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Brightview Woodburn(FAIRFAX CO)
3450 Gallows Road
Annandale, VA 22003
(703) 462-9998

Current Inspector: Jacquelyn Kabiri (703) 397-3017

Inspection Date: Nov. 5, 2020 and Nov. 10, 2020

Complaint Related: No

Areas Reviewed:

22VAC40-73 RESIDENT CARE AND RELATED SERVICES

Comments:

This inspection was conducted by licensing staff using an alternate remote protocol, necessary due to a state of emergency health pandemic declared by the Governor of Virginia.

A focused monitoring inspection was initiated on 11/5/2020 and concluded on 11/10/2020. A self-reported incident was received by the department regarding allegations in the area of resident care. The administrator was contacted by email to conduct the investigation. The licensing inspector emailed the administrator a list of documentation required to complete the investigation. One resident record was reviewed. The exit interviewed was held with the administrator by telephone.

The evidence gathered during the investigation supported the self-report of non-compliance with standards or law, and violations were issued.

Please complete the "plan of correction" and "date to be corrected" for each violation cited on the violation notice and return to the licensing office within 10 calendar days.

Please specify how the deficient practice will be or has been corrected. Just writing the word "corrected" is not acceptable. The plan of correction must contain: 1) steps to correct the non-compliance with the standard(s), 2) measures to prevent the non-compliance from occurring again; and 3) person(s) responsible for implementing each step and/or monitoring any preventative measure(s).

Thank you for your cooperation and if you have any questions please call 703-479-5247 or contact me via e-mail at jamie.eddy@dss.virginia.gov.

Violations:

Standard #:	22VAC40-73-640-A
Description:	Based upon a review of records, the facility failed to implement a written plan for medication management that would ensure that medication orders have been accurately transcribed to medication administration records (MARs) within 24 hours of receipt of a new order or change in an order. Evidence: The written physician's order received on 7/15/2020 to discontinue the administration of Lexapro does not appear on the Medication Administration Records (MARS), nor does the written physicians' order received on 7/15/2020 to begin the administration of Remeron.
Plan of Correction:	The resident was assessed by the prescribing physician immediately upon discovery of the medication error. There was no adverse outcome noted as a result of this occurrence. An audit of all resident records was conducted and there was no other finding of this deficient practice. The Wellness Nurse who documented the order in the Progress Notes but did not transcribe the order in the Quick Mar system was counseled and re-educated on 11/5/2020 on the Resident Care Order policy and process for completing order entries in a timely manner. The nurse was also re-educated on confirming orders entered by other nurses, prior to, and after shifts. The other Wellness Nurse who documented the order on the succeeding shift, is on extended leave at this time. Upon return to the facility, the nurse will receive counseling and re-education on 11/30/2020. All nurses will be re-educated on the order approval process as outlined in the Resident Care Order policy and the use of the 24-Hour Report sheet to communicate by 11/30/2020. The Health Services Director has resumed and will continue auditing all resident care orders on a daily basis to monitor and ensure compliance with the Resident Care Order policy.

Standard #:	22VAC40-73-650-A
Description:	Based upon a review of records, the facility failed to ensure that no medication, dietary supplement, diet, medical procedure, or treatment shall be started, changed, or discontinued by the facility without a valid order from a physician or other prescriber. Medications include prescription, over-the-counter, and sample medications. Evidence: On 7/15/2020 the facility received a written physicians' order to discontinue administration of Lexapro. According to the Medication Administration Records (MARS), Resident #1 continued to receive the discontinued medication from 7/16/2020 through 11/3/2020.
Plan of Correction:	The resident was assessed immediately by the prescribing physician upon discovery of the medication error. There was no adverse outcome noted as a result of the occurrence. An audit of all resident records was conducted and there was no other finding of this deficient practice. The Wellness Nurse who documented the order in the Progress Notes but did not transcribe the order in the Quick Mar system was counseled and re-educated on 11/5/2020 on the Resident Care Order policy and process for completing order entries in a timely manner. The nurse was also re-educated on confirming orders entered by other nurses, prior to, and after shifts. The other Wellness Nurse who documented the order on the succeeding shift, is on extended leave at this time. Upon return to the facility, the nurse will receive counseling and re-education on 11/30/2020. All nurses will be re-educated on the order approval process as outlined in the Resident Care Order policy and the use of the 24-Hour Report sheet to communicate by 11/30/2020. The Health Services Director has resumed and will continue auditing all resident care orders on a daily basis to monitor and ensure compliance with the Resident Care Order policy.

Standard #:	22VAC40-73-680-D
Description:	Based upon a review of records, the facility failed to ensure that medications shall be administered in accordance with the physician's or other prescriber's instructions and consistent with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing. Evidence: The physician for Resident #1 wrote an order for Remeron 7.5 mg (milligrams) to be taken by mouth every evening. According to the Medication Administration Records (MARS) from 7/15/2020 through 11/4/2020, the Remeron was never administered. The Remeron medication was discontinued per physicians' order on 11/4/2020.
Plan of Correction:	An audit of all resident records was conducted and there was no other finding of this deficient practice. All nurses will be re-educated on the Resident Care Order policy to ensure that all medications are administered according to the prescriber's order by 11/30/2020. The Health Services Director will continue auditing all resident care orders on a daily basis to monitor and ensure compliance with prescriber's orders for medication administration.