PRINTED: 01/31/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER AVANTE AT HARRISONBURG STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801 FREDLY CONSTRUCTION WIST BE PRECIDED BY TALL FREDLATORY OR LSC IDENTIFYING INFORMATION) FREDLATORY OR LSC IDENTIFYING INFORMATION FREDLATORY OR LSC IDENTIFYING INFORMATION FREDLATORY OR LSC IDENTIFYING INFORMATION) FREDLATORY OR LSC IDENTIFYING INFORMATION An unannounced Medicare/Medicaid standard survey was conducted on 1/24/17 through 1/26/17. No complaints were investigated. Corrections are required into the survey. The survey sample consisted of 19 current Resident reviews (Residents # 11 frough 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record review (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record reviews (Residents # 19 through 18 and 22) and three closed record review (Residents # 19 through 18 and 22) and three closed record review (Residents # 19 through 18 and 22) and three closed record review (Residents # 19 through 18 and 22) and three closed record review (Residents # 19 through 18 and 22) and three closed record review (Residents # 19 through 18 and 22) and three closed record review (Residents # 19 through 18		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
AVANTE AT HARRISONBURG (XA1) D (XA2) D (XA3)			495146	B. WING_		01/26/2017
FREERIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 1/24/17 through 1/26/17. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 103 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents # 1 through 121). F176 483.10(c)(7) RESIDENT SELF-ADMINISTER SS=D DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by \$483.21(b)(2/ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff falled to assess one of 22 residents for self-administration of medications. Resident #13 was left unsupervised during a nebulizer treatment without a prior assessment to determine if the resident was safe to self-administer the medication. The findings include:					94 SOUTH AVENUE	
An unannounced Medicare/Medicaid standard survey was conducted on 1/24/17 through 1/26/17. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 117 certified bed facility was 103 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents # 1 through 18 and 22) and three closed record reviews (Residents # 9 through 21). F176 483.10(c)(7) RESIDENT SELF-ADMINISTER SS=D DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. F176 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, facility document review and clinical record review, the facility staff failed to assess one of 22 residents for self-administration of medications. Resident #13 was left unsupervised during a nebulizer treatment without a prior assessment to determine if the resident was safe to self-administer medication no changes to current plan of care required. The findings include:	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
ARORATORY DIRECTOR'S OR DECOMPEDISHED DIRECTOR'S SIGNATHER.	F 176 SS=D	An unannounced Narvey was conduct 1/26/17. No complications are requirements are requirements. The survey/report will for the census in this 103 at the time of the consisted of 19 curror (Residents # 1 through closed record review 21). 483.10(c)(7) RESID DRUGS IF DEEME (c)(7) The right to some the interdisciplinary §483.21(b)(2)(ii), has practice is clinically This REQUIREMENT by: Based on observated document review and facility staff failed to for self-administration. Resident #13 was leaded to the resident #13 was leaded to the findings included Resident #13 was a self-administer the resident #13 was a self-administer #13 was a sel	Medicare/Medicaid standard fed on 1/24/17 through aints were investigated. Juired for compliance with 42 Federal Long Term Care Life Safety Code Illow. 117 certified bed facility was the survey. The survey sample rent Resident reviews ugh 18 and 22) and three was (Residents # 19 through DENT SELF-ADMINISTER D SAFE elf-administer medications if team, as defined by as determined that this appropriate. It is not met as evidenced ion, staff interview, facility and clinical record review, the assess one of 22 residents on of medications. eft unsupervised during a without a prior assessment to ident was safe to medication.	F 17	of Correction does not consider admission or agreement by the protection the truth of the facts alleged or consist forth on the Statement of Deficion This Plan of Correction is prepared executed solely because required provisions of Health and Safety Section 1280 and 42 405.1907 F - 176 Deficiency Correcte (c)(7) The right to self-admedications if the interdisciplinary 483.21(b)(2)(ii), has determined the practices clinically appropriate. 1) How Corrective action was accomplished for those found to been effected. Resident #13 was reviewed interdisciplinary team on 2/1/17 and determined that it is not appropriate time for her to self-admedications. 2) How corrective action was accomplished for those having put to be affected by the same practice. Current residents with Not treatments were audited by Interdisciplinary Team on 2/6 determine ability to self-admedication no changes to current.	onstitute vider of clusions ciencies. d and/or by the y Code C.F.R. 2/24/17 minister y team, hat this vill be to have by the d it was e at this minister vill be otential ce. ebulizer y the i/17 to minister

ABORATORY DIFECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Hamis rulor

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE **AVANTE AT HARRISONBURG** HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 176 | Continued From page 1 F-176 Continued F 176 3) What measures will be put into place 10/1/15 with a re-admission on 11/25/16. or systemic changes made to ensure that Diagnoses for Resident #13 included heart the deficient practice will not occur. failure, Alzheimer's, anxiety, depression, In-services were initiated on 1/27/17 for pneumonia and COPD (chronic obstructive current licensed staff to include proper pulmonary disease). The minimum data set visualization of resident during nebulizer (MDS) dated 12/6/16 assessed Resident #13 with treatment and staff will remain with severely impaired cognitive skills. resident until nebulizer treatment is completed. The Unit manager or designee During the initial tour of the facility on 1/24/17 at will randomly observe the administration 1:50 p.m., Resident #13 was observed seated in her wheelchair in her room. The resident had a of the nebulizer treatment weekly times 4 weeks then randomly thereafter reporting nebulizer mask in place with the nebulizer machine running. There were no staff members findings to the Director of Nursing. in the room. Resident #13's roommate asked at this time if someone could check the resident 4) How the facility plans to monitor its because she thought all the medicine was gone performance to make sure that solutions in the mask as it had been running for "guite are sustained. awhile." The Director of Nursing or designee will review reports weekly 4 times four weeks Resident #13's clinical record documented a reporting findings to the monthly Quality physician's order dated 1/18/17 for Albuterol Assurance Committee and then randomly Sulfate nebulizer solution 0.083% to be as needed based on the ۸r administered via nebulizer four times per day for recommendations of the Quality shortness of breath associated with COPD. The Assurance Committee. record documented no assessment regarding the resident's ability to safely self-administer any medications. There was no physician's order or care plan entries regarding self-administration of medications.

On 1/25/17 at 9:30 a.m. the licensed practical nurse (LPN #1) administering medications to Resident #13 was interviewed about the resident being unsupervised with the nebulizer treatment. Concerning the resident's ability to self-administer the nebulizer medication, LPN #1 stated, "Each

[self-administration]." When asked if the resident had been assessed to self-administer medicines.

nurse makes the call about that

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	hospice." LPN #1 s mask on the resider stayed "across the last was sometimes the mask in place distated, "Sometimes on 1/25/17 at 9:35 at (DON) was interview. Resident #13 to self DON stated the numeroritoring the resider treatments. The DO assessment had be Resident #13 was s medications. On 1/2 stated Resident #13 while receiving the resider abilities, to determine that assess each resider abilities, to determine that self-administer medical administer the resider administer the resider administrator and directing on 1/25/17 at 125/17 at 125/	She [Resident #13] is on tated she usually put the nt, started the machine and nall." LPN #1 stated Resident is non-compliant with leaving uring the treatment. LPN #1 she will take off the mask." a.m. the director of nursing wed about an assessment for fadminister medicines. The ses were supposed to be ents during nebulizer DN stated no prior en completed indicating afe to self-administer 27/17 at 9:45 a.m. the DON should have been observed rebulizer treatment. Ittled Self-Administration of 1st 2012) stated, "Residents in 1to self-administer their so, if it is determined that doing so As part of their ne staff and practitioner will nt's mental and physical e whether a resident is nistering medications If the a resident cannot safely cations, the nursing staff will ent's medications"	F 17				
	483.20(d);483.21(b)(COMPREHENSIVE		F 279	9 F - 279 Deficiency Co	rrected	2/24/17	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM): 01/31/2017 1 APPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	assessments complemenths in the resideresults of the assess and revise the resideresults of the assess and revise the resideresults. 483.21 (b) Comprehensive (1) The facility must comprehensive perseach resident, consiset forth at §483.10(includes measurable to meet a resident's and psychosocial necomprehensive assecare plan must describe plan must describe for maintain the resident or maintain the resident of the provided due to the runder §483.24, §483 provided due to the runder §483.10, includereatment under §483.	cust maintain all resident leted within the previous 15 ent's active record and use the sments to develop, review ent's comprehensive care Care Plans develop and implement a con-centered care plan for stent with the resident rights c)(2) and §483.10(c)(3), that e objectives and timeframes medical, nursing, and mental eds that are identified in the essment. The comprehensive ribe the following - are to be furnished to attain ent's highest practicable in psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized	F 2	279	F – 279 Deficiency Correcte (d) Use. A Facility must maintain resident assessments completed with the previous 15 months in resident's active medical record use the results of the assessment develop, review and revise resident's comprehensive care plant. 1) How Corrective action will accomplished for those found have been effected. Resident #9's comprehensive care was updated on 1/25/17 to reappropriate plan of care for videficits. 2) How corrective action will accomplished for those has potential to be affected by the spractice. MDS staff completed an audit 2/5/17 for current resident care plant triggered for vision; wappropriate care plans were update necessary. 3) What measures will be put place or systemic changes madensure that the deficient practice not occur. In-service was completed for the 1 staff on 2/1/17 including Care review, revision and implemental Random care plan audits by MD	n all within the and ts to the in. I be it to plan effect risual is ame into le to will MDS Plan tion. Is or	
	provide as a result of	s the nursing facility will PASARR a facility disagrees with the			Designee will be completed on week for four weeks reporting find to the Director of Nursing for fol	lings	

up.

	OF CORRECTION	IDENTIFICATION NUMBER:		NG		DATE SURVEY COMPLETED
		495146	B. WING_			01/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, 94 SOUTH AVENUE HARRISONBURG, VA 2280	ZIP CODE	0112012017
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F 279	rationale in the resident (iv) In consultation we resident's represent (A) The resident's godesired outcomes. (B) The resident's purpose future discharge. Fawhether the resident community was assolical contact agence entities, for this purpose (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on staff interview, the facility stromprehensive care Resident # 9. Resident # 9 did not plan to include vision. Findings include: Resident # 9 was act with a readmission of including Optic atropherve).	ARR, it must indicate its dent's medical record. with the resident and the tative (s)- poals for admission and reference and potential for acilities must document it's desire to return to the essed and any referrals to less and/or other appropriate pose. In the comprehensive care in accordance with the rith in paragraph (c) of this is not met as evidenced traff failed to develop a plan for one of 22 residents, thave a comprehensive care	F 27	F-279 Continued: 4) How the facility pits performance to solutions are sustain. The Director of Nurwill review reports of weekly 4 times four findings to the massurance Committee recommendations of Assurance Committee.	make sure that ed. sing or designee of MDS findings weeks reporting nonthly Quality tee and then ed based on the f the Quality	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
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F 280	reference date) of assessed as being Resident # 9's elect 1/24/17 and evident dated 4/5/16, section triggered for a care weakening of the order weakening of the order weakening of the order wision as this survey in Resident # 9's clin Resident # 9's clin Resident # 9's clin Resident # 9 had trideveloped for vision MDS coordinator, the triggerence on 1/26 483.10(c)(2)(i-ii,iv,v) PARTICIPATE PLANT 483.10 (c)(2) The right to pand implementation plan of care, including the right to be included in the prequest meetings are visions to the person to the person of	ent with an ARD (assessment 1/10/17. Resident #9 was moderately cognitively intact. Itronic record was reviewed on ced, via comprehensive MDS on "V" that Resident #9 had plan for vision due to plan for was unable to review this nical record. a.m. the DON verbalized that iggered for a care plan to be a but was overlooked by he herefore not completed.	F 279	F – 280 Deficiency Corre 483.10 (C)(2) The right to participate	e in the on of his are will be to have updated of eye updated deels up esident's dated on n of care	7

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		E SURVEY PLETED
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F 280	amount, frequency, other factors related plan of care. (iv) The right to recincluded in the plan (v) The right to see right to sign after si of care. (c)(3) The facility shright to participate in shall support the replanning process must be resident representation (ii) Facilitate the inclusion resident representation (iii) Include an assess trengths and need (iiii) Incorporate the cultural preferences 483.21 (b) Comprehensive (2) A comprehensive (iii) Developed within the comprehensive	d outcomes of care, the type, and duration of care, and any ed to the effectiveness of the seive the services and/or items of care. The care plan, including the ignificant changes to the plan seident of the in his or her treatment and esident in this right. The nust Substantial services and/or items of care. Substantial services and/or items of the resident of the in his or her treatment and esident in this right. The nust Substantial services and/or active. Substantial services and/or items of the resident and/or active. Substantial services and/or items of the resident and/or active. Substantial services and/or items of the resident and/or active. Substantial services and/or items of the care plan must be and active active active and active active active and active acti	F 28	F-280 Continued: 2) How corrective action accomplished for those potential to be affected by practice. Residents who currently have orders for eye drops were ensure their care Plan were reflected eye drop use. Residents who currently have orders for use of a "heels were audited to ensure their were updated and reflected placement and use. Current residents who have orders to address either right contractures were audited to their care plan reflected interventions. 3) What measures will be place or systemic change ensure that the deficient p not occur. In-service was completed for staff on 2/1/17 including review, revision and implement and once a week for then randomly thereafter. Au	y the same ye physician audited to updated and ye physician up cushion" r Care Plan appropriate e physician or left hand ensure that appropriate the put into s made to uractice will or the MDS Care Plan lementation. e for will be four weeks udit findings Director of	

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE **AVANTE AT HARRISONBURG** HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE F-280 Continued: CIENCY) F 280 Continued From page 7 4) How the facility plans to monitor its F 280 performance to make sure that solutions are sustained. (B) A registered nurse with responsibility for the The Director of Nursing or designee will resident. review audit reports findings weekly for four weeks and report findings to the (C) A nurse aide with responsibility for the monthly Quality Assurance Committee resident. and then randomly or as needed based on the recommendations of the Quality (D) A member of food and nutrition services staff. Assurance Committee. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced. Based on observation, staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for three of 22 residents in the survey sample, Residents #4, #3 and #1.

placement.

1. Facility staff failed to update Resident #4's CCP for the use of eye drops, intermittent self catheterization, ambulation and call bell

Facility staff failed to revise the CCP for

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, Z 94 SOUTH AVENUE HARRISONBURG, VA 22801	IP CODE	112012011
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	Resident #3 to included ROM (range of mot contracture. Findings included: 1. Facility staff failed CCP for the use of catheterization, amb placement. Resident #4 was or on 06/03/2013 and diagnoses including Hypertension, Depre Bladder, Urinary Reperipheral Vascular. The most recent ME significant change at (assessment reference Resident #4 was as impaired in her cogrecognitive score of 10 Resident #4's CCP of 7:30 a.m. The focus function included 11 ordered. Subseque current physician or 01/31/17 and Januar	ide use of a foot in up in a wheelchair. ed to include interventions for ion) to Resident #1's hand ed to update Resident #4's eye drops, intermittent self pulation and call bell iginally admitted to the facility readmitted on 12/20/2016 with it, but not limited to: ession, Anxiety, Neurogenic tention, Polyosteoarthritis and Disease. OS (minimum data set) was a essessment with an ARD ince date) of 01/10/2017. sessed as moderately nitive skills with a total	F 2			
	for eye drops or any drops.	administration record of eye area of "Intermittent				

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY 94 SOUTH AVENUE HARRISONBURG, V	Y, STATE, ZIP CODE	<u> </u>
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	catheterization r/t Urinary retention" intervention, "Inter (physician) order ADL's (activities of and revised on 05, stated, "Toilet Us as needed" The not include any ord catheterization by The focus area of Deficit" dated 06 included these inter ambulates with as 07/18/13, revised Resident #4 prefer the privacy curtain survey conducted Resident #4 was no or ambulating. Re on 01/24/17 at 3:19 and 01/26/17 at 8:19 and 01/26/17 at 8:19 and 01/26/17 at 8:19 was attached to he during all three obs The Administrator were informed of the meeting with the si approximately 4:30 interviewed regard updating care plan nurses." No further informat team prior to the ex-	(related to) dx (diagnosis) of dated 06/14/2013 was an rmittent self cath per MD" Also under the focus area of f daily living) dated 06/04/13 i/13/16 was an intervention that se: resident performs self cath courrent physician orders did der or instructions for self Resident #4. "ADL Self Care Performance 6/04/13 and revised on 05/13/16 erventions: "Ambulation: sist of 1 (one) person" dated 11/14/13 and "(Name) rs to have call bell hanging on on" dated 04/08/16. During the 01/24/17 through 01/26/17 never observed out of the bed esident #4 was observed in bed 0 p.m., 01/25/17 at 7:30 a.m. 30 a.m. Resident #4's call bell er bed sheet by her pillow	F 2	280		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE 94 SOUTH AVENUE HARRISONBURG, VA 228	, ZIP CODE	112012011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 280	Resident # 3 was a 01/14/13, with the r 12/05/16. Diagnos but were not limited mellitus), arthritis, a The most current for was an annual asso (assessment refere resident was assess score of 15, indicate cognitively intact for The resident was a for pressure and tri assessment summ Resident # 3 was of approximately 3:30 resident was sitting cushion in the seat with her feet resting. The resident was of a.m., lying flat in he shoes. The resident to get her up with the Two staff members lift and got Resident resident was again the floor. Resident # 3's clinical The resident's current resident resident's current resident	admitted to the facility on most current readmission on sis for Resident # 3 included, d to: anemia, DM (diabetes and renal insufficiency. full MDS (minimum data set) sessment with an ARD ence date) of 10/11/16. The seed as having a cognitive ting the resident was or daily decision making skills. Also assessed at being at risk iggered in the CAAS (care area early) for pressure. Observed on 01/24/17 at 0 p.m. in her room. The g in her w/c (wheelchair), with a care to the floor. Observed on 01/25/17 at 9:30 or bed, fully dressed, including and stated that staff were about	F 2	280		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		TE SURVEY MPLETED
		495146	B. WING		01	/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIF 24 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	corporate DON (di what the heels up explained that it was floor. The DON was observations for R that she would look. At approximately 2 the information in the information in the chair. The DO department updates not taken out. No further information provided prior to that 12:00 p.m. 3. For Resident #1 update care plan to for contractures and since 2013. Resident # 1 was refered to the information of the in	-	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING			01/	26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZI 94 SOUTH AVENUE HARRISONBURG, VA 22801			
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F 280	addition, the Minim 1 requiring extensive dependence, on state (bed mobility, dress care. Resident # 1 was of approximately 9:05 observed in bed with or washcloth) in collong finger nails precontracted hand. R LPN (Licensed Pracapproximately 11:00 observed in bed with or washcloth) in collong finger nails precontracted in bed with or washcloth) in collong finger nails prechand. On 1/24/17 and 1/2 record was reviewed current physician's contracture. Reviewed Administration Record treatments for Resident than the collowing: Focus: Impaired modeft hand, bilateral keldiagnosis of hemip 9/15/2011, Created 1/16/2017 by MDS Goal: Maintain higher care.	rate cognitive impairment. In um Data Set coded Resident # ve assistance and total aff for Activities of Daily Living sing, and hygiene/bathing) bserved on 1/25/17 at a.m. Resident #1 was thout assistive device (a carrot intracted left hand with very essing against and into the esident #1 was observed with ctical Nurse) #4 on 1/25/17 at 0 a.m. Again, the resident was thout assistive device (a carrot intracted left hand with very essing against the contracted orders pertaining to left hand of the Treatment ord showed no current dent #1's contracted left hand are Plan presented by the riewed and included the obility due to contractures of nees and ankle, dx paresis. Date initiated on 9/15/2011, Revision on Coordinator.	F 2	80			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	9/15/2011, Created 1/16/2017 by MDS 4/12/2017. Interventions: Active and passive extremities PRN [as 9/15/2011 Created 9/11/2012 [nothing of Coordinator. Administer pain me painful prior to start 9/15/2011 Created 9/11/2012 [nothing of Coordinator. Encourage active papraise all efforts. Da on 9/15/2011, Revisadded] by MDS Coordinator. Encourage [Resider possible for himself care to enhance join 9/15/2011 Created 6/11/2012 [nothing of Coordinator. Explore possible usinobility. Date initiate 9/15/2011, Revision added] by MDS Coordinator. Explore possible usinobility. Date initiate 9/15/2011, Revision added] by MDS Coordinator. On 1/26/17 facility s Director of Nursing) Plan regarding Residedress observation	d on 9/15/2011, Revision on Coordinator, Target date: a range of motion of affected as needed]. Date initiated on 9/15/2011, Revision on new added] by MDS addication if range of motion is ting program. Date initiated on 9/15/2011, Revision on new added] by MDS articipation when possible and ate initiated 9/15/2011 Created sion on 9/11/2012 [nothing new ordinator. ant #1] to do as much as as much as possible during new ordinator. ant #1] to do as much as as much as possible during new ordinator. ant #1] to do as much as as much as possible during new ordinator. and #1] to do as much as as as much as possible during new added] by MDS are of assistive devices to aid ted 9/15/2011 Created on an 9/11/2012 [nothing new added] in on 9/11/2012 [nothing new added]	F 28	30		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDED/SURPLIED/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED				
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	assistive device (a contracted left hand pressing against and Focus: [Resident #* for assistance, refuse physically abusive to refuses bathing. Da on 9/13/2012 by So 8/24/2016 [nothing of Coordinator.] Goal: [Resident #1] improvements and I facility. Interventions include Explain to [Resident prior to doing it to as 9/13/2012, Created Worker, Revision or added] by MDS Coordinates. Date if on 9/13/2012 by Soordate with any new in Another focus on the presented by the fact with ADL care. Focus: [Resident #1] [related to] dx [diagn sided hemiparesis [verequires extensive a care.	carrot or washcloth) in divith very long finger nails ind into the contracted hand): If has behaviors of yelling out sing care at times, and being to staff at times, 8/24/16 ite initiated 9/13/2012, Created cial Worker, Revision on new added] by MDS will continue to show signs of have all his needs met at this led but not limited to: If #1] what you are about to do sist him. Date initiated on 9/13/2012 by Social in 10/21/2012 [nothing new ordinator. If refused in about 10-15 initiated 9/13/2012, Created cial Worker, and no revision interventions. If most current Care Plan cility staff included assistance in last an ADL care deficit r/t weakness]. [Resident #1] ssistance to complete ADL	F 28			
	Interventions include	ed but not limited to:				

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE **AVANTE AT HARRISONBURG** HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 15 F 280 Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date initiated 9/14/2011, Created on 9/14/2011 by MDS Coordinator, and no revision date with any new interventions. Bathing: Provide sponge bath on days when a full bath or shower is not given 1/16/17 [Resident #1] frequently refuses to take a shower. Date initiated 9/14/2011 Created on 9/15/2011, Revision on 1/16/2017 [nothing new added since readmission 7/15/2013 until 1/16/2017] by MDS Coordinator. The ADL task sheets were reviewed for January 2017. The ADL tasks for January 2017 included but were not limited to: Under the title "Personal Hygiene": Gentle ROM [Range of Motion] to left upper extremity and left hand/wrist daily as tolerated. Apply left carrot splint on at all times except for bathing as tolerated. These tasks were to be performed and checked Q [every] shift. On 1/26/17 a nursing note was presented by the facility Interim DON dated 10/02/2013 at 6:28 p.m. The note read, that Resident #1 had been refusing Restorative Nursing Program (RNP) care and had been removing splint after application by restorative CNAs. The note stated that Resident #1 was spoken to on this date regarding discontinuation of RNP due to refusals, and

reads, "he [Resident #1] is in agreement with this. Will refer to floor CNA for PROM [Passive Range of Motion] and application of splint as [Resident

Occupational Therapy notes were presented by the Interim DON on 1/26/17. An OT Daily

#1] will tolerate." According to a Medical Dictionary, Passive Range of Motion involves someone else moving the joint for you."

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 280	[Patient's] L [left] had a carrot for proper's Evaluation and Plar identified the follow documented physical associated function [Resident #1] is at refunction, falls, limited contractures." The dated 11/2/2014 our diagnosis (effects of on 10/30/2011 and (feeding difficulties onset date of 11/5/2 Plan of Treatment of survey findings] not contracture and other and treatment for contracture and treatment for contracture and treatment for contracture and treatment for contracture and	red 11/5/2014 read: "Pt's and is contracted and he uses splinting of L hand." An OT n of Treatment dated 2/4/2015 ing risk factors: "Due to	F 2	80		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	A review of clinical through 1/26/17 was On 11/06/2016 a no #1]yelling out con medicated without unsuccessful refuse On 12/24/16 a wee #1] to be "cooperat times, becomes agmention of PROM on Nursing Notes. On 1/25/17 at appropriate in Florida had opened." Resident because I have no going into my skin to staff] to helpthey no cream and its cooperated or a wash cloth so hands." LPN #4 als suppose to be in the hand] all the time. New years of the say, "Yes, his nails are pressing into his gently observed residents."	e high pain levels in left hand. nursing notes from 11/01/16 as conducted on 1/26/17. ote read, "[Resident instantly complained of pain and resultsredirection sed ADL care" ekly summary noted: [Resident tive with care most of the gitated periodically." No or nail care refusal in Clinical roximately 9:05 a.m. Resident d. Resident #1 stated, "I have left handthe doctor down d it better, the doctor had it #1 added, "I try to help myself therapy and yes my nails are but I don't ask them [facility [facility staff] don't do nothing,	F 28	30		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE 94 SOUTH AVENUE HARRISONBURG, VA 228	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 280	yelled in pain initial open each finger the into his contracted cooperative and will #4 added, "I would washcloth to help por On 1/26/17 at 9:13. Therapist was interwas evaluated this nursing was concerexplained that Resipain and refused R and became aggree notified nursing of the has behaviors to handed it over to not on 1/26/17 at approximate the pain and if the resistant with the resistant will be a lot, if he lets mand wash it out." Con daily and if the resistant refusal on the Ahave not had successful hurts." Owill let the nursing sand ADLs. CNA #2 did receives pain medical don't know if he is in the rapy they would of motion with him."	contracted hand. Resident #1 by but when he helped LPN #4 he wash cloth was able to go hand. Resident #1 was lling to work with LPN #4. LPN use both the carrot and the brotect his hand." a.m. an Occupational viewed. The OT stated, "He morning at 7:00 a.m. because rned about his hand." The OT ident #1 complained of a lot of OM and refused the carrot ssive. The OT stated, "I the pain and the refusal, I feel to not allow anything so I ursing." oximately 9:30, CNA #2 (works esident #1 on the day shift) NA #2 stated, "He won't let you he, I put the carrot in his hand NA #2 explains that she tries dent refuses she will document ADL log. CNA #2 stated, "I hes with nailsfor quite a te you to touch his hands CNA also explained that she estaff know if he is in pain after not know when Resident #1 cation. CNA #2 also stated, "I n restorative therapyask knowand no I don't do range	F 2	280			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		ATE SURVEY MPLETED
		495146	B. WING _		0.	1/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP 94 SOUTH AVENUE HARRISONBURG, VA 22801		
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F 280	OT evaluation." LPI Resident #1 often. talk with the resider not want anything for would try 2 to 3 time refused. LPN #1 sa weeks ago and the LPN #1 stated, "Froof life for him [Resident moments of life for him [Resident moments of life for him [Resident moments of life for him simple communicate with too ther avenues, like medications at 7:30 use Norco for bread or use the Aspercreplacing the carrot, a MCGs (Micrograms A final interview was 9:45 a.m. with Resident #1 said, "I the carrot] and "I was cut regularly]." Resident #1 said, "I the carrot] and I want don't trust them [facileft hand] is really put they don't listen." On 1/26/16 at approwas interviewed and for Resident #1 and watch the nails while he would get nervote would get nervote the said of the would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote the said of the would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was interviewed and for Resident #1 and watch the nails while he would get nervote was and the property was interviewed and the watch the nails while he would get nervote was and the property was not was a watch the nails while he would get nervote was a watch the nails while he was a watch the nails while he was a watch the nails was a watch the nails while he was a watch the nails was	I put a note in regarding he N #1 does not work with LPN #1 said she went in to not around 7:45 a.m. and he did for pain. LPN #1 said she less to assist with pain if he lid, "I spoke with family a few by feel he may be giving up." from here I would look at quality dent #1], talk with family, keep laybe talk with the doctor about ativan because liquid is easy to liquid his life so I am going to the doctor or NP to explore	F 28			

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE **AVANTE AT HARRISONBURG** HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 280 Continued From page 20 F 280 refuses care. The care plan did not reflect any new interventions or attempts or approaches to Resident #1's left hand contracture/ ROM since. Only one Social Work Resident Progress Review was presented regarding Resident #1's behaviors dated 1/5/2016 and when asked for an updated review, the DON stated, "We have none." No policies were presented regarding updated care plans. The facility administration was informed of the findings during a briefing on 1/26/17 at approximately 11:00 a.m.. The facility did not present any further information about the findings. F 281 483.21(b)(3)(i) SERVICES PROVIDED MEET F 281 SS=E PROFESSIONAL STANDARDS F – 281 Deficiency Corrected 2/24/17 (b)(3) Comprehensive Care Plans (b)(3) Comprehensive Care Plans The services provided or arranged by the facility. as outlined bv The services provided or arranged by the facility. comprehensive care plan, must, as outlined by the comprehensive care plan. (i) Meet professional standards of mustquality. Meet professional standards of quality. 1) How Corrective action will be This REQUIREMENT is not met as evidenced accomplished for those found to have been effected. Based on observation, staff interview, clinical Resident #14's Medication regimen was record review and facility document review, the reviewed & updated by the attending facility staff failed to follow professional standards

of nursing practice for three of 22 residents in the

1. The facility staff failed to follow manufacturer's

instructions for the administration use of single

dose diazepam syringes for Resident # 14; the facility staff accessed the single dose units multiple times putting the medication at risk for

survey sample, Resident #14, #17 and #18.

physician on 1/25/17. Upon further

Physician review the medication was

re- education on the proper medication

discontinued. Resident #17's and Resident #18's nurses' were given 10n1

administration on 2/2/17.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 281	 During observat and Pour, medication on the resident's be took the medication without being observation. During the observation of the pour, the admit back to Resident # 	the resident at risk of infection. tion of the Medication Pass ions for Resident # 18 were left edside table. The resident ns without supervision and erved by the administering ervation of the Medication Pass inistering nurse turned her 17, leaving an aerosol spray onate) on the bedside table	F 2	81	F-281 Continued: 2) How corrective action accomplished for those potential to be affected by the practice. The facility has determined current residents have the potential affected. In-services initiated or for current licensed nursing included proper administration of dose vial medications as per manguidelines and observation medications until consumpticompleted, this will be included or of new licensed staff. 3) What measures will be presented the section of the	that all ial to be a 2/7/17 staff to of single ufacture of all ion is aded in .		
	instructions for the adose diazepam syrifacility staff accessed multiple times putting contamination and to the Resident # 14 was a 06/14/14, with the mos/15/15. Diagnose but were not limited disorder, psychotic disorder, psychotic seizure disorder. The most current M quarterly assessme assessed the reside of 6, indicating the most current of	failed to follow manufacturer's administration use of single inges for Resident # 14; the ed the single dose units ng the medication at risk for the resident at risk of infection. admitted to the facility on most current readmission on es for Resident # 14 included, I to: dementia, anxiety disorder, schizophrenia, and ADS (minimum data set) was a ent dated 11/08/16, which ent as having a cognitive score resident had severe decision making skills.			place or systemic changes mensure that the deficient pract not occur. The Unit Manager or designee we during a weekly medication observation weekly times 4 we determine compliance with adher proper medication administration protocol weekly times 4 weeks refindings to the Director of Nursappropriate follow-up. 4) How the facility plans to more performance to make sure solutions are sustained. The Director of Nursing or design review reports weekly 4 times weeks reporting findings to the a Quality Assurance Committee a randomly or as needed based	ill audit n pass eeks; to rence to istration eporting sing for nitor its e that nee will es four monthly nd then		

On 01/25/17 the facilities medication carts on A

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'''	X2) MULTIPLE CONSTRUCTION L. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 281	RN (Registered N the process for na stated that first shensure the order, narcotic log book cart and turns to the medication, verified drawer and retrieving the book and the RN # 2 was asked 2 opened the narch Resident # 14's paraged drawer and retrieving the book and the RN # 2 was asked 2 opened the narch Resident # 14's paraged drawer and [midicate the amour pen/syringe was of the process of milling in the pen left in this bag is what is left of the pen l	ved at approximately 11:15 a.m. Nurse) # 2 was asked to explain arcotic administration. RN # 2 he looks at the computer to then retrieves the 'sign out' from the side of the medication the resident's page for that es and then opens the narcotic ves the medication, sign's it out hen administers it. In to give a demonstration. RN # cotic book and turned to age. age listed the drug as edule IV/4 medication] with lure hilligrams/milliliter] DISP SYRIN INTRAMUSCULAR NOW * ML) EVERY 30 MIN AS DAYS FOR SEIZURES" The date received, 11/14/16 received), 5 pens/syringes-10		281				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP 94 SOUTH AVENUE HARRISONBURG, VA 22801	<u></u>	The View 1.	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
F 281	administered to the then asked how the medication and was standard syringe to the glass syringe or end of the glass syringe or end of the glass syringe or end of the glass syringe who that this The RN was asked what is needed and medication back in The RN stated, "It leasked to provide a for this medication. would notify pharmafaxed. At approximately 12 pharmacist and the nursing) were asked findings and to claribe used as a multiple the medication from and handed the medication from and handed the medication from and handed the medication from the pharmacist states that would be a sing was then taken out removed, there was the pharmacist the should actually say went on to say, "It distated that the rest in the glass syringe or the glass syringe of	e resident). The nurse was ey (staff nurses) administer this as asked if the nurses use a of draw the medication out of or do they put a needle on the wringe and administer that way. Well it's IM [intramuscular], I have never administered it inge] before." was observed again and did mation on the actual package is was a multi dose syringe. If if they (staff nurses) just use of then store the unused in the cart for the next dose. Hooks that way." The RN was manufacturer's package insert in the RN stated that she hacy to have the information 2:15 p.m., the facility e corporate DON (director of ed to observe the above rify if the glass syringe was to dose vial. RN # 2 removed on the locked narcotic drawer edication to the pharmacist. ated, "If it has a needle then gle dose." The glass syringe it of the plastic tube and the top	F 28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495146	B. WING		0.	1/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZII 94 SOUTH AVENUE HARRISONBURG, VA 22801			
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 281	for the above medical package insert info Supplied: Carpujed Luer LockConcer ml)Carpuject [TM cartridge with Luer System" Upon further review sheet for diazepam count of this medical between 12/29/16 arecord of administration being wasted. At approximately 3: and concerns were administrator and of that the medication been accessed one medication should livere single dose medication countre unaccounted for 0.3 Resident # 14. At approximately 4: stated that the facilitias requested above subscription to a nufacility) uses for reference titled, "Injectal Administration", wa "The Association"	ered on 01/16/17. 2:30 p.m., the package insert cation was presented. The rmation documented, "How ct Sterile Cartridge Unit with ntration 10 mg/2 ml (5 mg/1 l/trademark], Single-dose Lock for the Carpuject Syringe Lock for the Carpuject Syringe was found that the narcotic ation was off by 0.3 ml and 01/06/17, there was no ation or of the medication 30 p.m., the above information discussed with the orporate DON. Both agreed syringe should only have a time and then any remaining have been wasted, since these redication units. No ovided regarding the econciliation of the sml of the diazepam for 15 p.m., the corporate DON ty did not have specific policy, a but did have a paid ursing resource that they (the erence and presented an	F 2	B1			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		=	(X3) DATE SURVEY COMPLETED	
		495146	B. WING			01/2	6/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, S' 94 SOUTH AVENUE HARRISONBURG, VA	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROP FICIENCY)	BE	(X5) COMPLETION DATE
F 281	World Health Organsingle-use or single possible. A multido transmission by ina follow manufacture use of medication with the date immereduce the risk of codispense parentera vialsyou should othere's no alternative labeled by the manufisingle use" for a simedications lack arcan become contaminative administered administration"	age 25 anization recommend using e-dose vials whenever ose vial poses a risk of appropriate handlingAlways er's instructions for storage and vials and label multidose vials ediately upon opening. To contamination, most facilities al medications in single-dose only use multidose vials only if weYou should use vials nufacturer as "single dose" or single patient only. These antimicrobial preservatives and minated and serve a source of appropriatelyRecord the d, injection site, and time of tion or documentation was see exit conference on 01/26/17	F 2	281			
	6/30/17. Diagnoses but are not limited to depression, hyperte reflux disease, and #18's Minimum Data protocol) with an As 1/3/17 coded Residindependent and no addition, the Minimum	ras admitted to the facility on es for Resident #18 included to urinary retention, infection, ension, gastroesophageal I overactive bladder. Resident ta Set (an assessment ssessment Reference Date of dent #16 as modified o cognitive impairment. In um Data Set coded Resident rvision for Activities of Daily					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	LTIPLE CONSTRUCTION DING		ATÉ SURVEY OMPLETED
— <u>. </u>		495146	B. WING		_ 0	1/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STA 94 SOUTH AVENUE HARRISONBURG, VA 22	ATE, ZIP CODE	If the Western Co.
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 281	Medication Administurned her back and least 3 minutes lead bedside table and F without supervision medication administurned her back and least 3 minutes lead bedside table and F without supervision medication administed on 1/25/17, Reside reviewed. The reviewed. The reviewed. The reviewed. The reviewed. The reviewed. Resident #18 pills: 1. Flomax Capsule capsule by mouth on retention. 2. Doxycycline Hycl tablet by mouth one day and give 1 tablet for infection for 10 of 3. Duloxetine HCL (Release Particles 3 mouth one time a doubt one time a doubt one time a doubt one time a day for h5. Omeprazole Tablet 2 one time a day for h5. Omeprazole Tablet Give 20 MG by mouth of the supervision of the control of	roximately 8:08 a.m. during stration Observation LPN #2 and washed her hands for at aving a cup with 7 pills on the Resident #18 took the 7 pills and LPN #2 did not observe the stration. LPN #2 did not observe the stration or ders ough 1/25/2017. The orders ough 1/2	F 2	81		
		l) was interview as she was				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		ONSTRUCTION		ATE SURVEY OMPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE	D BE	(X5) COMPLETION DATE
F 281	the DON (Director of to the current interior "Residents are to bo "nursing should be are in reach of resides currently care plasmedications." On 1/26/17 at approximate (Licensed Practical #2 agreed that she Resident #18 to wa #18 took 7 pills place the resident. LPN # residents when giving why do you watch remedications LPN #2 [pills] are taken and some [pills] and the [residents] don't missome [pills] and the [residents] don't missome (pills) are taken and some [pills] and the [residents] don't missome [pills] and the [residents] don't missome (pills) are taken and some [pills] and the [residents] don't missome [pills] and the [residents] don't missome [pills] and the staff to watch resident #17 at approximate the staff to watch resident #17 as more cognitive impairment Data Set coded Resextensive assistance care.	of Nursing) at the facility prior im DON. RN #1 stated, be kept in sight of nursing" and a watching while medications ident." RN #1 added, "No one anned to self administer roximately 9:20 a.m. LPN#2 of Nurse) was interviewed. LPN as had turned her back on ash her hands while Resident aced on the bedside table near aced on the state of the same successful on the same successful of the same successful on the same s	F 2	81			
	On 1/25/17 at appro	oximately 8:30 a.m. during)				li .

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495146 B WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE **AVANTE AT HARRISONBURG** HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 281 Continued From page 28 F 281 Medication Administration Observation LPN #1 turned her back and stood at the medication cart at the door for at least 5 minutes leaving medication (Fluticasone Propionate Aerosol Spray) at the bedside table within reach of Resident #17. On 1/25/17, Resident #17's clinical record was reviewed. The reviewed showed physician orders dated 1/1/2017 through 1/25/2017. The order read, Resident #17 was to get: Fluticasone Propionate HFA Aerosol, 1 spray alternating nostrils two times a day for Allergic Rhinitis (hay fever-inflammation of the nose). On 1/25/17 at approximately 8:45 a.m, LPN #1 was interviewed. LPN #1 stated, "Yes I did turn my back on the resident and left the spray at bed side." LPN #1 added, "I should not have done that." On 1/25/17 at approximately 3:15 p.m. the MDS Coordinator (RN #1) was interview as she was the DON (Director of Nursing) at the facility prior to the current interim DON. RN #1 stated, "Residents are to be kept in sight of nursing" and "nursing should be watching while medications are in reach of resident." RN #1 added, "No one is currently care planned to self administer medications." On 1/26/17 at approximately 9:25 a.m. the Interim DON stated that the expectation was for nursing

staff to have eyes on the resident at all times and

The Lippincott Manual of Nursing Practice 10th edition states on page 16 concerning standards of nursing care, "Legal claims most commonly

never leave medication at the bed side.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
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F 281	made against profe following departure failure to assess the fashion, follow phys appropriate nursing information about the policy or procedure information in the medications as ordereference states constandards of care in observe a patient is administer medication fashion or to report appropriately Fail is action or adverse facility policy or procedure.	ssional nurses include the s from appropriate care: e patient properly or in a timely sician orders, follow measures, communicate ne patient, adhere to facility, document appropriate nedical record, administer ered "Page 17 of this mmon departures from aclude, "Failure to monitor or s clinical status Failure to ons properly and in a timely and administer omitted doses ture to observe a medication 'effect Failure to adhere to be dural guidelines "(1)	F 281			
SS=D	The facility administ findings during a bri approximately 11:00 present any further 483.24, 483.25(k)(l) FOR HIGHEST WE 483.24 Quality of life Quality of life is a fu applies to all care at residents. Each res facility must provide services to attain or	o a.m. The facility did not information about the findings. PROVIDE CARE/SERVICES LL BEING and amental principle that not services provided to facility ident must receive and the the necessary care and maintain the highest, mental, and psychosocial	F 309	F-309 Deficiency Correct 483.24 Quality of Life Quality of life is a fundamental pr that applies to all care and so provided to facility residents. Resident must receive and the must provide the necessary car services to attain or maintain the l practicable physical, mental psychosocial Well-being, consistent the resident's comprehensive assessand plan of care.	inciple ervices Each facility re and highest and ant with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION ULDING		(X3) DATE SURVEY COMPLETED	
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F 309	483.25 (k) Pain Management The facility must en provided to resident consistent with profit the comprehensive and the residents' (greater) (I) Dialysis. The facility staff failed to assess residents who required practice, the compact care plan, and the preferences. This REQUIREMENT by: Based on observation in the sure of practice and clinical staff failed to assess residents in the sure of the facility staff failed assessment for Resident in the sure of the facility staff failed assessment for Resident in the sure of the facility staff failed assessment for Resident in the sure of the facility staff failed assessment for Resident in the sure of the facility staff failed assessment for Resident in the sure of the facility staff failed assessment for Resident in the sure of the facility staff failed to assess the facility of the facility staff failed to assess the facility staff failed to assess the facility of the facility staff failed to assess the facility of the facility staff failed to assess the facility of the facili	sessment and plan of care.	F 3	F-309 Continued: 1) How Correct accomplished for been effected. Resident # 6's s completed on interventions were 2) How correct accomplished f potential to be a practice. An audit of cu completed on 2 validated complian assessment protoco 3) What measu place or systemi ensure that the d not occur. In-services for cur initiated on 2/7/17 timely completion assessment and compliance. The designee will morprotocol compliance four weeks with re	tive action will be those found to have skin assessment was 1/26/17, no further required. tive action will be for those having affected by the same arrent residents was 2/6/17. The audit nee with weekly skin ols. res will be put into ic changes made to deficient practice will rent licensed staff was to include proper and a of a weekly skin facility protocol Unit Manager or nitor skin assessment ce 5 times a week for porting of the findings of Nursing for		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING	i		01	/26/2017
NAME OF PROVIDER OR SUPPLIER AVANTE AT HARRISONBURG			94	REET ADDRESS, CITY, STATE, ZIP COL SOUTH AVENUE ARRISONBURG, VA 22801			
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	resident as having impairment with sidecision making sassessed as requivate for all ADL's (including transfers). On 01/25/17 at ap # 6's husband require this interview their regarding Resident resident's left great the resident's hustoe had become reported it approxis (Registered Nurse on to say that he the communicated, under January 22, 2017 worse. The husbangain. The husbangain. The husbangain. The husbangain. The husbangain that it was just approximately 2 removed the resident reported sevupset that it was just approximately 2 removed the resident's toes. The slightly swollen, with of the toe, close to yelled out, "Ouch" husband again stated been several that it was provinced the resident out, "Ouch" husband again stated been several that it was provinced the resident out, "Ouch" husband again stated been several that it was provinced the resident out, "Ouch" husband again stated been several that it was provinced that it was province	g long and short term memory severe impairment in daily skills. The resident was also uiring extensive assistance from (activities of daily living) s, dressing and hygiene. Oproximately 2:15 p.m., Resident quested an interview. During husband brought up concerns int # 6, specifically regarding the at toe. Sband stated that the resident's red and sore and that he had simately 3 weeks ago to RN e) # 3. The husband then went thought the this issue had been intil he came in to on Sunday and the toe actually looked and stated that he reported it and stated that his wife was s on Monday, January 23 and stated that the NP (nurse come to see it and that he (the did to the NP that this had actually veral weeks ago and was very		309	F-309 Continued: 4) How the facility plans to performance to make solutions are sustained. The Director of Nursing or dreview monitoring audit rep for -four weeks, reporting firmonthly Quality Assurance and then randomly or as need the recommendations of Assurance Committee.	lesignee will corts weekly adings to the Committee ded based on	

resident received two baths per week, as well and

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have."

nurse was asked, why a skin assessment sheet was not completed at that time. The wound care nurse stated, "I was looking at it every day." The

wound care nurse was asked why that information would not be documented to let everyone know there was an issue with the resident's toe and to document the progress of the toe. The wound care nurse stated. "I should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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AVANTE AT HARRISONBURG					.20,2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	wounds. A policy on "Preven presented and revied documented, "were performed by nursir will be addressed by required" The administrator and nursing) were made Resident # 6's skin completed as orderstreatment. No further information presented prior to the 1/26/17 at 12:00 not 483.24(a)(2) ADL C. DEPENDENT RESI (a)(2) A resident what activities of daily living services to maintain personal and oral hy This REQUIREMEN by: Based on observation interview, facility doc clinical record review provide nail care for (Resident # 1). The	tion of Pressure Ulcers" was ewed. The policy ekly skin assessment will be not staff and any issues noted by a Physician or designee as a mid corporate DON (director of a aware of concerns regarding assessment not being ed, which resulted in delayed on or documentation was not exit conference on bon. ARE PROVIDED FOR DENTS o is unable to carry out not receives the necessary good nutrition, grooming, and regiene. IT is not met as evidenced fon, resident interview, staff cumentation review, and w, the facility staff failed to one of 22 residents. facility staff failed to provide to 1/11/2017 to 1/26/2017.	F 312	F – 312 Deficiency Corrects (a)(2) A resident who is unable to out activities of daily living receiv necessary services to maintain nutrition, grooming, and persons oral hygiene. 1) How Corrective action w accomplished for those found to been effected. Resident # 1's fingernails were tri on 1/26/17 by facility nurse. 2) How corrective action w	o carry ves the good al and ill be o have immed ill be having same esident 17 and	2/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, '	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER AVANTE AT HARRISONBURG				94	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVENUE ARRISONBURG, VA 22801			
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F 312	7/15/2013. Diagno but are not limited to (history of a stroke) (left), hemiplegia (do osteoarthritis, depropsychosis not due to physiological conditional Set (an assess Assessment Refere Resident # 1 with inthinking with moder addition, the Minimal requiring extensive dependence, on state (bed mobility, dress care. Resident # 1 was of approximately 9:05 observed in bed with or washcloth) in corrected hand. Resurveyor with LPN (on 1/25/17 at approximately 4:00 number of the contracted hand. Resident #1 was observed in left hand. On 1/24/17 and 1/2 record was reviewed current physician's Review of the Treat showed no current:	e-admitted to the facility on ses for Resident # 1 included to cerebrovascular disease of the contracture unspecified hand one side weakness), pain, ession, and unspecified to a substance or known tion. Resident # 1's Minimum sment protocol) with an ence Date of 1/3/17 coded nattention and disorganized rate cognitive impairment. In turn Data Set coded Resident # we assistance and total aff for Activities of Daily Living sing, and hygiene/bathing) bserved on 1/25/17 at a.m. Resident #1 was thout assistive device (a carrot intracted left hand with very essing against and into the esident #1 was observed by (Licensed Practical Nurse) #4 eximately 11:00 a.m. Again, the eved in bed without assistive washcloth) in contracted left finger nails pressing against d. On 1/26/2017 at 9:45 a.m. observed with nails cut and the event of the event with the event w	F	312	F-312 Continued 3) What measures will be place or systemic changes ensure that the deficient pranot occur. In-service was initiated on 2/current nursing staff to inclunail care during ADL's and indicated, the CNA will refer to the nurse for appropriate into The Unit Manager or designee 5 residents for compliance with protocols, no less than 5 days a 4 weeks of nail observation compliance findings will be rethe Director of Nursing for a review and where necessary, for 4) How the facility plans to measure sustained. The Director of Nursing or desireview audit reports weekly weeks reporting findings to the Quality Assurance Committee randomly or as needed base recommendations of the Assurance Committee.	made to actice will 7/17 with de proper that when esidents to ervention will audit in nail care a week for s. Audit eported to ppropriate ollow-up. It conitor its ure that signee will for four e monthly and then		

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE **AVANTE AT HARRISONBURG** HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 312 Continued From page 35 F 312 by the facility staff was reviewed and included the following about nail care: Focus: [Resident #1] has an ADL care deficit r/t [related to] dx [diagnosis] of CVA [stroke] with left sided hemiparesis [weakness]. [Resident #1] requires extensive assistance to complete ADL care. Interventions included but not limited to: Bathing: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Date initiated 9/14/2011. Created on 9/14/2011 by MDS Coordinator, and no revision date with any new interventions. Bathing: Provide sponge bath on days when a full bath or shower is not given 1/16/17 [Resident #1] frequently refuses to take a shower. Date initiated 9/14/2011 Created on 9/15/2011, Revision on 1/16/2017 [nothing new added since readmission 7/15/2013 until 1/16/2017] by MDS Coordinator. Focus: [Resident #1] has behaviors of yelling out for assistance, refusing care at times, and being physically abusive to staff at times, 8/24/16 refuses bathing. Date initiated 9/13/2012, Created on 9/13/2012 by Social Worker, Revision on 8/24/2016 [nothing new added] by MDS Coordinator. Goal: [Resident #1] will continue to show signs of

facility.

improvements and have all his needs met at this

Explain to [Resident #1] what you are about to do prior to doing it to assist him. Date initiated 9/13/2012, Created on 9/13/2012 by Social

Interventions included but not limited to:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495146	B. WING	·	01	/26/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 94 SOUTH AVENUE HARRISONBURG, VA 22801	IP CODE	120/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 312	offer services whominutes later. Date on 9/13/2012 by S date with any new The Interim DON I Resident #1's refuunknown [no docutime Resident #1' from 1/11/17 docutime Resident #1 had reduced to cut I Shower List from 1 Resident #1 had reduced to cut I Shower List from 1 Resident #1 had reduced to cut I Shower List dated Resident #1 refuse other documentation followere made to cut I Shower List dated Resident #1 refuse other documentation attempt was made An OT Assessmen "Current value chawith pathology con CVA with L hand con date with focus on length/skin integrity report, "Patient subhand. On 1/25/17 at appr #1 was interviewed arthritis pain in my there in Florida had	on 10/21/2012 [nothing new cordinator. en refused in about 10-15 e initiated 9/13/2012, Created ocial Worker, and no revision	F3	12			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_		495146	B. WING	;		01	/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			9	STREET ADDRESS, CITY, STATE, ZIP CODE P4 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	going into my skin be staff] to helpthey no cream and its composition or a wash cloth so be hands." LPN #4 also suppose to be in the hand] all the time. If we wash cloth in the say, "Yes, his nails are pressing into his gentle observed respective and will open each finger the into his contracted in cooperative and will #4 added, "I would a washcloth to help proceed the was interviewed. Che do a lot, if he lets meand wash it out." Che daily and if the residence while, he doesn't like because it hurts." Composition or the cooperative and will washcloth to help proceed the say interviewed. Che was interviewed. Che was interviewed to a lot, if he lets meand wash it out." Che daily and if the residence while, he doesn't like because it hurts." Che was interviewed in the cooperative and wash it out." Che daily and if the residence while, he doesn't like because it hurts." Che was interviewed it hurts." Che was interviewed in the cooperative and wash it out." Che daily and if the residence while, he doesn't like because it hurts." Che was interviewed it hurts."	therapy and yes my nails are but I don't ask them [facility [facility staff]don't do nothing, old sometimes." roximately 10:55 a.m. LPN #4 swith resident) and surveyor ent #1. LPN #4 stated, "Yes, his acted. Usually he has a carrot his nails don't go into his so stated, "The carrot is here [Resident #1's contracted Neither Resident #1 nor LPN e carrot. LPN #4 continued to need to be cut, they [his nails] is hand but no marks." LPN #4 sident's hand and opened it to sident #1 helped LPN #4 place contracted hand. Resident #1 ly but when he helped LPN #4 ne wash cloth was able to go hand. Resident #1 was lling to work with LPN #4. LPN use both the carrot and the	F3	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495146	B. WING		01	1/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP COE 94 SOUTH AVENUE HARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE	
F 312	interviewed. Reside [referring to the car [referring to nails or stated, " I want my to tell me its ok-I do He added, "It [his let alk about it but the!" On 1/26/16 at approwas interviewed and for Resident #1 [this he did not watch the he looked he would stated several times behaviors and refus and DON agreed the and in need of cuttil	45 a.m. Resident #1 was ent #1 said, "Its ok in my hand" rot] and "I want that done ut regularly]." Resident also nails cut and I want the doctor on't trust them [facility staff]." eft hand] is really painful and I by don't listen." oximately 10:00 a.m., the DON at stated, "LPN #4 cut the nails is morning] and he was fine if e nails while cutting but when a get nervous." Also the DON is that Resident #1 has sees care. Administrative staff nat Resident's nails were long	F3	12			
F 318 SS=D	concerning nail care follow the plan of care findings during a brian proximately 11:00 present any further 483.25(c)(2)(3) INC DECREASE IN RAM (c) Mobility. (2) A resident with live receives appropriate increase range of medecrease in range of medical plans of the plans o	tration was informed of the riefing on 1/26/17 at 0 a.m. The facility did not information about the findings. CREASE/PREVENT NGE OF MOTION imited range of motion e treatment and services to notion and/or to prevent further	F 3 ⁻	F – 318 Deficiency Cor. (c) Mobility (2) A resident with limit of motion receives approtreatment and services to range of motion and/or to further decrease in range motion	ted range opriate o increase o prevent	2/24/17	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING			01/	26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			94	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVENUE ARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	to maintain or impropracticable indepermobility is demonst. This REQUIREMENT by: Based on observatinterview, facility doclinical record review evaluate and provide motion) services ar residents (Resident to evaluate Resident to evaluate Resident from 2013 to 1/26/1 treatment and service The findings included Resident # 1 was resident # 1 with interesident # 2 with interes	s, equipment, and assistance ove mobility with the maximum idence unless a reduction in rably unavoidable. NT is not met as evidenced stion, resident interview, staff ocumentation review, and w, the facility staff failed to de appropriate ROM (range of the teatment for 1 of 22 to #1). The facility staff failed in to the teatment for 1 of 22 to #1). The facility staff failed in to the teatment for 1 of 22 to #1, and failed to provide itees to assist with contracture.	F	318	F-318 Continued: 1) How Corrective action waccomplished for those four have been effected. Occupational Therapists of Therapy Department, attestimes 2 on 1/26/17 to everesident #1's left hand, but rewell the times 2 on 1/26/17 to everesident #1's left hand, but rewell the times 2 on 1/26/17 to everesident #1's left hand, but rewell the therapy Department staff again was refused by the rewell the term again was refused by the term as a completed with non-acceptant treatment. Resident #1's Care was updated to reflect his refunction and offered thera care to address clinically identeds. 2) How corrective action waccomplished for those he potential to be affected by the practice. A complete audit of current reswith hand contractures completed by the clinical tea 2/6/17. No other residents identified as having unmet conteds.	f the impted valuate esident is. On ade by ff, but sident. d by arding and is risks are of e Plan isal of inpeutic intified vill be aving esame sidents was arm on were	

approximately 9:05 a.m. Resident #1 was

observed in bed without assistive device (a carrot

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		495146	B. WING			01/	26/2017
AVANTE	PROVIDER OR SUPPLIER AT HARRISONBURG			94	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVENUE ARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 318	long finger nails precontracted hand. R surveyor with LPN on 1/25/17 at approresident was obserdevice (a carrot or hand with very long the contracted hand. A nursing note pres DON (Director of N 10/02/2013 at 6:28 had been refusing I (RNP) care and had application by resto Assistant). The note spoken to on this dof RNP due to refus #1] is in agreement CNA for PROM [Pa application of splint According to the MR Range of Motion in the joint for you." On 1/24/17 and 1/2 record was reviewed current physician's contracture. Review Administration Recording to the most current C facility staff was reviewed following: Focus: Impaired most contraction and the point of the most current C facility staff was reviewed following:	essing against and into the desident #1 was observed by (Licensed Practical Nurse) #4 oximately 11:00 a.m. Again, the ved in bed without assistive washcloth) in contracted left of finger nails pressing against d. Sented by the facility Interimal Aursing) on 1/26/17 dated p.m., read that Resident #1 Restorative Nursing Program do been removing splint after orative CNAs (Certified Nursing e stated that Resident #1 was atte regarding discontinuation sals, and reads, "he [Resident with this. Will refer to floor assive Range of Motion] and as [Resident #1] will tolerate." edical Dictionary, Passive volves someone else moving 15/17, Resident #1's clinical and orders pertaining to left hand	F	318	F-318 Continued: 3) What measures will be place or systemic changes ensure that the deficient will not occur. In-service was initiated on 2 current nursing staff regard of Residents with hand con and range of motion service training will be inclusorientation of new nursing such than an an an anger or designed we residents with hand contract ensure range of motion provided. An Audit will weekly four weeks then rare reporting findings to the Din Nursing for appropriate follow. 4) How the facility promotion its performance to sure that solutions are sustated. The Director of Nursing or will review above audit reporting to the monthly Quality A Committee and then random needed based on recommendations of the Assurance Committee.	7/17 for ng Care tractures es. This ded in taff. The rill audit tures to services be done indomly, rector of w-up. I ans to make tined. I designee rts from the weekly findings sesurance	

[diagnosis] of hemiparesis. Date initiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	0	(X3) DATE SURVEY COMPLETED	
		495146	B. WING			01/26/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 94 SOUTH AVENUE HARRISONBURG, VA 22801	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BI HE APPROPRIA		
F 318	1/16/2017 by MDS Goal: Maintain hig prevent further dea of the observation 9/15/2011, Created 1/16/2017 by MDS 4/12/2017. Interventions: Active and passive extremities PRN [a 9/15/2011 Created 9/11/2012 [nothing Coordinator. Administer pain mainful prior to star 9/15/2011 Created 9/11/2012 [nothing Coordinator. Encourage active praise all efforts. Don 9/15/2011, Revadded] by MDS Coordinator. Encourage [Reside possible for himsel care to enhance jo 9/15/2011 Created 9/11/2012 [nothing Coordinator. Explore possible umobility. Date initial	d on 9/15/2011, Revision on Coordinator. hest level of function and gree of contractures by the end period. Date initiated on 9/15/2011, Revision on Coordinator, Target date: e range of motion of affected as needed]. Date initiated on 9/15/2011, Revision on Inew added] by MDS edication if range of motion is rting program. Date initiated on 9/15/2011, Revision on new added] by MDS participation when possible and pate initiated 9/15/2011 Created ision on 9/11/2012 [nothing new poordinator. ent #1] to do as much as if as much as possible during int mobility. Date initiated on 9/15/2011, Revision on new added] by MDS se of assistive devices to aid ated 9/15/2011 Created on non 9/11/2012 [nothing new non 9/11/201	F3	118			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495146	B. WING		0	1/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, Z 94 SOUTH AVENUE HARRISONBURG, VA 22801	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 318	Continued From pa	age 42	F 3	18			
	Director of Nursing Plan regarding Res address observation #4 (Resident #1 was assistive device (a contracted left hand pressing against and Focus: [Resident # for assistance, refur physically abusive to refuse bathing. Date on 9/13/2012 by So 8/24/2016 [nothing Coordinator.	staff (Administrative-Acting I) presented the following Care sident #1's Behaviors to ons made by surveyor and LPN as observed in bed without carrot or washcloth) in d with very long finger nails and into the contracted hand): #1] has behaviors of yelling out using care at times, and being to staff at times, 8/24/16 ate initiated 9/13/2012, Created ocial Worker, Revision on new added] by MDS					
	improvements and facility. Interventions includ Explain to [Residen prior to doing it to a 9/13/2012, Created	will continue to show signs of have all his needs met at this ded but not limited to: at #1] what you are about to do assist him. Date initiated on 9/13/2012 by Social on 10/21/2012 [nothing new ordinator.					
	minutes later. Date	n refused in about 10-15 initiated 9/13/2012, Created ocial Worker, and no revision interventions.					
		ne most current Care Plan acility staff included assistance					
	Focus: [Resident #*	1] has an ADL care deficit r/t					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILE		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495146	B. WING		_ 01	/26/2017	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STA 94 SOUTH AVENUE HARRISONBURG, VA 22	ATE, ZIP CODE	124124	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCED	IN OF CORRECTION FE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 318	sided hemiparesis requires extensive care. Interventions inclus athing: Check not bath day and as not the nurse. Date 9/14/2011 by MDS date with any new Bathing: Provide is bath or shower is frequently refuses 9/14/2011 Created 1/16/2017 [nothing 7/15/2013 until 1/7] The ADL task she 2017. The ADL task she 2017. The ADL task she 2017. The ADL task upper extremity and tolerated. Apply le except for bathing to be performed a Facility staff were documentation and On 1/26/17 a nurs facility Interim DO p.m The note rearefusing Restorative and had been rem restorative CNAs. #1 was spoken to discontinuation of	agnosis] of CVA [stroke] with left is [weakness]. [Resident #1] is assistance to complete ADL uded but not limited to: ail length and trim and clean on necessary. Report any changes initiated 9/14/2011, Created on S Coordinator, and no revision interventions. Isponge bath on days when a full not given 1/16/17 [Resident #1] is to take a shower. Date initiated if on 9/15/2011, Revision on g new added since readmission 16/2017] by MDS Coordinator. The state of Motion included and to: Under the title "Personal ROM [Range of Motion] to left and left hand/wrist daily as as tolerated. These tasks were and checked Q [every] shift. not completing the tasks per	F3	318			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495146	B. WING			01/	01/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG	;		94	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVENUE ARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 318	of Motion] and app #1] will tolerate." An Dictionary, Passive someone else move Occupational Therathe Interim DON or notes from 2017 with exact same with Treatment Note da [Patient's] L [left] has a carrot for proper Evaluation and Plaidentified the follow documented physicassociated function [Resident #1] is at a function, falls, limited contractures." The dated 11/2/2014 oudiagnosis (effects on 10/30/2011 and (feeding difficulties onset date of 11/5/2 Plan of Treatment of survey findings] not contracture and other and treatment for contracture and other and treatment for contracture and other with pathology consected with focus on a length/skin integrity report, "Patient subhand. Therapist requirements of the contracture of	NA for PROM [Passive Range lication of splint as [Resident coording to a Medical Range of Motion involves ing the joint for you." apy notes were presented by 1/26/17. Several quarterly ere presented with notations in no changes. An OT Daily ted 11/5/2014 read: "Pt's and is contracted and he uses splinting of L hand." An OT nof Treatment dated 2/4/2015 ing risk factors: "Due to cal impairments and lad deficits, the patient risk for future decline in ed out-of-bed activity and OT therapy Progress Report the tined the onset date of stroke, muscle weakness) 3/12/2012 with Treatment and lack of coordination) 2014. The OT Evaluation and dated 1/26/2017 [based on red onset date of diagnosis of the cerebrovascular disease contracture on 1/26/2017. Int dated 1/26/2017 read: need from 'Patient presents sistent with diagnosis of prior intracture. Patient seen this assessment of ROM/nail." The note continued to jectively reported pain in his Liquested to see his hand a she wanted to assess his	F	318				

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE AVANTE AT HARRISONBURG HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 318 Continued From page 45 F 318 ROM both passively and actively, with patient giving hand to therapist. Upon very gentle ROM and holding his hand, he screamed in pain and became physically aggressive and velled. 'Just leave it alone." The note also documented that patient was shown the carrot orthosis and refused to allow therapist to place it. The conclusion by the therapist was documented and read, "Skilled services not indicated at this time secondary to patient refusing." Nursing was notified regarding patient's subjective high pain levels in left hand. A review of clinical nursing notes from 11/01/16 through 1/26/17 was conducted on 1/26/17. On 11/06/2016 a note read, "[Resident #1]...yelling out constantly complained of pain and medicated without results...redirection unsuccessful refused ADL care..." On 12/24/16 a weekly summary noted: [Resident #1] to be "cooperative with care most of the times, becomes agitated periodically." No mention of PROM or nail care refusal in Clinical Nursing Notes. On 1/25/17 at approximately 9:05 a.m. Resident #1 was interviewed. Resident #1 stated, "I have arthritis pain in my left hand...the doctor down there in Florida had it better, the doctor had it opened." Resident #1 added, "I try to help myself

because I have no therapy and yes my nails are going into my skin but I don't ask them [facility staff to help...they [facility staff]don't do nothing. no cream and its cold sometimes."

On 1/25/17 at approximately 10:55 a.m. LPN #4 (consistently works with resident) and surveyor interviewed Resident #1. LPN #4 stated, "Yes, his hand is very contracted. Usually he has a carrot or a wash cloth so his nails don't go into his

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER AT HARRISONBURG			STI	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVENUE ARRISONBURG, VA 22801	<u> Ui</u>	<u>/26/2</u> 017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	DBE	(X5) COMPLETION DATE	
	hands." LPN #4 also suppose to be in the hand] all the time. N #4 could locate the say, "Yes, his nails are pressing into his gently observed ressee no marks. Residually a washcloth in the coyelled in pain initially open each finger the into his contracted his cooperative and will #4 added, "I would to washcloth to help promote the intervent was evaluated this resultant that Residual pain and refused Roand became aggres notified nursing of the has behaviors to handed it over to nur on 1/26/17 at approximate the promote that Residual pain and refused Roand became aggres notified nursing of the has behaviors to handed it over to nur on 1/26/17 at approximate the promote that residually and if the residual pain in the All have not had success while, he doesn't like because it hurts." Chill let the nursing st	so stated, "The carrot is here [Resident #1's contracted Neither Resident #1 nor LPN e carrot. LPN #4 continued to need to be cut, they [his nails] is hand but no marks." LPN #4 sident's hand and opened it to ident #1 helped LPN #4 place contracted hand. Resident #1 ly but when he helped LPN #4 he wash cloth was able to go hand. Resident #1 was lling to work with LPN #4. LPN use both the carrot and the protect his hand." a.m. an Occupational viewed. The OT stated, "He morning at 7:00 a.m. because rined about his hand." The OT dent #1 complained of a lot of OM and refused the carrot ssive. The OT stated, "I he pain and the refusal, I feel on not allow anything so I	F3	318				

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE **AVANTE AT HARRISONBURG** HARRISONBURG, VA 22801 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 318 Continued From page 47 F 318 receives pain medication. CNA #2 also stated, "I don't know if he is in restorative therapy...ask therapy they would know ... and no I don't do range of motion with him." On 1/26/17 at approximately 9: 35 a.m. LPN #1 (On duty and was told by OT of the Resident#1's pain) was interviewed. LPN #1 stated, "Yes, it was reported to me and I put a note in regarding he OT evaluation." LPN #1 does not work with Resident #1 often. LPN #1 said she went in to talk with the resident around 7: 45 a.m. and he did not want anything for pain. LPN #1 said she would try 2 to 3 times to assist with pain if he refused. LPN #1 said, "I spoke with family a few weeks ago and they feel he may be giving up." LPN #1 stated, "From here I would look at quality of life for him [Resident #1], talk with family, keep him comfortable maybe talk with the doctor about

liquid morphine or ativan because liquid is easy to get into people to keep comfortable." LPN #1 said. "Pain is impacting his life so I am going to communicate with the doctor or NP to explore

medications at 7:30 a.m. prior to ADLs, we could use Norco for break through pain prior to ADLs, or use the Aspercream prior to nail care and placing the carrot, and we could increase the MCGs (Micrograms) on the Fentanyl patch."

A final interview was conducted on 1/26/2017 at 9:45 a.m. with Resident #1. Resident #1 was observed with nails cut and carrot in left hand. Resident #1 said, "Its ok in my hand" [referring to the carrot] and "I want that done [referring to nails cut regularly]." Resident also stated, "I want my nails cut and I want the doctor to tell me its ok-I don't trust them [facility staff]." He added, "It [his left hand] is really painful and I talk about it but

other avenues, like we could schedule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495146	B. WING_		01	/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG)		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 318	was interviewed an for Resident #1 and watch the nails whi he would get nervo several times that I refuses care. The conew interventions of Resident #1's left honly one Social Wowas presented regidated 1/5/2016 and review, the DON st was no evidence thongoing treatment.	oximately 10:00 a.m., the DON and stated, "LPN #4 cut the nails of he was fine if he did not le cutting but when he looked us." Also the DON stated Resident #1 has behaviors and care plan did not reflect any or attempts or approaches to and contracture/ ROM since. Ork Resident Progress Review arding Resident #1's behaviors I when asked for an updated ated, "We have none." There hat Resident #1 was provided for pain prior to ROM to ROM exercises to assist	F 3	18			
	The facility adminis findings during a br approximately 11:00 present any further 483.45(d) DRUG R UNNECESSARY D (d) Unnecessary Dr drug regimen must drugs. An unnecessused	tration was informed of the iefing on 1/26/17 at 0 a.m The facility did not information about the findings. EGIMEN IS FREE FROM	F 32	F – 329 Deficiency Corrected (d) Unnecessary Drug-Gent Each resident's drug regime must be free from unnecessary drugs. An unnecessary drugs often when used	eral en sary	2/24/17	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			495146	B. WING		_	01/	26/2017
		PROVIDER OR SUPPLIER AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801				
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION SI	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	
	F 329	(5) In the presence which indicate the ordiscontinued; or (6) Any combination paragraphs (d)(1) the This REQUIREMENT by: Based on staff interview, the facility sersidents was free formedications. Residents without an areduction or document attempted dose red. The findings included Resident #11 was a 7/22/15 with diagnosimitable bowel, department of the minimum data assessed Resident cognitive skills. Resident #11's clinical physician's order data administered twice physician's order data administered twice physician's order data.	te monitoring; or te indications for its use; or of adverse consequences lose should be reduced or as of the reasons stated in nrough (5) of this section. IT is not met as evidenced rview and clinical record traff failed to ensure one of 22 rom unnecessary ent #11 was on daily doses of dication Lorazepam for eleven attempted gradual dose ented clinical rationale that an auction was contraindicated. Edmitted to the facility on ses that included Alzheimer's, ession, anxiety and bronchitis. Set (MDS) dated 1/10/17 #11 with severely impaired cal record documented a ted 2/25/16 for the medication	F3	29	F – 329 continued: 1) How Corrective actic accomplished for those for been effected. Resident # 11's Drug reviewed by the Omnicare pl 1/28/17 and recommendate conveyed to the attending provided direction as necessary. Grace Reduction was received physician. 2) How corrective actic accomplished for those potential to be affected be practice. The Omnicare Pharmacist condition of the Commendation for Grace Reductions. Any recommendation for Grace Reductions. Any recommendation for Grace Reductions and the physician for further review, and order modification as incompleted to the physician for the Unit Manager or dereview the monthly Pharmat for appropriate Gradual Dose recommendations for the physician's review and direction in the physician in the p	egimen was harmacist on tions were obysician for adual Dose from the on will be see having y the same ompleted and resident's to include dual Dose indications for ician orders e resident's assessment dicated. The put into the made to the put into the	

per day for anxiety. The resident's medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495146	B. WING			0.	1/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG			94 :	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVENUE ARRISONBURG, VA 22801		1124,24	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	through 1/24/17 do administered the Lo as ordered. Resident #11's clini attempted dose red 2/25/16. There was justification of why Lorazepam was co progress notes date and 12/2/16 documpsychoactive medic was not attempted with anxiety and s/s depression." The rindicating the clinical additional attempte Lorazepam would light instability or exacer condition. Physician progress following assessment psychiatric status. 7/12/16 - "No acute behaviors. Continual depressionMemo judgement impaired times. Moderate ar interactive. Difficult topic"	age 50 ords (MARs) from 2/25/16 ocumented the resident was corazepam three times per day nical record documented no duction of the Lorazepam since as no documented clinical a dose reduction for the ontraindicated. Physician ted 7/12/16, 9/7/16, 11/2/16 mented a reduction in ications including Lorazepam because "patient continues 's [signs/symptom] of record had no documentation cal rationale for why an ed dose reduction for likely impair, cause psychiatric rebation of symptoms or a s notes documented the ent/review of Resident #11's e change in mental status or uses with significant anxiety, ory impaired. Insight and d. Difficulty finding words at anxiety. Talkative and the change in mental status or uses with significant anxiety, ory impaired. Insight and d. Difficulty finding words at anxiety. Talkative and d. Difficulty finding words at mxiety. Talkative and	F3	129	F – 329 continued: 4) How the facility plans to a performance to make a solutions are sustained. The Director of Nursing or dereview the pharmacists mont for 3 months reporting finding monthly Quality Assurance and then randomly or as needs the recommendations of the Assurance Committee.	signee will hely reports ngs to the Committee ded based on		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 329	topic" 11/2/16 - "No chang status/behaviorAv only. Somewhat ap Insight/memory imp somewhat distant 12/2/16 - "Awake Somewhat appropri Insight/memory imp somewhat distant Monthly medication facility's pharmacist December 2016 maresident's daily Lora recommendations of at a dose reduction reasons a dose	by focusing on discussion and spe in mental wake and oriented to person propriate and cooperative. Paired. Affect flat and specified and oriented to person only. The area and cooperative. Paired. Affect flat and specified. Affect flat and	F3	329			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED			
		495146	B. WING _		01	/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801				
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	during a meeting or information was requattempted dose red Lorazepam or of an justification the dose contraindicated as to no further information. On 1/26/17 at 9:45 at #11's last dose reduction of Lorazep from 3 times per dar DON stated there we dose reduction of the DON stated the pharmacist of a dose inaccurate. The DO documented on proceontinued with anxiet documentation of with reduction was contrained with anxiet documentation of with reduction was contrained with anxiet documentation of with the Drug Information edition on page 743 benzodiazepine use anxiety disorder or stolly 4 months) relief of anxiety associated with the process of t	e reviewed with the irector of nursing (DON) 1/25/17 at 4:30 p.m. Further uested at this time about any uction for Resident #11's y documented clinical e reduction was he pharmacist had provided on about Resident #11. a.m. the DON stated Resident ection for the Lorazepam was DN stated the resident's 0.5 am was reduced on 2/25/16 by to 2 times per day. The ere no further attempts at a e Lorazepam since 2/25/16. Information stated by the ereduction on 11/20/16 was DN stated the physician gress notes the resident ety but there was no further hy another attempted dose aindicated. In Handbook for Nursing 13th describes Lorazepam as a d for the "management of short-term ([less than or equal of the symptoms of anxiety or with depressive symptoms." s, "Use with caution in elderly is" (1)	F 32				
	_	n, Ohio: Lexi-Comp, 2011. DRUG REGIMEN REVIEW,	F 428	F - 428 Deficiency Corre	cted	2/24/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495146	B. WING_		01/26/2017	
	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE COMPLÉTI	ION
SS=D RE c) (1) rev pha (3) bra and lim (i) (ii) (iii) (iv) (4) to 1 fact and (i) dru (d) (ii) dur sep atte dire mir and (iii) res	riewed at least or armacist. A psychotropic of ain activities assord behavior. The ited to, drugs in the Anti-psychotic; Anti-psychotic; Anti-depressant; Anti-anxiety; and Hypnotic. The pharmacist the attending physicial did these reports in the attending physician gettor and director and director in the irregularity. The attending physician gettor and director in the irregularity. The attending physician gettor and director in the irregularity. The attending physician gettor and director in the irregularity. The attending physician gettor and director in the irregularity.	AR, ACT ON eview en of each resident must be nce a month by a licensed drug is any drug that affects ociated with mental processes se drugs include, but are not the following categories:	F 42	c) Drug Regimen Review (1) The drug regimen of each remust be reviewed at least once a month by a licensed pharmacist (3) A psychotropic drug is any of that affects brain activities assort with mental processes and behavior 1) How Corrective action accomplished for those for have been effected. Resident # 11's Drug regime reviewed by the Omnicare phase on 1/28/17 and recommendation conveyed to the attending pheroretic on as necessary. Once reduction was received fin physician. 2) How corrective action accomplished for those potential to be affected by the practice. The Omnicare Pharmacist coman audit on 2/8/17 of current respectively. Any recommendation for Gradual Reductions. Any recommendation for Gradual Reductions have been submitted	sident drug ciated will be and to en was rmacist as were sysician Gradual rom the will be having e same appleted sident's include Dose dations	

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(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 428	be no change in the physician should do the resident's medicate resident's medicate resident's medicate for the findings included assessed Resident cognitive skills. Resident #11's clinic physician's order dafor Lorazepam 0.25 medicate for the physician's order dafor Lorazepam 0.25 for review that included the physician's order dafor Lorazepam 0.25 medicate for resident to the physician's order dafor Lorazepam 0.25 medicate for resident dafor the physician's order dafor Lorazepam 0.25 medicate for resident dafor the physician's order dafor Lorazepam 0.25 medicate for the physician's	ken to address it. If there is to a medication, the attending ocument his or her rationale in cal record. It develop and maintain policies the monthly drug regimen but are not limited to, time rent steps in the process and st must take when he or she arity that requires urgent action ent. In it is not met as evidenced excited failed to make a pharmacy or one of 22 residents in the armacy failed to make a pharmacy failed to make a pharmacy or one of 22 residents in the armacy failed to make a pharmacy fail	F 42	3) What measures will place or systemic channels ensure that the deficit will not occur. The Omnicare Pharma serviced by the Director 2/2/17 to regulatory Gradual Dose Reduction The Unit Manager or review the monthly report for appropriate Reductions recommendate attending physician's direction. 4) How the facility plantis performance to massolutions are sustained. The Director of Nursing will review monthly	cist was in- of Nursing on and facility expectations. designee will Pharmacist's Gradual Dose tions for the review and as to monitor ke sure that g or designee pharmacists adings to the ce Committee needed based			

administration records (MARs) from 2/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495146	B. WING			01/	26/2017		
	PROVIDER OR SUPPLIER AT HARRISONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801						
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE		
F 428	administered the Las ordered. Resident #11's clin attempted dose red 2/25/16. There wa justification of why Lorazepam was coprogress notes dat and 12/2/16 documpsychoactive medic was not attempted with anxiety and s/s depression." The rindicating the clinic additional attempte Lorazepam would linstability or exacer condition. Physician progress following assessment psychiatric status. 7/12/16 - "No acute behaviors. Continue depressionMemory judgement impaired times. Moderate an interactive. Difficultopic"	age 55 commented the resident was orazepam three times per day ical record documented no duction of the Lorazepam since is no documented clinical a dose reduction for the ontraindicated. Physician ed 7/12/16, 9/7/16, 11/2/16 mented a reduction in cations including Lorazepam because "patient continues is [signs/symptom] of record had no documentation al rationale for why an ad dose reduction for ikely impair, cause psychiatric relation of symptoms or a motes documented the ent/review of Resident #11's echange in mental status or res with significant anxiety, any impaired. Insight and the contraction of symptoms or a motes documented the ent/review of Resident #11's echange in mental status or res with significant anxiety, any impaired. Insight and change in mental status or res with significant anxiety, any impaired. Insight and change in mental status or reserved in mental	F 4	28					
	times. Moderate a	d. Difficulty finding words at nxiety. Talkative and ty focusing on discussion and							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495146	B. WING		٠٠ ا	1/26/2017		
	PROVIDER OR SUPPLIER AT HARRISONBURG			ZIP CODE	<u> </u>			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 428	only. Somewhat ap Insight/memory impomewhat distant 12/2/16 - "Awake Somewhat appropri Insight/memory impomewhat distant Monthly medication facility's pharmacist December 2016 maresident's daily Lorarecommendations of at a dose reduction reasons and attemption of the last attemption of	ge in mental wake and oriented to person opropriate and cooperative. paired. Affect flat and ." and oriented to person only. riate and cooperative. paired. Affect flat and ." regimen reviews by the t from March 2016 through ade no mention of the excepam use and included no concerning a possible attempt or any documented clinical fuction was contraindicated. a.m. the facility's pharmacist out any recommendations mpted dose reduction for excepam. The pharmacist ontary recommendations mpted gradual dose reduction corazepam was on 11/20/16. The pharmacist was asked are dates for Resident #11's 25/16 if there was a change The pharmacist stated he cords and advise. The ed no further information to out Resident #11's Lorazepam	F 4	28				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495146	B. WING _		(1/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP COE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	during a meeting or information was recattempted dose red Lorazepam or of an justification the dose contraindicated as the no further information of 1/26/17 at 9:45 #11's last dose reduction 2/25/16. The DO mg dose of Lorazepfrom 3 times per da DON stated there we dose reduction of the DON stated the pharmacist of a dose inaccurate. The DO documented on procontinued with anxiety.	irector of nursing (DON) in 1/25/17 at 4:30 p.m. Further quested at this time about any uction for Resident #11's by documented clinical e reduction was the pharmacist had provided on about Resident #11. a.m. the DON stated Resident action for the Lorazepam was DN stated the resident's 0.5 oam was reduced on 2/25/16 by to 2 times per day. The are no further attempts at a fire Lorazepam since 2/25/16. It information stated by the are reduction on 11/20/16 was DN stated the physician gress notes the resident atty but there was no further thy another attempted dose	F 42	28		
	edition on page 743 benzodiazepine use anxiety disorder or s to] 4 months) relief anxiety associated v This reference state or debilitated patien	1,				
	Elizabeth A. Tomsik for Nursing. Hudsor 483.45(b)(2)(3)(g)(h	ce B., Brenda R. Lance and Drug Information Handbook n, Ohio: Lexi-Comp, 2011. DRUG RECORDS, UGS & BIOLOGICALS	F 43	F – 431 Deficiency Cor	rected	2/24/17

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		495146	B. WING		01/	/26/2017	
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CO	***************************************	_+,,	
AVANTE	AT HARRISONBURG	i		94 SOUTH AVENUE			
				HARRISONBURG, VA 22801	<u> </u>		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 431	drugs and biological them under an agree §483.70(g) of this punlicensed personn law permits, but onlicensed personnels and permits and a licensed personnels. A figure of the pharmaceutical sentiated assure the accordispensing, and adribiologicals) to meet	ovide routine and emergency als to its residents, or obtain eement described in part. The facility may permit nel to administer drugs if State ly under the general	F 431	F - 431 Deficiency Cor. The facility must provide emergency drugs and biologous residents, or obtain then agreement described in §483 part. The facility may permit personnel to administer drug permits, but only under supervision of a licensed nurs. 1) How Corrective active active accomplished for those for the been effected. Resident #1, #5, #9 and #1 assessed and determined to adverse clinical issues repossible non-receipt of unamedications.	routine and ogicals to its m under an 3.70(g) of this nit unlicensed gs if State law the general se. ion will be ound to have 13 have been have had no clated to the		
	(2) Establishes a sy disposition of all cordetail to enable an a (3) Determines that that an account of a maintained and period (9) Labeling of Drugs and biological labeled in accordant professional principle appropriate access instructions, and the applicable. (h) Storage of Drugs (1) In accordance we	gs and Biologicals. als used in the facility must be accepted accepted also and include the accepted and cautionary acceptation date when		Resident #10 and Resident and Medication Utilization Redetermined to be calculation part of the Nurses; the Nurseceived lon1 re-education including how to accurately document on a declining Medication Utilization Recordance 2) How corrective activated by the same part of the current resident's medication were audited to determine been further unaccounted for Controlled Medication Records out of compliance The audit was completed on new instances have been determines to be a same part of the sam	ecords were a errors on the arses involved on 1/25/17 v subtract and g Controlled ord. ion will be ving potential practice. Cation supplies if there have or medications on Utilization e with count.		

through this audit.

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F 431	controls, and permit have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Druc Control Act of 1976 abuse, except when package drug distriquantity stored is mbe readily detected. This REQUIREMEN by: Based on, staff interest and facility docume to implement a syst of controlled medica Resident #'s 9, 13, 1. Resident #9's Not could not be account as Resident #13's Conarcotic) could not be account as Resident #1's Not could not be account as Resid	it only authorized personnel to keys. It provide separately locked, decompartments for storage of ted in Schedule II of the ug Abuse Prevention and is and other drugs subject to in the facility uses single unit libution systems in which the ninimal and a missing dose can library of the review, clinical record review, ent review the facility staff failed tem of records and deposition ations for four of 22 resident's, 5, 1, 14 and 10. Orco (schedule 2 narcotic) inted for. Oxycodone (schedule 2 narcotic) inted for. ercocet (schedule 2 narcotic) inted for. orco (schedule 2 narcotic) inted for. failed to ensure accurate stering, storage and schedule IV (4) narcotic	F4	3) We place ensur will not recount medic each so orient nursin. 4) Ho its persolution the recount medic each so orient nursing the recount medical each so orient nursing the recount medical each so orient the recount medical each so orient the recount of th	Vhat measures will be or systemic changer that the deficient of occur. ucation was initiated urrent licensed nurses ew implemented processing and verific cation cards for each shift. This will be incutation process of near staff. The word of the facility plans erformance to make ions are sustained. Director of Nursing randomly monitor the counting of medication newly implemented a complied with by the weekly 4 times for ring the three shiftings will be report hely Quality Assurance then randomly or on a light on the recommendatity Assurance Committed	on 2/10/17 s to include cess for the cation of resident by cluded in the ew licensed to monitor e sure that or designee e change of ons to ensure process is the licensed four weeks its. Audit ted to the committee in as needed attions of the		

6. The facility staff failed to ensure accurate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 431	Findings include: 1. Resident #9's N could not be account Resident #9 was as with a readmission including chronic panerve damage), and The most recent M quarterly assessment reference date) of assessed as being A facility reported in dated 8/17/16 was missing doses of N 2016. Resident #9's elect documented per physical scheduled to be given and two tablets at resident #9's medifor August 2016 increceived the medical received the medical resident received the medical received receive	orco (schedule 2 narcotic) ident # 10. orco (schedule 2 narcotic) inted for. dmitted to the facility on 3/5/15 on 6/22/15 with diagnoses ain, neuropathy (peripheral d osteoporosis (bone loss). DS (minimum data set) was a ent with an ARD (assessment 1/10/17. Resident #9 was moderately cognitively intact. incident (FRI) for Resident #9 reviewed concerning 26 orco for the month of August ronic record was reviewed and hysician orders that Norco was ren, 1 tablet three times a day hight for pain. Review of cation administration record licated that Resident #9	F 4	31			
	director of nursing of the time of the incidenurse, RN #1) was the reason for the F of multiple drug divence previous DON's res	(DON) and the acting DON (at dent, identified as registered interviewed. RN #1 verbalized FRI was due to the uncovering ersions identified upon the signation secondary to mentation of parcetic count					

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		495146	B. WING			01/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, S 94 SOUTH AVENUE HARRISONBURG, VA	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 431	accounted for narco follows: The facility receives and the shift nurses medications recond pharmacy manifest with a copy going be copy going into a mand file. The medications concard usually has 30 has a count down sadministered the nedown sheet) the pills the number of pills of down sheet. Once all the pills had card and the count down sheet and the count the count down sheet and the original manificant the original manificant then is kept on RN #1 was asked he #1 verbalized that we (for example) he made and the count down sheet (a went onto verbalized resigned, there was manifest's that when	e process of how the facility offics coming into the facility as an arcotics from the pharmacy are supposed to count the faciling the count against the the manifest is signed off ack to the pharmacy and a fail box for the DON to pick up to me on a medication card (a fail box for the pharmacy and a fail box for the poly and each card heet (every time a fail is fail arse documents on the count as on the card should match documented on the count are been dispensed from the down sheet balance is zero, the fail and the to evidence completion	F4	.31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495146	B. WING		01	/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIF 94 SOUTH AVENUE HARRISONBURG, VA 22801		720/2017	
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 431	RN #1 speculated medications was a sheets so that a nu would only be cour that particular cour with the surveyor, k system, medication On 1/25/17 at 11:40 interviewed the pharegarding the above that the staff nurse narcotics from shift narcotics. As far a pharmacist will condon a quarterly basis OS #1 was asked if to identify narcotics they were suppose usage or possible of supply on hand at the OS #1 verbalized the pharmacy system to being ordered early confirm or provided of pharmacy was tracearly. No other information conference on 1/26 2. Facility staff faile the opioid medication #13.	that whoever was taking the so taking the count down are doing a count of narcotics ating what was on hand against at down sheet. RN #1 agreed because of the poor filing as could not be accounted for. O a.m. the survey team armacist (other staff, OS #1) armacist of accounting for to shift to account for all as pharmacy services, the duct a random narcotic count are to ensure accuracy. If the pharmacy would be able abeing ordered sooner than to be ordered to detect over the facility has been used up). The facility has been used up and it should show in the consure medications wasn't are of the count and the standard of the standard of the standard of the facility has not able to documentation that the standard of	F 4:	31			
	10/1/15 with a re-ad	admitted to the facility on Imission on 11/25/16. dent #13 included heart				!	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING			01/	26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			94	REET ADDRESS, CITY, STATE, ZIP CODE S SOUTH AVENUE ARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	pneumonia and CO pulmonary disease (MDS) dated 12/6/1 severely impaired of Five facility reported the state agency in investigation of posmultiple residents. facility dated 9/28/1 was missing 13 dos Oxycodone in April facility received 15 Oxycodone for Resresident's April med documented a dose Resident #13 on 4/8 on 4/8/16. The facility received 15 on 4/8/16. The facility for Resident #13 on 4/8 on 4/8/16 and the ren Oxycodone were must be resident #13's cliniphysician's order da 2.5 milligrams (mg) hours as needed for April 2016 document 4/5/16 and on 4/8 investigation. On 1/25/17 at 9:35 #1) that served as iduring the drug divestigation.	s, anxiety, depression, OPD (chronic obstructive s). The minimum data set 16 assessed Resident #13 with	F	i31			
	then reviewed all re	e diversion in August 2016 and ecords back to January 2016 estigation in an attempt to	!			I	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIF 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	account for the mean never found a count Oxycodone that was the facility on 3/31/resident's April 2010 Oxycodone was ad 4/5/16 and an addit stated the remainin never found. RN # #13's Oxycodone, "meds [medicine] we Resident #13's miss facility issue with m involving multiple resident #13's miss facility issue with m involving multiple resident patient on pages 91 Oxycodone as an omanagement of moreference states, "T Medication Practice medication among in have a heightened in patient harm when in provider should be a misuse, and diversion. The U.S. Drug Enfolists Oxycodone in the classification. The I "Schedule II drugs, defined as drugs with use potentially psychosocial or phydrugs are also constituted."	dications. RN #1 stated they t sheet for Resident #13's s delivered and received at 16. RN #1 stated the 6 MAR documented a dose of ministered to the resident on ional dose on 4/8/16. RN #1 g 13 pills of Oxycodone were 1 stated concerning Resident The entire count sheet and ere missing." RN #1 stated sing Oxycodone was part of a issing controlled medicines esidents in the facility. On Handbook for Nursing 13th 2 and 913 describes pioid analgesic used for the derate to severe pain. This is Institute for Safe is (ISMP) includes this ts list of drug classes which risk of causing significant used in error Healthcare alert to problems of abuse, on." (1) recement Administration (DEA) the schedule II drug DEA website states, substances, or chemicals are the a high potential for abuse, leading to severe sical dependence. These idered dangerous." (2)	F 43			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		495146	B. WING _		o	1/26/2017
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 431	Continued From pa	age 65	F 43	31		
	Elizabeth A. Tomsik for Nursing. Hudso (2) Drug Schedules Administration. U.S	ice B., Brenda R. Lance and k. Drug Information Handbook on, Ohio: Lexi-Comp, 2011. s. U.S. Drug Enforcement S. Department of Justice.				
	3. Facility staff faile and disposition of P 05/27/16 through 08	ww.dea.gov/druginfo/ds.shtml> ed to keep an accurate record Percocet for Resident #5 from 18/08/16, resulting in 368 ocet tablets and 18 narcotic				
	on 05/24/16 and readiagnoses including Hypertension, Cong	riginally admitted to the facility eadmitted on 06/11/16 with g, but not limited to: Anxiety, gestive Heart Failure, tes and Chronic Pain.				
	quarterly assessme reference date) of 1	DS (minimum data set) was a ent with an ARD (assessment 11/29/16. Resident #5 was tively intact with a total 13 out of 15.				
	was reviewed on 01 Order Sheets (POS 08/31/16 were revie	R (electronic medical record) 1/25/17 at 8:15 a.m. Physician S's) dated 05/01/16 through ewed. Specific physician t during that time period		4 7		
	10-325 MG (milligra (Oxycodone-Acetan	/2016: "Percocet Tablet ams) minophen) Give 1 (one) tablet six) hours as needed for				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
		495146	B. WING		01	/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 66	F 431	,		
	10-325 MG (Oxyco	/2016: "Percocet Tablet done-Acetaminophen) Give 1 ery 6 hours for pain"				
	10-325 MG (Oxyco tablet by mouth ever pain one tablet Q4 and one t	/2016: "Percocet Tablet done-Acetaminophen) Give 1 ery 4 (four) hours for chronic (every four) hours while awake as needed for pain during the ablet by mouth every 4 hours nic pain"				
	10-325 MG (Oxyco tablet by mouth even one tablet Q4 hours	(2016: "Percocet Tablet done-Acetaminophen) Give 1 ery 4 hours for chronic pain s while awake and one tablet d for pain during the night"				
	10-325 MG (Oxyco	2016: "Percocet Tablet done-Acetaminophen) Give 1 ry 6 hours as needed for				
	10-325 MG (Oxycoo tablet by mouth as ****MAY ONLY BE 0 HOURS OF 2400-0	2017: "Percocet Tablet done-Acetaminophen) Give 1 needed for sever (sic) pain GIVEN BETWEEN THE 400**** (12:00 a.m 4:00 ablet by mouth four times a"				
		s for the same time frame did ed doses of Percocet, s needed).				
	pharmacist was inte	1:40 a.m. the facility contract erviewed by the survey team.				

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		495146	B. WING		0	1/26/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 94 SOUTH AVENUE HARRISONBURG, VA 228	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 431	over the building in January he was the from one pharmack stated, "I was notificated, "I was notificated, "I was notificated, and it is responsibility to pharmacist stated diversion. The pharmacist stated diversion. The pharmacist stated diversion. The pharmached, and the pharmached from the checks as narcotics to the fact "Controlled drugs a special packages, packages verifying the nurse then signed receives a tracking Regarding the read delivered in such is stated, "It has a lost resident has Medic insurance they do between long term pharmacies. Partice recognized. For Machine they do between long term pharmacies. Partice of all control prescription is partice script is void and a needed before the At approximately 3 nurse) was intervisitive stigation of Retablets and narcotil "I took over as the	ary 2016. His pharmacy took in February 2016. During ere to help with the transition by to other. The pharmacist fied of the investigation of a rision in August 2016. If it did my pharmacy." Regarding to prevent drug diversions the prevent drug diversions are diversed to make sure they are macy nurse is in and does to well." Regarding delivery of cility the pharmacist stated, are delivered to the facility in the nurse visualizes the prevent diversions are delivered to the facility of manifest with each delivery." It is no controlled medications are dear quantities the pharmacist of the diversion of the did and some types of Part Diedical and some types of Part Diedical prescription fills are not dedical you must have a hard led medications. If a failly filled the remainder of the medication can be refilled."	F 4	31		

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495146	B. WING		01	1/26/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 94 SOUTH AVENUE HARRISONBURG, VA 2280	, ZIP CODE	12012011
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 431	sheets stuck eventor reconcile the pherocontrolled med were trying to reconoticed the manifes sheets and doses I alerted the Admir to January 1 and a with the pharmacy about three weeks with what we did. corporate, the poli board, nursing boanever missed any of Percocet that where we discovered starting implement accepting controlled and have continuent needed. I am hap missing medication since September of the weeks with what we discovered starting implement accepting controlled and have continuent needed. I am hap missing medication since September of the weeks with what we discovered starting implement accepting controlled and have continuent needed. I am hap missing medication since September of the weeks with what we discovered starting implement accepting continuent needed. I am hap missing medication since September of the weeks with what we discovered starting implement accepting continuent needed. I am hap missing medication since September of the weeks with what we did.	overed pharmacy manifest where. Part of the DON job is narmacy manifest sheets with its received. As we (the facility) oncile all these sheets we est sheets, narcotic count of drugs were not matching up. nistrator and he had us go back audit all the narcotics received manifest sheets. It took us a working everyday to come up Everyone was notified, ce, your office, pharmacy and, etc. (Name) Resident #5 doses because of the amount as delivered for her every time. The problem we immediately ting new procedures for ed drugs from the pharmacy d to implement new things as py to say we have not had any ns or narcotic count sheets of last year." Ition was received by the survey exit conference on 01/26/2017.	F 4	31		

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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZI 94 SOUTH AVENUE HARRISONBURG, VA 22801	P CODE	- V 11-0/-	<u> </u>
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD B HE APPROPRIA		(X5) MPLETION DATE
F 431	Assessment Refer Resident # 1 with in thinking with mode addition, the Minim 1 requiring extensive dependence, on state (bed mobility, dress care. On 1/25/2017 and clinical record was showed a physiciar order read, Resider Hydrocodone-Acets MG (Milligrams). To Tablet by mouth threvery 4 hours as nephysician's order with Medication Review through August 2014 A review of Resider Administration Rec 2016 through August 2016 through August 2016 through August 2016 through August 2016 (Director of Nicoordinator found the missing and document May 2016: On 5/6/11 card of 30 was finis started until 5/21/16 MAR. 30 pills were	essment protocol) with an ence Date of 1/3/17 coded nattention and disorganized rate cognitive impairment. In um Data Set coded Resident # ve assistance and total aff for Activities of Daily Living sing, and hygiene/bathing) 1/26/2017, Resident #1's reviewed. The reviewed of order dated 5/16/2016. The not #1 was to get aminophen (Norco) 7.5-325 the instructions read: Give 1 free times a day for pain and deeded for pain. This has present on Resident #1's Report from May 2016. 1.5. Medication ord for the months of May, st 2017 documented that and Norco daily and as needed destigation in August 2016, the ursing) and current MDS the following Norco pills	F 4:	31			

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	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, 2 94 SOUTH AVENUE HARRISONBURG, VA 2280	ZIP CODE	IZOIZO II	
(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 X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 431	June 2016: On 6/12 received. On 7/7/16 of 30 was finished. 7/11/16 at 17:29 (6: administrations wer 7/11/16. 49 pills wer July 2016: On 7/5/1 received. On 7/26/1 card of 30 was finishon 8/4/16 at 2152 (9: administrations were 8/4/16. 32 pills were August: On 7/20/16 received. On 8/12/1 of 30 was finished. / 8/15/16 at 0948 (9:2 administrations were 8/14/16. No declinin 112 pills were missin August: On 7/31/16 On 8/15/16 the decli accurate. Since ther was located. 60 pills A total of 295 Norco from May 2016 throw Cn 1/24/17 at appro (Registered Nurse) stated that she work account for the miss that documentation pills which made it did so the stated of the stated of the made it did so the stated of the stated of the made it did so the stated of the stated	AR. 12 pills were missing. 3/16 180 Norco pills were 3 at 17:29 (6:29 p.m.) the card Another card was started on 29 p.m.). Per the MAR 11 re given between 7/8 and re missing. 6 120 Norco pills were 16 at 17:16 (6:16 p.m.) the 16-16 the MAR 28 re given between 7/26 and 19:52 p.m.). Per the MAR 28 re given between 7/26 and 19:52 p.m.) the card 19:52 p.m.) the card 19:52 p.m.) the MAR 8 19:52 p.m.) the card 19:50 Norco pills were 19:50 p.m. the MAR 8 19:50 p.m. the mark 10:50 p.m. 19:50 Norco pills were received. 19:51 p.m. the mark 10:50 p.m. 19:52 p.m. the mark 10:50 p.m. 19:52 p.m. the mark 10:50 p.m. 19:52 p.m. the mark 10:50 p.m. 19:50 p.m. the mar	F4	31			

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F 431	Continued From pa	age 71	F 43	31		
	was that the prescri	ugh medication." The problem ibing doctor would prescribe medications and someone (or e some pills and the counting				
	Pharmacist (Others entire survey team. monthly and quarter Pharmacy staff in the "Pharmacy Services package and the rethe number is according occurs from the packing occurs f	oximately 11:00 a.m. the s #1) was interviewed by the Others #1 explained that a erly review is conducted by the facility. Others #1 added, is send medications in ecciving nurse signs to ensure ounted for and received.				
	pharmacy has the New have proof of de with sheets and phases a medior destroyed." Other are not counting cor #1] will review what quarterly basis." Fin "We didn't catch this by the facility staff."	Manifest Tracking signed, then elivery. Then nursing counts armacy reviews on a quarterly lication needs to be sent backers #1 added, "We [Pharmacy] entrols every month! [Others in nursing documents on a hally, the pharmacist admitted, is [drug diversion] until notified. No policies were submitted by				
	the pharmacy when #1 stated, "We follow	n asked for procedures: Others www.the Board of Pharmacy."				
	Administrator stated tirelessly on this [dru Administrator added dealt withthe polic Ombudsman was not Health Professions] FRIs [Facility Report Also, staff members tested and some stated	d, "Local concerns have been				

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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CHARLES OF THE CONTROL OF THE CO	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 431	corporate/risk man are still in process with pharmacy to of Administration state Enforcement Agen had cooperated on authorities in the in also conducted its findings to the approximately 11:00 present any further 5. The facility staff dispensing, administration of a Smedication for Res Resident # 14 was 06/14/14, with the ros/15/15. Diagnos but were not limited disorder, psychotic seizure disorder. The most current May quarterly assessment assessed the residual of 6, indicating the impairment in daily on 01/25/17 the factorial wing were observed.	o mentioned that the nagement team for the facility and had not finalized working correct the process. The facility ated that the DEA (Drugney) was involved and that staff in every level to assist investigation. The facility staff is own investigation and reported propriate authorities. Instration was informed of the priefing on 1/26/17 at 100 a.m. The facility did not are information about the findings. If failed to ensure accurate instering, storage and Schedule IV (4) narcotic	F 4:	31			

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F 431	ensure the order, the narcotic book from and turns to the resemble of the narcotic book from and turns to the resemble of the property of the book and the RN # 2 was asked 2 opened the narcot Resident # 14's page "diazepam [a scheolock 5 mg/1 ml [mil M GIVE (0.2 ML II THEN GIVE (0.2 ML II THEN GIVE (0.2 M NEEDED FOR 3 Deage documented the quantity (receive mg in each pen/syrone left in this bag, is what is left of this one manufactured, tubular sleeve. The and observed as a syringe had "gradual measure/scale mar centimeters of milliful indicate the amount pen/syringe was ob (meaning that .5 ml resident). The nurse (staff nurses) admir asked if the nurses	e looks at the computer to hen retrieves the 'sign out' the side of the medication cart sident's page for that and then opens the narcotic es the medication, sign's it out en administers it. It o give a demonstration. RN # otic book and turned to ge. ge listed the drug as dule IV/4 medication] with lure ligrams/milliliter] DISP SYRIN NTRAMUSCULAR NOW * IIL) EVERY 30 MIN AS AYS FOR SEIZURES" The the date received as 11/14/16, ed) was 5 pens/syringes-10	F 4	31			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACI	OVIDER'S PLAN OF CORR H CORRECTIVE ACTION S -REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 431	syringe and admin "Well it's IM [intranhave never adminisyringe] before." The glass syringe not have any information to indicate that this The RN was asked what is needed and medication back in looks that way." The manufacturer's paramedication. The Romanufacturer's paramedication. The Romanufacturer's paramedication. The Romanufacturer's paramedication. The Romanufacturer's paramedication and the pharmacist and the nursing) were asked findings and to clar be used as a multiple the medication from and handed the medication from and handed the medication from the pharmacist stated that would be a sin was then taken out removed, there was the pharmacist the should actually say went on to say, "It of stated that the rest syringe should have dose was administed."	ister that way. The RN stated, nuscular], I really don't know I stered it [from the glass was observed again and did mation on the actual package was a multi dose syringe. If they (staff nurses) just use of then store the unused the cart. The RN stated, "It he RN was asked to provide a ckage insert for this is stated that she would notify ave the information faxed. 2:15 p.m., the facility corporate DON (director of the do observe the above if y if the glass syringe was to dose vial. RN # 2 removed in the locked narcotic drawer edication to the pharmacist. Inted, "If it has a needle then gle dose." The glass syringe of the plastic tube and the top is no needle. In stated that the package if it is a multi dose syringe and does not." The corporate RN of the medication in that is been wasted when the last	F4	31				
	for the above medic	cation was presented. The rmation documented, "How						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495146	B. WING			01	12612047	
	PROVIDER OR SUPPLIER AT HARRISONBURG			94 9	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH AVENUE RRISONBURG, VA 22801	<u> UI</u>	<u>/26/2017</u>	
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	Luer LockConcer ml)Carpuject [TM cartridge with Luer System" Upon further review sheet for diazepam count of this medicabetween 12/29/16 a was unaccounted for administration or of At approximately 3:3 and concerns were administrator and contact the medication been accessed one medication should be facility policy, since medication units. Note a medication administration administration administration administration administration units. At approximately 4:1 stated that the facility as requested above subscription to a nurfacility) uses for reference insert titled, "Injectated Administration", was "The Association of and Control and Epic World Health Organical and Control a	ct Sterile Cartridge Unit with Intration 10 mg/2 ml (5 mg/1 l/trademark], Single-dose Lock for the Carpuject Syringe Lock for the Carpuject Syringe of Resident # 14's narcotic it was found that the narcotic ation was off by 0.3 ml and 01/06/17, the medication for, there was no record of the medication being wasted. 30 p.m., the above information discussed with the corporate DON. Both agreed syringe should only have time and then any remaining have been destroyed per these were single dose to explanation was provided cation count/reconciliation of 0.3 ml of the diazepam for olicy was requested on tration, as far as infection d use of single or multi-dose 15 p.m., the corporate DON by did not have specific policy, but did have a paid resing resource that they (the prence and presented an	F4	31				

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB					
STATEMENT	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION DING	(X3) DA	ATE SURVEY DMPLETED
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	PROVIDER OR SUPPLIER E AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP CO 94 SOUTH AVENUE HAPPISONBURG, VA. 22904		
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	possible. A multido: transmission by inal follow manufacturer use of medication viewith the date immedication there's no alternative labeled by the manusingle use" for a sir medications lack an can become contaminfection if used inapdrugs administered, administration" No further information provided prior to the at 12:00 p.m. 6. The facility staff for reconciliation of a Somedication for Residual Resident # 10 was a 12/17/15, with diagnote: spinal stenosis, I anemia, migraines, costeomyelitis. The most recent MD assessment with an adate) of 11/19/16, who with the residual reconstruction of the provided prior to the at 12:00 p.m.	ose vial poses a risk of appropriate handlingAlways r's instructions for storage and vials and label multidose vials diately upon opening. To contamination, most facilities al medications in single-dose nly use multidose vials only if veYou should use vials urfacturer as "single dose" or ngle patient only. These ntimicrobial preservatives and minated and serve a source of appropriatelyRecord the injection site, and time of sexit conference on 01/26/17 failed to ensure accurate schedule IV (4) narcotic dent # 10. admitted to the facility on noses including, but not limited DM (diabetes mellitus), chronic kidney disease, and	F 4	131		

making skills.

resident was cognitively intact for daily decision

PRINTED: 01/31/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495146 B. WING 01/26/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE AVANTE AT HARRISONBURG HARRISONBURG, VA 22801 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 431 Continued From page 77 F 431 On 01/25/17 at approximately 12:26 p.m., the other med cart on A wing was observed with RN # 5. RN # 5 was asked if there were any injectables on this medication cart. RN # 5 stated that there was no injectables on the cart, only a bottle of liquid morphine. The RN was asked to observe that medication and the narcotic medication log. RN # 5 pulled the medication bottle from the locked drawer and opened the narcotic log book to Resident # 10. The narcotic log sheet and the morphine bottle for Resident # 10 documented that the morphine sulfate was supplied in a 30 ml bottle, with a concentration of 20 mg/1 ml. The ordered dose for Resident # 10 was, "Take 0.5 ml (10 mg) by mouth every hour as needed for pain/dyspnea [shortness of breath]..." The morphine bottle came with a graduated syringe to measure the dose to be given in 0.5 ml [10 mg] increments. Resident # 10's narcotic log sheet was reviewed and documented the following: On 12/30/16 the amount documented as given was 0.5 ml (10 mg) and the amount remaining

administration of 0.5 ml.

amount remaining was 8 ml.

was 22 ml.

On 12/31/16 the amount documented as given was 0.5 ml (10 mg) and the amount remaining was 21 ml. This showed an error in calculation or

documented as given was 0.5 ml (10 mg) and the

On 01/19/17 at 9:00 p.m., the amount

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495146	B. WING_		01.	/26/2017	
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP (94 SOUTH AVENUE HARRISONBURG, VA 22801			
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	was made that documents." This was the 11-7 shift, which amount of morphine unaccounted for any the total amount undocumentation was RN # 5 could not extend to the corporate DON made aware in a me 01/25/17 at approxicorporate DON was information above, documentation was discrepancies. No further information provided prior to the at 12:00 noon.	23 p.m., a handwritten notation umented, "Dosage was signed by two nurses on a documented the remaining to be 5 mls, which left an accounted amount per the 3.5 mls. Explain the discrepancies found. I and the administrator were the eeting with the survey team on mately 4:30 p.m. The sunaware of the identified	F 43	F – 441 Deficiency Con		2/24/17	
	(a) Infection prevent The facility must est and control program a minimum, the follo (1) A system for pre investigating, and co communicable diseavolunteers, visitors, providing services u	tion and control program. tablish an infection prevention (IPCP) that must include, at owing elements: venting, identifying, reporting, ontrolling infections and asses for all residents, staff, and other individuals	F 444	program. The facility must establish prevention and control programust include, the following (1)A system for preventing reporting, investigating, an infections and communicab all residents, staff, voluntee other individuals providing a contractual agreement be facility assessment conducte §483.70(e) and followin national standards (facility implementation in Phase2);.	h an infection ram (IPCP) the elements: ng, identifying, nd controlling ale diseases for rs, visitors and services under ased upon the ed according to ng acceptable ty assessment		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING		01/	26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG	·	9	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE 1ARRISONBURG, VA 22801		
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F 441	accepted national simplementation is F (2) Written standard for the program, whimited to: (i) A system of surv possible communicable communicable communicable diserported; (ii) When and to who communicable diserported; (iii) Standard and the to be followed to provide the followed to provid	ng to §483.70(e) and following standards (facility assessment Phase 2); ds, policies, and procedures nich must include, but are not eillance designed to identify able diseases or infections read to other persons in the some possible incidents of asse or infections should be ansmission-based precautions event spread of infections; isolation should be used for a put not limited to: uration of the isolation, einfectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility by es with a communicable skin lesions from direct not or their food, if direct	F 441	F – 441 Continued: 1) How Corrective action accomplished for those have been effected. Resident #14's medication reviewed on 1/26/17; the most was discontinued by the phys 2) How corrective action accomplished for those potential to be affected by practice. An audit of the single use Valvas completed 1/25/17, residents were determined affected. 3) What measures will be place or systemic changes ensure that the deficient will not occur. In-service was initiated on a the current licensed nursing include proper administration single dose medication vial leftover contents disposed of facility protocol. This will be in Orientation of new licenses staff. The Unit manager or will monitor compliance with of single dose vial medication a minimum weekly 4 we randomly thereafter reporting to the Director of Nurappropriate follow-up.	on was edications ician. will be having the same alium vial no other l to be put into made to practice 2/7/17 for g staff to on of a and any of as per eincluded ad nursing designee h the use a protocol eeks than g findings	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495146	B. WING _		01	/26/2017
	PROVIDER OR SUPPLIER E AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIF 94 SOUTH AVENUE HARRISONBURG, VA 22801		Luizy
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	under the facility's lactions taken by the actions taken by the (e) Linens. Person process, and transpapered of infection. (f) Annual review. Tannual review of its program, as necess This REQUIREMEN by: Based on observation document review, the ensure proper dispendication for the process.	cording incidents identified IPCP and the corrective e facility. Incl must handle, store, port linens so as to prevent the term of the facility will conduct an a IPCP and update their	F 44	F-441 Continued: 4) How the facility plaits performance to m solutions are sustained. The Director of Nursin will review audit report basis for four weeks repto the monthly Qual Committee and then raan as needed bases.	F-441 Continued: 4) How the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing or designee will review audit reports on a weekly basis for four weeks reporting findings to the monthly Quality Assurance Committee and then randomly or on an as needed based on the recommendations of the Quality	
	The facility staff failed to follow manufacturer's instructions for the use of single use diazepam syringes for Resident # 14; the facility staff accessed the single dose units multiple times and put the medication at risk for contamination and the resident at risk of infection. Findings include: Resident # 14 was admitted to the facility on 06/14/14, with the most current readmission on 08/15/15. Diagnoses for Resident # 14 included, but were not limited to: dementia, anxiety disorder, psychotic disorder, schizophrenia, and seizure disorder.					
	The most current M	IDS (minimum data set) was a			!	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495146	B. WING	<u> </u>		01/26/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 94 SOUTH AVENUE HARRISONBURG, VA 2280	, ZIP CODE	V 1120122	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	assessed the resident of 6, indicating the impairment in daily. On 01/25/17 the fawing were observed. RN (Registered Nuthe process for narstated that first she ensure the order, to narcotic book from and turns to the remedication, verified drawer and retrieved in the book and the RN # 2 was asked 2 opened the narcon Resident # 14's pare "diazepam [a schelock 5 mg/1 ml [mil M GIVE (0.2 ML I THEN GIVE (0.2 ML I THEN GIVE (0.2 M NEEDED FOR 3 Deage documented the quantity (receive mg in each pen/symmat is left of this one manufactured, tubular sleeve. The	nent dated 11/08/16, which dent as having a cognitive score e resident had severe y decision making skills. acilities medication carts on A ed at approximately 11:15 a.m. urse) # 2 was asked to explain a recotic administration. RN # 2 elooks at the computer to then retrieves the 'sign out' in the side of the medication cart esident's page for that its and then opens the narcotic res the medication, sign's it out en administers it. It to give a demonstration. RN # exito book and turned to age. age listed the drug as edule IV/4 medication] with lure illigrams/milliliter] DISP SYRIN INTRAMUSCULAR NOW * ML) EVERY 30 MIN AS DAYS FOR SEIZURES" The the date received as 11/14/16, wed) was 5 pens/syringes-10	F 4	441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 94 SOUTH AVENUE HARRISONBURG, VA 22801	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 441	syringe had "gradine measure/scale macentimeters of millindicate the amoupen/syringe was of (meaning that 0.5) the resident). The they (staff nurses) was asked if the nurse of the medication they put a needle and administer that it's IM [intramuscunever administere. The glass syringe not have any inforto indicate that this The RN was asked what is needed and medication back in looks that way." The RN stated that have the information to the information of the RN stated that have the information of the	uation marks" (units of arkings listed in cubic liliters), which are marks to not left in the syringe. This observed with 1.5 ml remaining ml had been administered to enurse was then asked how administer this medication and surses use a standard syringe to on out of the glass syringe or do on the end of the glass syringe at way. The RN stated, "Well alar], I really don't know I have d it [from glass syringe] before." was observed again and did mation on the actual package is was a multi dose syringe. If they (staff nurses) just use and then store the unused in the cart. The RN stated, "It is the RN was asked to provide a ckage insert for this medication. It she would notify pharmacy to	F 4	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495146	B. WING		01	/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STATE, ZIP 94 SOUTH AVENUE HARRISONBURG, VA 22801		
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F 441	Continued From pa	ge 83	∫ F4	41		
	went on to say, "It of stated that the rest syringe should have dose was administed. At approximately 12 for the above medic package insert info Supplied Carpuject Luer LockConcerml)Carpuject [TM]	does not." The corporate RN of the medication in that been wasted when the last				
	sheet for diazepam count of this medic between 12/29/16 a	of Resident # 14's narcotic , it was found that the narcotic ation was off by 0.3 ml and 01/06/17, there was no ation or of the medication				
	discussed with the DON. Both agreed should only have be then any remaining wasted, since these units. No explanati medication count/re	tion and concerns were administrator and corporate that the medication syringe een accessed one time and medication should have been a were single dose medication on was provided regarding the econciliation of the 3 ml of the diazepam for				
	stated that the facil as requested above subscription to a nu facility) uses for ref insert titled, "Injecta	15 p.m., the corporate DON ity did not have specific policy, a but did have a paid arsing resource that they (the erence and presented an able Medication as presented and documented:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING			01/26/2017
	PROVIDER OR SUPPLIER AT HARRISONBURG			STREET ADDRESS, CITY, STAT 94 SOUTH AVENUE HARRISONBURG, VA 22		
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F 441	and Control and Ep World Health Orgar single-use or single possible. A multido transmission by ina follow manufacturer use of medication v with the date immed reduce the risk of codispense parenteral vialsyou should or there's no alternative labeled by the manufactions lack are can become containing administered, administeration"	ge 84 of Professionals in Infection idemiology guideline and the nization recommend using dose vials whenever se vial poses a risk of appropriate handlingAlways is instructions for storage and ials and label multidose vials diately upon opening. To ontamination, most facilities a medications in single-dose only use multidose vials only if eYou should use vials ufacturer as "single dose" or nigle patient only. These attimicrobial preservatives and minated and serve a source of appropriatelyRecord the injection site, and time of the on or documentation was a exit conference on 01/26/17	F4	41		