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

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION  DING	(X3) DATE SURVEY COMPLETED
	,	405262	B. WING	,	С
		495362	D. 971140		01/16/2018
ASHLAN	PROVIDER OR SUPPLIER  ID NURSING AND REI  * *	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
E 000	Initial Comments		E (	000	
	survey was conducted and 1/16/18. Correct compliance with 42 Requirement for Lo complaint(s) was in	ong-Term Care Facilities. One vestigated during the survey. haring Plan with Patients	Ε(	Preparation and /or execution of this does not constitute admission or agreement with the provider of trut facts alleged or conclusion set forth statement of deficiencies. This plan correction is prepared and /or exect solely because it is required by the provisions of federal and state law.	th of the hon the
00-1	0171(0): 100170(0)(0	-/		<u>E 035</u>	
	and maintain an em communication plar State and local laws updated at least and plan must include a (8) A method for she emergency plan, that	aring information from the at the facility has determined residents [or clients] and their		1. Emergency Preparedne Plan requirements regal evidence of documenta that the communication included a method for sthe information with residents/clients and the families or representative	rding tion 1 plan shàring eir
	This REQUIREMEN	NT is not met as evidenced		regulation 1/22/2018.	
	review it was detern have a complete em The facility staff faile documentation that	rview and facility document mined, the facility staff failed to nergency preparedness plan.  ed to provide evidence of the communication plan!  for sharing information from		2. Quality review of Emergency Preparednes Plan requirements regarevidence of documentat that the communication included a method for si	ding ion plan
	the emergency plan			the information with residents/clients and the	ir
	clients and their fam	nilies or representatives.		families or representativ	es per
	The findings include	2:		regulation completed by Executive Director (ED)	the /
		ximately 11.00 a.m. a review gency preparedness plan was		designee.	

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

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Event ID: 727W11 Facility ID: VA0008

(X6) DATE

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

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CENTER	19 LOV MEDICAVE	A MILDICAID SLIVICES	-		OMD NO. 0930-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		405252	B. WING		C
		495362	B. WING		01/16/2018
	PROVIDER OR SUPPLIER ID NURSING AND REI	LARII ITATION		STREET ADDRESS. CITY, STATE, ZIP CODE 906 THOMPSON STREET	
ASHLAN	5 F.			ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLÉTION
E 035	conducted. Review preparedness plan documentation that included a method the emergency plar determined is approand their families of On 1/11/18 at 5:35 was conducted with member) #1, the ac director of nursing. evidence that facility	of the facility's emergency failed to provide evidence of the communication plan for sharing information from the facility had opriate with residents or clients or representatives.  p.m. an end of day meeting the ASM (administrative staff dministrator, and ASM #2, the ASM #1 was asked to provide by residents, family members	E	3. ED re-educated by the Regional Vice Presiden Operations (RVPO) ens Emergency Preparednes Plan requirements regal evidence of documentar that the communication included a method for sthe information with residents/clients and the families or representative completed annually per	suring ss rding tion plan sharing eir
SS=F	and / or responsible the information regaredness plan.  On 1/16/18 at 12:20 did not provide any family members and ASM #1 further stat (the facility emerger more."  No further information end of the survey property in the EP Training and Test CFR(s): 483.73(d)  (d) Training and test develop and maintal preparedness training based on the emerging paragraph (a) of this paragraph (a) of this paragraph (a) (1) of procedures at paragthe communication	e parties had been provided arding the facility emergency  D p.m. ASM #1 stated that she training to the residents, d / or responsible parties. ted, "I need to work on this ncy preparedness plan) a little fon was obtained prior to the rocess. sting	ΕC	regulation.  4. ED/designee to conduct quality monitoring of Emergency Preparedne Plan to ensure Emerger Preparedness Plan requirements regarding evidence of documentathat the communication included a method for the information with residents/clients and the families or representation completed annually per regulation weekly x 2 x monthly x 2 months, the	eir ives is r weeks,

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 2 of 107



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PRINTED: 02/02/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Olvid MO. 0938-0397
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		C 01/16/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHLAN	D NURSING AND REI	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION SHO	OULD BE COMPLETION
E 036	*[For ICF/IIDs at §4 testing. The ICF/IID an emergency prep program that is bas forth in paragraph ( assessment at parapolicies and proced section, and the corparagraph (c) of this testing program muleast annually. The requirements for ev §483.470(h).  *[For ESRD Facilities testing, and orientation program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this and orientation program emergency plan set section, and orientation program emergency plan set section, a paragraph (c) of this and orientation program this REQUIREMEN by:  Based on staff interreview it was determined to the section of	addated at least annually.  83.475(d):] Training and must develop and maintain aredness training and testing ed on the emergency plan set a) of this section, risk agraph (a)(1) of this section, rures at paragraph (b) of this munication plan at section. The training and style reviewed and updated at ICF/IID must meet the accuation drills and training at the accuation drills and training, the an emergency ng, testing and patient that is based on the forth in paragraph (a) of this ment at paragraph (b) of the section. The training, testing gram must be reviewed and must be re	E	quarterly and PR indicated. Findings to be re QAPI committee updated as indicated monitoring scheen based on finding.  5. Date of Compliant	eported to monthly and ated. Quality dule modified s.
	requirements of the	program that meets the regulation and the training and testing			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 727W11 Facility ID: VA0008

If continuation sheet Page 3 of 107



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

PRINTED: 02/02/2018 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	- & MEDICAID SERVICES			OMR NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B WING		C 01/16/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE
ASHLAN	D NURSING AND RE	HABILITATION	norma e discontinuo de la contractina del la contractina del la contractina de la contractina del la contractina de la contractina del la contr	906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COMPLETION
E 036	facility.  The findings includ  On 1/11/18 at appr	initiated for all staff in the e: oximately 11:00 a.m. a review	Ε0	E036:  1. Emergency Properties Plan requirement evidence of document that the communication is a second control of the communication in the communication is a second control of the communication in the communication is a second control of the communication in the communication is a second control of the communication in the communication is a second control of the communication in the communication is a second control of the communication in the communication is a second control of the communication in the communication is a second control of the communication in the communication is a second control of the control of the communication is a second control of the control of	nts regarding cumentation inication plan
	conducted. Review preparedness plan documentation tha conducted for the f	rigency preparedness plan was of the facility's emergency failed to provide evidence of training and testing had been acility emergency plan.		included a methe information staff annually parties.	n with facility per regulation
	was conducted with member) #1, the addirector of nursing, evidence that training conducted by the fa preparedness plan			2. Quality review Emergency Property Plan requirement evidence of do that the committee information	eparedness ents regarding ecumentation unication plan thod for sharing
	and testing had not further stated that s	m. ASM #1 stated that training theen conducted. ASM #1 she did not have a policy gency preparedness plan.		staff annually completed by Director (ED)/	per regulation the Executive
F 000	No further informatend of the survey partial COMMEN		F O	Emergency Pr	President of VPO) ensuring reparedness
	complaint survey w 1/11/18 and 1/16/16 required for compli Federal Long Term Immediate Jeopard Quality of Care at F of pattern, level 4, a	Medicare/Medicaid abbreviated ras conducted 1/10/18 through 8. Significant corrections are ance with 42 CFR Part 483 Care requirements. It was identified in the area of 689 at a Scope and Severity and which constituted ty of Care. A second	:	Plan requirem evidence of do that the comm	ents regarding ocumentation nunication plan othod for sharing on with facility eted annually

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 4 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

DEPART	WENT OF HEALTH	A MEDICAID SEDVICES			C	MB NO. 0938-0391
<u>CENTER</u>	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:				
PA 180 1 80 1 1 1	;		ĺ			C 04/46/2019
		495362	B. WING		THE STATE THE OFFICE	01/16/2018
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	as particular delication of the second of th
		LARII ITATION			6 THOMPSON STREET SHLAND, VA 23005	and the state of t
	NURSING AND RE			A	PROVIDER'S PLAN OF CORRECTION	)N (X5)
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DRE COMPLETION
F 000	Nursing Services a Severity of pattern	y was identified in the area of at F 729 at a Scope and , level 4.	F	000	4. ED/designee to conquality monitoring Emergency Prepare Plan ensuring Eme Preparedness Plan	of edness
	165 at the time of survey sample correviews (Resident	190 certified bed facility was the survey. The standard asisted of 5 current resident at through #5) and 1 closed esident #1). The expanded asisted of the 5 current resident #2 through #5).			requirements regar evidence of docum that the communic included a method the information wistaff is completed	ation plan for sharing th facility
F 606 SS=E	Immediate Jeopa 689 from the Adm the Immediate Je deficiency was as level of isolated, I the plan for remo- Jeopardy in the a from the Administ Immediate Jeopa was assigned a S widespread, leve Not Employ/Enga CFR(s): 483.12(a	e plan for removal of the first rdy in the area Quality of Care Finistrator, and determining that opardy was removed, the signed a Scope and Severity evel 3 pattern. After accepting val of the second Immediate rea of Nursing Services F 729 rator, and determining that the rdy was removed, the deficience cope and Severity of 2.  Ige Staff w/ Adverse Actions (1)(3)(4)	у	F 609	per regulation weekly x 2 weeks, monthly x 2 monthly then quarterly and PRN a indicated.  Findings to be reported QAPI committee monthly updated as indicated. Quantitoring schedule monthly based on findings.  5. Date of Compliance: 3-2	ins, and to y and ality dified
	Individuals who- (i) Have been for exploitation, mist mistreatment by	nt employ or otherwise engage and guilty of abuse, neglect, appropriation of property, or				

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

Event ID: 727W11 Facility ID: VA0008

If continuation sheet Page 5 of 107



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	<u>0. 0938-039</u> 1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) D/	ATE SURVEY DMPLETED
		495362	B. WING_		0	C 1/16/2018
	PROVIDER OR SUPPLIER  NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 606	exploitation, mistre-misappropriation of (iii) Have a discipling or her professional body as a result of exploitation, mistre-misappropriation of §483.12(a)(4) Reported in the service as a nurse at This REQUIREMENT by:  Based on staff intereview, it was detensive by failing to vote the service out of (certified nursing as CNA #7 and CNA #7 certification expiration.)	atment of residents or their property; or ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property.  Int to the State nurse aide authorities any knowledge it court of law against an ould indicate unfitness for aide or other facility staff.  IT is not met as evidenced  review and facility document mined the facility staff failed to ad nursing assistants) for erify certifications upon hire 79 currently employed CNAs sistant), (CNA #3, CNA #5,	F 60	F606:  1. Identified Certified Assistant (C.N.A)'s certification verification verification obtained and placed employee file 1/11/1 Identified CNAs perviolation documents validated/addressed placed in the employeed in the employee criminal backgrounchecks/Virginia State obtained and placed employee file 1/11/1	ation I in the 18. Inding I sobtained, and yee file C.N.A's d te Police I in the	
	verification for sever employed CNAs (ce Seventeen out of the CNAs had expired co	ailed to obtain certification name out of 79 currently rtified nursing assistant). is 79 currently employed ertifications in their employee ded CNA #3, CNA #5, CNA bugh 32.				-
	verifications prior to	illed to obtain certification hire for three of 79 currently IA#3, CNA#10 and CNA		· ,		

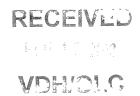
FORM CMS-2567(02-99) Previous Versions Obsolete

#11. All three CNAs were found to have a pending violation against their certification and

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 6 of 107



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	-	(X3) DATE SURVEY COMPLETED
	495362	B. WING		C 01/16/2018
ROVIDER OR SUPPLIER  NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
were providing dire- 3. The facility staff f background checks within thirty days of	ct care to residents.  Called to obtain criminal at the Folice of the for two of 79 currently	F 60	2. A quality review of CNA employee file Human Resources Coordinator (HRC) completed to ensure	s by the e CNA
1. On 1/10/18 at 1:1 facility to investigate the course of investigate the course of investigated and expanded survey and expanded survey assistants) have regovertifications. A list was requested on 1,0.m. with their employee facility and an up-to-employee file.  On 1/11/18 at 10:44 conducted with OSM auman resources directed she verified on the process for the course of the course of the course of the conducted with OSM auman resources directed she verified on the course of the course o	5 p.m., surveyors entered the e a two-day complaint. During igation, an immediate fied and a substandard review by was initiated.  Idard review is to ensure all CNAs (certified nursing pistry verification of their of currently employed CNAs /10/18 at approximately 5:30 byce file.  Eximately 9:00 a.m., review of illes was conducted. Less no 79 currently employed date certification in their  I a.m., an interview was 1 (other staff member) #2, the rector. When asked who was ving certifications, OSM #2 ertifications. When asked llowed for verifying		current, pending violations documents obtained addressed as applic validated by Execu Director (ED)/Dire Nursing Services (I documentation in the employee file per r CNA's without a c certification and/or violations to be ren from the schedule certification and/or violation documen and validated by the ED/DON with doc in the employee file regulation prior to an assignment.	plation I and able and tive ctor of DON) with ne egulation. urrent pending noved until pending ts obtained ne umentation ne e per
	ROVIDER OR SUPPLIER  O NURSING AND RE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa were providing directly to the character of the substance the course of investigate of the substance currently employed cassistants) have registered to the course of the CNA employee file.  On 1/11/18 at appropriate the course of investigated she verified on the course of the course of investigated she verified on the course of investigated she verified on the course of the course of investigated she verified on the course of investigated she verified on the course of the	ROVIDER OR SUPPLIER  D NURSING AND REHABILITATION  t:  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6 were providing direct care to residents.  3. The facility staff failed to obtain criminal background checks from the Virginia State Police within thirty days of hire for two of 79 currently employed, CNA#3 and CNA#10.  The findings include:  1. On 1/10/18 at 1:15 p.m., surveyors entered the facility to investigate a two-day complaint. During the course of investigation, an immediate deopardy was identified and a substandard review and expanded survey was initiated.  Part of the substandard review is to ensure all currently employed CNAs (certified nursing assistants) have registry verification of their certifications. A list of currently employed CNAs was requested on 1/10/18 at approximately 5:30 p.m. with their employee file.  On 1/11/18 at approximately 9:00 a.m., review of the CNA employee files was conducted. Less than 50 percent of the 79 currently employed CNAs had an up-to-date certification in their	(X1) PROVIDER:SUPPLIER (X2) MULTI A BUILDIN A95362  ROVIDER OR SUPPLIER D NURSING AND REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6 Were providing direct care to residents.  3. The facility staff failed to obtain criminal background checks from the Virginia State Police within thirty days of hire for two of 79 currently employed, CNA#3 and CNA#10.  The findings include:  1. On 1/10/18 at 1:15 p.m., surveyors entered the facility to investigate a two-day complaint. During the course of investigation, an immediate isopardy was identified and a substandard review and expanded survey was initiated.  Part of the substandard review is to ensure all currently employed CNAs (certified nursing assistants) have registry verification of their certifications. A list of currently employed CNAs was requested on 1/10/18 at approximately 5:30 p.m. with their employee file.  On 1/11/18 at approximately 9:00 a.m., review of the CNA employee files was conducted. Less than 50 percent of the 79 currently employed CNAs had an up-to-date certification in their employee file.  On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the tuman resources director. When asked who was esponsible for verifying certifications. When asked bout the process followed for verifying the certifications.	A 95362  ROVIDER OR SUPPLIER  495362  ROVIDER OR SUPPLIER  SIMMARY STATEMENT OF DEPICIENCIES (EACH DETICIENCIES) (EACH DETICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 6  Were providing direct care to residents.  3. The facility staff falled to obtain criminal background checks from the Virginia State Police within thirty days of hire for two of 79 currently employed, CNA#3 and CNA#10.  The findings include:  1. On 1/10/18 at 1:15 p.m., surveyors entered the facility to investigate a two-day complaint. During the course of investigation, an immediate isopardy was identified and a substandard review and expanded survey was initiated.  Part of the substandard review is to ensure all currently employed CNAs (certification of their partifications. Allist of currently employed CNAs was requested on 1/10/18 at approximately 9:00 a.m., review of the CNA employee files was conducted. Less han 50 percent of the 79 currently employed 2NAs had an up-to-date certification in their employee file.  On 1/11/18 at 10:44 a.m., an interview was conducted with OSM (other staff member) #2, the tuman resources director. When asked bout the process followed for verifying certifications. When asked bout the process followed for verifying but the process followed for verifying certifications. When asked bout the process followed for verifying certifications.

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

from the application if they are a good fit for the company. She will then have the applicant come

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 7 of 107





PRINTED: 02/02/2018

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES			FORM APPROVED MB NO. 0938-0391
and the same party of the same and the same	***************************************	& MEDICAID SERVICES	/V2) 1410 T	TIPLE CONSTRUCTION	(X3) DATE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	NG	COMPLETED
	•			•	C
		495362	B. WING		01/16/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ACIII ANI	D NURSING AND RE	HARII ITATION		906 THOMPSON STREET	
			<u>_</u>	ASHLAND, VA 23005	
(X4) ID PREFIX TAG	JEACH 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)	DBE COMPLETION
F 606	Continued From painto the facility to in	age 7 ntroduce them to the DON g). OSM #2 stated she will	F 6	i06	
	then run a backgro background check their certification. other times, she w #2 stated she has program) that aler certification needs why certifications a stated certifications that certifications a there are no violat When asked wher OSM #2 stated ce	ound check and if the comes out clean, she will run When asked if there were any rould verify certifications, OSM a computer system (payroll ts her when an employee's to be verified. When asked need to be verified, OSM #2 s need to be verified to ensure are not expired and to ensure ions against the certification. The certifications should be filed, rtifications should be filed in the DSM #2 stated she would try to		A quality review CNA employee f HRC completed to criminal backgro checks/Virginia sis current, and va ED/DON with do in the employee days of hire. CN current criminal check to be remoschedule until a locheck is obtained	iles by the to ensure und State Police lidated by ocumentation file within 30 As without a background oved from the background
	handed this writer were verified on 9, realized that some certifications in the printed out current department of hea #2 stated if a current employee file or in this writer, then show 1/11/18 at app.	roximately 3:00 p m., OSM #2 a stack of certifications that /10/17. OSM #2 stated she had a CNAs had expired air employee file and she had a certifications from the alth professions website. OSM ent certification was not in the a the stack of paper just given to be did not have them.		validated by the with documentate employee file praccepting an ass	ED/DON ion in the ior to
	the stack of CNA seventeen out of CNAs did not have Seventeen out of expired certification.	certifications was conducted. the 79 currently employed e their certification verified. the 79 current CNAs had ons in their employee file. The		· ·	

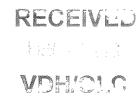
FORM CMS-2567(02-99) Previous Versions Obsolete

CNA #19 through 32. Review of the as-worked schedule from the past two weeks prior to entrance, revealed that the 17 CNAs identified

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 8 of 107



PRINTED: 02/02/2018

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM APPROVED OMB NO. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	I			(X3) DATE SURVEY
CTATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION .	COMPLETED
MADELANCE	,	495362	B, WING	;		C 01/16/2018
		493302	L	STR	REET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER				THOMPSON STREET	
ASHLAN	D NURSING AND RE	HABILITATION		ASI	HLAND, VA 23005	
MOHEN	j		ID	<u> </u>	PROVIDER'S PLAN OF CORREC	TION (X5) ULD BE COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC	EΙΧ	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	
				······································	3. HRC re-educate	ed by the
	a ii i Errona	aao 9	F	606	ED/DON/design	nee regarding
F 606	Continued From p	age o			ensuring CNA c	ertification
	had been directly t	working with residents and			verification is co	arrent,
Marie Control of the	providing care.				pending violation	on documents
					reviewed/addres	ssed as
	On 1/11/18 at 4:00	p.m., facility staff presented			applicable and	validated by
	rtification	n ventications of the lucinines			the ED/DON pe	er regulation
	17 CNAs. The ce	rtifications were printed from			prior to accepting	ng an
	the DHP (Departing	nent of Health Professions) 8. All identified CNA's had a			assignment ens	uring CNAs
	current certification	in			are screened fo	r Abuse.
					HRC re-educate	ed by the
	On 1/11/18 at 4:4	4 p.m., an interview was			ED/DON/desig	nee regarding
	nanductod with A!	AM #1. THE BUILDINGS ALON. MON			new CNA appl	icant's
	#1 stated the hum	nan resources director was			certification ve	rification to be
	responsible for ve	erifying certifications. When cations should be verified, ASM			reviewed, pend	ling violation
	asked why certific	ations should be verified to			documents	*
	and a contifica	tion is current and in dood			reviewed/addre	essed as
	atandina ASM#	1 stated certifications should be	:		applicable and	validated by
	t the dhoforoh	or interview with the applicant			the ED/DON p	er regulation
	A CNA #1 etated st	ne cannot interview the applicar	IT.		upon hire and	prior to
	without the emple	wee tile and a copy or mor			extending an o	offer of
	current certificati	on. ASM #1 stated all CNAs rrent certification in their			employment to	
	should have a cu	ment bernnbanon in thos			applicants are	screened for
	employee file.				abuse.	
	On 1/11/18 at 4:4	44 p.m., ASM (administrative			HRC re-educ	ated by the
	atoff mamber) #	the administrator and ADM #2	1		FD/DON/desi	gnee regarding
	the DON (Direct	or of Nursing) were made aware	;		ensuring crim	inal background
	of the above con	cerns.			checks/Virgin	ia State Police
					is obtained, p	laced in the
	O The facility of	aff failed to obtain certification			employee file	and validated
	varifications prin	r to hire for three of 79 currently	r		hy ED/DON	within 30 days
	amployed CNAs	CNA#3, CNA#10 and CNA			of hire to ensi	ure employees
	#44 All three C	NAs were found to have a			are screened	for abuse.
	nonding violation	n against their certification trial	í		HRC re-educ	ated by the
	had not been in	restinated by administration. At	1		TD/DON/Do	signee regarding
	three CNAs had	directly worked with residents t	уу		ED/DON/De	ntinuation sheet Page 9 of 10

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

Event ID:727W11

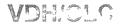
Facility ID: VAC008

ED/DON/Designee regarding

If continuation sheet Page 9 of 107







## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	45 FOR MEDICARE	& MEDICAID SERVICES		************	(	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUING		(X3) DATE SURVEY COMPLETED
		495362	B. WING	Addition in the contract of th	,	C 01/16/2018
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADD	PRESS, CITY, STATE, ZIP CODE	
	D NURSING AND RE	HABILITATION		906 THOMP ASHLAND,	SON STREET , VA 23005	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFL TAG	X (EA	PROVIDER'S PLAN OF CORRECTION CONTROLL ACTION SHOULD SS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES.	D BE COMPLETION
F 606		oximately 9:00 a.m., review of	F 6	06		
	CNA #3's employeed did not have a curre	file was conducted. CNA#3 ent certification in her a#3's hire date was 9/19/17.			CNAs whose certific due to expire within month are to be prov	the rided a
	conducted with OSI human resources of responsible for verified about the process for certifications, OSM employee fills out a from the application company. She will into the facility to into (Director of Nursing then run a background check of their certification. In the certification of the certification of the certifications should certifications should certifications should file.  On 1/11/18 at appropriate the certification of the certification	A.m., an interview was of (other staff member) #2, the irector. When asked who was fying certifications, OSM #2 certifications. When asked certifications. When asked certifications. When asked certification, she will decide if they are a good fit for the interview of the applicant come roduce them to the DON of the comes out clean, she will run when asked why certifications of ensure certifications are not rethere are no violations on. When asked where be filed, OSM #2 stated be filed in the employee's eximately 3:00 p.m., OSM #2 stack of certifications that 17 through 9/10/17. OSM #2 ced some CNAs had expired employee file and she had ertifications from the professions website. CNA tion could not be found in the			letter requiring sign communicating certification in the employee file. CNA without proof of curcertification to be reform the schedule un of current certification provided and validate ED/DON with document the employee file. ED/DON to be provided and validate	effication th e c c's rent moved ntil proof orkis ted by the mentation dided a list fied re- regarding aintaining e CNA roviding a Monitor

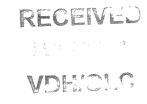
FORM CMS-2567(02-99) Previous Versions Obsolete

stack of certifications. OSM #2 stated if a current

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 10 of 107



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	TWENT OF TIERET					TORWATEROUSED
		& MEDICAID SERVICES	L			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
		495362	B. WING	A112.2.2.4.200000000000000000000000000000		C 01/16/2018
NAME OF F	PROVIDER OR SUPPLIER	4		1	REET ADDRESS, CITY, STATE, ZIP CODE	
ASHLAN	D NURSING AND RE	HABILITATION			STHOMPSON STREET SHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	DBE COMPLÉTION
F 606	Continued From pa		F	306		
	certification was no stack of paper just did not have them.	t in the employee file or in the given to this writer, then she			<ol> <li>HRC/Designee to co random quality moni C.N.A employee file ensure certification</li> </ol>	toring of s to
	the current certification ve The certification ve Department of Hea 1/11/2018. CNA#3 against her certificatesolved by the Boa was documented of "Additional public in means that there is Health must make pursuant to 54.1-24 please note that thi	p.m., facility staff presented tion verification for CNA #3. rification was printed from the lth Professions Website on B had a pending violation ation that had not been ard of Nursing. The following n CNA #3's certification: information: YES"YES" information the Department of available to the public s may also include the a finding of "no violation."			verification is current in the employee and by the ED/DON upon ensure employees are screened for abuse peregulation 2 times as 4 weeks, weekly x4 with the monthly, PRN a indicated.  HRC/Designee to corrandom quality moni C.N.A employee file ensure new CNA apprentification verificat	validated in hire to e er week for weeks and as onduct toring of s to olicant's
	conducted with OS about the process from CNA's certification certification indication pending violation at #1 stated she would time. OSM #1 state about the certification pending violation minvestigated by the	administrator. OSM #1 could nen a CNA had a pending			reviewed and validat ED/DON upon hire a to extending an offer employment to ensur employees are screer abuse per regulation 4 weeks, twice month	ed by the and prior of re ned for weekly x
	On 1/11/18 at 4:23 conducted with ASI	p.m., an interview was M (administrative staff			\$	

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member) #2, the DON. The DON was asked about her involvement in the hiring and

Event ID: 727W41 ECERVID: VA0008

If continuation sheet Page 11 of 107



# TAND HUMAN SEDVICES

PRINTED: 02/02/2018 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			0	MB NO. 0938-039
TATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	r CORRECTION ,		B. WING			C 01/16/2018
		495362			EET ADDRESS, CITY, STATE, ZIP CODE	**************************************
NAME OF F	ROVIDER OR SUPPLIER	i.		1	THOMPSON STREET	
ASHLAN	D NURSING AND RE	EHABILITATION		1	HLAND, VA 23005	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) RE COMPLETION
F 606	after the application resources, she won for an interview and administrator. As applicant, they would be the background or resources would be stated the adminited decision to hire an aware of a time would be application. ASM #2 could not certification. ASM pending violation, decision whether the conducted with A #1 stated the hur responsible for we asked why certification whether asked why certification asked why certification. ASM #1 stated for their current or CNAs should have employee file. We followed if a CNA their certification hire an applicant.	page 11 sation process. ASM #2 stated on was reviewed by human ould have the applicant come in the introduce the applicant to the SM #2 stated if they liked the buld run a background check. If heck was clean, then human verify the certification. ASM #2 strator would make the final in applicant. ASM #2 was not where they hired an applicant oblation against their certification. It recall verifying CNA #3's if would be the administrator's the applicant was hired.  4 p.m., an interview was SM #1, the administrator. ASM man resources director was erifying certifications. When cations should be verified, ASM ations should be verified to ation is current and in ASM #1 stated certifications and before her interview with the employee file and a concertification. ASM #1 stated all we a current certification in their when asked about the process A had a pending violation agains, ASM #1 stated her decision to would depend on the violation. If the violation were still pending, re that person until she found.	py t	606	weeks, then monthly, P and as indicated.  HRC/Designee to condrandom quality monitor C.N.A employee files the ensure criminal backgrochecks/Virginia State P is obtained, placed in the employee file and valid by ED/DON within 30 of hire per regulation to ensure employees are screened for abuse 2 times week for 4 weeks, weeks then monthly, P and as indicated.  HRC/designee to condrandom quality monitor regarding CNAs whose certification is due for renewal within the monto be provided a letter requiring signature communicating certification in the	luct ring of cound rolice ne lated days o mes a kly x4 RN uct ring e nth are

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

additional information from the Board of Nursing. When asked if she had recently hired a CNA that

had a pending violation against their certification, Event ID: 727W11 Facility ID: VA0008

If continuation sheet Page 12 of 107





## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-		. 0938-0391	
	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		DNSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495362	B. WING	B 		ı	C /16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION		906 TI	ET ADDRESS, CITY, STATE, ZIP CODE HOMPSON STREET LAND, VA 23005		American Ame
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	at all." When asker hiring CNA #3, ASM that CNA #3 had a certification. ASM # suspended until she information regarding the Board of Nursin On 1/11/18 at 5:25 p DON (Director of Nursing they had suspended investigation. The Alable to evidence the working schedule do Conducted with ASM what CNA #3's violated ASM #2 stated her gandled to evidence of his pending violation off she could not obtain regarding the violations on their ceto work. ASM #2 was that these CNAs had certification. ASM # in touch with the departing pendings.	o, not recently. Not at this job d what she could recall about #1 stated she was not aware bending violation against her #1 stated that CNA #3 will be execives additional ang her pending violation from g.  o.m., the Administrator and ursing) were able to evidence if CNA #3 until further administrator and DON were expremoved this CNA from the lated 1/11/18 through 1/16/18.  a.m., further interview was 1 #2, the DON. When asked tion was on her certification, bending violation was from an was found. ASM #2 stated had not yet taken the the website. ASM #2 stated additional information on. ASM #2 stated additional information on. ASM #2 stated she had ional CNAs who had pending ertification but they were clear as asked to provide evidence if no violations on their 1/2 stated she would try to get	F	606	employee file to ensure employees are screened Abuse per regulation 2 a week for 4 weeks, we x4 weeks then monthly and as indicated. HRC/designee to conduct random quality monito employee files regarding CNA's without proof of current certification to removed form the sche until proof of current certification is provide validated by the ED/Dewith documentation in employee file to ensure employees are screene abuse per regulation 2 week for 4 weeks, week weeks then monthly, Pland as indicated. Findings to be reported QAPI committee montupdated as indicated. In monitoring schedule in based on findings.	d for times eekly , PRN uct ring of ag of be edule d and ON the e d for times a ekly x4 PRN ed to thly and Quality modified	
	had worked approxir providing direct patie	mately 70 shifts as a CNA ent care from 10/05/17 until #3 was suspended). Further			5. Date of Complianc	e: 3-2-18	

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

review of the time card revealed CNA #3 was removed from the schedule on 1/11/18 and

Event ID:727W1RECEIND:VA0008

If continuation sheet Page 13 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENIE	RS FOR MEDICARE	: & MEDICAID SERVICES	•			DMB NO	D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ECONSTRUCTION	(X3) DA	
		495362	B. WING			01	C I/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		90	REET ADDRESS, CITY, STATE, ZIP CODE 16 THOMPSON STREET SHLAND, VA 23005	C 01/16/2 IP CODE  CORRECTION ION SHOULD BE CONTHE APPROPRIATE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 606	an "Employee Corre", documented the suspended via telegrof level 2 -#30. Employees cannot clock in or reinvestigation is communderstanding and in from the board."  The facility had ider CNA #10 and CNA #10 was hire certification was not of her time card reveapproximately 73 ship patient care from 9/CNA #10 was suspetime card revealed (the schedule on 1/16/18 Corrective Action For documented the following suspended secondary was informed that slinvestigation. Employees board of nursing for cleared it and said I from the verbal abus certification."	hedule on 1/16/18. Review of ective Action Form" for CNA a following: "Employee was obnone secondary to violation ployee was told that she eturn to work until the plete. Employee verbalized stated she had a letter to bring stiffed two additional CNAs, #11 who had pending ertifications.  ed on 6/6/17 and her verified until 9/10/17. Review ealed she had worked lifts as a CNA providing direct 21/17 until 1/12/18 (when ended). Further review of the CNA #10 was removed from 2/18 and remained off the second for CNA #10, powing: "Employee was ry to level 2 -#30. Employee he is suspended pending byee stated she has a letter at Employee was informed to comments: I went to the verbal abuse and they wasn't guilty and cleared me see and nothing was on my	F 6	06			

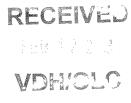
FORM CMS-2567(02-99) Previous Versions Obsolete

approximately 83 shifts as a CNA providing direct

Event ID. 727W11

Facility ID: VA0008

If continuation sheet Page 14 of 107



PRINTED: 02/02/2018

CENTERS FOR MEDICARE	S MEDICAID SERVICES				FORM APPROVED
		T	***************************************	<u>O</u>	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED
	495362	B. WING			C 01/16/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	AND THE RESIDENCE OF THE PARTY
ASHLAND NURSING AND RE	HABILITATION	onii deona alimo, annii	906 THOMPSON STREET ASHLAND, VA 23005	-	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPE FICIENCY)	BE COMPLETION
was removed from of the time card rev removed from the se remained off the sec an "Employee Corre#11, documented the suspended secondary was informed that se investigation. Employee state boards for have the floor from a sit to the other strap on a never had used a situal is could hook the get someone to transport to the conducted with OSM Discipline Specialist Nursing. OSM #6 seand CNA #11 had not certification. OSM #6 professional has a pecertification, an information certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional has a pecertified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur. OSM #6 stat nursing will review the certified professional cocur.	/27/17 until 1/12/18 (when she the schedule). Further review realed that CNA #10 was schedule on 1/12/18 and hedule on 1/16/18. Review of ective Action Form" for CNA he following: "Employee was any to level 2 -#30. Employee whe is suspended pending loyee stated she has a letter at Employee was informed to be comments: I went to the ving to put a woman down on o stand because I went to put nd the chair moved. And I it to stand before and I was em up by myself and then go	F	i06		

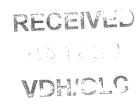
FORM CMS-2567(02-99) Previous Versions Obsolete

any information of when each CNA was cleared

Event ID: 727W11

Facility ID: VA0006

If continuation sheet Page 15 of 107



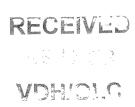
PRINTED: 02/02/2018

ncpART	MENT OF HEALTH	AND HUMAN SERVICES				1APPROVED 0. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DA COI	TE SURVEY MPLETED
ND PLAN O	F CORRECTION		B. WING		01	/16/2018
		495362		STREET ADDRESS, CITY, STATE,	ZIP CODE	
	ROVIDER OR SUPPLIER			906 THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION		ASHLAND, VA 23005	- COCDECTION	(Y5)
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	EACH CORRECTIVE A	O THE APPROPRIATE	(X5) COMPLETION DATE
E 606	Continued From p	age 15	F	606		
r 000	from their pending	y violation.				
		0 p.m., ASM #1, the ASM #2, the DON were made				
ON THE REAL PROPERTY AND THE PROPERTY AN	background chec within thirty days employed, CNA#					
	CNA #3's employ was hired on 9/1 check was not of 1/10/18 (over 3 r background che Further review o she had a signe prior to hire.	proximately 10:30 a.m., review yee file was conducted. CNA# 9/17. Her criminal background hecked by administration until months). Review of her crimina ck revealed that it was clean. If her employee record revealed d a "Sworn Disclosure Stateme	al i ent"			
	of CNA#10's er #10 was hired of background che administration to CNA#10 had a	pproximately 10:00 a.m., review mployee file was conducted. Clain 6/6/17. Her criminal eck was not checked by until 1/13/18 (over 7 months). clean criminal background che of her employee record revealed a "Sworn Disclosure Statem	ock.			
	conducted with human resource future employed decide from the	10:44 a.m., an interview was a OSM (other staff member) #2, be director. OSM #2 stated who are fills out an application, she we application if they are a good by. She will then have the applicatility to introduce them to the	ill fit icant		If continuation	sheet Page 16 of
1		Event ID:	727W11	Facility ID: VA0008	to make that the more than to	_

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

Event ID: 727W11

Facility ID: VA0008



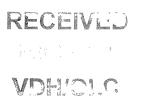
PRINTED: 02/02/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1''	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING		C 01/16/2018
	PROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLÉTION BE APPROPRIATE DATE
F 606	will then run a back background check their certification.	age 16  Jursing). OSM #2 stated she kground check and if the comes out clean, she will run OSM #2 stated a crimina! must be completed prior to	F	606	
	conducted with OS assistant business stated she was resensure certification background check stated that OSM # survey on 1/11/18. criminal backgrounthe job is offered twhy it is important check, OSM #7 stachecks are done to not have a history misdemeanor, or i	1 a.m., an interview was SM (other staff member) #7, the office manager. OSM #7 sponsible as of 1/11/18, to noverifications and criminal is were conducted. OSM #7 had walked out during the OSM #7 stated that the not checks should be done after to the applicant. When asked to run a criminal background ated criminal background of ensure that an applicant does of assault, have a significant as a sex offender etc. OSM #7 etc be suitable to take care of			
	conducted with AS member) #1, the a DON (Director of I criminal backgrout to the applicant's I resources director	D.p.m., an interview was SM (administrative staff administrator, and ASM #2, the Nursing). ASM #1 stated and checks must be done prior hire. ASM #2 stated the human was responsible and now it will usiness office manager's	1		
**************************************	administrator and	D p.m., ASM #1, the ASM #2, the DON (Director of de aware of the above			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 727W11 Facility ID: VA0008

concerns.

If continuation sheet Page 17 of 107



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

FRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	T	-		(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED
AND PLAN O	F CORRECTION	DENTIFICATION NOMBER	A. BUILD	ING	and the latter of the second contracting a group and a finish decided and a second contracting and the	C
		495362	B. WING	,		01/16/2018
	ROVIDER OR SUPPLIER	7000		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
					THOMPSON STREET	
ASHLAN	D NURSING AND RE	HABILITATION		ASH	LAND, VA 23005	NT0781 1975
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	part, the following: employment with the history of abuse, no misappropriation of includes but not ling.	ory				
F 6C7 SS=E	and registries, price - Documentation continues form (sic) and other registrie - Information from	n appropriate licensing board or to hire of status of any disciplinary licensing or registration boards is. former employers." nt Abuse/Neglect Policies		607	F607:	
	§483.12(b)(1) Pro	cility must develop and policies and procedures that: hibit and prevent abuse, plation of residents and of resident property.			employee fil	N.A)'s verification placed in the
A	8483 12(b)(2) Est	Establish policies and procedures ny such allegations, and			violation doo validated/ad	cuments obtained,
	§483.12(b)(3) include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document				1/11/18. Ide eriminal bac checks/Virg	entified C.N.A's ekground inia State Police d placed in the
	to implement abu	ermined that facility staff failed se policies and screen CNAs assistants) for abuse by failing			employee II	ic 17 1 17 10.

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 18 of 107



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

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION ,	(X3) DATE SURVEY COMPLETED
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#### F 607 Continued From page 18

to verify certifications upon hire and certification expiration, and by failing to run criminal background checks within thirty days of hire.

- 1. The facility staff failed to implement abuse policies and obtain certification verification for seventeen out of 79 currently employed CNAs (certified nursing assistant). Seventeen out of the 79 currently employed CNAs had expired certifications in their employee file. The CNAs included CNA #3, CNA #5, CNA #7 and CNA #19 through 32.
- 2. The facility staff failed to implement abuse policies and obtain certification verifications prior to hire for three of 79 currently employed CNAs, CNA#3, CNA#10 and CNA#11. All three CNAs were found to have a pending violation against their certification and were providing direct care to residents.
- 3. The facility staff failed to implement abuse policies and obtain criminal background checks from the Virginia State Police Department within thirty days of hire for two of 79 currently employed CNAs, CNA#3 and CNA#10.

The findings include:

1. On 1/10/18 at 1:15 p.m. surveyors entered the facility to investigate a two-day complaint. During the course of investigation an immediate jeopardy was identified and a substandard review and expanded survey was initiated.

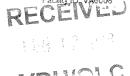
Part of the substandard review is to ensure all currently employed CNAs (certified nursing assistants) have registry verification of their

F 607

2. A quality review of current CNA employee files by the Human Resources Coordinator (HRC) completed to ensure CNA certification verification is current, pending violation documents obtained and addressed as applicable and validated by Executive Director (ED)/Director of Nursing Services (DON) with documentation in the employee file per regulation. CNA's without a current certification and/or pending violations to be removed from the schedule until certification and/or pending violation documents obtained and validated by the ED/DON with documentation in the employee file per regulation prior to accepting an assignment. A quality review of current CNA employee files by the HRC completed to ensure criminal background checks/Virginia State Police is current, and validated by the ED/DON with documentation in the employee file within 30 days

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

Event ID:727W11



PRINTED: 02/02/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
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F 607	was requested on 1 p.m. with their emp. On 1/11/18 at approach the CNA employee than 50 percent of t	of currently employed CNAs //10/18 at approximately 5:30	F	607	of hire. CNAs wit current criminal be check to be remov schedule until a be check is obtained,	ackground red from the ackground and
	conducted with OSI human resources diresponsible for verificated she verified cabout the process for certifications, OSM are properties out are from the application company. She will into the facility to into (Director of Nursing) then run a backgroup background check cotheir certification. Woother times, she would responsible to the certification of the certification of the certification of the certification of the certification.	#2 stated when a future application, she will decide if they are a good fit for the hen have the applicant come roduce them to the DON.  OSM #2 stated she will nd check and if the omes out clean, she will run then asked if there were any ald verify certifications, OSM.			validated by the E with documentation employee file prion accepting an assig	on in the or to
	#2 stated she has a program) that alerts certification needs to why certifications ne stated certifications are there are no violation When asked where cOSM #2 stated certification of the complete the there are no violation when asked where the certification of the complete the there are no violation when asked where the certification of the complete the certification of the complete the complete the certification of the complete the complete the certification of the ce	computer system (payroll her when an employee's be verified. When asked ed to be verified, OSM #2 need to be verified to ensure a not expired and to ensure as against the certification. Descriptions should be filed, ications should be filed in the M #2 stated she would try to			,	

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

On 1/11/18 at approximately 3:00 p.m., OSM #2

Event ID: 727W11 Facility ID: VA0008

If continuation sheet Page 20 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO 0938-0391

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	406363	B. WING		01/16/2018		
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F 607 Continued From p	page 20	F 607	2 HRC re-educated by	/ the		

handed this writer a stack of certifications that were verified on 9/10/17. OSM #2 stated she had realized that some CNAs had expired certifications in their employee file and she had printed out current certifications from the department of health professions website. OSM #2 stated if a current certification was not in the employee file or in the stack of paper just given to this writer, then she did not have them.

On 1/11/18 at approximately 3:00 p.m., review of the stack of CNA certifications was conducted. Seventeen out of the 79 currently employed CNAs did not have their certification verified. Seventeen out of the 79 current CNAs had expired certifications in their employee file. The CNAs included CNA #3, CNA #5, CNA #7 and CNA#19 through 32 Review of the as-worked schedule from the past two weeks prior to entrance, revealed that the 17 CNAs identified had been directly working with residents and providing care.

On 1/11/18 at 4:00 p.m., facility staff presented current certification verifications of the identified 17 CNAs. The certifications were printed from the DHP (Department of Health Professions) website on 1/11/18. All identified CNA's had a current certification.

On 1/11/18 at 4:44 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated the human resources director was responsible for verifying certifications. When asked why certifications should be verified, ASM #1 stated certifications should be verified to ensure a certification is current and in good-standing. ASM #1 stated certifications should be checked before her interview with the

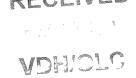
3. HRC re-educated by the ED/DON/designee regarding ensuring CNA certification verification is current, pending violation documents reviewed/addressed as applicable and validated by the ED/DON prior to accepting an assignment to ensure implementation of Abuse Policy per regulation. HRC re-educated by the ED/DON/designee regarding new CNA applicant's certification verification to be reviewed, pending violation documents reviewed/addressed as applicable and validated by the ED/DON per regulation upon hire and prior to extending an offer of employment to ensure implementation of Abuse Policy per regulation. HRC re-educated by the ED/DON/designee regarding ensuring criminal background checks/Virginia State Police is obtained, placed in the

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 21 of 107



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

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

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F 607	the applicant without of their current certic CNAs should have employee file.  On 1/11/18 at 4:44 staff member) #1, the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the DON (Director of the above concerts) which is the DON (Director of the DON (Director of the DON (Director of the above concerts) which is the providing care.  On 1/11/18 at approach of the DON (Director of the above of the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the above concerts) which is the DON (Director of the DON (Director of the above concerts) which is the DON (Director of the DON (	stated she cannot interview at the employee file and a copy fication. ASM #1 stated all a current certification in their o.m., ASM (administrative ne administrator and ASM #2, of Nursing) were made aware rns.  failed to obtain certification hire for three of 79 currently NA #3, CNA #10 and CNA is were found to have a gainst their certification that igated by administration. All eathy worked with residents by eximately 9:00 a.m., review of file was conducted. CNA #3 and certification in her c. #3's hire date was 9/19/17.  a.m., an interview was M (other staff member) #2, the frector. When asked who was ying certifications. When asked	Fe	employee file and valid by ED/DON within 30 of hire to ensure implementation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation. HRC re-educated by the ED/DON/Designee regulation of Abrolicy per regulation.	days use ne garding ion is the
	into the facility to int	then have the applicant come roduce them to the DON  OSM #2 stated she will			,

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

then run a background check and if the

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 22 of 107



PRINTED: 02/02/2018

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		h a finding of "no violation				

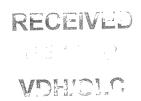
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Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 23 of 107



PRINTED: 02/02/2018 FORM APPROVED

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On 1/11/18 at 4:20 p.m., further interview was conducted with OSM #1. OSM #1 was asked about the process followed if she were to verify a CNA's certification and found a "YES" on their certification and found a "YES" on their certification against their certification. OSM #1 stated she would not know what to do at that time. OSM #1 stated she would go to the DON about the certification may also need to be invastigated by the administrator. OSM #1 could not recall a time when a CNA had a pending violation against their certification.  On 1/11/18 at 4:23 p.m., an interview was conducted with ASM (administrator would make the final decision to verification in the hiring and certification in the hiring and certification was reviewed by human resources, she would have the applicant to the administrator would make the final decision to bite an applicant. ASM #2 stated if it not ware of a time where they hired an applicant with a pending violation against their certification. ASM #2 stated if a cNA had a pending violation, it would be the administrator's decision whether the applicant was hired.  On 1/11/18 at 4:44 p.m., an interview was conducted with ASM (acministrator would make the final decision to bite an applicant. ASM #2 was not aware of a time where they hired an applicant with a pending violation, it would be the administrator's decision whether the applicant was hired.  On 1/11/18 at 4:44 p.m., an interview was	PREFIX	/EXCHIDEFICIENG)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	
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pending violation, it would be the administrator's decision whether the applicant was hired.  On 1/11/18 at 4:44 p.m., an interview was		ASM #2 could not	recall verifying CNA #35					
decision whether the applicant was hired.  On 1/11/18 at 4:44 p.m., an interview was	Ì	certification, ASM	: #Z Stateu II a ONA Hau a It would be the administrator's			•		
On 1/11/18 at 4:44 p.m., an interview was		pending violation,	it would be the authinistrator s the applicant was hired			* .		
Ori 1/11/18 at 4:44 p.m., an interview was conducted with ASM #1, the administrator. ASM		decision whenler t	no applicant mas miles.			`		
conducted with ASM #1, the administrator. ASM		Ori 1/11/18 at 4:44	p.m., an interview was					
www.energenergenergenergenergenergenergener		conducted with AS	SM #1, the administrator. ASM					

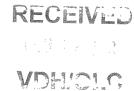
FORM CMS-2567(02-99) Previous Versions Obsolete

#1 stated the human resources director was

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 24 of 107



PRINTED: 02/02/2018

DELVIO	TIMENT OF HEALT	AND HOMAN SEKVICES				FOR	RM APPROVE
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		-Westernan		OMB N	IO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) C	OMPLETED
		495362	B. WING			-	С
NAME OF	PROVIDER OR SUPPLIER	1700001	10.77		OTDEET ADDRESS SILV STATE 212 CONS		1/16/2018
					STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET		
ASHLAI	ND NURSING AND RE	HABILITATION		ĺ	ASHLAND, VA 23005		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 607	Continued From pa	ne 24	F 6	207	*		
		fying certifications. When	1 0	101	weeks, then monthly,	PRN	
		tions should be verified, ASM			and as indicated.		
	#1 stated certification	ons should be verified to			HRC/designee to con		
	ensure a certificatio				random quality monit		
	good-standing. ASI	M #1 stated certifications before her interview with the			C.N.A employee files		
		stated she cannot interview			ensure criminal backg		
		it the employee file and a copy			checks/Virginia State		
	of their current certi-	fication. ASM #1 stated all			is obtained, placed in		
		a current certification in their			employee file and vali	dated	
		n asked about the process			by ED/DON within 3(		
	their certification AS	ad a pending violation against SM #1 stated her decision to			of hire per regulation t		
	hire an applicant wo	uld depend on the violation.			ensure implementation		
	ASM #1 stated if the	violation was still pending,			Abuse Policy per regu		
		nat person until she found			times a week for 4 wee	:Ks,	
		n from the Board of Nursing.			weekly x4 weeks then monthly, PRN and as	,	
	had a pending violat	nad recently hired a CNA that ion against their certification,			indicated.		
		not recently. Not at this job			HRC/designee to cond	4	
	at all." When asked	what she could recall about			random quality monito		
		#1 stated she was not aware			regarding CNAs whose		
	that CNA#3 had a p	ending violation against her 1 stated that CNA #3 will be			certification is due for	?	
	suspended until she				renewal within the mor	ath are	
		g her pending violation from			to be provided a letter	nii ait	
	the Board of Nursing				requiring signature		
					communicating certific	ation	
		m., the Administrator and			renewal due date with	11011	
	they had suspended	rsing) were able to evidence			documentation in the		
	investigation. The Ad	dministrator and DON were			employee file to ensure		
					1 9 01136110		1

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

able to evidence they removed this CNA from the

working schedule dated 1/11/18 through 1/16/18.

On 1/16/18 at 9:30 a.m., further interview was

conducted with ASM #2, the DON. When asked

what CNA #3's violation was on her certification, ASM #2 stated her pending violation was from

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 25 of 107

implementation of Abuse

Policy per regulation 2 times a week for 4 weeks, weekly

x4 weeks then monthly, PRN

and as indicated.



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			DMB NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER:SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		495362	B. WING	,	C 01/16/2018	
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	1 01110.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 607	2013 and no violation the board of nursing pending violation of she could not obtain regarding the violations on their cito work. ASM #2 w	age 25 on was found. ASM #2 stated g had not yet taken the fithe website. ASM #2 stated in additional information ion. ASM #2 stated she had tional CNAs who had pending ertification but they were clear as asked to provide evidence id no violations on their	F 607	HRC/designee to conduct random quality monitoring employee files regarding CNA's without proof of current certification to be removed form the schedu	og of	

Review of CNA #3's time card revealed that she had worked approximately 70 shifts as a CNA providing direct patient care from 10/05/17 until 1/11/18 (when CNA #3 was suspended). Further review of the time card revealed CNA #3 was removed from the schedule on 1/11/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #3, documented the following: "Employee was suspended via telephone secondary to violation of level 2 -#30. Employee was told that she cannot clock in or return to work until the investigation is complete. Employee verbalized understanding and stated she had a letter to bring in from the board."

certification. ASM #2 stated she would try to get

in touch with the department of health

professions.

Also on 1/11/18 at 4:00 p.m. the facility staff presented documentation evidencing two additional CNAs, CNA#10 and CNA#11 had been identified as having pending violations on their certifications.

1. CNA #10 was hired on 6/6/17 and her certification was not verified until 9/10/17. Review of her time card revealed she had worked approximately 73 shifts as a CNA providing direct

random quality monitoring of employee files regarding CNA's without proof of current certification to be removed form the schedule until proof of current certification is provided and validated by the ED/DON with documentation in the employee file to ensure implementation of Abuse Policy per regulation 2 times a week for 4 weeks, weekly x4 weeks then monthly, PRN

Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

and as indicated.

5. Date of Compliance: 3-2-18

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

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 26 of 107



## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

		E & MEDICAID SERVICES				OMB NO. 0938-039		
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) C	DATE SURVEY COMPLETED	
NAME OF		495362	B. WING				C 01/16/2018	
	NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 607: Continued From page 26 patient care from 9/21/17 until 1/12/18 (when CNA #10 was suspended). Further review of the time card revealed CNA #10 was removed from the schedule on 1/12/18 and remained off the schedule on 1/16/18. Review of an "Employee Corrective Action Form" for CNA #10, documented the following: "Employee was suspended secondary to level 2 -#30. Employee was informed that she is suspended pending investigation. Employee stated she has a letter a home clearing her. Employee was informed to		The second secon	90€	REET ADDRESS, CITY, STATE, ZIP COO 6 THOMPSON STREET 6HLAND, VA 23005		7 5 1 W 1 M 2 F W	
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	patient care from 9/CNA #10 was suspetime card revealed the schedule on 1/16/18 Corrective Action For documented the follows suspended secondary was informed that sinvestigation. Employee board of nursing for cleared it and said I	/21/17 until 1/12/18 (when rended). Further review of the CNA #10 was removed from 12/18 and remained off the 8. Review of an "Employee orm" for CNA #10, "Iowing: "Employee was ary to level 2 -#30. Employee she is suspended pending toyee stated she has a letter at	F 6	)7				
	of her timecard reve approximately 83 sh patient care from 9/2 was removed from the of the time card reve removed from the so remained off the sch an "Employee Correct #11, documented the	ed or, 2/2/15 and her verified until 9/9/17. Review paled that she had worked lifts as a CNA providing direct 27/17 until 1/12/18 (when she he schedule). Further review paled that CNA #10 was chedule on 1/12/18 and hedule on 1/16/18. Review of loctive Action Form" for CNA e following: "Employee was ry to level 2 -#30. Employee						

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get someone to transfer."

was informed that she is suspended pending investigation. Employee stated she has a letter at home clearing her. Employee was informed to bring it in. Employee comments: I went to the state boards for having to put a woman down on the floor from a sit to stand because I went to put the other strap on and the chair moved. And I never had used a sit to stand before and I was told I could hook them up by myself and then go



If continuation sheet Page 27 of 107



PRINTED: 02/02/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FO	IRM APPROVED NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495362	B. WING	S			С
	PROVIDER OR SUPPLIER	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP COD THOMPSON STREET HLAND, VA 23005	DE T	01/16/2018
(X4) ID PREFIX TAG	. (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	conducted with OSI Discipline Specialist Nursing. OSM #6 s and CNA #11 had no certification. OSM # professional has a post-ification, an information of the certified professional docur. OSM #6 statements of the certified professional with the certified professional cocur. OSM #6 statements of the certified professional cocur. OSM #100 professional cocur.	is a.m., an interview was M (other staff member) #6, the to for the Virginia Board of tated that CNA#3, CNA#10, o violation pending on their #6 stated when a certified bending violation on their mal conference with the all and board of nursing will ed that is when the board of ne case and decided whether it is guilty of a violation or ated that all CNAs should er from the board stating that and. OSM #6 stated it takes a stion to come off the website. Is son for each CNA to be ard, OSM #6 stated, "That is nut," OSM #6 could not give hen each CNA was cleared olation.  In., ASM #1, the EM #2, the DON were made indings.		607			

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background check revealed that it was clean.

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 28 of 107





## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMBN	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495362	B. WING	*			C
	PROVIDER OR SUPPLIER	HARII ITATION			EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET		1/16/2018
~		TOTAL TOTAL		ASF	HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	Χ .	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD RE	(X5) COMPLETION DATE
F 607	Continued From pa Further review of he she had a signed a prior to hire.	ge 28 er employee record revealed "Sworn Disclosure Statement"	F 6	07			
:	of CNA #10's emplo #10 was hired on 6/ background check vadministration until CNA #10 had a clea Further review of he						
	conducted with OSM human resource dire future employee fills decide from the app for the company. Si come into the facility DON (Director of Nu will then run a backg background check cotheir certification.	a.m., an interview was I (other staff member) #2, the ector. OSM #2 stated when a out an application, she will lication if they are a good fit he will then have the applicant to introduce them to the rsing). OSM #2 stated she round check and if the omes out clean, she will run SM #2 stated a criminal rust be completed prior to					
· .	conducted with OSM assistant business of stated she was respondered on the consure certification vackground checks wated that OSM #1 had survey on 1/11/18. Comminal background	a.m., an interview was (other staff member) #7, the fice manager. OSM #7 onsible as of 1/11/18, to erifications and criminal were conducted. OSM #7 had walked out during the uSM #7 stated that the checks should be done after the applicant. When asked					

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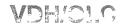
why it is important to run a criminal background

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 29 of 107





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

PRINTED: 02/02/2018 FORM APPROVED

		A MEDICAID SERVICES			<u>OMI</u>	<u>3 NO. 0938-039</u>
	NT OF DEFICIENCIES 1 OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG	(X	(3) DATE SURVEY COMPLETED
and the second s		495362	B. WING		AMARIAN A	C 01/16/2018
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	01/10/2010
ASHLA	ND NURSING AND RE	HABILITATION		906 THOMPSON STREE	T	
				ASHLAND, VA 23005	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)	(X3) E COMPLETION TE DATE
F 601	check, OSM #7 sta checks are done to not have a history o misdemeanor, or is	ted criminal background ensure that an applicant does	F 6	07		
	conducted with ASM member) #1, the ac DON (Director of No criminal background to the applicant's hin resources director v	p.m., an interview was  If (administrative staff If (administrative staff Iministrator, and ASM #2, the Interview ASM #1 stated If checks must be dene prior If it is a stated the human If it is a stated the stated If it is a stated If it				
	. On 1/16/18 at 2:00 p administrator and Al Nursing) were made concerns.	o.m., ASM #1, the SM #2, the DON (Director of e aware of the above				
	part, the following: "I employment with the history of abuse, neg	o's abuse policy documents in Persons applying for e center will be screened for a glect, and exploitation, or resident property. This ed to:				
F 609	and registries, prior t - Documentation of	nd check appropriate licensing board o hire status of any disciplinary ensing or registration boards ormer employers."	F 60	9		

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 30 of 107





## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	t	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		C
		HABILITATION  FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFI	STREET ADDRESS, CITY, STATE, ZIP 906 THOMPSON STREET ASHLAND, VA 23005 PROVIDER'S PLAN OF CO	DRRECTION (NO.
	Continued From page CFR(s): 483.12(c)(1		TAG F 6	CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE DATE
	§483.12(c) In responeglect exploitation must:  §483.12(c)(1) Ensurinvolving abuse, negmistreatment, includes ource and misappeare reported immedithours after the allegatinat cause the allegatinat cause the allegatinat cause that cause and do not restlement of the administrator of the allegation and if the allegation and if the allegation of the administrator of th	nse to allegations of abuse, or mistreatment, the facility e that all alleged violations plect, exploitation or ing injuries of unknown opriation of resident property, ately, but not later than 2 ation is made, if the events ation involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to he facility and to other the State Survey Agency and ces where state law provides pterm care facilities) in the law through established		F609: Reporting of Allege  1. Resident #1 re-admitted Reported Incident (FRI) No further events require occurred.  2. Quality review of event 30 days by the Executive (ED)/Director of Nursin completed to ensure resi of unknown origin, resu bodily injury are reporte appropriate state agency Follow up based on find  3. ED and DON re-educate Vice President of Opera regarding ensuring resid unknown origin, resultire injury are reported to the agency timely per regulation.	2/7/18. Facility submitted 1/08/18. ing a FRI have  reports in the last e Director g Services (DON) dents with injury lting in serious d timely to the per regulation. ings.  ed by the Regional tions (RVPO) lents with injury of ing in serious bodily e appropriate state

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

survey sample, Resident #1.

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 31 of 107





PRINTED: 02/02/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FURIV OMB NO	APPROVEE . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DISTRUCTION	(X3) DAT	E SURVEY MPLETED
		495362	B. WING			1	C (4.6/204.0
AND PLAN OF CORRECTION  495362  NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 609 Continued From page 31  The facility staff failed to notify the appropriate state agency within the two hour required timeframe following Resident #1's egregious injury of second and third degree burns to the face, hand and chest.  The findings include:  Resident #1 was admitted to the facility on 3/11/15 and readmitted on 8/15/17 with diagnoses that included but were not limited to traumatic brain injury, dementia and seizures. The most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 10/3/17 coded the resident as having a three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as being able to complete activities of daily living independently. The resident was coded as being 5'6" tall.  Review of the care plan initiated on 8/21/17 and revised on 9/12/17 documented, "Focus. (Name of Resident #1) has the potential for injury r/t (related to) Confusion, epilepsy (seizures).			906 T	ET ADDRESS, CITY, STATE, ZIP CODE HOMPSON STREET -AND, VA 23005	1 01,	/16/2018	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
	The facility staff failstate agency within timeframe following injury of second and face, hand and chest The findings include Resident #1 was ad 3/11/15 and readmit that included but we brain injury, dementing recent MDS (minimulassessment with an date) of 10/3/17 cod timee out of 15 on the mental status) indicaseverely impaired occoded as being able living independently, being 5'6" tall.	ed to notify the appropriate the two hour required Resident #1's egregious of third degree burns to the st.  mitted to the facility on ted on 8/15/17 with diagnoses are not limited to traumatic in and seizures. The most arm data set) a quarterly ARD (assessment reference ed the resident as having a e BIMS (brief interview for atting the resident was a to complete activities of daily. The resident was coded as	F 6		4. ED/DON/designee to conduct qua monitoring through morning clinic meeting of event reports to ensure with injury of unknown origin, resserious bodily injury are reported appropriate state agency timely peregulation 3 times weekly x 4 weetimes weekly, then PRN an as ind ED/DON/designee to conduct qua monitoring through morning clin meeting of the 24 hour report to eresidents with injury of unknown resulting in serious bodily injury a reported to the appropriate state at timely per regulation 3 times week weeks, 2 times weekly, then PRN indicated. Findings to be reported to QAPI comonthly and updated as indicated monitoring schedule modified bas findings.	residents sulting in to the residents ks, 2 icated. lity cal asure origin, are gency kly x 4 an as Ommittee Quality	
	revised on 9/12/17 do f Resident #1) has to (related to) Confusion Psychoactive drug us and Wandering AEB (history) of falls. Inter from spills and/or clu- ight: a working and re	ocumented, "Focus. (Name he potential for injury r/t			5. Date of Compliance 3-2-18.		
i 3	Review of the SBAR ( essessment and reco	(situation, background, mmendation) dated 1/8/18			3		

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at 8:45 a.m. documented, "BACKGROUND Resident Description Primary diagnoses TBI

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 32 of 107



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

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391
AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
All control and color and any specific color and any specific color and colo	495362	B. WING	C 04/45/2042
NAME OF PROVIDER OR SUI		STREET ADDRESS, CITY, STATE 906 THOMPSON STREET ASHLAND, VA 23005	01/16/2018 ; ZIP CODE
PREFIX (EACH DEF	RY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN C PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
alcohol use. F Status Evalua all that you ob consciousnes Functional Sta baseline; chec mobility. Need (activities of d [were all ched Burn. Discolor Describe symp face + (plus) ( (swelling), bur heater, 10. Ne level of consci hemiparesis (v Summarize yo Resident apper face + (R) han stroke very we drainage to face  Review of the s documented, "I cheek - (L) 3 (s Reddened area area - sacrum due to arrival or service) + diffic  Review of the r p.m. document to room to chec observed reside of face + hand v drainage comin room to assess	ain injury), seizures from TBI, par Resident Evaluation: 1. Mental tion (compared to baseline; che serve) Decreased level of s (sleepy, lethargic) [was check atus Evaluation (compared to ck all that you observe) Decreas is more assistance with ADLs aily living). Weakness (general) ked]. 8. Skin Evaluation. Abrasic ation Wound (were all checked otoms or signs. (R) [right] side of R) hand noted with edema in d/t (due to) resident layed (sio urological Evaluation. Decrease ousness. Weakness or vere all checked). APPEARANO ur observations and evaluations ared to have burns to (R) side of d also appeared to have had a ak + lethargic (with) yellow	eck ed]. sed on. ). of ) on ed  CE S. of  8 R) d - ody	

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 33 of 107



FEB 17 208

VDH/OLC

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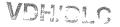
	E & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495362	B. WING	Na.	C 04/46/2040
NAME OF PROVIDER OR SUPPLIES  ASHLAND NURSING AND R			STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005	01/16/2018 DDE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		SHOULD BE COMPLETION
appeared to be conoted leaning to the bed, cleaned up vice (blood pressure) - 104 (temperature) (liters) O2 (oxygen medical transport) hospital) MD (med RP (responsible pathis AM @ approx (8:15 a.m.), this wichair by heater + a 445 AM (4:45 a.m. distress @ the time residents (sic) conthat resident has his trying to rule out bit will keep up update will go to hospital to Review of the facili revealed the FRI wagency at 10:13 p.r. after the injury occur. An interview was considered to send agency, ASM #2 strong ASM #1, the admire porting. My initial the resident is safe #1)." When asked waware of Resident #1"Maybe about 9:15	r-discolored yellow substance ming from face. (R) side weak hat side resident transferred to se (vital signs) obtained 90/86 116 (pulse) - 18 (respirations) - 0 (sic) [oxygen] - 93% on 2 L) 911 called EMT (emergency arrived resident to (name of ical doctor) aware at this time arty) notified, prior to incident (at approximately) 815 AM iter observed resident sitting in ppeared (sic) sleep @ approx of did not appear to be in any etalked (with) RP in regards to dition RP states she is aware and a decline, states hospital is eading of brain and or stroke and a decline, states hospital is eading of brain and or stroke and a decline and the state of the	· · · · · · · · · · · · · · · · · · ·	509	

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

Event ID: 727W11 Facility ID: VA0008

If continuation sheet Page 34 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

1		= & MEDICAID SERVICES	<del></del>			OMB N	<u>IO. 0938-039</u>
STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495362	B. WING				С
NAME OF PROVIDER OR S ASHLAND NURSING		HABILITATION		5	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		01/16/2018
PREFIX (EACH DE	EFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG	***************************************	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
hours. I do l changes in t	ng is the know the	ge 34 at abuse and neglect is two at there have been some (regulations) on the 28th of not really solid on those	F 6	09			
a.m. with RN director of no responsible the appropriate the accompleting to (Information) When asked was, RN #3 called a state nurses and no what happen	I (regist ursing, I (regist ursing, I for com ate stated the FRI I from the what the stated, " (immed ny bossed." Wit which till which till the stated the stated of the s	nducted on 1/11/18 at 11:40 ered nurse) #3, the assistant When asked who was pleting and sending a FRI to a agency, RN #3 stated, "I rator is responsible for but she gets the info as appropriate department." He timeframe for reporting My reporting is immediately. I fate) so I could get all the immediately so they know then asked if she knew the ne state agency was to be dd, "No."				· · · · · · · · · · · · · · · · · · ·	
p.m. with ASI the administrative send a FRI to and the ombus investigation. resident from investigation a When asked the one Resident at the state ag	M (admi ator. AS ne state i (office idsman Well firs harm a fand sen when ar lent #1 s gency, A	iducted on 1/11/18 at 2:45 nistrative staff member) #1, iM #1 was asked when a FRI agency. ASM #1 stated, "I of licensure and certification) If it's abuse, I start my; ist thing I do is remove the nd then start the id it in within five days." In egregious injury such as sustained would be reported ask #1 stated they had 24 hade aware of the concern					
Review of the Neglect, Explo	facility's oitation (	policy titled, Abuse, Misappropriation"					

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 35 of 107



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

PRINTED: 02/02/2018 FORM APPROVED

STATE MENT OF SECURIORS		T		<u> </u>	1391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	7
	495362	B. WING	3	С	
NAME OF PROVIDER OR SUPPLIER		1	CTDCCT ADDDCOO OCTA OTTO	01/16/2018	3
			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
ASHLAND NURSING AND REI	HABILITATION		906 THOMPSON STREET		
			ASHLAND, VA 23005		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		HOURD BE CONCLE	
and dignity of each in he/she be afforded in the right to be free firm istreatment, explosive property. The manage these rights and the statements, policies these rights and to exhibit a cocurrences of resident occurrences of resident providers which results in the foccurrences of resident providers which results in the foccurrences of resident providers which was proprieted in firm and the providers of the state of the providers of the state of the providers which including injuries of the state of the providers of the state of the providers of the design of the providers of the design of the providers of the	CY: It is inherent in the nature resident at the center that basic human rights, including rom abuse, neglect, itation/or misappropriation of ger of the facility recognizes reby establishes the following and procedures to protect establish a disciplinary policy, facility and timely treatment of lent abuse.  Any employee or contracted to witnesses or has of abuse or an allegation of citation or mistreatment, anknown source and resident property, to a to report such information later than 2 hours after the inthe events that cause the use, or result in serious after the eallegation do not involve sult ins serious bodily injury, and other official in the law. In the absence of the ne Direct of of Clinical nated abuse coordinator, if abuse is reported, the side abuse coordinator, is ing that reporting is appropriately to appropriate e with Federal and State	F	609		
	individual requirements and porting as required by law."				-

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 36 of 107



# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

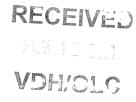
1		A MEDICAID SERVICES		My -2-1		OMB N	D. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	HABILITATION		906 THOMPS		<u> </u>	17 10/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	VA 23005  ROVIDER'S PLAN OF CORRECTH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPROPRIECTION DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
F 641 SS=D	Accuracy of Assess CFR(s): 483.20(g)  §483.20(g) Accurace The assessment muresident's status. This REQUIREMEN by: Based on staff interreview, it was deterraceurately complete assessment for one sample, Resident #5  The facility staff incourinary incontinence quarterly MDS assess reference date of 11/ The findings include.  Resident #5 was admonthing the finding include.  The findings include.	on was obtained prior to exit. ments  y of Assessments.  ust accurately reflect the  IT is not met as evidenced  view and clinical record nined the facility staff failed to an MDS (minimum data set) of six residents in the survey i.  rrectly coded the resident's status on Resident #5's sament, with an assessment IZ1/17.  nitted to the facility on readmission on 3/15/17 with led but were not limited to: 6) (a progressive disease in the brain and spinal cord er, it progresses slowly with 1)), muscle weakness, of the lower limbs (2)), high ession, dysfunction of the e of toe.	F 60	<b>F</b>	Resident #5 Minimu Set (MDS) quarterly assessment with an assessment reference (ARD) of 11/21/17 / and re-submitted.  Quality Review of c residents with indwelling/supra-put catheters completed MDS Coordinator/D Nursing Services (DON)/designee to e MD\$ is accurately consection H/ Bladder at Bowel, H 0300 Urina Incontinence is Code noted rated within the specified ARD to incomodifications and resubmission(s) as indibased on findings.	e date modified current by the irector of nsure the oded in adary d 9, e lude	

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 37 of 107



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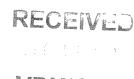
		& MEDICAID SERVICES				FOR	MAPPROVE
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		MB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1			CC	MPLETED
		495362	B. WING	at and the property of the same	NO. 11 TO 1	0.	C 1/16/2010
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/16/2018
ASHLA	ND NURSING AND RE	HABILITATION			6 THOMPSON STREET SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLÉTIO DATE
F 64 <b>1</b>	Section H - Bladder coded as having an "Appliances" and w. Continent" under ur	make daily decisions. In and Bowel, Resident #5 was indwelling catheter under as coded as being "Always	F 6	41			
	the physician on 12. "Supra Pubic Cathe neurogenic bladder. A supra pubic cathe bladder from the out. The physician progredocumented in part, catheter for neuroge changes himself."  The comprehensive documented in part, bladder elimination renlargement, history infections) neurogen evidenced by) Cathernal progressions.	/30/17, documented in part, ter care every shift - " ter is a catheter put into the side above the pubis. (3). ess notes dated, 12/3/17, "He has a suprapubic nic bladder which he care plan dated, 12/4/17, "(Resident #5) has altered /t (related to) prostate of UTI (urinary tract ic bladder, AEB (as ter - per order."			<ol> <li>MDS Coordinator reeducated by the DON/designee regardensuring section H/E and Bowel, H 0300 U Incontinence is accurded 9, noted rated reflect the resident's status and services prefor residents with indwelling/supra-publicatheters within the section ARD.</li> <li>MDS Coordinator/DON/de</li> </ol>	ding Bladder Jrinary ately to current ovided ic pecified	
	nurse) #3, the MDS is a.m. RN #3 was asked quarterly MDS with a date of 11/21/17. One "It's incorrect, it shou will make the correct reference they use to assessments, RN #3. The RAI (resident assessments)	iducted with RN (registered nurse, on 1/11/18 at 10:42 ed to review Section H of the n assessment reference be reviewed, RN #3 stated, ld be coded as 'not rated.' I on." When asked what complete the MDS stated, "The RAI manual."			conduct quality moni MDS assessments pri submitting to ensure a of section H/ Bladder Bowel, H 0300 Urina Incontinence is accura Coded 9, noted rated breflect the resident's of status and services pri for residents with	toring o or to accuracy and ry ately to current	f

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

"Section H - Bladder and Bowel. H 0300 - Urinary

Event ID: 727W11

If continuation sheet Page 38 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

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

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 39 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

1		A MEDICAID SERVICES				OMB N	O. 0938-039
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	In Milmonia and a			1	906 THOMPSON STREET		
ASHLAR	ND NURSING AND RE	HABILITATION			ASHLAND, VA 23005		
/2 () (E)	CHANADYCTA	TEMENT OF OFFICIENDED		<u></u>		~	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 39	F 6	356			
	provide as a result of		, ,	700			
	recommendations.	If a facility disagrees with the			F656:		
	findings of the PASA	ARR, it must indicate its			1 050.		
	rationale in the resid	dent's medical record.			1. Resident #3 floor til	a in	
		ith the resident and the			resident room replac		
	resident's represent	ative(s)-			resident foom replac	JU.	
	(A) The resident's g	oals for admission and			2. Quality review of re	aidont's	
	desired outcomes.				with falls within the		
	(B) The resident's p	reference and potential for					
	future discharge. Fa	cilities must document			days completed by M		
		t's desire to return to the			Coordinator/Director	of	
	community was assi	essed and any referrals to			Nursing Services		
	optition for this manner	es and/or other appropriate			(DON)/designee to e	nsure	
	entities, for this purp	in the comments and the			care plan intervention	ı(s)	
		in the comprehensive care in accordance with the			accurately reflect the	. ,	
		th in paragraph (c) of this			residents, current star	iis and	
	section.	m m paragraph (c) or this			the comprehensive ca		
		T is not met as evidenced			was implemented for		
	by:	. W Hot mar do evidenced			residents with falls. Q		
		on, staff interview, facility			review of Resident R		
	document review and	d clinical record review, it					ľ
	was determined the	facility staff failed to ensure			cracked or missing flo		
	the comprehensive of	are plan was implemented			completed. Follow u	p based	
	for one of 6 residents	in the survey sample;			on findings		
	Resident #3.				3		
	- MA						
	The facility staff failed						:
•	environment for Resi	dent #3 including even floors					
	as per the comprehe	nsive care plan to prevent					
1	ians. Multiple observa	ations of Resident #3's room					
Ē	evealed an entire 12	inch by 12-inch floor tile					
1	missing in the middle	or the room.					- Anna Carlo
٦	The findings include:				Y		
	3 11 112						
ŀ	kesident #3 was adm	itted to the facility on					

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

7/10/15 with the diagnoses of but not limited to

Event ID: 727W11

11 Facility ID: VACOCS
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If continuation sheet Page 40 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICARD SERVICES  (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	1	CTION (X5) DULD BE COMPLETION
	495362	B. WING		01/16/2018
	The state of the s		STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER			906 THOMPSON STREET	
ASHLAND NURSING AND R	EHABILITATION		ASHLAND, VA 23005	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CUMPLETION
		Andrew Control of the	5	

#### F 656 Continued From page 40

chronic kidney disease, high blood pressure, Alzheimer's Disease, diabetes, and psychosis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/17/17. Resident #3 was coded as being severely cognitively impaired in ability to make daily life decisions, scoring a 1 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring total care for bathing; extensive care for bed mobility, dressing, toileting, and hygiene; Supervision to limited assistance for ambulation; and as frequently incontinent of bowel and bladder.

On 1/10/18 at 2:30 p.m., 5:11 p.m., 6:10 p.m., and 7:35 p.m.; and on 1/11/17 at 8:30 a.m., Resident #3's room was observed. During each observation an entire 12-inch by 12-inch floor tile was observed missing in the middle of the room.

On 1/11/18 at 8:25 a.m., in an interview with CNA #2 (Certified Nursing Assistant) she stated the resident is ambulatory without the use of a walking assuasive device. When asked about the missing floor tile, CNA #2 stated she was not aware it was missing. When asked if the missing tile would cause a tripping hazard for Resident #3, CNA #2 stated it would. When asked if she ever looks at the resident's care plan, CNA #2 stated no. When informed Resident #3's comprehensive care plan documented the resident should have an even floor surface for safety, and asked if the care plan being followed, CNA #2 stated, "No."

On 1/11/18 at 8:30 a.m., in an interview with LPN #1 (Licensed Practical Nurse) she stated the resident is an ambulatory resident. When asked

F 656

3. MDS Coordinator reeducated by the DON/designee regarding ensuring care plan intervention(s) accurately reflect the current status and the comprehensive care plan was implemented for residents with falls. Interdisciplinary team (IDT) re-educated by the Executive Director (ED)/Maintenance Director to ensure cracked/missing floor tiles are communicated via Mock 🕓 Survey rounds and /or documented in the maintenance book.

#### 4 MDS

Coordinator/DON/designee to conduct, quality monitoring through morning clinical meeting to ensure care plan intervention(s) accurately reflect the residents current status and the comprehensive care plan was implemented for residents with falls 3 times weekly x 2 weeks, twice weekly x 4 weeks then weekly and PRN as indicated. ED/Maintenance

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 41 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

		A MEDIOMID DETAILES	~		O	<u>IMB NO. 0938-0391</u>
	T OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTR	RUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER		-	STREET ADD	DRESS, CITY, STATE, ZIP CODE	) 01/10/2010
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				ASITEAND	, VA 23005	
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F 684 SS=E	LPN #1 stated she wasked if this would to resident, LPN #1 stated #3's comprehensive resident should have safety, and asked if followed, LPN #1 stated #3's comprehensive resident should have safety, and asked if followed, LPN #1 stated A review of the facilit documented, " Defindividualized Personplan of care by the information was provisurely.  Quality of Care CFR(s): 483.25  § 483.25 Quality of compality of care is a functional facility residents. Bas assessment of a residents receive accordance with profipractice, the comprehension, and the residents REQUIREMENT by.  Based on staff intervand facility document	oor tile in Resident #3's room, was not aware of it. When be a tripping hazard for the ated yes it would be. When oks at the resident's care no. When informed Resident care plan documented the ean even floor surface for the care plan was being ated, "No."  Ity policy, "Plans of Care" evelop and implement an in-Centered comprehensive interdisciplinary Team"  Im., the Administrator was indings. No further indeed by the end of the eare undamental principle that int and care provided to sed on the comprehensive dent, the facility must ensure a treatment and care in essional standards of nensive person-centered	F6	3.4	Director/designee to quality monitoring the Mock Survey rounds ensure cracked/missing tile are communicated. Mock Survey rounds documented in the maintenance book 5 to weekly x 4 weeks, 3 to weekly x 4 weeks, 2 to weekly, then PRN and indicated. Cracked on tiles repaired as indicated. Quality Review finding Findings to be report QAPI committee monoupdated as indicated. In monitoring schedule report on the properties of the properties.  5. Date of Compliance:	rough to ng floor d via and /or imes times times as missing ated by ngs. ed to tably and Quality modified
(	care were provided in	accordance with				

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 42 of 107



PRINTED: 02/02/2018 FORM APPROVED

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		495362	B. WING_		C 01/16/2018
	PROVIDER OR SUPPLIER  ND NURSING AND RE			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 684	Continued From pa	age 42	F 68	F684:	
	comprehensive pe of six residents in t #4, and #2.  1. The facility staff vital signs every sh  2. The facility staff	ards of practice, and the rson-centered care plan for two he survey sample, Resident failed to obtain Resident #'s ift per physician's order.  failed to administer a to to treat head lice as ordered	. 17	1. Resident #2's rece medication treatme lice per physician o and did not suffer a adverse effects. Resident #4 Vital S every shift disconti- physician order.	nt for head order on ny s/s of Signs

The findings include:

for Resident #2 on 10/10/17.

1. Resident #4 was admitted to the facility on 12/21/17 with diagnoses that included but were not limited to altered mental status, muscle weakness, difficulty walking, abnormality of gait, seizure disorder, and unspecified viral hepatitis. Resident #4's most recent MDS (minimum data set) assessment was an admission MDS with an ARD (assessment reference date) of 12/28/17. Resident #4 was coded as being severely impaired in cognitive function scoring 00 out of 15 on the Brief Interview for Mental Status Exam. Resident #4 was coded as requiring supervision only, with most ADLS (activities of daily living).

Review of Resident #4's physician order sheet revealed the following order signed by the physician on 12/22/17, "Vital signs: (frequency) TEMP (temperature) Q shift (every shift), Pulse Q shift, Resp (Respirations) Q shift, Blood Pressure Q shift."

Review of Resident #4's December 2017 and January 2018 MARS (Medication Administration Record) and TARS (Treatment Administration

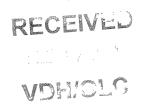
- physician order.
- 2. Quality review of current residents completed by the Director of Nursing (DON)/Unit Manger (UM) to ensure medication treatment for head lice is administèred per physician order without omission on the Medication Administration Record (MAR). Quality review completed by the DON/UM/designee to ensure vital signs obtained per physician order without omission on the MAR. Follow up based on findings.

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 43 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

OF IAI F	NO LOW MEDIOVIVE	- A MEDICAID OF MACE				INR NO. 05	138-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	i	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		495362	B. WING		AATT	C 01/16/	2018
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION	***************************************	STREET ADDRESS, 906 THOMPSON S ASHLAND, VA 2		, 01.10,	20,0
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F 684	were checked per processions on 12/21/17. documented: BP (brulse: 80, Respiration 99.1."  Review of Resident revealed that vital strong dates and 12/22/17 3-11 shift; 12/24/17 11-7, 7-3 at 12/26/17 11-7 shift; 1/05/17 11-7 shift; 1/06/17 11-7 and 7-1/08/17 7-3 and 3-1. No further vital signs record for Resident within normal limits.	weal evidence that vital signs whysician's order.  #4's vital sign log located in evealed his admission vital. The following was lood pressure): "124/84, ons: 18, Temp (temperature):  #4's skilled nursing notes igns were taken on the shifts:  and 3-11 shifts;  s shifts; 1 shifts.  s could be found in the clinical #4. All above vital signs were  #4's care plan dated 12/22/17 revealed no interventions to	F	by regregation by regregation by the comment of the	censed Nurses re-eduthe DON/UM/designarding ensuring vital ned are obtained per/sician order without ission on the MAR. ensed Nurses re-eduthe DON/UM/designarding ensuring dication treatment for is administered per/sician order without ission on the MAR.	cated ee	
	conducted with LPN and LPN #2. When signs would be chec stated vital signs wo any change in condit medication regimen such as a blood pres	a.m., an interview was (licensed practical nurse) #1 LPN #1 was asked why vital ked every shift, LPN #1 uld be checked every shift for ion, if a resident is on a that could affect vital signs sure medication, or if there the chart. When asked		Y			

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 44 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

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and denote the second	PROVIDER OR SUPPLIER	HABILITATION	-	906 TI	ET ADDRESS, CITY, STATE, ZIP CODE HOMPSON STREET LAND, VA 23005		1/10/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	signs are documen nursing notes or wr stated there is also residents' charts why vital signs. When a obtaining vital signs (certified nursing as obtain the vital signs (certified nursing as obtain the vital signs for ensuring vital signs stated she was not stated that she was asked why Resident shift, LPN #2 stated received vital signs a skilled resident. Vithere were some dawere missing from the stated, "If it was not done."  Or. 1/11/18 at approximation and AS Nursing) were made concerns.  The facility policy title address the above or information was presidents that feed on the stated of the stated shampoor insects that feed on the stated of the stated of the stated of the stated of the stated shampoor insects that feed on the stated of the stated of the stated of the stated shampoor insects that feed on the stated of the state	hift vital signs are #1 stated that Q shift vital ted on the front of the skilled litten in the note. LPN #1 a vital sign log in the here nurses could document sked who was responsible for LPN #1 stated the CNAs sistants) were designated to so but nurses are responsible year are obtained. LPN #1 Resident #4's nurse. LPN #2 Resident #4's nurse. When the was on vital signs every the only reason Resident #4 every shift was because he is when asked what it meant if yeard shifts that vital signs ne clinical record, LPN #2 documented, then it wasn't wasn't wasn't place. When asked what it meant if yeard shifts that vital signs ne clinical record, LPN #2 documented, then it wasn't wasn't place. When a skill point it wasn't wasn't place. When a skill point it wasn't wasn't place. When it wasn't place was a place was place wasn't place was pla	F	684	4. DON/UM/designee to conduct quality rando monitoring to ensure medication treatment head lice is administed physician order witho omission on the MAR weekly x 4 weeks, 3 to weekly x 4 weeks, 2 to weekly, then PRN an indicated. Quality monitoring to ensure weekly and the conduct quality randomonitoring to ensure without omissio MAR 5 times weekly weeks, 3 times weekly weeks, 3 times weekly weeks, 2 times weekly weeks, 3 times weekly weeks, 2 times weekly weeks, 3 times weekly weeks, 2 times weekly we	for red per ut 5 times mes as nitoring ed on vital risician n on the x 4 x 4 y, then Quality dings.	

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

Resident #2 was admitted to the facility on 9/24/16 with diagnoses that included, but were

Even! ID: 727W11

Facility ID: VA0008

If continuation sheet Page 45 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO 0938-0391

CEIVIE	RS FUR MEDICARE	: & MEDICAID SERVICES			OMB NO	<u>0. 0938-0391</u>		
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		of the second spirit of the second		
ASHLAN	ID NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BF	(X5) COMPLETION DATE		
	Resident #2's most set), a quarterly ass (assessment refere Resident #2 as beir questions provided for mental status). Resident #2's cogni making coded Resident #2's cogni making coded Resident #2's cogni making coded Resident #2's cogni making that Resident with a car containing personal and a sign that doct contact precautions  A review of Residen revealed, in part, the #10/10/17. Rid X (he treatment to head. If (related to) lice. Rep dated by physician composition of the party at 10/10/17. Resident Responsible party) at 110/10/17. Resident revealed. If (responsible party) at 110/10/17. Resident reatment. Clothes at Repeat tx (treatment	entia, acute kidney failure, hasia (difficulty finding words).  recent MDS (minimum data sessment with an ARD nce date) of 12/8/17, coded ng able to answer the on her BIMS (brief interview The staff assessment for tive ability for daily decision dent #2 as a three (3), dent #2 was cognitively  b.m. Resident #2's room was toutside of the door protective equipment (PPE) umented Resident #2 was on the two protective equipments are following physician order, and lice trealment; [2]  b. (diagnosis) head lice. R/t heat in 14 days." Signed and on 10/10/17.  It #2's progress notes following nursing notes: not asses (sic) for lice. Found poetor) aware. New order for ead. Repeat in 14 days. RP inware."  It was treated with rid x & (and) room fumigated.	F 6		,			
	runner review of Re	siderit #25 cirrical record did						

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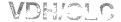
not reveal any documentation to evidence that

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 46 of 107





PRINTED: 02/02/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495362	B. WING	H-h		0	C 1/16/2018	
	PROVIDER OR SUPPLIER  ID NURSING AND RE	A STREET ADDRESS, OR SUPPLIER  IG AND REHABILITATION  UMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  STREET ADDRESS, OR  906 THOMPSON S'  ASHLAND, VA 2:  PREFIX (EACH COP  1 TAG CROSS-REFE				1/10/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILDRE	(X5) COMPLETION DATE	
·	Resident #2 had redays following the in On 1/10/17 at 7:35 conducted with CN/#18. CNA #18 was on isolation. CNA # lice."  On 1/11/18 at 2:16 p conducted with RN was asked why Resident #4 stated, "She (Resident #4 was asked if Resident #2's Octoberation administration the nurse had been applied on Resident #2's Octoberation administration there was no docum Resident #2 had rectatment as ordered asked what should his stated, "The order shwritten."  On 1/11/18 at 5:35 p. was conducted with member) #1, the admidirector of nursing. A made aware of the alla policy regarding follorequested.	p.m. an interview was A (certified nursing assitant) asked why Resident #2 was 18 stated, "She has head p.m. an interview was (registered nurse) #4. RN #4 ident #2 was on isolation. RN sident #2 has head lice." RN ident #4 has head lice in October. RN #4 ident #4 reviewed in Ident #4 reviewed er and November MARs tration records) and stated entation to evidence	F 6	34				
(	Orders" revealed, in p							

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

Event ID: 727W11 RECEDITION VA0008

If continuation sheet Page 47 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

I .		T WILDIOAID SERVICES	<del></del>			OWR M	D. 0938-039 <sup>-</sup>	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3	LTIPLE CONST	(X3) DA	(X3) DATÉ SURVEY COMPLETED		
		495362	B. WING		· .	0.	C 1/16/2018	
NAME OF	PROVIDER OR SUPPLIER		.1	STREET AF	DDRESS, CITY, STATE, ZIP CODE		1/10/2018	
					IPSON STREET	~		
ASHLAI	ND NURSING AND RE	HABILITATION			D, VA 23005			
0.43.10	CHANGO	TEMENT OF PROPERTY.		ASITLANI	-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECEACH CORRECTIVE ACTION SHOOSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	Physician Assistant order shall be repeat his/ner verbal confir	ge 47 none order from the Physician, or Nurse Practitioner. The ated back to the physician for mation. The nurse shall sign completion or verification of	F (	584				
	[1] This information following website; https://www.mayocliead-lice/symptoms-	was obtained from the nic.org/diseases-conditions/h causes/syc-20356180						
F 639 SSHK	following wabsite; https://www.ridiice.cr eatment-kits/	was obtained from the cm/en/rid-lice-products/lice-tr zards/Supervision/Devices i(2)	F 6	39 <b>F</b>	689: Free of Accident	٩		
! !	§483.25(d) Accidented Trie facility must ensign §483.25(d)(1) The reas free of accident he gas free of accident he gas free of accident as accidents. This REQUIREMENT by:  Based on observation interview, facility doctrected review, it was to ensure adequate senvironment free from	ure that - ure that - usident environment remains azards as is possible; and esident receives adequate stance devices to prevent  is not met as evidenced n, resident interview, staff ument review and clinical determined that staff failed			Hazards/Supervision/Dev Resident #1 re-admitted 2/0 services being provided per orders. Special care plan wi 2/08/18. Resident #3 floor room replaced. Resident #5 broken/missing tiles replace PTAC Units model number AZ22EO9D5BM2 in resider completed by a certified outs 1/09/18. Identified PTAC ur thermostat stop adjusted to the position in order to prevent t from allowing the air to rise unsafe temperature ensuring safety.	07/18 care and rephysician ith family tile in reside bathroom ed. Identifie trooms side vendor in the lowest to a higher	ent d on ical	

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

Event ID: 727W11

Facility ID: VA0008

if continuation sheet Page 48 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

OLIVILING FUN	VIEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING	2 17 shamman a sa garagana da an	C 01/16/2019
	### PEAN OF CORRECTION   IDENTIFICATION NUMBER.  #### 495362  ###################################			STREET ADDRESS. CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005	01/16/2018 DDE
PRÉFIX (EAC	H DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF COR	SHOULD BE COMPLETION
#1, Resi sustaine 1/8/18 to right han unconso (package mounted AZ22EO model not the facilit air tempo resulting Jeopardy	dent #3 and third and the right so the star are tous and so the star are the second the	d Resident #5). Resident #1 second degree burns on ide of the face, back of the ad left shoulder after becoming umping over onto the PTAC air conditioner [a wall ad cooling unit]) model number this room. The facility had 37 2EO9D5BM2 PTAC units in the provided in the residents with ambient efficient to cause tissue injury, tification of immediate	F 6	2. Quality review of resident identified PTAC model at AZ22E09D5BM2 comple Maintenance Director/des mechanical thermostat sto lowest position when in he order to prevent the therm allowing the air to rise to a temperature ensuring resice Follow up based on findin Quality review of resident Maintenance Director/desi or missing floor tiles compresident's safety. Follow the findings.  Quality review of resident the Maintenance Director/	umber eted by the ignee to ensure p adjusted to the eat mode in ostat from a higher unsafe dent's safety. gs. rooms by the ignee for cracked oleted to ensure up based on bathrooms by
burns on right hand and left s and slum AZ22EOS required t and admi percent to ambient a Resident staff mem using a fa unit's tem easily set heat settic accessible temperatu When the to the unit	the right side and secon houlder after ping over controller after to a scient to the controller and the proper after was 13; surveyor's and on the product of the product of the product and on the product and and on the product and and on the product and	de of his face, the top of his and degree burns on the chest er becoming unconscious anto the PTAC [model number his room. Resident #1 a local hospital for treatment, a intensive care unit with tenurface burns. On 1/10/18 the ture of the PTCA unit in was obtained, by OSM (other e maintenance technician, thermometer, following the bing set to high heat. OSM #4 unit to high heat and the high TCA unit was easily		cracked or missing floor ti ensure resident's safety. Fo on findings.	les completed to

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

Random observation and ambient air

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 49 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCING AND PLAN OF CORRECTION	(to the same of	(X2) MULTIF A. BUILDING	1	X3) DATE SURVEY COMPLETED
	495362	B. WING	,	C 01/16/2018
NAME OF PROVIDER OR SU ASHLAND NURSING A		,	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
PREFIX (EACH DE	IARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEPIGIENCY)	
for the motivation is a dissemble and consideration as it is <b>100 for 100 for </b>				

#### F 689 Continued From page 49

temperature checks of PTAC units in resident rooms, revealed PTCA units with ambient air temperatures ranging from 118 to 165 degrees Fahrenheit (F), temperatures sufficient to cause tissue injury, resulting in the identification of immediate jeopardy at a pattern. After receipt and verification of the facility plan of correction, the immediate jeopardy was abated and the deficiency was assigned a level III isolated.

- 2. The facility staff failed to ensure a safe environment for Resident #3 including even floors as per the comprehensive care plan to prevent fails. Multiple observations of Resident #3's room revealed an entire 12-inch by 12-inch floor tile missing in the middle of the room.
- 3. The facility staff failed to ensure a safe environment in the resident's bathroom for one of six residents in the survey sample, Resident #5. Observation of Resident #5's bathroom revealed broken and missing tiles. The broken tiles had sharp pointed edges and some tiles pushed into the wall.

#### The findings include:

1. Resident #1 was admitted to the facility on 3/11/15 and readmitted on 8/15/17 with diagnoses that included but were not limited to traumatic brain injury, dementia and seizures. The most recent MDS (minimum data set) a quarterly assessment with an ARD (assessment reference date) of 10/3/17 coded the resident as having three out of 15 on the BIMS (brief interview for mental status) indicating the resident was severely impaired cognitively. The resident was coded as completing activities of daily living independently.

F 689

3. Maintenance Director re-educated by the Executive Director (ED) regarding ensuring PTAC model number AZ22EO9D5BM2 mechanical thermostat stop adjusted to the lowest position when in heat mode in order to prevent the thermostat from allowing the air to rise to a higher unsafe temperature ensuring resident's safety. Maintenance Director re-educated by the ED regarding ensuring resident rooms and bathroom are free from missing/broken/cracked tiles ensuring resident's safety. Interdisciplinary Team re-educated by the ED/Director of Nursing Services (DON) to ensure resident safety while the PTAC model number AZ22EO9D5BM2 when in heat mode and maintaining the mechanical thermostat stop adjusted to the lowest position in order to prevent the air from rising to a higher unsafe temperature. Resident Council re-educated by the ED/DON during the months of February and March regarding risk of injury when using PTAC units when in heat mode.

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 50 of 107





PRINTED: 02/02/2018

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO	1APPROVE . 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	I	E CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		495362	E. WING			C / <b>16/20</b> 18
	PROVIDER OR SUPPLIER		90	REET ADDRESS, CITY, STATE, ZIP CODE 16 THOMPSON STREET SHLAND, VA 23005	U1/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	revised on 9/12/17 of Resident #1) has (related to) Confusion Psychoactive drug used and Wandering AEE (history) of falls. Interneeds a safe environ from spills and/or oblight: a working and low position at night, items within reach."  Review of the physic not evidence any sig #1's condition.  Review of the physic signed on 12/31/17 ochanges in the residual Review of the nurses did not evidence any condition.  Review of the SBAR assessment and recovered with a time of 8:45 a "BACKGROUND Residiagnoses TBI (traum from TBI, past alcoholisment of the past alcoho	plan initiated on 8/21/17 and documented, "Focus. (Name is the potential for injury r/t on, epilepsy (seizures), use, poor safety awareness D (as evidence by) a hx erventions. The resident inment with: (even floors free utter; adequate glare-free reachable call light, the bed in the hadrails on walls, personal cian's notes dated 11/7/17 did gnificant change in Resident change in Resident ent's medications.  s' notes from 1/1/18 to 1/7/18 y changes in the resident's  (situation, background, ommendation) dated 1/8/18.  a.m. documented, issident Description Primary matic brain injury), seizures of use. Resident Evaluation: aluation (compared to nat you observe) Decreased is (sleepy, lethargic) [was Status Evaluation ne; check ail that you	F 689	4. Maintenance Director/designe quality monitoring through monitoring through monitoring through monitoring through monitoring through monitoring through monitoring the lowest position when in order to prevent the air from rishigher unsafe temperature ensuresidents safety.  Maintenance Director/designed quality monitoring through monounds for residents who are not ambulatory and/or unable to be with a BIMS less than 13 regar model number AZ22EO9D5BM mechanical thermostat stop adjuvest position when in heat monitoring residents who are not prevent the air from rising to unsafe temperature ensuring resident twice daily 5 times a week weeks, weekly x4 weeks then not prevent the air from rising to unsafe temperature ensuring resident roomality which is a week weeks, weekly x4 weeks then not prevent the air from grading ensuring resident roomality monit regarding ensuring resident roomality monit regarding ensuring resident roomality monit regarding ensuring resident roomality and updated as indicated monitoring schedule modified be findings.  5. Date of Compliance 3-2-18.	eeks, weekly RN to ensure D9D 5BM2 op adjusted heat mode in sing to a uring et to complete ek survey one educated ding PTAC M2 units usted to the ode in order a higher sidents ek for 4 monthly and gnee to oring ms and suring for 4 monthly and I committee ed. Quality	

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 51 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

		Table SERVICES	T		OMB NO. 0938-039
	VT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WINC	3	C 01/16/2018
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION	and the second s	STREET ADDRESS, CITY, STATE, Z 906 THOMPSON STREET ASHLAND, VA 23005	#P CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 689	Evaluation. Abrasio (were all checked).  (R) [right] side of faredema (swelling), be (sic) on heater. 10.1 Decreased level of chemiparesis (were a Summarize your obtended face + (R) hand also stroke very weak + I drainage to face."  Review of the skin edocumented, "Bliste cheek - (L) 3 (sic) or Reddened areas - urarea - sacrum - unaidue to arrival of EMS service) + difficulty (versit dated 1/8/18 at 19 part, "History of Prespresents with major to prior to arrival. The occurred of symptoms: altered le (year old) DNR (do ne PMHx (prior medical presented to the ED EMS as DELTA TTA (after being found askefor unknown length of degree burns (1) burn	(a) [were all checked]. 8. Skin on. Burn. Discoloration Wound Describe symptoms or signs. See + (R) hand noted with urn d/t (due to) resident layed Neurological Evaluation. Consciousness. Weakness or all checked). APPEARANCE servations and evaluations to have burns to (R) side of the papeared to have had a ethargic (with) yellow avaluation form dated 1/8/18 or - (R) eye/ (R) forehead/ (R) and finger - (R) top of hand and finger - (R) top of hand and finger - (R) side of body of congregations.	F	689	

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 52 of 107





# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

PRINTED: 02/02/2018 FORMAPPROVED OMB NO. 0938-0391

		a MEDICAID SERVICES	<del></del>	No	OMB NO. 0938-0391
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
**************************************		495362	B. WING		C 01/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP ( 906 THOMPSON STREET ASHLAND, VA 23005	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE COMPLETION
	Review of the hospi physical dated 1/8/1 OF PRESENT ILLN 57-year-old patient a found over a space questions by blinking His vital signs on an 106/81(3), heart rate 27 (5), O2 (oxygen) non-rebreather (7) due to significant ed with inability to open mm (millimeters) and the face has blisterin maxilla (8) There is (centimeter) along the blistering over the rigaround to the hypoth some surrounding er Review of the nurse's p.m. documented, "A to room to check on robserved resident lyin of face + (and) hand drainage coming from room to assess residname (no) answer ob (R) hand swollen + diappeared to be coming	tal's admission history and 8 documented, "HISTORY ESS: The patient is a at a nursing home who was heater. He was responsive to g. PHYSICAL EXAMINATION: rival here are blood pressure to 140 (4), respiratory rate of sat (saturation) 94% (6) on a The right pupil is obscured ema around the right orbit the eye. The left pupil is 4 d reactive The right side of a small blister of 2x3 cm re right lower chest. He has the dorsal (9) hand wrapping enar eminence (10) with	F	589	
t (	ped, cleaned up vs (v blood pressure) - 116 104 (temperature). O	ital signs) obtained 90/86 6 (pulse) - 18 (respirations) - (sic) [oxygen] - 93% on 2 L 11 called EMT (emergency			

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 53 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO 0938-0394

		RE & MEDICAID SERVICES	_			OMB N	0.0938-039	
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495362	B. WING				C	
	PROVIDER OR SUPPLIE	EHABILITATION		.6	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	, 0	1/16/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	77.60	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	tirn ac	COMPLETION DATE	
	hospital) MD (med RP (responsible paths AM @ approx (8:15 a.m.), this was chair by heater + 445 AM (4:45 a.m.) this was tresidents (sie) contract residents (sie) contract residents (sie) contract resident has I trying to rule out be will keep us updat will go to hospital to will keep us updat will go to hospital to will go to hospital to will go to hospital to wender company) (General Electric) (Maauthorized servicer we also service all A facility tour was company) (General Electric) (Maauthorized servicer) (Maauthorized	arrived resident to (name of dical doctor) aware at this time party) notified, prior to incident (at approximately) 815 AM riter observed resident sitting in appeared sleep (slc) @ approx.) did not appear to be in any re, talked (with) RP in regards to addition RP states she is aware and a decline, states hospital is leeding of brain and or stroke ed + will be in town tonight but to see resident in AM."  C vendor's letter to the facility manted in part, "(Name of was asked to check out GE PTAC Mode) In Room 315 (Resident #1's a unit was thoroughly checked in good working order to the		389				

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right. The dials on the PTAC unit were easily

Event ID:727 RECEIVED VADOOR

If continuation sheet Page 54 of 107

FEB 1 2 2018

PRINTED: 02/02/2018

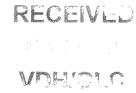
CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES		,	FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
***		495362	B. WING		C
NAME OF	PROVIDER OR SUPPLIEF	}	1	TREET ADDRESS, CITY, STATE, ZIP CODE	01/16/2018
	ID NURSING AND RE		1 -	06 THOMPSON STREET SHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D.BE COMPLETION
	temperature setting had a digital displat were one inch wide were found in any market on 1/10/18 at 2:45 member) #4, the market was again red nylon camping PTAC unit. OSM #4 unit onto high heat surface temperature dial easily to high heat thermometer. The was closed and the The surface temperature was closed and the surface temperature was surveyor's held the within 30 seconds it hands on the unit. Vicheck the heat comhand, OSM #4 did nasked what the ther OSM #4 stated, "I will stated the (PTAC said that the unit was asked how many dif	ible to residents to adjust gs. The other newer model y and the plastic grill openings e. No portable space heaters resident rooms.  Resident #1's room was made p.m. with OSM (other staff raintenance technician. There lents in the room. Resident ist the left wall. There was a chair sitting in front of the l was asked to turn the PTAC and to check the PTAC unit's e. OSM #4 adjusted the unit eat and obtained the facility laser radiation door to the resident's room temperature was checked. Tature of the unit registered esident's practice and the e of the unit was rechecked. The status of their hands to the unit, was too hot to keep the When OSM #4 was asked to ing from the unit with his not have a response. When mostat was set at on the unit, ould have to look it up." OSM is operating correctly. When ferent types of PTAC units	F 689	DEFICIENCY)	
† !	wo types and that a Resident #1's room) units were put in pla	1 #4 stated that there were s the older units (as in broke down the newer digital ce. When asked how many of still in use in resident rooms			

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

Event ID: 727W11

Facility ID: VA0003

If continuation sheet Page 55 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 09		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	TIPLE CONSTRUCTION ING	(X3) DATE SUR COMPLETE	RVEY	
		495362	B. WING		C 01/16/2	<b>01</b> 0	
PROPOSAL CANADA	PROVIDER OR SUPPLIER  NO NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZI 906 THOMPSON STREET ASHLAND, VA 23005	P CODE	UIG	
(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 ( X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COM HE APPROPRIATE	(X5) PLETION PATE	
	in the facility, OSM were 24 of the old were in the facility, OSM #3, and ASM (administrator. When preventative mainted units, OSM #3 stated month. We don't phase the heat on the weak we replay check the heat on the hands and to check mesh behind the wire when asked what the wire when asked what the winder were without the winder on a digital PTAC or maximum 90 degrees F." A surfact then made with the long a digital PTAC or maximum 90 degrees resident room door of minutes. The surfact degrees. The grill to touch. When asked were in the facility, OSM #5 stated he hasked were in the facility of the winder was operating of the win	#4 stated he thought there units remaining.  Inducted on 1/10/18 at 2:55 the director of maintenance rative staff member) #1, the masked how often mance was done on the PTAC rd, "They're cleaned once a ysically service them. When ce them." When asked to be surface of the unit with their the temperature of the wire II, ASM #1 stated, "Yeah, you has the slot there." ASM #1 mesh was hot to the touch he maximum temperature be, OSM #3 stated, "We have aser radiation thermometer wit. The unit was turned to the sand allowed to run with the closed for approximately five a temperature check was 90 the unit was warm to the how many of the older units allowed the unit was conducted on 1/10/18 M #3 stated there were 37.  In was conducted on 1/10/18 M #5, the PTAC vendor. The unit in on 1/9/18. OSM #5 stated the	F 6	89			

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 56 of 107



PRINTED: 02/02/2018 FORM APPROVED

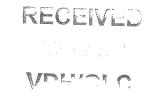
		A NILDICAID SERVICES	T	Piter and the second second		OMB N	<u>0. 0938-0391</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B. WING			0.	C 1/16/2018
ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689 Continued From page 56 the surface. The thermostat will shut off at 136 degrees." When asked if a steak would cook on the surface of the PTAC unit with this temperature, OSM #5 stated it would burn if it came in contact with the PTAC unit's grill, OSM				906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET ILAND, VA 23005	01/10/2016	
PREFIX	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	the surface. The the degrees." When as the surface of the P temperature, OSM is take hours. When as came in contact with #5 stated, "I just told On 1/10/18 at 3:15 is for the incident with from ASM #8, Region Services. The investigation of the 1/8/18 part.  "1/7/2018-10 p.mR tolerated medication 1/8/2018- 2 a.m R up in chair with eyes 1/8/2018- 3:30 a.m sitting up in chair with 1/8/2018- 5:30 a.m. up in chair with eyes responsive and accelling in chair with eyes responsive and accelling in chair with eyes responsive and accelling in chair beside 11(sic)/8/2018- 8-8; ((certified nursing assisted about patient. 1/8/2018 8:26 a.m to assess resident ar Review of the four-porevealed the plan was mitigate the concern four-point plan of cordocumented, "A com	ermostat will shut off at 136 ked if a steak would cook on TAC unit with this #5 stated it would but it would sked if skin would but it would sked if skin would but it would but it would steak if skin would cook."  o.m., the facility's investigation Resident #1 was requested in all Director of Clinical tigation was received at 3:25 four-point plan of correction. Sinvestigation documented in esident accepted and esident was observed sitting closed. Resident was observed sitting closed. Resident observed sitting close. Resident alert and epted medications as a.mResident observed e heater with eyes closed. sic) 15 am alerted by CNA sistant) #6 to come to room to RN (registered nurse) asked and it is a 911"	F 6	89			

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 57 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

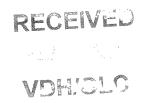
Utul I I Lui	TO LOW MEDICALLA	L & MEDIOTAD CETTOLO		\	71410 140. 0330-033 1	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B. WING		C 01/16/2018	
	PROVIDER OR SUPPLIER  D NURSING AND RI	3	906	REET ADDRESS, CITY, STATE, ZIP CODE S THOMPSON STREET SHLAND, VA 23005	01/10/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 689	Education has been in the facility on the close proximity of The plan did not a temperatures would future burns to oth twenty-three residence and Certification (Company of the concern for immediate model PTAC resident #1's seconcern for immediate model properties and concern for immediate model properties with temperature properties and concern for immediate Jeopar Con 1/10/18 at 4:40 administrator, ASM #8 were made of Resident #1 have degree burn injuried unit, and the concepting accessible to temperatures suffice the perature of the p	proper working order. en provided to current residents e importance of not being in the PTAC when in heat mode." ddress how the PTAC unit's ld be controlled to prevent her residents. In addition, only ents had signed that they had h.  7 p.m. the supervisors at the nt of Health, Office of Licensure OLC) were contacted regarding ond and third degree burns older model PTAC unit and the diate Jeopardy as a result of units being accessible to peratures sufficient to cause and second degree burns. After Supervisors agreed with the				

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 58 of 107



PRINTED: 02/02/2018 FORMAPPROVED OMB NO. 0938-0391

		: & MEDICAID SERVICES	т			<u>OMB NO</u>	0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		495362	B. WING	***************************************		0.	C 1/16/ <b>20</b> 18
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	DE  ECTION (X5) HOULD BE COMPLETE	
ASHI AN	ND NURSING AND RE	HABILITATION		906	6 THOMPSON STREET		
				AS	SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFEDERCY)	D BE	COMPLETION
F 689		-		89.			
	to the risk of burns unsafe environmen	to other residents, creating an t.					
	1/10/18 starting at 4 another surveyor. A upon entering room almost all the way o obtained the ambier from the unit with a temperature reader thermometer had be nad been. The tem turned up all the way temperature reading fluctuating between 4:57 p.m., in Room on high upon entering temperature coming OSM #3 using the fatemperature reader, the thermometer wal and 150 degrees F.	pen calibrated, OSM stated it perature reading was 133 apperature on the unit was by. At 4:55 p.m., the grafter 4 minutes on high was 135 and 140 degrees F.  312, the PTAC unit heat was ag the room. The ambient air from the unit was tested by acility infrared/laser. The temperature reading on s fluctuating between 144				-	
	the PTAC heat was t maintenance directo at 5:08 pm. At 5:10 temperature coming OSM #3 using the in	308, upon entering the room, curned off. OSM #3, the rurned the heat up to high p.m., the ambient air from the unit was tested by frared/laser temperature ature reading was 146					
	the PTAC heat was r ambient air temperat	09, upon entering the room, unning on high. The ure coming from the unit was the facility infrared/laser					

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

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 59 of 107



PRINTED: 02/02/2018 FORM APPROVED

STATEMENT OF	DEFICIENCIES	WILDIGAID SERVICES	T			OWR M	<u>). 0938-0391</u>
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF ODG	VIDER OR SUPPLIER	495362	B. WING			. 01	C /16/2018
	IURSING AND REI			906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	<ul> <li>(EACH DEFICIENCY</li> </ul>	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D BE	(X5) COMPLETION DATE
ter de 5:: the ma to : 5::1 the dire p.n cor tem deg 5::2 the dire p.n tem infra tem tem the l	grees F.  15 p.m., in Room PTAC heating unaintenance director furn on. The PTA  9 p.m., in Room PTAC unit was on ector, turned the Fin., OSM #3 tested ming from the unit apperature reader. grees F.  6 p.m., in Room PTAC unit was on ector, turned the Fin. At 5:31 p.m., OS perature coming ared/laser temperature was 132  2 p.m., in Room 2 perature was 132  2 p.m., in Room 2 perature was 132  2 p.m., in Room 2 perature was 132  3 p.m., in Room 2 perature was 132  4 p.m., in Room 9 perature was 132  9 p.m., in Room 10 perature was 132  11 p.m., in Room 12 perature was 132  12 p.m., in Room 13 perature was 132  14 p.m., in Room 15 perature was 132  16 p.m., in Room 16 perature was 132  17 p.m., in Room 17 perature was 132  18 p.m., in Room 18 perature was 132  19 p.m., in Room 19 perature was 132  19 p.m., in Room 19 perature was 132  20 p.m., in Room 19 perature was 132  21 p.m., in Room 19 perature was 132  22 p.m., in Room 19 perature was 132  23 p.m., in Room 19 perature was 132  24 p.m., in Room 19 perature was 132  25 p.m., in Room 19 perature was 132  26 p.m., in Room 19 perature was 132  27 p.m., in Room 19 perature was 132	305, upon entering the room, nit was off, OSM #3 the or, was not able to get the unit C unit was not functioning.  301, upon entering the room, off., OSM #3 the maintenance of the ambient air temperature with the facility infrared/laser. The temperature was 150 of the ambient air temperature of the ambient air temperature of the ambient air temperature of the temperature was 150 of the ambient air temperature of the ambient air from the unit with the facility ature reader. The degrees F.  36, on entering the room the of the one of the unit of the unit of the unit of the unit of the the facility ature reader. The degrees F.  36, on entering the room the of the one of the unit of the facility of the	Fe	89			
p.m. F. An a #1's	, the temperature dditional observa unit with another	was 118 degrees F. At 5:36 reading was 130 degrees tion was made of Resident surveyor on 1/10/18 at m. The red nylon camper					

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 60 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938, 0301

CENTERS FOR MEDICAR	E & MEDICAID SERVICES			OMP NO BOOK
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	495362	B WING		C
NAME OF PROVIDER OR SUPPLIEF ASHLAND NURSING AND RE			STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005	01/16/2018 DDE
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION :	SHOULD BE CONDICTION
the floor. The seat bottom of the grill of was sitting in the converted when he slumped directly over the grows observed to converte wide. There was a left lower grill of the to touch the wire much the grill. The and high fan setting hold the back of the than 30 seconds be touch.	age 60 ed to be 14 and 1/2 inches off of the chair came up to the on the unit. When Resident #1 hair next to the heater and over, his cheek would be ill. The grill on the PTAC unit ontain four fixed sections o one and one half inches dried yellow substance on the unit. The surveyors were able esh with their fingertips are unit was placed on high heat as. The surveyors could not eir hands to the unit for longer effore the unit was too hot to	F 6	:89	
p.m. with CNA (cert aide who worked wing asked to enter Resi the unit's grill and the "Yeah, it's hot." Whe temperature the resident #1 a keep it warm. It's ac normal."  On 1/10/18 at 8:45 prom ASM #1 to hav Resident #1's room. ASM #2, the director of the regional director of the director of maint.	ified nursing assistant) #9, an th Resident #1. CNA #9 was dent #1's room and to touch the wire mesh. CNA #9 stated,			

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corporate director of maintenance stated, "We've

Event ID: 727W11

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If continuation sheet Page 61 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	T. (10)	79. M	OMR MC	<u>). 0938-0391</u>
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		TE SURVEY
						C
		495362	B. WING	Management	n <sub>1</sub>	1/16/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE , O,	1/10/2016
ASHLA!	ND NURSING AND RE	HARII ITATION		906 THOMPSON STREET		
				ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI		HOULD BE	(X5) COMPLETION
		oo is Error Tiro I'd Origination)	TAG	CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE	PATE
F 689	Continued From pa	ae 61	F (	200	**************************************	
		rature so the residents can't	F 6	89		
	put it on high " OSA	#5, the PTAC vendor stated.				
	"That laser thermor	neter must have measured				
	the element temper	rature." OSM #5 was asked to				
	measure the unit's	surface temperature with his				
	equipment. The tem	perature registered at 136				
	degrees F. When a	sked what the room				
	temperature was, O	SM #5 stated, "About 90				
	degrees." When asl	ked when the heater would				Í
	turn off OSM #5 sta	ted, "It'll turn off when the				
	room gets to tempe	rature but with the door open				The same of the sa
	it's going to keep rul	nning." OSM #5 asked OSM				
	#3 if the laser therm	ometer had been calibrated,				
	OSM #3 stated yes.	When asked if the surface	,			ĺ
	temperature of the u	ınit would remain as hot,				
	USIM #5 stated, "Th	e internal coli will shut down				
	at 130 degrees." All	present were asked to check				
	CUD ON OF A PROPERTY	#1 and ASM #8 and two				
	touch. OSM #5 then	that the unit felt not to the				
	femnerature again h	y placing a metal peg under				-
	the temperature dial	preventing the dial from				-
	being turned to the h	sigh heat setting. OSM #5				
	stated, "It's set for 72	2 to 74 degrees." A recheck				
	of the unit's surface	temperature by OSM #5,				
	three minutes later s	howed the temperature to				
	range between 77.4	degrees to 104 degrees F.				
	On 1/10/18 at 9:51 p	.m., ASM #1 provided a				
		rection that documented the				
	following:					elitrida.
	1. "Resident found sl	umped over PTAC unit at				and redefinition
		m. The Resident was				į
	provided treatment a					Accompanies
		r further evaluation and				the state of the s
		unit was locked out and				
	rayyeu our and piace	out of use pending an				
;	roommate was votun	ection. The resident's tarily moved to another room				
	I VOITIMALE WAS VUIUII	iamy moved to another room				1

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Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 62 of 107



VDH/CLC

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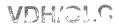
	NT OF DEFICIENCIES	WILDICAID SERVICES	******************		OMB NO. 0938-039
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		С
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP 906 THOMPSON STREET	01/16/2018 CODE
-	del melanamental coppe que por establique describendo de la companyación de la colonidad de la colonidad de la			ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE
	resident rooms comvendor on 1/10/18. I mechanical thermos lowest position in or from allowing the air temperature ensuring. Education provided Director, IDT (interdistaff on the important safety while in PTAC maintaining the mechanical to the residuals of injury when consider the individual to the residuals of injury when consider the individual to the residuals of injury when consider the mode. During February, and March at Resident Council of PTAC units in heat must resident Council of PTAC units in heat must resident complete quality more week, weekly x4 week (as needed) to ensurthermostat stop adjust order to prevent the aunsafe temperature of Quality monitoring scion findings.  Results to be discuss assessment plan and Completion date: 1/1	pection. If identified PTAC Units in pleted by a certified outside dentified PTAC units stat stop adjusted to the der to prevent the thermostat to rise to a higher unsafe ig resident's safety. If the Maintenance sciplinary team) and facility lice of ensuring resident is in use in heat mode and hanical thermostat in the der to prevent the air from lare temperature. Education lents in the facility on the using the FTAC system while of the months of January, residents to be re-educated of risks of injury when using libration of times a week for 4 like then monthly and PRN le PTAC units mechanical listed to the lowest position in lift from rising to a higher lift from rising to	F 6	89	
F	PTAC unit manufactur ASM #1, the administr	er's manual to was made to			

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

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 63 of 107



PRINTED: 02/02/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES	(V1) POOMOSSIGNATIONS		*************	1	OMB NO	0.0938-039
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
	495362	B. WING	-		1	C
NAME OF PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 01	/16/2018
ASHLAND NURSING AND RE	HADILITATION			THOMPSON STREET		
ASSICAND NORSING AND RE	HADILITATION			HLAND, VA 23005		
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES		*	***************************************	~	
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 689 Continued From pa	ae 63	F 6	00			
	a.m., the manufacturer's	F 0	09			
manual was receive	ed. Review of the manual did					
not document inform	mation regarding the surface					
temperature of the	unit.					
An interview was co	onducted on 1/11/18 at 8:48					
a.m. with CNA (cert	ified nursing assistant) #6,					
Resident #1's aide o	on 1/8/18. When asked what					
routine staff follow v	vhen they come on duty. CNA					
#6 stated, "I get rep	ort and I go walk down the					
hall. I visualize the r	esidents and start my day."					
When asked what o	courred on 1/3/18, CNA #6					
Stated, "I Visualized	(name of Resident #1) sitting					
That was about save	b) but that's normal for him.					
Resident #1's nosition	on in the chair, CNA #6					
stated. "He was sign	nped over with his right arm					
across the chair arm	touching the floor by the					
heater." When asked	d if that was an unusual					
position for Resident	#1, CNA#6 stated, "No. It					
wasn't unusual to se	e him in all sorts of unusual					
positions. Sometime	s he slept with his head off					
the side of the bed o	r he'd sleep on the floor."					
vvnen asked it Kesid	lent #1 was resting his head					
his face was no the h	f6 stated, "i couldn't tell that neater. I thought he was					
asleen because whe	n I brought his breakfast in I					
said. '(Name of Resid	dent #1) you have to eat your					
cheerios and drink yo	our coffee' and when I					
straightened him up t	hat's when I saw his hand					
and face." When ask	ed what time the breakfast		1			
was brought in, CNA	#6 stated, "Around 8:15					
(a.m.)." When asked	what she saw, CNA#6				F	
stated, "I see this giga	antic blister on his hand."					Ì
When asked about R	esident #1's face, CNA #6					and involves
stated, "At that point I	didn't (see his face)					
Decause I'm standing	behind him in the chair."					
vynen asked what she	e did next, CNA #6 stated, "I					
new out, went, and go	of the nurse. I told the nurse					1

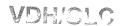
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 64 of 107





PRINTED: 02/02/2018 FORMAPPROVED OMB NO. 0938-0391

ŧ.		& MEDICAID SERVICES	· • · · · · · · · · · · · · · · · · · ·		OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
overdade positive en en en estado e a escripción e		495362	B. WING	}	C 01/16/2018
	PROVIDER OR SUPPLIER  1D NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, Z 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		FION SHOULD BE COMPLETION THE APPROPRIATE DATE
	blister on his hand. When asked what his stated, "The nurse of up and then we saw swollen and there walong the side of his When asked if Resilife stated, "He was a When asked about the CNA #6 stated, "He when asked if she hin the room, CNA #6 they'd get that hot to had received any ed CNA #6 stated, "We rounding. Make sure may have been previously have been previously have been previously have been grevitheir rounds. Keep the belongings off the he on 1/11/18 at 9:08 a conducted with the Conducted was allowed temperature was checked immed temperatures of the aunit was obtained wit temperature reader petemperature range of to 157 degrees F, de already been running	ne of Resident #1) he's got a It's the size of a grapefruit." rappened after next, CNA #6 came in. We straightened him the right side of his face was ras dried yellow substance if face and mouth and nose." dent #1 was responsive, CNA sorta kinda unresponsive." the temperature in the room, loved that room boiling hot." had ever touched the heater is tated, "No. I didn't think burn." When asked if she ucation since the incident, had an in-service on a you do your rounds and it ented if someone had done he residents and their eaters."  .m., a tour of the facility was DSM #3, the director of of the 37 rooms that was C heating unit was checked. In entering, if the unit was off, in on. Then a period of 1 to 2 to pass and then the eacked by OSM #3. If the unit unning upon entering the eference, the temperature lately. The ambient air coming from the PTAC he the same infrared laser.	F	689	

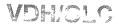
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 65 of 107





PRINTED: 02/02/2018 FORM APPROVED

		E & MEDICAID SERVICES	1		OMB NO	D. 0938-0391
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY
Orostonio de la composició de la composi		495362	B. WING		0.0	C
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIF 906 THOMPSON STREET ASHLAND, VA 23005	P CODE	1/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ABILITATION  495362  B. WING  ABILITATION  MENT OF DEFICIENCIES (IDENTIFYING INFORMATION)  B. G.		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	the PTAC units turn unit ran for approximately	ed off automatically after the mately 1 to 3 minutes. The e of the PTAC units did not get	F 6	689		
	1/11/18 between 9:4 asked if they had re the heaters under the past few days, be not had any education listed on the education resident stated, "no, they had spoken to be resident emphatically had a BIMS (brief in	anducted with two residents on 40 a.m. and 9:45 a.m. When ceived education regarding the windows in their rooms in 30th residents stated they had son, though their names were on sign off sheet. The one 1 am blind. When asked if 30th about his heating unit, the 3 stated, "No." Both resident terview for mental status) g they were cognitively intactions.				
	supervisor was updated and that it which residents were	Id with OLC supervisor. The sted regarding the facility staff nere was no definition of a to be educated. A decision refacility update the plan of				
	were made aware of when facility staff wo residents were appro #1 and ASM #7 were residents who had sign	a.m., ASM #1 and ASM #7 the need to clearly state uld be educated and which priate to be educated. ASM made aware that two gned the education form that ted about the PTAC units, educated.				
i		ducted on 1/11/18 at m. with RN (registered :1's nurse on 1/8/18. When				

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 727W/11

Facility ID: VA0008

If continuation sheet Page 66 of 107



PRINTED: 02/02/2018 FORMAPPROVED OMB NO 0938-0301

CENTERS FOR MEDICAR	E & MEDICAID SERVICES			OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) D	ATE SURVEY DMPLETED
	495362	B. WING			C 1/16/2018
NAME OF PROVIDER OR SUPPLIEF ASHLAND NURSING AND RE			STREET ADDRESS, CITY 906 THOMPSON STRE ASHLAND, VA 2300	'. STATE, ZIP CODE ET	1/10/2018
PRÉFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NGED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
she was the night: #1 stated, "I went i (Resident #1) sittin down towards his of arms of the chair." was, RN #1 stated (a.m.)." When aske unusual about Res stated, "No ma'am be in the heat and heater." When ask stated, "The aide of said she gave him when he was sat up When asked what shad gone into the re yellow substance of and that substance asked what she tho was from, RN #1 st his skin. It didn't se mouth." When aske #1 sustained the bli she did not know. V looked, RN #1 state have had a stroke be (the right) side." Whe at the time the aide stated she was. Whe Resident #1 since 4 had not. When aske received in report al #1 stated, "I hadn't se They told me he wa in the chair."	scurred on 1/8/18, RN #1 stated shift supervisor that night. RN in there and I seen him ig in his chair with his head chest and his arms were on the When asked what time that if there was anything ident #1 at that time, RN #1 in the at all. He always liked to the liked to sit next to the ed what happened then, RN #1 alled me into the room. She (Resident #1) his tray and that to he was not responding." she did next, RN #1 stated she down and that she noted a in the resident's face and hand was on the heater. When the heater, when seed if the was fluid from the like it was coming from his and how she thought Resident #1 stated when asked how Resident #1 and, "It looked like he might because he was weak on that hen asked if she was his nurse came to get her, RN #1 stated she and was information she cout the resident that day, RN seen him for about a year. It is himself and he was sleeping inducted on 1/11/18 at 10:30	F6			

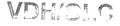
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 67 of 107





PRINTED: 02/02/2018

CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			OMP NO ARRANGE
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIFLE CONSTRUCTION ING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495362	B. WING		C 04/46/2040
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005	01/16/2018 DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE COMPLETION
	staff follow when the stated, "I started my o'clock. I counted or medications) and I residents." When as Resident #1 on her (name of Resident # asked what the resident # asked what the resident # asked what the resident # prior to "It was around 5:30 room. I said 'Hey (nate go to bed? He saides # 4 stated he was sitt heater. LPN # 4 was they notice a resident LPN # 4 stated, "I've Common sense wou over on the radiator if When asked if she wounds got hot to touch I've never touched the she had received any incident, LPN # 4 statemake sure patients a radiators. Ask them to cups or anything coming onto their shifts sure staffing is appropri	se. When asked what routine by arrive on duty, LPN #4 x shift about 5:30 (p.m.) to six at my cart (checked the made rounds on all my sked when she had seen shift, LPN #4 stated, "I saw #1) a couple times." When dent was doing, LPN #4 he was sitting straight up (in ms folded. His baseline at and down. He never sleeps." was the last time she saw going home, LPN #4 stated, (a m.) I was just passing the me of Resident #1) you want d, no leave me alone." When in #1 was at that time, LPN ing in his chair next to the asked what staff should do if It slumped over in a chair, been a nurse for 14 years. Id be if you saw him slumped would reposition him." was aware that the PTAC, LPN #4 stated, "No ma'am, em at all." When asked if y education since the ed, "My education was to ren't sitting too close to the property of the same was a ware there are	F 6	39	

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

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If continuation sheet Page 68 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

OLIVIL	NOTONIMEDICANE	A MILDIOAID SERVICES	<del></del>		OMB NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495362	B WING		C 01/16/2018
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION	The second secon	STREET ADDRESS, CITY, STATE, Z 906 THOMPSON STREET ASHLAND, VA 23005	IP COGE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
	back and get their (asked the routine C their shift, RN #3 stafor their assignment When asked how of RN #3 stated, "Ever nurse or the CNA." do if they see a resign was going on." W 1/3/18 at 8:25 a.m., (Resident #1) was liby turning her face of (right) hand was on was going on." Whe right hand looked lik large blister. "RN #3 4 to 5 inches from the size of the blister. W received the blister. W received the blister to did not know. RN #3 that were opening." In and got him on the best was going on. EMS (services) got here rewind you have an axilla armpit) on the left sice point something and asked if Resident #1 stated, "He was moa resident kept the doo RN #3 stated Reside	Lick round. Then they come medication) cart." When NAs follow when coming onto ated, "They don't have to wait to check on the residents." Iten residents were checked, y two hours either by the When asked what staff should dent in a slumped position, ald expect them to kinda sure he roused up. Find out hen asked what occurred on RN #3 stated, "I came in, he ke this (RN #3 demonstrated down and to the right) and his his leg. I wasn't sure what it asked what Resident #1's e, RN #3 stated, "It had a held her hand approximately to of her hand to show the hen asked how Resident #1 to his hand, RN #3 stated she stated, "His face had blisters We checked his vital signs ed to further assess what	F 6	89	

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

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 69 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0038 0304

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			FURM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CL!A IDENTIFICATION NUMBER:	(X2) MULTIP	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
Account of the second s		495362	B. WING		C
NAME OF F	ROVIDER OR SUPPLIER		1 8	TREET ADDRESS, CITY, STATE, ZIP CODE	01/16/2018
ASHLANI	D NURSING AND RE	HABILITATION	g	06 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
# # # # # # # # # # # # # # # # # # #	the PTAC heaters g stated, "No I didn't k An interview was coa.m. with ASM #2, tilesked what the CNA arrived on duty, ASI is that they should rear that moment." Withoutine was, ASM #2 report. They are resewhere they are supply what occurred on 1/42 stated, "At 8:25, 8 immediale) page. Varied how the resident #1) for trainshed how the resident #10 for trainshed how the resident seizure. He had ye indicating the right owning from his mouelieve that he had a ad had a seizure." Valumped over should 2 stated, "Absolutely ducation provided to My thought process	ge 69 vas. When asked if she knew tot hot to the touch, RN #3 know how hot they got."  Inducted on 1/11/18 at 10:50 the director of nursing. When A's routine was when they M #2 stated, "My expectation ound. They should get report. Indicate to any patient needs the nurse's 2 stated, "They should receive ponsible that the CNA's are toosed to be." When asked 8/18 with Resident #1, ASM 8:26 (a.m.) I heard the stat When I ran down there (RN #3 tready preparing him the stat I was the hospital)." When any it was the hospital they thought it was the which also led us to possible aspiration (11) if he When asked if a resident was the staff assess them, ASM y." When asked about the other said, 'every eye closed	F 689	DEFIGIENCY)	
de or re	pesn't mean you're a n the residents. We esidents. I want then	asleep'. Staff are checking also started educating the note aware of the risk of a heater). We tried to pin			

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point (residents) who really like their room really

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 70 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					KM APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) [	NO. 0938-0391 DATE SURVEY COMPLETED
		495362	B. WING				С
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	(	01/16/2018
ASHLAN	ND NURSING AND RE	HABILITATION		906	THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION;	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JIDBE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 70	E 6	89			V A. Mariante de Caractería de
		(name of Resident #1) did."	, (	.09			
	correction was rece were as follows: 3) education prior to a and/or to be remove education is provide current residents wh BIMS of 13 - 15 on the the PTAC system what rational for maintain thermostatistop in the the air temperature of temperature ensuring who are non-ambulated ucated with a BIM	ne lowest position to prevent from rising to a higher unsafe g resident's safety. Resident story and/or unable to be S less than 13 to have safety 'AC/Air temp twice daily					
	at 2:15 p.m. with ASI physician. When ask a resident to sustain lying on a surface will 130 degrees F, ASM minutes. It's quick if i hand." ASM #4 stateget a third degree bu pads put in the micro #4 was asked why Retemperature of 104 d probably put himself I	was conducted on 1/11/18					
	physician. When aske	ed if there had been any resident. ASM #5 stated					

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there was not. When asked what he thought

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 71 of 107





PRINTED: 02/02/2018 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.		CONSTRUCTION	(X3) DA	TE SURVEY
		495362	B. WING		7 (2) 4 (2)	0.	C
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005	:	1/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) CONFLETION DATE
	stated, "They (the pit may have been a the Keppra (12) by He had to be unconfrom the heat). This blue."  An interview was edp.m. with ASM #1, r what occurred on 1/4/1 stated, "I got a call up because i was 3 minutes later. The Resident #1) with the large blister on his fit boss and told her I related her I readed to a learning opportunity or just can't tell stathings away from the stop the heater from Throughout the day staff were interviewed staff could verbalize safety in regards to timportance of round every two hours.  On 1/11/18 at 3:35 phonoducted with one I nurse) and one CNA from the 3:00 p.m. to could verbalize educted patient safety in regards to the could verbalize educted with one I nurse) and one CNA from the 3:00 p.m. to could verbalize educted with regards to the patient safety in regards to the pat	ent #1 on 1/8/18, ASM #5 hysicians at the hospital) think seizure. He was weaned off the neurologist in November. scious (to not move away just happened out of the administrator. When asked 8/18 with Resident #1, ASM all at 8:27 a.m. I couldn't pick getting blood work. I got a call y to'd me about (name of e bilste: on his hand and a see I got here. I called my need someone here today. I address this today. This was ty (the immediate Jeopardy). If and residents to keep heater. I wasn't thinking to getting so hot (to touch)."  on 1/11/18 multiple facility and regarding education. All education regarding patient he PTAC units and the ing and assessing residents	F	, 189			

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

Event ID: 727W11 Facility ID: VA0008

If continuation sheet Page 72 of 107





PRINTED: 02/02/2018 FORMAPPROVED OMB NO 0938-0391

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	T OF DEFICIENCIES OF CORRECTION			TIPL ING	E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495362	B. WING			1	C 1/16/2018
	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE. ZIP CODE 06 THOMPSON STREET		1/10/2016
ASHLAP	ND NURSING AND RE				SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 689	On 1/11/18 at 3:40 conducted with one three units regarding residents had a BIM	ge 72 p.m., interviews were resident from each of the g PTAC unit education. All the AS of 15 and were able to regarding safety and the	F6	889			
	conducted with OS! maintenance. Wher education regarding stated, "We got edu	p.m., an interview was M #3, the director of asked if he had received g the PTAC units, OSM #3 located on how to adjust the perature) doesn't get too					
	On 1/11/16 at 4:08 p was abated. ASM # abatement at that tir						
	No further information	on was provided prior to exit.					(MA) of width to the transfer of the transfer
	COMPLAINT DEFIC	DIENCY					1
	when the epidermis subcutaneous tissue charring and extrem- and sometimes hard information was obta	Third-degree burns occur is lost with damage to the Burn victims will exhibit e damage of the epidermis, eschar will be present. This lined from: .nih.gov/pmc/articles/PMC29					
	manifest as erythem:	rm Second-degree burns a with superficial blistering of					The second secon

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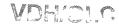
dermis and may also involve the deep (reticular)

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 73 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

İ		A MICDICAID SERVICES				OMB NO	<u>0. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B. WING			0.	C 1/16/2018
	PROVIDER OR SUPPLIER  ND NURSING AND REF	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X3) COMPLETION DATE
	https://www.ncbi.nlm 35806/  3. Blood pressure	formation was obtained from: n.nih.gov/pmc/articles/PMC29  Normal blood pressure for a systolic pressure below 120 ic pressure below 80 mmHg. s obtained from: n.gov/health-topics/high-blood  resting pulse for an adult is minutes. This information  nih.gov/pubmedhealth/PMH  The best alternative in a uld be to choose an 10 to 20 breaths per minute.	F	689			
	by utilizing a sensor a toe, or ear to determi oxyhemoglobin in blo network of capillaries obtained from:	attached typically to a finger.					
: : !	mask and gas supply from which one can b concentrations of oxy	sk an apparatus with face forming a closed system reathe as long as the gen and carbon dioxide a limits. This information					

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 74 of 107





PRINTED: 02/02/2018 FORMAPPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Larra	New 2 days and 100 and	OMB NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		C
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	01/16/2018
ASHLA	ND NURSING AND REI	LIADUITATION		906 THOMPSON STREET	JE
AOTICA	TAD MONOWING WAD VE	TABILITATION		ASHLAND, VA 23005	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	Compared to the second
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOURS CONTINUE
F 689	Continued From pa	ne 74			
		n-webster.com/dictionary/rebr	F 68	39	
	<ul> <li>and other mammals</li> </ul>	er jaw especially of humans in which the bony elements			
	from: https://www.merriam	nis information was obtained n-webster.com/dictionary/max			
	illa	•			
	9. Dorsal — the back opposite the palm. T from:	of the hand; surface of hand his information was obtained			
		on.com/dictionary/26488			
	the hypothenar emin the ulner side of the side of the little finge obtained from:	ience An abnormality of ence, i.e., of the muscles on pain of the hand (i.e., on the r). This information was .nih.gov/medgen/869380			
,	gastric contents into la common event in clead to pneumonia or pneumonia is the lead the intensive care unities factors for acute la respiratory distress sywas obtained from:	ration of oropharyngeal or the lower respiratory tract is ritically ill patients, and can pneumonitis. Aspiration ding cause of pneumonia in t and is one of the leading lung injury and acute and the common of the leading lung injury and acute and common or the leading lung injury and acute and common or the leading and acute and common or the leading lung injury and acute and common or the leading lung injury and acute and common or the leading lung injury and acute and common or the leading lung injury and common or the leading lung lung lung lung lung lung lung lu			
t i	therapy in the treatme in adults and children	A is indicated as adjunctive nt of partial onset seizures 1 month of age and older ormation was obtained			

from:



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMR	10.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495362	B. WING				C
	PROVIDER OR SUPPLIER	HABILITATION		9	STREET ADDRESS, CITY, STATE, ZIP CODE 106 THOMPSON STREET ASHLAND, VA 23005		01/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE
	https://dailymed.nlm m?setid=3ca9df05-1 2. The facility staff environment for Recas per the compreh falls. Multiple observedled an entire 1 missing in the middl Resident #3 was ad 7/10/15 with the diag chronic kidney disea Alzheimer's Disease The most recent ME quarterly assessment Reference Date) of coded as being seve ability to make daily of a possible 15 on t Mental Status) exam requiring total care for bed mobility, dressin Supervision to limite and as frequently incibiadder.  On 1/10/18 at 2:30 p and 7:35 p.m.; and o Resident #3's room v observation an entire was observed missin On 1/11/18 at 8:25 a. #2 (Certified Nursing resident is ambulator walking assuasive de the missing floor tile,	n.nih.gov/dailymed/drugInfo.cf a506-4ec8-a4fe-320f1219ab2 failed to ensure a safe sident #3 including even floors ensive care plan to prevent vations of Resident #3's room 2-inch by 12-inch floor tile	F	689			

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

Event ID:727W11

Facility ID: VA0008

If continuation sheet Page 76 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938, 0301

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB N	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUIL.C	TIPLE CONSTRUCTION DING	(X3) D/	(X3) DATE SURVEY COMPLETED		
		495362	B. WING			C 1/16/2040		
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STAT 906 THOMPSON STREET ASHLAND, VA 23005	E, ZIP CODE	1/16/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE	TO THE APPROPRIATE	(X5) COMPLETION DATE		
:	tile would cause a treatment of CNA #2stated it would looks at the resident no. When informed comprehensive care resident should have safety, and asked if CNA #2, stated, "Notice of the control of the	ripping hazard for the resident, ald. When asked if she ever it's care plan, CNA #2 stated Resident #3's e plan documented the e an even floor surface for the care plan being followed, ."  a.m., in an interview with LPN cal Nurse) she stated that the atory resident. When asked for tile, LPN #1 stated she When asked if this would be the resident, LPN #1 stated en asked if she ever looks at lan, LPN #1 stated no. When 3's comprehensive care plan dent should have an even sty, and asked if the care plan #1, stated, "No."  .m., in an interview with OSM ber - the Director of ted that the missing tile azard for the resident. OSM enance does a daily round to no and it had not been not the nursing and aid staff menting any issues in the maintenance log. When	F 6	;89				

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

A review of the maintenance log failed to reveal

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 77 of 107





PRINTED: 02/02/2018 FORM APPROVED

CENTENTAL OF DESIGNATION AND MEDICALD SERVICES		1	<del></del>		OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
MANE OF	DOOUBER OF AUROVERS	495362	B. WING		C 01/16/2018		
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 906 THOMPSON STREET ASHLAND, VA 23005	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMBITTION		
F 689	any concerns havin Resident #3's room repair needs.  A review of the facility documented that the immediately upon populicy did not documented staff and aid staff to	g been identified with as requiring any maintenance  ty policy, "Maintenance Log" e logs should be completed erforming the work. The nent any guidance for nursing complete a request or	Fe	789			
	residents' rooms.  A review of the facility Procedures' docume of a Resident's Room problems such as frobeds not working she maintenance via the policy did not address concerns identified d whire the resident was	ented, "2. Discharge Cleaning nW. Any maintenance ayed wire, broken plugs or build be reported to maintenance log." The s reporting of maintenance uring routine daily cleaning as still residing in the room.  m., the Administrator was addings. No further					
	B. The facility staff failed to ensure a safe environment in the resident's bathroom for one of six residents in the survey sample, Resident #5. Resident #5 bathroom was observed with proken and missing tiles. The broken tiles had sharp pointed edges and some tiles were pushed not the wall.  Resident #5 was admitted to the facility on 1/26/12 with a recent readmission on 3/15/17 with						

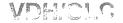
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 78 of 107





### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0361

CENTERS FOR WEDICARE & MEDICAID SERVICES			OMB NO. 09					
AND PLAN	√T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVE	ΕY		
		495362	B. WING	FRIBLE IS AN ADDRESSES. A SECTION OF THE PROPERTY OF THE PROPE	C 01/16/201	10		
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	NUDBE CONDU	ÉTION		
i i	multiple sclerosis [N which nerve fibers of lose their myelin contince increasing disability paraplegia (paralysis blood pressure, depubladder, and absended the most recent ME assessment, a quark assessment referent Resident #5 as scort interview for mental cognitively intact to resident was coded transfers, moving on the was coded as recensive assistance members for his toile hygiene. In Section C in Range of Motion, the having no impairment extremities. In Section Transitions and Walk as being unsteady bustaff assistance in mostanding position, was facility the opposite distribution was made 1/10/18 at 1:30 p.m. of there were broken tile pathroom wall. There were broken tile pathroom wall.	AS] (a progressive disease in of the brain and spinal cord ver, it progresses slowly with (1)), muscle weakness, sof the lower limbs (2)), high ression, dysfunction of the ce of toe.  OS (minimum data set) terly assessment, with an oe date of 11/21/17 coded ing a 15 on the BIMS (brief status) score, indicating he is make daily decisions. The as being independent in and off the unit, and eating quiring limited assistance for and walking in the corridor and of one or more staff eting needs and his personal 60400 - Functional Limitation he resident was coded as it in either his upper or lower on G0300 Balance During ing, Resident #5 was coded at able to stabilize without oving from seated to liking, turning around and irection while walking and	F 689					

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An interview was conducted with Resident #5 on



If continuation sheet Page 79 of 107



PRINTED: 02/02/2018 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				HUH IA QNAO	O OOSG DOG
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
		495362	B. WING				C 1/46/2046
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		906	REET ADDRESS, CITY, STATE, ZIP CODE 3 THOMPSON STREET 3HLAND, VA 23005		1/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES FMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	******	PROVIDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HIDRE	(X5) COMPLETION DATE
	the bathroom, Resister sometimes walked if he uses his hand bathroom, Resident indeed did ambulate the bathroom. The vagain observed. The wide by eight inches several with sharp e open area of missin by three inches.  On 1/11/18 at 8:36 a conducted with othe director of maintena process for the staff repair, OSM #3 state done every morning. The nurse or CNA (cowhoever sees it should be book at each nur. On 1/11/18 at 8:40 at the unit on which Reserviewed. There was the broken, missing conducted with Resideng the tiles on the boroken, Resident #5 conducted that it didn't he #5 stated, "Oh no, it's now."	When asked if he walks in dent #5 stated that he fin the bathroom. When asked crutches to ambulate into the #5 acknowledged that he wall in the bathroom was ere was an area 26 inches high, with five broken tiles, dges, nine loose tiles and an gitles measuring 8.5 inches and interview was restaff member (OSM) #3, the noe. When asked about the to report things in need of ed, "There are mock surveys by the administrative team, certified nursing assistant) or old log it in the maintenance se's station."  In the maintenance logs, for sident #5 resided, were no documentation regarding or loose tiles in Resident #5's ed.  In an interview was lent #5. When asked how eathroom wall have been stated, "A long time." When happen yesterday, Resident been there for a little while	F 6	89			

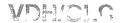
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 80 of 107





### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MED

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STATEMENT OF DEFICIENCIES					OMB i	OMB NO. 0938-0391			
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTR ING	RUCTION	(X3)	(X3) DATE SURVEY COMPLETED		
		495362	B. WING			## ## ## ## ## ## ## ## ## ## ## ## ##	С		
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		ZIP CODE	01/16/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	  E/	PROVIDER'S PLAN OF ACH CORRECTIVE ACT SS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	resident's room or a stated, "I let the charthem (maintenance over the loud speak a book she could wistated, "No, but I castation too."  An interview was copractical nurse) #5. When asked how she something that is in stated, "I can call or floor. I can notify my maintenance and ad (ASM) # 6, the regio were shown Resider asked if he was awa loose tiles, OSM #3 must have run his will stated, "This should in during morning surverselection was evidenced by) de deconditioning, disease proincontinence)." The "lin part, "Ensure that tappropriate footwear a clear pathway, free	s something broken in a a resident area, CNA #12 arge nurse know. Or I go find staff) in their office. I can call er." When asked if there was fite her concern in, CNA #12 in leave a note at the nurse's inducted with LPN (licensed on 1/11/18 at 10:54 a.m. he reports when she observes need of repair, LPN #5 page (maintenance) to the visupervisor or out it in the visupervisor or out it in the visupervisor of maintenance, at #5's bathroom. When he of the broken, missing and stated, "No, (Resident #5) heave been picked up on by rounds."  The electric into it." ASM #6 have been picked up on by rounds."  The electric into it." ASM #6 have been picked up on by rounds."  The electric into it." ASM #6 have been picked up on by rounds."  The electric into it." ASM #6 have been picked up on by rounds."  The electric into it. I was in a case of the broken, missing and stated, "No, (Resident #5) have been picked up on by rounds."  The electric into it. I was in a case of the part, "Focus: (Resident for injury r/t (related to) AEB creased mobility, allergy, osis (impaired vision and cess (MS, spasms, nterventions" documented the resident is wearing when ambulating. Maintain	F6	89					

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 81 of 107



PRINTED: 02/02/2018 FORM APPROVED

PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	
DENTIFICATION NUMBER:	A. BUILI	PING	(X3) DATE SURVEY COMPLETED
495362	B. WING		C
ITATION	4	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	01/16/2018
IT OF DEFICIENCIES BE PRECEDED BY FULL VTIFYING INFORMATION)	ID PREF TAG		NIIDBE COMPLETION
al services were made ern on 1/11/18 at 5:32  d walking in the hallway the restorative aide on sprovided prior to exit.	F€	689	
Medical Terms for the edition, Rothenberg and Medical Terms for the solition, Rothenberg and cation, Retraining incation. Retraining incation, all to serve as a nurse exergistry verification competency evaluation me employee in a valuation program in that he or she has leted a training and gram or competency ed by the State and in the registry, ensure that such an a registered.	F 7	29	
	ification.  Ification.  If to serve as a nurse exergistry verification competency evaluation me employee in a valuation program  If that he or she has leted a training and gram or competency ed by the State and in the registry.  If the registry ensure that such an exergistered.	ification.  Ification.  If all to serve as a nurse eregistry verification competency evaluation  If all to serve as a nurse eregistry verification competency evaluation program  If at he or she has letted a training and gram or competency ed by the State and in the registry.  If a registered.  If a gistry verification.	ification.  Ification.  If all to serve as a nurse or registry verification competency evaluation  If all to serve as a nurse or registry verification or competency evaluation program  If that he or she has letted a training and gram or competency ed by the State and or the registry.  If the registry verification.

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Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 82 of 107



VDH/CLC

PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391					
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495362	495362 B. WING		,	C 01/16/2018		
NAME OF F	PROVIDER OR SUPPLIER		1	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	**************************************		
4 20 11 6 5 1	A MUDONO AND DE	DADUITATION		906 TI	HOMPSON STREET			
ASHLAN	D NURSING AND REI	ABILITATION		ASHL	_AND, VA 23005	A CONTRACTOR OF THE CONTRACTOR		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION		
F 729	Continued From pa	ae 83	F 7	729				
1 1 100		ardy was abated and the			3. HRC re-educated by the ED/DON/			
	deficiency was assigned a level il pattern.				regarding ensuring CNA certificat verification is current, pending vio			
<b>*</b>	The findings include			documents reviewed/addressed as validated by the ED/DON per regula accepting an assignment per regula	lation prior to			
	On 1/10/18 at 1:15			HRC re-educated by the ED/DON regarding new CNA applicant's ce				
	facility to investigate a two-day complaint. During				verification to be reviewed, pendir			
		tigation an immediate jeopardy			documents reviewed/addressed as validated by the ED/DON per regu			
	was called and a st expanded survey w	ubstandard review and			hire and prior to extending an offe			
	oxportage emissy tractimental.				employment per regulation. HRC re-educated by the ED/DON/	/dasignee		
	Part of the substant			regarding ensuring criminal backg	round			
	currently employed			checks/Virginia State Police is obt in the employee file and validated	ained, placed			
	certifications Allat	gistry verification of their of currently employed CNAs			within 30 days of hire per regulation	on.		
		/ii0/18 at approximately 5:30			HRC re-educated by the ED/DON regarding CNAs whose certificati			
	p m. with their empl	oyee file.			expire within the month are to be p	provided a		
	On Alidera vi nonno	oximately 9:00 a.m., review of			letter requiring signature commun	nicating		
		files was conducted. Less			certification renewal due date with documentation in the employee file.	CNA's		
	than 50 percent of t	he 79 currently employed			without proof of current certification	n to be		
		-date certification in their			removed form the schedule until pro	of of current		
	employee file.				certification is provided and validate ED/DON with documentation in the	e employee		
	On 1/11/18 at 10:44	a.m., an interview was			file. ED/DON to be provided a list r	nonthly with		
	conducted with OSN	M (other staff member) #2, the			identified CNAs. Human Resources re-educated by th	e .		
		irector. When asked who was			ED/DON/designed regarding respo	nsibility for		
		ying certifications, OSM #2 certifications. When asked			maintaining the appropriate docume the CNA employee file and providing	ng a copy or 1		
	about the process for				the Quality Monitor monthly to the	DON and		
	certifications, OSM	#2 stated when a future			ED.			
		n application, she will decide						
	from the application	if they are a good fit for the then have the applicant come			•			
	into the facility to int	roduce them to the DON			*			
	(Director of Nursing	Director of Nursing). OSM #2 stated she will			•			
	then run a backgrou							
	background check of	comes out clean, she will run						

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

their certification. When asked if there were any

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 84 of 107





PRINTED: 02/02/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495362	B. WING			1	C <b>16/2018</b>
NAME OF	PROVIDER OR SUPPLIER	J.,	I	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
ACULAR	ID NURSING AND RE	HADILITATION		906 TI	HOMPSON STREET		
ASHLAN	AD IADIKOIIAO MAD VEI	HADILITATION		ASHL	AND, VA 23005		
(X4) ID PREFIX I'AG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Continued From paraide, a facility must State registry estab (2)(A) or 1919(e)(2) believes will include §483.35(d)(6) Required for the facility at training and competency evaluated for the facility endicated for the facility employed assistant) that been residents, CNA #3, if #19 through 32.	ge 82 seek information from every lished under sections 1819(e) (A) of the Act that the facility information on the individual. A price of the entraining and the entraining or nursing or nursing entraining and the entraining and the program or a new the program or a new the entraining and the program or a new the entraining and the facility document mined the facility document mined the facility document mined the facility staff failed to entraining direct care to CNA's (certified nursing providing direct care to CNA #5, CNA #7 and CNA ed to obtain certification teen currently employed sing assistants) CNA #3, CNA		<del>11. (*) 11. (*) 11. (*) 11. (*) 11. (*)</del> 11. (*) 11.		int (C.N.A)'s nd placed in d CNAs ned, he employee files in ployee files for (HRC) tion ation as applicable r (DON) with per tt ons to be riffication s obtained per gnment.	CATE
	providing direct care as-worked schedule prior to entrance, re had been directly we providing care, and	A #19 through 32, that been to residents. Review of the from the past two weeks vealed the 17 CNAs identified orking with residents and the facility staff failed to verify n prior to hire on 9/19/17,			current, and validated by ED/DON documentation in the employee file days of hire. CNAs without a curre background check to be removed fr schedule until a background check and validated by the ED/DON with documentation in the employee file accepting an assignment. Follow in	with within 30 int criminal om the is obtained, prior to	

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who was found to have a pending violation on her

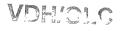
certification. This resulted in the identification of immediate jeopardy at a pattern. After a plan of correction was presented, verified and accepted,

Facility ID: VA0008

findings.

If continuation sheet Page 83 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

	TO TOIL MELDION			-		UND NU.	. U938-U391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONS		(X3) DAT	E SURVEY PLETED
		495362	B. WING	)		l l	C 16/2018
	PROVIDER OR SUPPLIER	HABILITATION		906 THC	ADDRESS, CITY, STATE, ZIP CODI OMPSON STREET ND, VA 23005	F 01/	16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 729	#2 stated she has a program) that alerts certification needs to why certifications not stated certifications are there are no violation. When asked where OSM #2 stated certifications find additional certifications from the property of the state of the employee's file. Os find additional certification of the employee's file of the employee of the employee file on given to this writer a cut the employee file or given to this writer, the stack of CNA certifications of the CNAs did not have the expired certifications CNAs included CNA CNA #19 through 32 schedule from the partner of the pa	ald verify certifications, OSM computer system (payroll her when an employee's o be verified. When asked eed to be verified, OSM #2 need to be verified to ensure e not expired and to ensure en against the certification. certifications should be filed, ifications should be filed in the M #2 stated she would try to cations.  ximately 3:00 p.m., OSM #2 stack of certifications that D/17. OSM #2 stated that she me CNAs had expired employee file and she had ertifications from the professions website. OSM errent certification was not in in the stack of paper just hen she did not have them.  ximately 3:00 p.m., review of tifications was conducted. The certification verified. The #3, CNA #5, CNA #7 and in their employee file. The #3, CNA #5, CNA #7 and Review of the as-worked ast two weeks prior to nat the 17 CNAs identified rking with residents and m., The Office of Licensure	F	729	HRC/Designee to conduct rando monitoring of C.N.A employee certification verification is curre employee and validated by the hire per regulation 2 times a weekly x4 weeks then monthly, indicated.  HRC/Designee to conduct rando monitoring of C.N.A employee new CNA applicant's certificatireviewed and validated by the E hire and prior to extending an of employment per regulation week twice monthly x 4 weeks, then rand as indicated.  HRC/Designee to conduct rando monitoring of C.N.A employee criminal background checks/Vir Police is obtained, placed in the and validated by ED/DON within per regulation 2 times a week for weekly x4 weeks then monthly, indicated HRC/designee to conduct rando monitoring regarding CNAs whis idue for renewal within the moprovided a letter requiring signal communicating certification ren with documentation in the employee gulation 2 times a week for 4 x4 weeks then monthly, PRN and HRC/designee to conduct rando monitoring of employee files regwithout proof of current certification is provided a letter requiring signal communicating of employee files regwithout proof of current certification is provided by the ED/DON we documentation in the employ regulation 2 times a week for weekly x4 weeks then month as indicated.  Findings to be reported to Qamonthly and updated as indicated.  Findings to be reported to Qamonthly and updated as indicating indicated.	files to ensure mit, located in the ED/DON upon ek for 4 weeks, PRN and as mit quality files to ensure on verification (D/DON upon fifer of kly x 4 weeks, monthly, PRN mit quality files to ensure employee file in 30 days of him 4 weeks, PRN and as mit quality ose certification onth are to be ture ewal due date oyee per weeks, weekly in a sindicated mit quality garding CNA's attion to be a liproof of ded and ith yee file per riff 4 weeks, hly, PRN and API committee cated. Quality	e
	and Certification long	term care division director		5.	. Date of Compliance 3-2-18.		

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 85 of 107



PRINTED: 02/02/2018 FORM APPROVED

1		A MEDICAID SERVICES				OMB N	<u>0. 0938-039</u>	1
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495362	B. WING			0	C 1/16/2018	
NAME OF	PROVIDER OR SUPPLIER		1	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/10/2018	
ACILLA	ND MUDCING AND DE				THOMPSON STREET			
ASHLAI	ND NURSING AND RE	HABILITATION			HLAND, VA 23005			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	al		PROVIDER'S PLAN OF CORRECTI	(A)		
PRÉFIX TAG	(EACH DEFIGIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 729	Continued From pa	ae 85	E -	'29			**************************************	netro
		above findings and concerns.	1. 1	28				
	The supervisor consecond immediate j	firmed that the facility was in a						
	On 1/11/18 at 3:27 p	o.m., the facility staff						
	(Administrator and I	DON (Director of Nursing)						
	were notified that the	e facility was in a second						
	p.m.	starting on 1/11/18 at 3:13	*					
	The facility staff pres	sented a POC (plan of						
	correction) on 1/11/1	18 at 4:00 p.m. The plan						
	documented the following	owing:						
	1 Identified CN Na	certification obtained and						On additional or or
	placed in the employ	ree file 1/11/18. Identified						Annual Cons
	C.N.A's without a cu	rrent certification removed				*		-
	from the schedule.							mail-datapa par
	2. A quality review of	current CNA employee files						-
	completed by the Hu	man Resources Coordinator						Annual Section
	(HRU) to ensure cert	tifications are current and						-
	certification to be rea	NA's without a current noved from schedule until a						-
	certification is obtained	ed, validated, and placed in						
	their employee file pr	for to accepting an					* Andrews	
	assignment.				*			
	3. HRC re-educated	by the Executive director						
		A.'s certifications are current						
	and located in the em	nployee file prior to accepting re-educated by the ED to						
	ensure CNAs without	a current certification are						
	removed from the sol	hedule until a certification is						
	obtained, validated ar	nd placed in their employee						
	file prior to accepting	an assignment.			•			
,	4. HRC/Designee to o	conduct random quality			· ` <b>,</b>		***************************************	
	monitoring of C.N.A e	mployee files 5 times a			•			
	week ful 4 Weeks, We	ekly x 4 weeks then monthly be reported to QAPI						
•	committee monthly ar	nd updated as indicated.						
							1	

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 86 of 107



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CENTE	<u>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</u>				FURM APPROVE
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495362	B. WING		С
NAME OF	PROVIDER OR SUPPLIER		<u>'                                     </u>	STREET ADDRESS, CITY, STATE, ZIP O	01/16/2018
ASHLAN	ND NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(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 COL	I SHOULD BE COLOUR
	findings. Results to be discussed. S. Completion date: On 1/11/18 at 4:00 particular certification. 17 CNAs. The certification. 18 Current certification. 19/19/17, had a pendicertification that had Board of Nursing. The CNA #3's certification the publication of CNA #3's certification the publication of CNA #3's certification the publication of CNA #3's certification was made."  On 1/11/18 at 4:20 p. Conducted with OSM partification, OSM #1 conducted that the conducted with ASM (1/11/18 at 4:23 p.f. onducted with ASM (1/11/18 at 4:23 p.f. on	schedule modified based on seed during QAPI.  1/11/2018.  D.m., facility staff presented verifications of the identified fications were printed from nt of Health Professions)  All identified CNA's had a CNA #3, who was hired on ing violation against her not been resolved by the he following was documented ation: "Additional public YES" means that there is artment of Health must make to pursuant to 54.1-2400. Good pursuant to 54.1-2400. Good present that this may lings in which a finding of "no line, further interview was #1. When asked the overify a CNA's certification in their certification against their stated that she would not at time. OSM #1 stated that DON about the certification may tigated by the administrator, call a time when a CNA had gainst their certification.  The an interview was fadministrative staff	F 72	29	
n	nember) #2, the DON	I. When asked the DON			Transfer of the second

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

about her involvement in the hiring and

Event ID: 727W i1

Facility ID: VA0008

If continuation sheet Page 87 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO 0938-0391

1		E & MEDICAID SERVICES				OMB N	<u>0. 0938-039</u>
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		495362	B. WING	1			C
	F PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005	<u> </u>	1/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDEE	(X5) COMPLETION DATE
F 729	certification verifical after the application resources, she would for an interview and administrator. ASM applicant, they would the background che resources would vestated the administration decision to hire an alware of a time whe with a pending violation. ASM #2 could not recertification. ASM #2 could not recertification. ASM #2 conducted with ASM #1 stated that the huresponsible for verify asked why certification ensure that a certification ensure that a certification asked why certification for the applicant without of their current certification. ASM #1 stated certification ensure that a certification ensure that a certification without of their current certification was a comployee file. When had a pending violation was a pending violation was the applicant of the that if the violation was not hire that person uninformation from the Lasked if she had received.	ge 87  tion process, ASM #2 stated was reviewed by human Id have the applicant come in introduce the applicant to the #2 stated if they liked the d run a background check. If ick was clean, then human rify the certification. ASM #2 ator would make the final applicant. ASM #2 was not are they hired an applicant tion against their certification. Asted if a CNA had a would be the administrator applicant was hired.  Image: ASM  man resources director was ing certifications. When ans should be verified to ation is current and in #1 stated certifications efore her interview with the tated she cannot interview the employee file and a copy cation. ASM #1 stated all current certification in their asked the process if a CNA on against their certification, ecision to hire an applicant violation. ASM #1 stated as still pending, she would ntil she found additional floard of Nursing. When ontly hired a CNA that had a inst their certification, ASM	F 7	29			

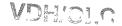
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 88 of 107





PRINTED: 02/02/2018 FORM APPROVED

1		E & MEDICAID SERVICES				OMB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ł		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
,		495362	B. WING			01/1	6/2018	
	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		90	REET ADDRESS, CITY, STATE, ZIP CODE 6 THOMPSON STREET SHLAND, VA 23005	1 01/1	UILU 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRF	(X5) COMPLETION DATE	
F 729	#1 stated, "No, not When asked what s CNA #3, ASM #1 st that CNA #4 had a p certification. ASM # CNA #3 until she re	ge 88 recently. Not at this job at all." she could recall about hiring ated that she was not aware pending violation against her \$1 stated she would suspend ceives additional information ng violation from the Board of		729		-	-	
	DON (Director of Ne CNA #4 had been sinvestigation. The A able to evidence the working schedule date.)	o.m., the Administrator and cirsing) were able to evidence uspended until further administrator and DON were by removed this CNA from the ated 1/11/18 through 1/16/18.						
	(administrative staff stated the human re had walked out of th the middle of survey revised POC. The form	ximately 9:30 a.m., ASM member) #2, the DON, sources director, OSM #2 e facility on 1/11/18 during . ASM #2 presented a ollowing was documented:						
	1. Identified C.N.A's placed in the employ C.N.A's without a curthe schedule. 2. A quality review of completed by the Ass Manager to ensure lifecated in the file. CN to be removed from s	certification obtained and ee file 1/11/18. Identified rent license removed from current CNA employee files sistant Business Office censes are current and IA's without a current license schedule until a license is and placed in their employee						

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

file prior to accepting an assignment.

Event ID: 727W11 Facility ID: VA0008

If continuation sheet Page 89 of 107



PRINTED: 02/02/2018 FORM APPROVED

1		& MEDICAID SERVICES				OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495362	B. WING				С	
M. Artista	PROVIDER OR SUPPLIER  ND NURSING AND RE	HABILITATION		90€	REET ADDRESS, CITY, STATE, ZIP CODE 5 THOMPSON STREET HLAND, VA 23005		1/16/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D RE	(X5) COMPLETION DATE	
	3. ABOM (assistant manager)/designee director (ED), to end current and located accepting an assign the ED (executive dividual accepting an assignment library assignment.  4. ABOM/Designee monitoring of C.N.A week for 4 weeks, wand PRN. Findings committee monitoring straings. Results to be discussed in the pendicular was requested along #2. When asked where certification, ASN violation was from 20 found. ASM #2 state not yet taken the pendicertification but they was asked to provide no violations on their she would try to get in of health professions.	business office re-educated by the Executive sure C.N.A.'s licenses are in the employee file prior to iment. HRC re-educated by irector) to ensure CNAs ense are removed from the nse is obtained, validated and oyee file prior to accepting an to conduct random qualify employee files 5 times a reekly x4 weeks then monthly to be reported to QAPI and updated as indicated, chedule modified based on sed during QAPI. 1/11/2018 *  I.m., CNA #3's employee file with her time card from ASM at CNA #3's violation was on M #2 stated her pending 13 and that no violation was did the board of nursing had ding violation off the red she could not obtain n regarding the violation, ad also found two additional ng violations on their were clear to work. ASM #2 evidence these CNAs had certification. ASM #2 stated in touch with the department	F 7:	29				

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 90 of 107





PRINTED: 02/02/2018 FORMAPPROVED OMB NO 0938-0301

CENTERS FOR MEDICARE						OMB NO. 0938-0391		
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495362	B. WING	Honoroma		C		
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION		9(	TREET ADDRESS, CITY, STATE, ZIP CODE 06 THOMPSON STREET SHLAND, VA 23005		)1/16/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	ix	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIEM OF THE A	CTION SHOULD BE CO THE APPROPRIATE		
	currently pending of for immoral purpose assault, arson, pand involving children, tachildren, abuse or n secure medical atternobscenity offenses, incapacitated adult. employee file reveal check was not run ure months after she was background check was not run ure months after she was background check was not run ure months after she was background check was not run ure months after she was background check was not run ure months after she was background check was not run ure months after she was background off the time care moved from the sor review of the time care moved from the sor remained off the son an "Employee Correct #3, documented the suspended via teleph of level 2 -#30. Emplocannot clock in or retinvestigation is compunderstanding and stin from the board."  Further review of the facility had identified the #10 and CNA #11 whicher certifications.  1. CNA #10 was hired certification was not very property of the facility had identified the property of the facility had identified the property of the property of the facility had identified the property of the property of the facility had identified the property of the propert	nad not been convicted of or narges of murder, abduction es, assaults, robbery, sexual dering, crimes against nature aking indecent liberties with eglect with children, failure to ntion for an injured child, or abuse or neglect of an Further review of her ed that CNA #3's background ntil 1/10/2018 (Over three is hired). CNA #3's vas clean.  Itime card revealed that she mately 70 shifts as a CNA ent care from 10/05/17 until #3 was suspended). Further and revealed that CNA #3 was shedule on 1/11/18 and edule on 1/16/18. Review of citive Action Form" for CNA following: "Employee was none secondary to violation by ee was told that she urn to work until the lete. Employee verbalized nated she had a letter to bring POC revealed that the two additional CNAs, CNA or had pending violations on	F 7	729				

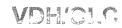
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 91 of 107





PRINTED: 02/02/2018 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	M APPROVED
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCT	ON	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
		495362	B. WING_				С
NAME OF	PROVIDER OR SUPPLIER	**************************************	I	STREET ADDRESS	S, CITY, STATE, ZIP CODE	0	1/16/2018
ASHLAN	MENT OF DEFICIENCIES LAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495362  E OF PROVIDER OR SUPPLIER  LAND NURSING AND REHABILITATION  ID SUMMARY STATEMENT OF DEFICIENCIES FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL G REGULATORY OR LSC IDENTIFYING INFORMATION)	The state of the s	906 THOMPSON ASHLAND, VA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	II D BE	(X5) COMPLETION DATE
i i	clean. Review of he worked approximate providing direct pati 1/12/18 (when CNA Further review of the #10 was removed from the Review of an "Employee was suspended pending stated she has a lett Employee was informated the certification was not #11's background chapproximately 83 shi patient care from 9/2 was removed from the school of the time card reversemented off the school of the time card reversemented off the school of the time card reversemented off the school of the time card reversemented the suspended secondary was informed that showestigation. Employee foring it in. Employee	er time card revealed she had ally 73 shifts as a CNA ent care from 9/21/17 until #10 was suspended). et ime card revealed that CNA from the schedule on 1/12/18 et schedule on 1/16/18. Expended secondary to level 2 informed that she is investigation. Employee for at home clearing her, and to bring in. Employee the board of nursing for early cleared it and said! wasn't et from the verbal abuse and sertification."  Indeed was clean and manner. Review of her at she had worked fits as a CNA providing direct 7/17 until 1/12/18 (when she he schedule). Further review aled that CNA #10 was hedule on 1/16/18. Review of following: "Employee was y to level 2 -#30. Employee et is suspended pending yee stated she has a letter at imployee was informed to comments: I went to the	F 72	9			

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

the floor from a sit to stand because I went to put

Event ID: 727W11

Facility ID: VA0008

if continuation sheet Page 92 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495362	B. WING		С
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP COI	01/16/2018
ASHLAN	ND NURSING AND RE	HABILITATION	manismaninishi di kabi	906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 729	F -		F 72	9	
	the other strap on and the chair moved. And I never had used a sit to stand before and I was told I could hook them up by myself and then go get someone to transfer."				
	conducted with OSI Discipline Specialis Nursing. OSM #6 s and CNA #11 had n certification. OSM #6 certification. OSM #6 certification of the certification of the certification of nursing will occur. Other board of nursing decided whether the guilty of a violation of that all CNAs should the board stating that to come off the websfor each CNA to be p#6 stated, "That is now #6 could not give an CNA was cleared from 1/16/18 at 11:31 conducted with OSM office manager. OSI regarding certification of a pending violation."	M #2, the DON were made			

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

Facility ID: VA0008

If continuation sheet Page 93 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	& MEDICAID SERVICES				OMB NO. 0938-039		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
Polymorbide Statement Communication Communic		495362	B. WING		**************************************	0.1	C /16/2018
NAME OF	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		/10/2010
ACLIAN	ID NURSING AND REI	HADII ITATION		906 TH	HOMPSON STREET		
ASITEAL	ID NOV2ING HAD KEI	HABILITATION	***************************************	ASHL	AND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 729	Continued From pa	ge 93	F 7:	29	- > 100		en e
		on was presented prior to exit.					
F 730	Nurse Aide Peform	Review-12 hr/yr In-Service	F 7:	30			
	CFR(s): 483.35(d)(7				F730: Nurse Aide Perform Revi	iew 12hr/y	<u>/r.</u>
					In-service	,	
		lar in-service education.					
	I he facility must co	mplete a performance review			<ol> <li>Identified Certified Nursing A</li> </ol>		
	months and must n	at least once every 12 rovide regular in-service			(CNA)'s received performance ev	aluations	
	education based on	the outcome of these			on1/24/18.		
		training must comply with the			a control of the standard by	41 T.T	_
	requirements of §48				<ol> <li>Quality Review completed by Resources Coordinator (HRC)</li> </ol>	Ine riumai	il Lo
		IT is not met as evidenced			ensure CNAs receive their per		
	by:				evaluation presented to them b		
	Baseo on staff inter	view and facility document			DCS/designee during the mon	th of their	
		nined the facility staff failed to			annual date of hire date and pl	aced in the	
		ormance review evaluations			employee file. Follow up base	a on	
	currently employed i	ed nursing assistants)			findings.		
	sarronny eneployed i	n me rounty.			3. Director of Nursing (DON) re-	-educated I	by
	The facility staff faile	ed to ensure that performance			the Executive Director (ED) re	egarding	Ť
		vere conducted annually.			ensuring CNAs to receive thei	r annual	
		•			performance evaluation preser	ited to ther	m .
	The findings include:				during the month of their annu hire.	iai date oi	
					HRC re-educated by the ED/D	ON	
		kimately 9:00 a.m. a review			regarding ensuring the HRC d	evelops a !	file
		CNA employee records.			alerting the DCS of annual per	rformance	
	THESE TEUDIUS Were varified as working in	all current CNAs who were the two weeks prior to this			reviews due monthly.		
	survey. There was n	no evidence in all 79 CNA			HRC re-educated by the ED/D	ON	
	emolovae records th	at performance review			regarding the responsibility fo the appropriate documentation	r maintain Lin tha	ing
		conducted on an annua!			employee file.	i ili ilic	
	basis.				employee me.		
					*,		
,	On 1/11/18 at 5:35 p.	m., an end of day meeting					-
		ASM (administrative staff			1		
		ninistrator, and ASM #2, the					
		ASM #1 and ASM #2 were d employee performance					-
,	was treed contactor	- omproyor ponormance					- 1

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 94 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u>DMB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION '	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING		C 01/16/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
40111 481	IN AUTODIA AND DE	LADIE STATION	The state of the s	906 THOMPSON STREET	
ASHLAN	D NURSING AND REI	TABILITATION	мания	ASHLAND, VA 23005	one in the second
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC  (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 730	Continued From pa	ge 94	F 7	30	
	collaborative effort I and department sup stated, "It is a gray resources) and nurs large turnover. It is  On 1/16/18 at 10:25 conducted with CNA she had received a evaluation on the arevery year. CNA#1 received a performamenths ago but that 1/16/18 at 10:50 a.m. with CNA#15. CNA received a performantiversary of her each of the collaboration o	ia.m. an interview was A #17. CNA #17 was asked if performance review nniversary of her employment 7 stated that she had ance review evaluation a few		<ul> <li>4. HRC/designee to conduct randon monitoring to ensure CNAs receiperformance evaluation presented by the DCS/designee during the range of their annual date of hire date and the employee file 2 times weekly then monthly and PRN as indicate Findings to be reported to QAPI of monthly and updated as indicated monitoring schedule modified bar findings.</li> <li>5. Date of Compliance 3-2-18.</li> </ul>	ve their I to them nonth of placed in x 4 weeks ed. committee . Quality
	conducted with ASM and ASM #2 were a conducting performa ASM #2 stated, "Per be done by the unit or myself. Our HR clet the staff know whevaluation is to be disupervisor the evaluation as asked performance evalua stated, "It would have broken system, we have a stated and asked performance evalua stated, "It would have broken system, we have a stated and asked and asked asked performance evalua stated, "It would have broken system, we have a same asked and asked as	o.m. an interview was 1 #1 and ASM #2. ASM #1 sked to explain the process of ence review evaluations. formance evaluations should manager, charge nurse and department is responsible to en the performance one. HR advises the ation is due to be done." who checks that the tions are done. ASM #2 e been HR. We have a nave had a lot of turnover in and our current HR person c."			

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 95 of 107





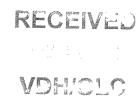
PRINTED: 02/02/2018 FORM APPROVED

		E & MEDICAID SERVICES	OMB NO. 0					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION		TE SURVEY MPLETED	
		495362	B. WING			01	C /16/2018	
NAME OF	PROVIDER OR SUPPLIER		T	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		710/2010	
ASHLAN	ID NURSING AND REI	HARII ITATIONI	-		HOMPSON STREET			
ASITEAN	AD MONORIO MIND INC.	HABILITATION		ASHL	AND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 730	Continued From pa	ge 95	F 7:	30		The state of the s		
		on was provided prior to the	1 1	J.()				
	end of the survey pr	rocess.						
	Use of Outside Res		F 8	40				
SS=D	CFR(s): 483.70(g)(1	1)(2)						
	qualified professions service to be provided must have that service person or agency of arrangement described. Act or an agreemen (2) of this section.  § 453.70(g)(2) Arranged to 1361(w) of the period of 1361(w) of the period of the timeliness of this REQUIREMENT by.	facility does not employ a all person to furnish a specific ed by the facility, the facility ice furnished to residents by a utside the facility under an bed in section 1861(w) of the t described in paragraph (g)  gements as described in the Act or agreements a furnished by outside cify in writing that the facility fores that meet professional ples that apply to ing services in such a facility;			<ol> <li>Ese of Outside Resource</li> <li>Contract with wound care phyobtained 1/10/18.</li> <li>Quality Review completed by Executive Director (ED)/ desensure outside vendors requiris current and accessible. Follon findings.</li> <li>ED re-educated by the Region President of Operations (RVI ensuring outside vendors requirent and access</li> <li>ED/RVPO/designee to conduct quality monitoring of outside requiring a contract ensuring current and accessible weekly monthly x 2 months, and quality monitored.</li> </ol>	y the ignee to ing a contract llow up base real Vice PO) regarding uiring a ible, act random vendors contracts are iv x2; weeks,	d g	
	review, it was detern obtain a contract with currently providing se The facility staff failed	nined the facility staff failed to an outside provider who is ervices in the facility.  It to obtain a contract with ician group prior to providing			Findings to be reported to QA monthly and updated as indic monitoring schedule modified findings.  5. Date of Compliance 3-2-18.	ated. Quality		
	The findings include:							

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 96 of 107



PRINTED: 02/02/2018 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/Y2) MI	TIDLEO	ONSTRUCTION		IO. 0938-039
	OF CORRECTION .	IDENTIFICATION NUMBER.	1		ONSTRUCTION	(X3) D	OATE SURVEY
		,		TO STREET,	- Committee of the Comm	Property of the Control of the Contr	С
		495362	B. WING	***************************************			01/16/2018
	PROVIDER OR SUPPLIER	HABILITATION		906 1	EET ADDRESS, CITY, STATE, ZIP CODE FHOMPSON STREET ILAND, VA 23005	Name of the last o	777372010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 840	requested from the 1:30 p.m. the admin member (ASM) #1, contract for (name of 1/11/18 at 2:45 p.m. process followed for obtained with provid ASM #1 stated, "If wa contract. I pass it legal review team. I changes they have r with the provider. Will can sign it, I sign it vendor and upload it I keep a copy in a bolt's not required but I	ge 96 tract of outside providers was administrator. On 1/11/18 at instrator, administrative staff stated she did not have a of wound care specialist).  Inducted with ASM #1 on When asked about the ensuring contracts are ers of services in the building, re get a new company, we get on to the corporate office and hey send it back with any equested and then confer then the corporate team says and send a copy to the to our portal with contracts, sok here at the facility also, prefer to keep a physical tract book in my office."	F	340			
	regional director of of aware of the above of p.m. A copy of the far requested as was the specialist started profession of the policy, "Copolicy documented in entered into by Facilit through e contract materials and are professionally and are professio	rector of nursing and the linical services were made concern on 1/11/18 at 5:32 cility policy on contracts was a date that the wound care viding services in the facility.  m., ASM #1 presented a contract Management." The part, "Policy: All contacts dies should be routed anagement software to appropriate approval prior to experily stored. Procedure: 1. e submitted via the contract e2. The contract system he (corporation network) s submitted through the		¥			

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 97 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	J. 0938-039° ATE SURVEY PMPLETED
		495362	B. WING		0.0	C
NAME OF PROVIDER OR SUF  ASHLAND NURSING AN  (X4) ID SUMMA	ID REH	ABILITATION  EMENT OF DEFICIENCIES	90	REET ADDRESS, CITY, STATE, ZIP CODE 6 THOMPSON STREET 6HLAND, VA 23005		1/16/2018
PREFIX (EACH DEFI	CIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DRE	(X5) COMPLETION DATE
F 840 Continued Fro	m pag	e 97	F 840			Para Caracan C
contract mana the appropriat personnel for will also be rev All contracts s possible so pre to entering a c executed until email instructio contracts shou corporate lega department im storage in the	agemer e opera review viewed hould b oper ap ontract the rec on to do lid be e I team) mediat contrac	nt system, it will be routed to ational and financial and approval. The contract by the legal department. a. be submitted as soon as proval can be received prior 4. Contracts should not be questor receives a clear o so. 5. Fully executed smalled to (email of or faxed to the legal ely upon execution for st system.				
wound care sp services to the	ecialist reside	m. ASM #1 stated that the group had been providing at since November 2015.  was provided prior to exit.			*	
F 880 Infection Preve SS=E CFR(s): 483.80	ntion 8	Control	F 880			
infection prever designed to pro comfortable en	st estab ntion ar vide a vironmend trans	olish and maintain an nd control program safe, sanitary and ent and to help prevent the smission of communicable				
program. The facility mus and control prog a minimum, the  §483.80(a)(1) A	t estab gram (I followi systen	evention and control  lish an infection prevention PCP) that must include, at ng elements:  for preventing, identifying, , and controlling infections				

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 98 of 107





PRINTED: 02/02/2018 D 1

CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION .	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495362	B. WING		C
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	01/16/2018
ASHLA	ND NURSING AND REI		9	06 THOMPSON STREET ASHLAND, VA 23005	toes
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 COMPLETION
	and communicable staff, volunteers, vis providing services us arrangement based conducted according accepted national stage of the part of the possible communication of the persons in the facility (ii) When and to who communicable disease or including but (iii) Standard and trage of the persons in the facility (iii) Standard and trage of the persons in the facility (iii) Standard and trage of the persons in the facility (iii) Standard and trage of the persons in the facility (iii) Standard and trage of the persons in the facility (iii) Standard and trage of the persons in the facility (iii) Standard and trage of the persons in the facility (iv) When and how is resident; including but (A) The type and during the persons of the perso	diseases for all residents, itors, and other individuals noter a contractual upon the facility assessment g to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, illiance designed to identify ble diseases or y can spread to other or, in possible incidents of se or infections should be ansatission-based precautions rent spread of infections; postion should be used for a set not limited to: ation of the isolation, infectious agent or organism at the isolation should be the pole for the resident under the se under which the facility was with a communicable in lesions from direct or their food, if direct or their food, if direct ne disease; and procedures to be followed ect resident contact.	F 880	F880: Infection Control  1. Linen cart removed from ron 1/10/18. Resident # 2 did not suffer physical or psychosocial and Nurse aide who cared for reducated regarding Infection practices r/t residents on Ist precautions.  2. Quality review by the Dire (DON)/Staff Education Nurcompleted regarding reside precautions to ensure Infection practices are followed per standards. Follow up based Quality review by the Exect (ED)/DON to ensure linent being stored in resident roctobased on findings.  3. Current staff re-educated by Staff Education Nurse/designesidents on isolation precautified practices per professional standards. Current staff re-educated by Staff Education Nurse/designer carts are not being storeoms.  4. ED/DCS/designee to conduct quality monitoring regarding Isolation precautions to ensure Control practices is followed professional standards 4 tin weeks, 3 times weekly x 4 twice weekly and PRN as in the side of the professional standards 4 tin weeks, 3 times weekly x 4 twice weekly and PRN as in the side of the professional standards 4 tin weeks, 3 times weekly x 4 twice weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly as in the professional standards 4 tin weeks, 3 times weekly x 4 twice weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards 4 tin weeks, 3 times weekly and PRN as in the professional standards the	and s/s of dverse effects, esident #2 re- for Control olation  ctor of Nursing arse/designee ents on Isolation tion Control professional d on findings, autive Director carts are not forms. Follow up  y the DON/ gnee to ensure autions to cnsure are followed by the DON/ gnee to ensure are followed y the DON/ gnee to ensure are followed by the DON/ gnee to ensure are followed y the DON/ gnee to ensure are followed by the DON/ gnee to ensure are followed y the DON/ gnee to ensure are followed

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 727W11 Facility ID: VA0003

corrective actions taken by the facility.

If continuation sheet Page 99 of 107



PRINTED: 02/02/2018 FORMAPPROVED OMB NO 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		40.5363			С
MANC OF	PROVIDER OR SUPPLIER	495362	B WING		01/16/2018
	ND NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		ULD BE COMPLETION
	transport linens so a infection.  §483.80(f) Annual re The facility will cond IPCP and update th This REQUIREMEN by: Based on observation record review, and follow infection containing units (the deresidents in the survoluments). The linen cart for containing clean line cobserved stored in Figure 1. The linen cart for contact prepautions from.  The findings include:  1. The linen cart for containing clean lines com.  The findings include:  1. The linen cart for containing clean lines observed stored in Resident #3 was admitted.	adle, store, process, and as to prevent the spread of eview.  uct an annual review of its eir program, as necessary. It is not met as evidenced on, staff interview, clinical actility document review, it is the facility staff failed to rol practices for one of 3 ementia unit) and for one of 6 ey sample, Resident #2.  the entire dementia unit, ns for all the residents, was resident #3's room.  If the entire dementia unit, as for all the residents, was esident #3's room.	F	ED/DCS/designee to conduct quality monitoring through no rounds to ensure finen carts a stored in resident rooms 4 tin weeks, 3 times weekly x 4 we twice weekly and PRN as inception of Findings to be reported to Qamonthly and updated as indiction monitoring schedule modified findings.  5. Date of Compliance 3-2-18.	nock survey re not being nes weekly x 4 leeks then licated. API committee ated. Quality
:	chronic kidney diseas Alzheimer's Disease, The most recent MD:	noses of but not limited to se, high blood pressure, diabetes, and psychosis. S (Minimum Data Set) was a t with an ARD (Assessment		Y	

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 100 of 107





PRINTED: 02/02/2018 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		***************************************		OMB N	O. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495362	B. WINC	Š		0	C 1/16/2018
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION .		9	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		1/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D BE	(X5) COMPLETION DATE
	coded as being sev ability to make daily of a possible 15 on Mental Status) exar requiring total care it bed mobility, dressin Supervision to limite and as frequently in bladder.  On 1/10/18 at 5:11 pp.m., an observation room. A mesh-cove containing clean she cloths, bed protector resident briefs, was Resident #3's room, entire unit and not for 0n 1/10/18 at 7:35 p #1 (Certified Nursing the linen cart was be (not just Resident #3 be in any other resid marshal said the car storage room; and, tithe unit that would ta they could not leave not recognize that this issue.  A review of the facility Plan: Linen Handling	10/17/17. Resident #3 was erely cognitively impaired in life decisions, scoring a 1 out the BIMS (Brief Interview for in. Resident #3 was coded for bathing; extensive care for ing, toileting, and hygiene; and assistance for ambulation; continent of bowel and comment of pads, and assorted sized cobserved being stored in This was a linen cart for the or the one resident.  In an interview with CNA in Assistant) she stated that ing stored in resident rooms in the could not be stored in the could not be		880			
	transported to linen s covered cart" The	torage areas using a policy did not indicate that					

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 101 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

ł.		A MEDICAID SERVICES				<u>OMB NO</u>	<u>). 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495362	B. WING	********		01	C //16/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
ASHLAN	ND NURSING AND RE	HABILITATION			006 THOMPSON STREET ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 880	linen carts should n room.  On 1/11/18 at 5:33 made aware of the stated the Fire Mars could not be stored.	ge 101 of be stored in a resident's o.m., the Administrator was findings. The Administrator shal never said the linen cart in the storage room. No was provided by the end of the	F	380			
	rentact precautions room. Resident #2 was ad 9/24/16 with diagnos	failed to use appropriate when entering Resident #2's mitted to the facility on that included, but were nita, acute kichey failure,					
	Resident #2's most reset), a quarterly asset), a quarterly asset (assessment references Resident #2 as being questions provided of for mental status). The Resident #2's cognit making coded Resident #2's most resident #2's cognit making coded Resident #2's cognit making coded Resident #2's most resident #2's cognit making coded Resident #2's most resident #2'	recent MDS (minimum data recent MDS (minimum data ressment with an ARD noe date) of 12/8/17, coded					
	observed with a cart personal protective e that stated Resident precautions. Residel assisted with ambula	.m. Resident #2's room was outside the door containing quipment (PPE) and a sign #2 was on contact nt #2 was observed being tion to her room by a CNA.					

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 102 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR OMB N	RM APPROVEE 10. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
COLOR DE LA COLOR		495362	B. WING				C 01/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION	A CONTRACTOR OF THE CONTRACTOR	9061	EET ADDRESS, CITY, STATE, ZIP THOMPSON STREET ILAND, VA 23005		11/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	#18 assisted Reside began helping her vos observed touching I bare hands and cut #18 was then remot Resident #2's bedsi herself, stating that CNA #18 left Reside wash her hands or the CNA #18 then proceed the entered other reside trays.  On 1/10/17 at 7:35 pronducted with CNA explain the isolation for Resident #2. CN was on contact preceded to the entered other state had not done that with room, but she was made and the entered other state had not done that with room, but she was made and the entered other than the state of the entered other than the complete other than the complete other than the complete other than than than the conducted with RN (in the	ot don any of the PPE. CNA ent #2 to sit on her bed and with her meal. CNA #18 was Resident #2's meal tray with ting Resident #2's meal tray with ting Resident #2's food. CNA wed an envelope from de table and begin fanning she was hot. At 6:55 p.m. ent #2's room, she did not use any anti-bacterial solution. ended to retrieve a cart and ent rooms to remove dinner.  a.m. an interview was a #18. CNA #18 was asked to procedures currently in place IA #18 stated Resident #2 autions and she should put a when entering the room. end she was aware that she nen entering Resident #2's nore focused on getting her room. CNA #18 stated, ed and gloved." CNA #18 eldent #2 was on isolation for e has head lice, and it can 8 was asked what should er residents from being ated, "I should have washed to it that time, I should have it."  m. an interview was registered nurse) #4. RN #4	F 8	80			
	on isolation. RN #4 s	uld happen for a resident is stated, "Always do the PPE, fore entering the room." RN					

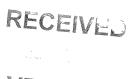
FORM CMS-2567(02-99) Previous Versions Obsolete

#4 was asked what should be done differently if

Event 10:727W11

Facility ID: VA0008

If continuation sheet Page 103 of 107





PRINTED: 02/02/2018 FORM APPROVED OMB NO 0938-0301

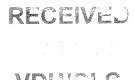
CIIYIL	INO I ON MEDIONICE	A MICDIONID STIMOTS			(	<u> 2MB NO. 0938-0391</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING			C 01/16/2018
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005	7711012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE COMPLETION
F 880	the resident was kn stated, "The staff sh their head before er On 1/11/18 at 5:35 was conducted with member) #1, the ad	own to have head lice. RN #4 nould place a shower cap on ntering."  o.m. an end of day meeting ASM (administrative staff ministrator, and ASM #2, the	F 8	, :80		
		ASM #1 and ASM #2 were above findings at this time and affection control was				
	Categories of Trans revealed, in part, the "Contact Precaution Precautions, implemented that the residents known or emicroorganisms that contact with the resident with the re	ty policy titled, "Isolation - mission - Based Precautions" of following documentation; is 1. In addition to Standard nent Contact Precautions for suspected to be infected with the can be transmitted by direct dent. 4. Gloves and addition to wearing gloves andard Precautions, wear terile) when entering the cloves before leaving the land hygiene. 5. Gown. a. spwn upon entering the groom or cubicle."				
	end of the survey pro	Training for Nurse Aides	F 94	17		
	§483.95(g) Required aides. In-service training mu	in-service training for nurse				
	§483.95(g)(1) Be suf	ficient to ensure the				

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 104 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED
		495362	B. WING	***************************************		C 01/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRES 906 THOMPSON ASHLAND, VA		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH	OVIDER'S PLAN OF CORR CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
	\$483.95(g)(2) Include training and resident \$483.95(g)(3) Address the special determined by the factorial to individuals with considered to ease of This REQUIREMENT by:  Based on staff interroview, it was determined to ensure 18 consistants) had com	nce of nurse aides, but must hours per year.  de dementia management it abuse prevention training.  ess areas of weakness as aides' performance reviews lent at § 483.70(e) and may needs of residents as acility staff.  Urse aides providing services orgitive impairments, also the cognitively impaired.  This not met as evidenced view and facility document mined that the facility staff if 79 CNAs (certified nursing pleted their mandatory 12 heir anniversary dates of	FS	1. Current professis physica 2. Quality Staff Ec (DON)/ per the complet hire date 3. Staff Ed regardin Annual 12HR n 4. Staff Ec random CNA's: Calenda training weeks, 2 as indical findings and upds.	ducation Nurse/Director designee to ensure C.N Annual Education Cale tion of 12HR required to E. Follow up based on fucation Nurse re-education State of Education Calendar to required trainings from a ducation Nurse/DON/D equality monitoring of Creceive education per that to validate completions from hire date to hire 2 times weekly x 4 wee ated.	e and services per not suffer and s/s of rese effects  A files completed by the r of Nursing I.A's receive education andar to validate trainings from hire date to findings.  ated by the DON eive education per the validate completion of hire date to hire date.  The signee to conduct CNA files to ensure the Annual Education of 12HR required date 3 times weekly x 4 ks then weekly and PRN
	On 1/11/18 at approx was conducted of 79 These records were verified as working in survey. There was n	cimately 9:00 a.m. a review CNA employee records. all current CNAs who were the two weeks prior to this to evidence in all 79 CNA at 12 hours of mandatory completed by their			Compliance 3-2-18.	

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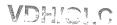
On 1/11/18 at 5:35 p.m. an end of day meeting was conducted with ASM (administrative staff member) #1, the administrator, and ASM #2, the

Event ID:727W11

Facility ID. VA0008

If continuation sheet Page 105 of 107





PRINTED: 02/02/2018 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	7723.10	I will have to be written as a management of the second	OMB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING	3	С
	PROVIDER OR SUPPLIEF  ND NURSING AND RE		en Promotional Language and American	STREET ADDRESS, CITY, STATE, 906 THOMPSON STREET ASHLAND, VA 23005	01/16/2018 ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAG	1- TOTA COLLECTIVE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
· · · · · · · · · · · · · · · · · · ·	director of nursing, asked to provide e received their 12-h anniversary dates.  On 1/16/18 at approved the director of nursiconding the total his writer of the On 1/16/18 at approved the 79 CNAs in a provide the 79 CNAs in a provide to CNAs in suestion his mandatory education on 1/16/18 at 1:40 ponducted with ASM #2, the directo ASM #2 were made all CNAs had the reduced to have 12 education on their are ASM #2 confirmed to the required education on their are ASM #2 confirmed the required education was staff was completed the staff coordinator unavailable for intervinavailable for intervinavailable for intervination.	ASM #1 and ASM #2 were vidence that all CNAs had our mandatory training by their oximately 11:00 a.m. ASM #2, ing, provided a print out of all ript of their education, rours. A review was conducted information provided.  Dximately 1:00 p.m. ASM #2 de further evidence for 18 of ocumented completion of the y training.  Dximately 1:30 p.m. ASM #2 er and stated that she was vidence that 18 of the 79 and received 12 hours of the n.	F	947:	

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

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 106 of 107



PRINTED: 02/02/2018 FORM APPROVED OMB NO. 0938-0301

TOTAL EMPERAL DE DEFIDIENDES TEXTS PROVIDER STEPPINE LA CONTRA CO	CTATELIC	the same terminated and the same	1				OWR M	<u>). 0</u> 938-0391
ASHLAND NURSING AND REHABILITATION    SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION PREFIX TAG   TAG	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
ASHLAND NURSING AND REHABILITATION  (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 947 Continued From page 108 board of nursing and (name of corporation) guidelines. We do a lot of abuse training. We have monthly scheduled classes." ASM #2 was asked how the facility tracks who has completed the education. ASM #2 stated, "We have a calendar of mandated training, we schedule classes in the computer system and we also make written material available." ASM #2 was asked who ensures that the education is completed. ASM #2 stated, "We have had some missed opportunities."  No further information was provided prior to the end of the survey process.  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 434.  (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 434.			495362	B. WING	3			С
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX   CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG    F 947   Continued From page 108   board of riursing and (name of corporation)   guidelines. We do a lot of abuse training. We have monthly scheduled classes." ASM #2 was asked how the facility tracks who has completed the education. ASM #2 stated, "We have a calendar of mandated training, we schedule classes in the computer system and we also make written material available." ASM #2 was asked who ensures that the education is completed. ASM #2 stated, "We have had some missed opportunities."  No further information was provided prior to the end of the survey process.  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 434. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 434. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 434.			HABILITATION		906	THOMPSON STREET		1/16/2018
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 727W11

Facility ID: VA0008

If continuation sheet Page 107 of 107



