s. Section G coded g extensive assistance of obility and toileting and two Section M coded Resident geable pressure ulcer that			DNS and/or designee will perform week e-TAR of residents with wound care dur weekly wound round for three months to compliance with MD orders.  DNS and/or designee will report results audits at the Quality Assurance and Performance Improvement (QAPI) Comfor the next 3 months.  During and at the conclusion of the 3 mithe QAPI Committee will re-evaluate and the necessary action or extend the review.  The Administrator and/or designee is responsible for confirming implementationgoing compliance with the component the Plan of Correction and addressing a resolving variances that may occur.	of the amittee onths, and initiate ew period on and ats of	
	8/3/2021 documented unstageable sacral wide 08/03/2021." The care "The resident has unstand potential for press (related to) disease prinitiated: 08/08/2021, documented in part, "treatment plan for the	•					

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495197	B. WING_			C 08/11/2021	
	ROVIDER OR SUPPLIER WOODS HEALTH CARE	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		7071172021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 686	ordered and monitor Initiated: 08/08/2021.  The physician's order documented in part the unstageable to include wound cleanser, paterial with calazime ever and cover with board Order Date: 08/03/20/08/04/2021" Under the order it document every day shift, Sche Time Code 0700-150/Start on: 8/4/2021 Date the etal of the etal for Reside 8/1/2021-8/31/2021 of treatment orders as constageable pressure was completed on Date a.m3:00 p.m.) each 8/10/2021. The etal evidence documental treatment being compas ordered by the physical process of the part, - "7/11/2021 19:33 (7) Resident head to toe assessment done aften noted MASD (moistut to both under arm pit upper extremities and rash all over buttock	ns and treatments as for effectiveness. Date"  r summary for Resident #21 he following: "Cleanse le bilateral buttocks with dry, apply soothe and cool ery day and evening shift er gauze until resolved. 121. Start Date: r the "Scheduling Details" of ted in part, "Frequency: dule Type: Everyday; Facility 10 (7:00 a.m3:00 p.m.); ay 7-3"  Int #21 dated documented the physician documented above, to the eulcer and documented it ay shift (between 7:00 day from 8/4/2021 through R for Resident #21 failed to tion of the pressure ulcer oleted on the evening shift ysician.	F	886			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495197	B. WING_			C 08/11/2021
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	<u> </u>	VO. 1372021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	skin assessed, no necream to bilateral buttool to dry scaly skin extremities) and BLE No worsening noted."  - "7/19/2021 21:54 (9: Resident arrived at the 6:20 pm, on a stretche paramedics and his stwo pressure ulcer"  - "7/21/2021 14:23 (2: Resident head toe se readmit done 07/20/2 Unstageable to includ lower extremities, DTI heel, Fistula (dialysis with RP (responsible issues."  - "7/22/2021 13:41 (1: meeting held today. EdiscussedResident unstageable pressure bilateral buttocks, DTI heel and very dry skir refusing care from no place, currently has log prevent further skin be - "8/3/2021 23:44 (11: Note:Arrived on 8/3. [Name of Hospital] in transportation team a x 3 (person, place and wound"  - "8/5/2021 11:50 (11: held today. Resident risk for skin breakdow."	w skin noted. Antifungal tock and groin. Sooth and to both BUE (bilateral upper (bilateral lower extremities).  54 p.m.) Admission Note e facility on the 7/19/2021 at er accompanied by 2 onResident has a stage  23 p.m.) Note Text: cond skin check after 021 with the following noted: le bilateral buttocks, dry skin I (deep tissue injury) to right access) noted to left arm party) made aware of skin  41 p.m.) Note Text: At risk tesident reviewed and admitted from hospital with injury to sacrum to include I (deep tissue injury) to right access mattress to reakdown"  44 p.m.) Admission (2021 at 9:35 pm from the company of and sonalert and oriented at time), denies pain. sacral	F	886		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  IG		ATE SURVEY MPLETED	
		495197	B. WING _		,	C 08/11/2021	
-	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX	STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060				
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F 686	Continued From page	29	F6	86			
	Risk" dated 7/8/2021 #21 documented in part #21 documented in part #21 documented in part #21 documented in part, "Etiology: pressure und L x W x D (length, wid (unable to determine)  The "Skilled Wound C Daily Rounds" for Res documented in part, "x W x D (length, width x x D	Care Communication Log for sident #21 dated 7/27/2021Location: Sacrum; stag (unstageable); Pre-Op ath, depth): 6 x 15 x UTD"  Care Communication Log for sident #21 dated 8/10/2021 Location: Sacrum; Pre-Op L. 10, depth): 7 x 10.5 x .3"  Evaluation Skilled" for 1/21/2021 documented in stageable include bilateral Date Acquired able pressure irrements: Length- 10.0 cm 15.5 cm, Depth- 0.0 : Undetermined: First  Evaluation Skilled" for 1/28/2021 documented in 1/28/2021 documen					
		Evaluation Skilled" for /11/2021 documented in					

NAME OF PROVIDER OR SUPPLIER  BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX    SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PORT BELVOIR, VA. 22899    CALL DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   REGULATORY OR LISC. DENTIFYING INFORMATION   PREFIX   PROVIDERS PLAN OF CORRECTION   CACH CONSECTIVE ACTION SHOULD   PREFIX   CROSS-REFLERENCED TO THE APPROPRIATE   CROSS-REFLEREN		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX    PROVIDERS   PRO			495197	B. WING_	<del>.</del>			
### CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 686  Continued From page 30 part, "Seen by wound physician [Name of wound physician]Location: Sacrum extending to the bilateral buttockunstageable pressure injuryWound measurements: Length- 7.0 cm (centimeters), Width- 10.0 cm, Depth- 0.3 cmWound progress: Wound has decreased in size"  The "Weekly Evaluation" for Resident #21 dated 7/12/2021 documented in part, "Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcers- Yes; Improvement or change in wound or pressure ulcers- Yes; Improvement or change in wound or pressure ulcer based on current treatment- Yes"  The "Weekly Evaluation" for Resident #21 dated 7/26/2021 documented in part, "Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcers- Yes; Improvement or change in wound or pressure ulcer based on current treatment- Yes"  The "Weekly Evaluation" for Resident #21 dated 8/9/2021 documented in part, "Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcer- Yes; Improvement or change in wound or pressure ulcer based on current treatment- Yes"  The "Surgical Note" for Resident #21 dated 8/9/2021 documented in part, "Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcers- Yes; Improvement or change in wound or pressure ulcers- Yes; Improvement or change in wound or pressure ulcer based on current treatment- Yes"  The "Surgical Note" for Resident #21 dated 7/27/2021 documented in part, "Wound	-		CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY			
part, " Seen by wound physician [Name of wound physician] Location: Sacrum extending to the bilateral buttock unstageable pressure injury Wound measurements: Length- 7.0 cm (centimeters), Width- 10.0 cm, Depth- 0.3 cm Wound progress: Wound has decreased in size"  The "Weekly Evaluation" for Resident #21 dated 7/12/2021 documented in part, " Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcers- Yes; Improvement or change in wound or pressure ulcer based on current treatment- Yes"  The "Weekly Evaluation" for Resident #21 dated 7/26/2021 documented in part, " Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcers- Yes; Improvement or change in wound or pressure ulcer based on current treatment- Yes"  The "Weekly Evaluation" for Resident #21 dated 8/9/2021 documented in part, " Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcers- Yes; Improvement or change in wound or pressure ulcers- Yes; Improvement or change in wound or pressure ulcer based on current treatment. Yes"  The "Weekly Evaluation" for Resident #21 dated 8/9/2021 documented in part, " Skin: New skin concerns identified in the last 7 days- No; Current treatment(s) for wounds or pressure ulcers- Yes; Improvement or change in wound or pressure ulcer based on current treatment. Yes"	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI)	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE		COMPLETION
Wound Stage: Unstageable pressure injurySize: Length (cm) 6.0, Width (cm) 15.0, Depth (cm) UTD, Wound Area (cm2) 90; Wound progress: Undetermined: First Visit."  The "Surgical Note" for Resident #21 dated 8/10/2021 documented in part, "Wound Location:	F 686	part, "Seen by wou wound physician]Lot the bilateral buttock injuryWound meast (centimeters), WidthcmWound progress size"  The "Weekly Evaluat 7/12/2021 documente concerns identified in Current treatment(s) ulcers- Yes; Improve pressure ulcer based The "Weekly Evaluat 7/26/2021 documente concerns identified in Current treatment(s) ulcers- Yes; Improve pressure ulcer based The "Weekly Evaluat 8/9/2021 documented concerns identified in Current treatment(s) ulcers- Yes; Improve pressure ulcer based The "Weekly Evaluat 8/9/2021 documented concerns identified in Current treatment(s) ulcers- Yes; Improve pressure ulcer based The "Surgical Note" f 7/27/2021 documented Location: Sacrum; Et Wound Stage: UnstainjurySize: Length (Depth (cm) UTD, Wo progress: Undetermin The "Surgical Note" f	and physician [Name of cocation: Sacrum extending to cunstageable pressure urements: Length- 7.0 cm 10.0 cm, Depth- 0.3 c: Wound has decreased in sion" for Resident #21 dated end in part, "Skin: New skin the last 7 days- No; for wounds or pressure ment or change in wound or on current treatment- Yes" sion" for Resident #21 dated end in part, "Skin: New skin the last 7 days- No; for wounds or pressure ment or change in wound or on current treatment- Yes" sion" for Resident #21 dated end in part, "Skin: New skin the last 7 days- No; for wounds or pressure ment or change in wound or on current treatment- Yes" sion" for Resident #21 dated end in part, "Skin: New skin the last 7 days- No; for wounds or pressure ment or change in wound or on current treatment- Yes" or Resident #21 dated end in part, "Wound iology: Pressure injury/ulcer-geable pressure cm) 6.0, Width (cm) 15.0, und Area (cm2) 90; Wound ned: First Visit."	F	886			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE COMP	SURVEY LETED
		495197	B. WING_				11/2021
_	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060			
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F 686	Sacrum; Etiology: Pre Stage: Unstageable p (cm) 7.0, Width (cm) Wound Area (cm2) 73 Wound has decrease On 8/11/2021 at apprinterview was conducted practical nurse) #6. Leading to see residents. LPh provided the pressure physician was not in that pressure ulcer treas completed on the dadministration record physician order for Redocumented, "Cleans bilateral buttocks with apply soothe and cood day and evening shift gauze until resolved. Start Date: 08/04/202 should reflect the treathe day shift and the creviewed the eTAR for that there was only dot treatment being comp #6 stated that the treat on the eTAR for the enot aware that it was	essure injury/ulcer- Wound pressure injurySize: Length 10.5, Depth (cm) 0.3, 3.5; Wound progress: d in size"  Depth (cm) 0.3, 3.5; Wound progress: d in size"  Depth (cm) 0.3, 3.5; Wound progress: d in size"  Depth (cm) 0.3, 3.5; Wound progress: d in size"  Depth (cm) 0.3, 3.5; Wound progress: d in size"  Depth (cm) 0.4, 4.5, 4.5, 4.5, 4.5, 4.5, 4.5, 4.5, 4	F	686			
1.	the buttocks was writt	ent to the unstageable to en for day and evening shift eted twice a day. ASM #2					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		495197	B. WING	_		C 08/11/2021	
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		9	STREET ADDRESS, CITY, STATE, ZIP CODE 1460 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 686	was scheduled to be and was not being do ASM #2 stated that us with a schedule of day not show on the eTAF it. ASM #2 stated that scheduling to reflect the and evening shift.  On 8/11/2021 at approper request was made to for the facility policy of the	audit shows that the order completed on day shift only ne on the evening shift. Aless the order was entered by and evening shift it would at for the nurses to complete the they would change the the treatment order of day to be the treatment order of the treatment of th	F	686			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY LETED
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NAME OF D	RÖVIDER OR SUPPLIER	400107		STREET ADDRESS, CITY, STATE, ZIP CODE	08/	11/2021
NAME OF F	NO VIDEN ON SOFFEIER			9160 BELVOIR WOODS PKWY		
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		FORT BELVOIR, VA 22060		
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F 686	stage. Stage IV is the painful area on the sk when pressed. This is is forming. The skin m soft. Stage II: The ski sore. The area around irritated. Stage III: Th open, sunken hole ca below the skin is dam see body fat in the crapressure ulcer has be damage to the muscle to tendons and joints. obtained from the well	worst. Stage I: A reddened, in that does not turn white is a sign that a pressure ulcer may be warm or cool, firm or in blisters or forms an open id the sore may be red and e skin now develops an alled a crater. The tissue aged. You may be able to ater. Stage IV: The come so deep that there is and bone, and sometimes This information was	F 64	DEFICIENCY)		
	the body cannot regul the blood. This inform the website:	A chronic disease in which ate the amount of sugar in nation was obtained from ov/medlineplus/ency/article/		V.		
	no longer able to pum rest of the body efficie to occur throughout th was obtained from the	ndition in which the heart is p oxygen-rich blood to the ently. This causes symptoms the body. This information we website:				
	chronic kidney diseas can no longer support information was obtain https://medlineplus.go	ov/ency/article/000500.htm. ards/Supervision/Devices	F 6	89		

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	ROVIDER OR SUPPLIER WOODS HEALTH CARE	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	00/11/2021	
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F 689	as free of accident has §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observatio document review and was determined that provide assistive devienvironment free from	i.	F 689	A. Address how correction action will be accomplished for those residents found been affected by the deficient practice:  Upon receipt of the concern by survey the resident #17's floor mat was placed sides while in bed per care plan.  B. Address how the facility will identify residents having the potential to be affected the same deficient practice:  Facility's Administrator and/or designed conducted 100% audit for residents who floor mats to confirm the compliance will order and care plan.	eam, 8/11/ on both 8/25 other cted by 8/25	
	The facility staff failed ordered fall mats on the was in bed. The facili mats on the floor to the Resident #17's bed, win bed.  The findings include:  Resident # 17 was addiagnoses that include hypertension [1], Fractand muscle weakness.  Resident # 17's most set), a quarterly asse (assessment reference coded Resident # 17's most set).	fmitted to the facility with ed but were not limited to: cture of the right Ilium [2] s. recent MDS (minimum data		C. Address what measures will be put i or systemic changes made to ensure the deficient practice will not recur:  DNS and/or designee will provide eduction certified nursing aides (CNAs) regarding following MD order and care plan for flowing MD order and care plan for flowing made to make sure that solution sustained:  Administrator and/or designee will condition weekly audits for floor mat placement be week of 08/23/21 for three months to continue the compliance with plan of care.	at the ation for 9/10 g or mats. hitor its s are  uct 8/27 eginning	

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

Event ID: TEJD11

Facility ID: VA0028

If continuation sheet Page 35 of 47



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER WOODS HEALTH CARE	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 8160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	1 0001112021	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					
F 689	extensive assistance activities of dally living On 08/10/21 at 8:40 a Resident # 17 revealed bed. Further observation of the floor to the reside another fall mat was let the foot of the bed.  On 08/11/21 at 7:40 at Resident # 17 revealed bed. Further observation of the floor to the resident # 17 revealed bed. Further observation of the floor failed to evidence a face observation of Resident # 16 another fall mat was let the foot of the bed.  The physician's order documented, "Floor me every shift. Order Date of the property of the foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.  The care plan for Resident foot of the bed.	th 17 was coded as requiring of one staff member for december for december to the revealed one fall mat dent's right side of the bed. For to the resident's left side and against the wall at the wall	F 689	Administrator and/or designee will report of the audits at the Quality Assurance at Performance Improvement (QAPI) Confor the next 3 months.  During and at the conclusion of the 3 m the QAPI Committee will re-evaluate at the necessary action or extend the revious The Administrator and/or designee is responsible for confirming implementationgoing compliance with the component the Plan of Correction and addressing resolving variances that may occur.	and nmittee nonths, nd initiate ew period. ion and nts of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495197		8. WING		С	
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060	E	USI	11/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 689	conducted with Residabout the placement of 17 stated that both fall down when they are in the conducted with LPN [6]. LPN #6 observed to 17's bed. After comple #6 was asked about the that there was one fall Resident # 17's bed. "There should be two each side of the bed." There should be two each side of the bed. On 08/11/2021 at application (administrative staffind administrative staffind administrative and ASI were made aware of the No further information. References:  [1] High blood pressure obtained from the well https://www.nlm.nih.gessure.html.  [2] The broad, dorsal, three principal bones pelvis. This information website: https://www.merriam-interest.	2 a.m., an interview was lent # 17. When asked of the fall mats Resident # II mats were supposed to be n bed.  .m., an interview and ent # 17's room was licensed practical nurse] # the floor around Resident # eting the observation, LPN he fall mats. LPN # 6 stated II mat on the floor next to LPN # 6 further stated, fall mats down, one on construction of nursing, the above findings.  In was provided prior to exit.  This information was existe:  This information was existe:  The overall argest of the composing either half of the on was obtained from the on webster.com/dictionary/ilium		689			
F 695 SS=D	Respiratory/Tracheos	tomy Care and Suctioning	F	695			

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_			C 08/11/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	1112021
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY			
				F	ORT BELVOIR, VA 22080		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 695	CFR(s): 483.25(i)  § 483.25(i) Respirator tracheostomy care and The facility must ensure eds respiratory care and tracheal succare, consistent with practice, the compreherand 483.65 of this sufficiently. Based on staff intervifacility document review, it was determined to the facility staff failed residents in the survet a sanitary manner.  The findings include:  Resident #235 was ac 7/14/21. Resident #2 were not limited to: heart to pump enough body requirements) (1	ry care, including of tracheal suctioning. In that a resident who e, including tracheostomy tioning, is provided such professional standards of ensive person-centered tts' goals and preferences, part.  The is not met as evidenced sew, resident interview, ew and clinical record and the facility staff failed to envices consistent with s of practice for one of 25 y, Resident #235.  The obtain an order for of an incentive spirometer are spirometer was stored in dimitted to the facility on 35's diagnoses included but eart failure (inability of the a blood to maintain normal l), atrial fibrillation (random	F6	695	A. Address how correction action will be accomplished for those residents found to been affected by the deficient practice:  Upon receipt of the concern by survey the facility obtained an order for resident #23 use of an incentive spirometer. The incenspirometer was stored in a sanitary manicovered in Ziplock bag to minimize a risk health are associated infections.  B. Address how the facility will identify of residents having the potential to be affect by the same deficient practice:  DNS and/or designee will perform facility audit of respiratory devices and obtain Manual to frespiratory devices for sanitary so a constant of the consumer that deficient practice will not recur:  DNS and/or designee will provide nurses aide with education on storage of resider respiratory devices in a sanitary manner (e.g., covered in Ziploc bag with a date of the consumer that deficient and the consumer that the con	to have eam, 35's intive ner c of ther ted v wide lD order v wide storage. to place at the s and int's	9/3/21 9/3/21 9/10/21
	and fracture of the left thighbone) (3). Resident #235's most data set) assessment	s of the atria of the heart) (2) t femur (break in the left recent MDS (minimum , a five day Medicare assessment reference date			and changed weekly at night shift).		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495197	B. WING	B. WNG		C 08/11/2021		
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE		
F 695	of 7/20/21, coded the of 15 on the BIMS (br status) score, indicatic cognitively intact. MD Status: coded the result assistance with bed in with transfers, locome supervision with persindependence with earn and a review of MDS Sectoded the resident as bowel and bladder.  During the initial resident as bowel and bladder.  During the initial resident as bowel and bladder.  During the initial resident as bowel and bladder.  A review of Resident uncovered on Resident uncovered. The ince observed uncovered on 8/11/21 at 8:45 AM.  A review of Resident plan dated 7/22/21 fadocumentation of the A review of the physic 7/14/21-8/10/21 failed incentive spirometer.  A review of the facility Systems" assessment evidence incentive spirometer the ince	resident as scoring 15 out ief interview for mental ing the resident was S Section G- Functional ident as extensive nobility, limited assistance ofton, dressing, bathing; and hygiene and ating. Walking did not occur. It is always continent for both lent observation on 8/10/21 ive spirometer was also on 8/10/21 at 3:35 PM and 10:20 AM.  #235's comprehensive care ided to evidence incentive spirometer.  Isian orders dated I to evidence orders for the lent of th	F 69	D. Indicate how the facility plans performance to make sure that so sustained:  DNS and/or designee will conduct for respiratory devices for sanitar three months.  DNS and/or designee will report audits at the Quality Assurance a Performance Improvement (QAP for the next 3 months.  During and at the conclusion of the QAPI Committee will re-evaluate the necessary action or extend the necessary action or extend the The Administrator and/or designer for confirming implementation and compliance with the components Correction and addressing and revariances that may occur.	et weekly audits by storage for results of the nd I) Committee ne 3 months, hate and initiate he review period te is responsible d ongoing of the Plan of			

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AND DUAN OF CODDECTION IDENTIFICATION AND MADED.			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED			
		495197	B. WING _	B. WING		C 8/11/2021		
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE COMPLET			
F 695	5 Continued From page 39		F 6	95				
	AM with Resident #23 still using the incentive stated, "Yes, I use it at ten times an hour like after surgery, but I us."  An interview was condad with LPN (license regarding resident us. LPN #2 stated, "There order and it should be be in a plastic bag to about Resident #235' #2 stated, "I didn't ever incentive. Let's go low was accompanied to #2 entered the reside Resident #235 if she is spirometer. Resident lot, it helps my lungs asked Resident #235 spirometer came from answered, "I brought and I have one at hom On 8/11/21 at 1:08 Ph member) #1, the admidirector of nursing we ASM #2 provided the "Care Standards" date documented in part, "directs in accordance standards of clinical pof this policy, the Clin follows standards as of contents."	ducted on 8/11/21 at 10:41 d practical nurse) #2 e of an incentive spirometer. e should be a physician on the care plan. It should keep it clean." When asked s incentive spirometer, LPN en notice that she had an ok." At this time LPN #2 Resident #235's room. LPN nt's room, and asked used an incentive #235 stated, "Yes, I use it a stay good". LPN #2 then where the incentive n, and Resident #235 it with me from the hospital ne also."  M, ASM (administrative staff inistrator and ASM #2, the re informed of the concern.  team with the facility policy ed 2/29/16, which The Director of Nursing with care and services rractice. For the purposes ical Operations Department						

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Event ID: TEJD11

Facility ID: VA0028



i i i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495197	B. WNG		С	
NAME OF PE	ROVIDER OR SUPPLIER	400107	STREET ADDRESS, CITY, STATE, ZIP CODE		08/11/2021	
		CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		
	CURMANYCT	TEMENT OF PERIODENOIS	ID	<u> </u>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 695	5 Continued From page 40		F6	95		
	orders. Perry & Potte Procedures."	r: Clinical Nursing Skills &				
	part, "The skill of assi incentive spirometer of assistants. The nurse assessment, monitori	view health care provider's				
	In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract Contaminated respiratory therapy equipment."					
	No further information	was provided prior to exit.				
	Non-Medical Reader, Chapman, page 259. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 54. (3) Barron's Dictionar Non-Medical Reader, Chapman, page 232/2 (4) Perry & Potter Clir edition, Ostendorf, Els	y of Medical Terms for the 7th edition, Rothenberg and y of Medical Terms for the 7th edition, Rothenberg and y of Medical Terms for the 7th edition, Rothenberg and 219. hical Nursing Skills, 8th sevier Publishers, page				
F 880 SS=D	597-599. Infection Prevention & CFR(s): 483.80(a)(1)( §483.80 Infection Cor The facility must estate	(2)(4)(e)(f) ntrol	F8	A. Address how correction action will be accomplished for those residents found have been affected by the deficient practice.	to	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 2 1 2 2	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495197	B. WNG_			C 08/11/2021	
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	11/2021
			9160 BELVOIR WOODS PKWY		160 BELVOIR WOODS PKWY		
RELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		FORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 880	Continued From page 41 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.		F	380	Upon receipt of the concern by survey to resident #93 was assessed and has sing monitored for any signs or symptoms of infection. No signs or symptoms reported identified at this time.	ce been	8/11/21
		plish an infection prevention IPCP) that must include, at			Upon receipt of the concern by survey to community's DNS provided immediate of education for LPN #2 regarding infection measures while administering medication	orrective control	8/11/21
	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals				B. Address how the facility will identify or residents having the potential to be affective same deficient practice:		
	providing services und arrangement based u	der a contractual oon the facility assessment to §483.70(e) and following			The team member identified (LPN #2) we individually educated on infection control measures related to administering medical including hand hygiene and disinfecting surfaces.	l cation,	8/11/21
	procedures for the probut are not limited to: (i) A system of surveil possible communicab infections before they persons in the facility;	can spread to other			The team member (LPN #2) also went to additional medication administration obswith facility's DNS to confirm understand compliance with infection control measure the education on 08/24/21 and she pass	servation ding and res after	8/24/21
	reported; (iii) Standard and tran to be followed to prev	e or infections should be smission-based precautions ent spread of infections; lation should be used for a			C. Address what measures will be put in or systemic changes made to ensure the deficient practice will not recur:		
	resident; including but (A) The type and dura	not limited to:			Root Cause Analysis (RCA) was conduct 8/24/21 with assistance from facility's In Preventionist and QAPI Committee alon front line nurses. The RCA came up with following intervention plans.	fection g with	8/24/21

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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_	B. WNG			C 08/11/2021	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		00/	11/2021	
				9	160 BELVOIR WOODS PKWY			
BELVOIR	WOODS HEALTH CARE	CENTER AT THE FAIRFAX		F	ORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X6) COMPLETION DATE	
F 880	Continued From page 42  (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility		FE	380	DNS and/or designee will educate all nurses on proper infection control measures while administering medication, including hand hygiene and disinfecting of surfaces.		8/31/21	
	must prohibit employed disease or infected sk contact with residents contact will transmit the	ees with a communicable in lesions from direct or their food, if direct ne disease; and procedures to be followed	:		All nurses will go through medication administration observation by DNS and/o designee to confirm understanding and compliance with proper infection control measures while administering medication		9/16/21	
	§483.80(a)(4) A syste identified under the fa corrective actions take	•			Medication administration observation for new hires (regardless of their experience to working on the floor as a part of orienta program.	) prior	8/24/21	
	200	e, store, process, and to prevent the spread of			The new hires will also go through randomedication administration observation dutheir 90 day period to confirm the compliant	ıring	8/24/21	
	IPCP and update their	iew. ct an annual review of its r program, as necessary. is not met as evidenced			D. Indicate how the facility plans to monit performance to make sure that solutions sustained:			
	Based on observation record review, and fact was determined that the administer medication	n, staff interview, clinical cility document review, it he facility staff failed to is in a sanitary manner for 1 dedication Administration			DNS and/or designee will conduct randor medication observation beginning week of 08/23/21 weekly for 3 months to confirm medications are administered in accordar with appropriate infection control measure.	of nce	8/27/21	
	The findings include:			- 1	Issues identified will be addressed and realong with refresher training as needed.	esolved		
	8/2/21 with the diagno osteoporosis, Barrett's arrhythmia, high blood	mitted to the facility on uses of but not limited to sesophagus, cardiac dipressure, heart failure, ion of right hip prosthesis,			Administrator and/or designee will report of the audits at the Quality Assurance and Performance Improvement (QAPI) Common for the next 3 months	d		

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If continuation sheet Page 43 of 47



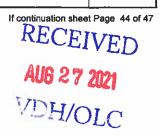
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С		
		495197	B. WNG		08/1	1/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
DEL VOID	MOODS HEALTH CADE	CENTER AT THE FAIRFAX		9160 BELVOIR WOODS PKWY			
BELVOIR	MOODS REALIR CARE	CENTER AT THE FAIRFAX		FORT BELVOIR, VA 22060			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	had not been complet admission BIMS (Brie Status) assessment of resident as being cog make daily life decisic assessment dated 8/2 resident as requiring a mobility, transfers, dre and bathing; and inde On 8/10/21 at 8:52 Af Practical Nurse) was administering medicat #2 was observed touc open the medication to the cart. During pre the Aldactone (1) on the She then without was picked up the Aldacto and put it in the medic medications to be admitted to the card and put it in the medic medication cards laying dropping the pill on to Once preparation of medication to the outside of the complete the on the outside of the composition of the cardinal transfer of the complete the on the outside of the composition of the cardinal transfer of the complete the cardinal transfer of the complete the cardinal transfer of the	ation. The admission MDS ted as of survey. The of Interview for Mental lated 8/2/21 coded the nitively intact in ability to ons. The admission nursing 2/21 documented the extensive assistance for bed essing, toileting, hygiene ependent for eating.  M, LPN #2 (Licensed observed preparing and tions to Resident #93. LPN ching the pill cards, keys to cart, and laying pill cards on cart before returning them eparation, LPN #2 dropped op of the medication cart. hing or sanitizing her hands, ne pill with her bare fingers cation cup with other ministered to Resident #93. e 6th of 8 medications she dent, having had the ng on top of the cart prior to p of the cart.  medications was completed, zing her hands, was then he medication cup with her e cup and her index finger cup to hold it. She then room and administered the een dropped on top of the	F 886	During and at the conclusion of the 3 m the QAPI Committee will re-evaluate and the necessary action or extend the review.  The Administrator and/or designee is responsible for confirming implementation on the component of the	d initiate w period. on and ts of the		

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Event ID: TEJD11

Facility ID: VA0028



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3	B) DATE SURVEY COMPLETED		
		495197	B. WING_	B. WING		C 08/11/2021		
	ROVIDER OR SUPPLIER	CENTER AT THE FAIRFAX		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 BELVOIR WOODS PKWY FORT BELVOIR, VA 22060		0071112021		
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE			
F 880	dropping the Aldactor then picking it up and resident, LPN #3 state done that and as it was stated that she did sa her hands before star However, when asked had touched as obsecards, keys to open the did not respond cart was sanitized pricken was sanitized pricken was sanitized pricken was sanitized pricken asked if she haresident, she stated the was not observed follobservation. When a medication cup with his stated that was an infinite should not have a did not recall doing the A review of the facility Preparation and Medidocumented, "2. Producing the documented of the facility of a medication which container is dropped, according to facility produced to the facility produced the facility staff should not the container is dropped, according to facility produced the facility p	#2. When asked about ne on top of the cart and administering it to the ed that she should not have as a risk of infection. She initize the top of the cart and ting med [medication] pass. d about all the items that she rived above, i.e. the pill ne medication cart, etc., that with the top of the cart prior ping on it (pill cards, etc.), other than to repeat that the or to med [medication] pass. nat she normally lays a clean art to prepare the meds. and done that for this she could not recall. LPN #2 owing this routine during this sked about holding the ner thumb down inside it, she rection control issue and that done that. She stated she at.  It policy, "General Dose ication Administration" rior to preparing or tions, authorized and aff should follow facility's y (e.g. handwashing)3.4 ot touch the medication a or unit dose package. 3.5 is not in a protective facility staff should discard it olicy"	F	380				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		405407	B. WNG			С	
		495197	B. WING		·	08/	11/2021
	NAME OF PROVIDER OR SUPPLIER  BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX			9	TREET ADDRESS, CITY, STATE, ZIP CODE 160 BELVOIR WOODS PKWY ORT BELVOIR, VA 22060		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	"Skill 1: Administering Prepare the required containers: When rempour the necessary not and then place the tal medication cup Do capsules with hands. or tablets into your hat Transport medications carefully 14. Perform PPE [personal protect Rationale: Hand hygies spread of microorgan on transmission base Administer the medication Act and ASM #2 (Administer Administrator and Dimespectively) were mat No further information the survey.	oral Medications: 6. In Oral Medications: 6. In Medications: b. Multidose Inoving tablets or capsules In Oral Medications: b. Multidose Inoving tablets or capsules In Oral Medications: b. Multidose Inoving tablets or capsules In Inoving tablets or capsules in a Inoversity or capsules in a Inoversity or capsules Indicated is unsanitary. 12. In Indicated is unsanitary. 13. In Indicated is unsanitary. 14. In Indicated is unsanitary. 15.	F	880			
	with hyperaldosteronic much aldosterone, a r hormone); low potass in patients with edema	sm (the body produces too naturally occurring ium levels; heart failure; and a (fluid retention) caused by cluding liver, or kidney d alone or with other igh blood pressure."					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405407	D MANO	B. WNG		С	
		495197	B. WING			08/	11/2021
NAME OF PE	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
BELVOIR	BELVOIR WOODS HEALTH CARE CENTER AT THE FAIRFAX				ELVOIR WOODS PKWY		
				FURIT	BELVOIR, VA 22060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page https://medlineplus.gottml	e 46 ov/druginfo/meds/a682627.h	F	380	DEFICIENCY)	22	

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

Event ID: TEJD11

Facility ID: VA0028

