PRINTED: 01/20/2017 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARI  | R MEDICAID SERVICES                                   |  |   | OWR NO: 0838-0391             |
|---|---|--|---|-------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED |
|   | 495147  | B, WING                                |   | 01/11/2017                    |
| NAME OF PROVIDER OR SUPPLIER  |   | 12                                     | REET ADDRESS. CITY, STATE, ZIP CDDE<br>21 ROSSER AVE<br>AYNESBORO, VA 22980                             |                               |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) |   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPE<br>DEFICIENCY) | ULD BE COMPLETION             |
| F 000 INITIAL COMMEN  | ιτs   | F 000                                  | Preparation and/or execution of Plan of Correction does not cor   | of this 2/8/2017              |

An unannounced Medicare/Medicaid standard survey was conducted 01/10/17 through 01/11/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long. Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were

The census in this 109 certified bed facility was 95 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 16) and 3 closed record reviews (Residents 17 through 19).

F 225 483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT SS=D ALLEGATIONS/INDIVIDUALS

investigated during the survey.

- (a) The facility must-
- (3) Not employ or otherwise engage individuals who-
- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
- (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or
- (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.
- (4) Report to the State nurse aide registry or

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth of the Statement of Deficiencies. This plan of Correction is prepared and / or executed solely because required by the provisions of Health and Safety Code Section 1280 and 42 C.F.R. 405.1907

F 225
1) Employee was suspended on 11/1/2016 upon receiving notification from Adult Protective Services (APS) regarding alleged verbal abuse towards Resident #2. On 11/7/2016, employee was terminated based on final investigation outcome.

A Facility Reportable Incident (FRI) along with the five day follow up investigation was submitted to VDH for reporting purposes on residen: #2 and #17.

2) The Administrator completed an audit of residents here during the year of 2016 to current. Any issues/concerns identified or Adult Protective Services (APS) contacted either internally or externally on any in-house resident, will have a FRI along with the 5 day follow up investigation submitted as deemed appropriate.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

EXECUTIVE Director 12711

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 oflowing 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.

Facility ID: VA0019

ENTH AND HUMAN SERVICES

PRINTED: 01/20/2017 FORM APPROVED

| EPAR I MEINT OF HEALTH   | AND HUMAN SERVICES   |                     | 1C  | MB NO. 0938-039  |
|--|--|---------------------|---|--|
| ENTERS FOR MEDICARE  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE C     |   | (X3) DATE SURVEY<br>COMPLETED  |
| ATEMENT OF DEFICIENCIES<br>ID PLAN OF CORRECTION   | (X1) PROVIDENSOPPLIENCEA<br>IDENTIFICATION NUMBER:   |                     |   | C  |
|  | 495147   | E. WING             |   | 01/11/2017   |
|  | 490141   |                     | ET ADDRESS, CITY, STATE, ZIP CODE   |  |
| AME OF PROVIDER OR SUPPLIER  |  |                     | ROSSER AVE  |  |
| WANTE AT WAYNESBORD  |  | WA                  | YNESBORO, VA 22980  |  |
| (CACH DEE/CIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ADTION SHOULD<br>CROSS-RÉFERENCED TO THE APPROP<br>DEFICIENCY)   | BE DOMITEIN  |
| F 225 Continued From palicensing authorities actions by a court of which would indication nurse aide or other (c) In response to exploitation, or miss.  (1) Ensure that all abuse, neglect, extinctuding injuries of misappropriation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injustified events that calcabuse and do not the administrator officials (including adult protective set for jurisdiction in accordance with Sprocedures.  (2) Have evidence thoroughly investing a protection of minutestigation is in (4) Report the readministrator of representative arrepresentative arrepr | as any knowledge it has of of law against an employee, the unfitness for service as a facility staff.  allegations of abuse, neglect, dreatment, the facility must: alleged violations involving ploitation or mistreatment, of unknown source and of resident property, are rely, but not later than 2 hours it is made, if the events that on involve abuse or result in rry, or not later than 24 hours if use the allegation do not involve result in serious bodily injury, to the facility and to other to the State Survey Agency are revices where state law provide ong-term care facilities) in State law through established er that all alleged violations are igated. | nd<br>es            | 3) In-service provided to employees on the Abuse and N Policy and procedure. All increported regarding any form of towards residents will have a Reportable Incident (FRI) con as well as a five day follow up from the investigation from the Administrator and/or designee.  4) On-going monitoring we conducted through resident intrand care planning meetings.  The results of this audit will be to monthly Quality Assurant Performance Improvement meeting for review and revision necessary. | leglect bidents abuse Facility upleted report facility  facility  bill be erviews  brought ce and (QAPI) |

if the alleged violation is verified appropriate

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| DODABTA  | MENT OF HEALTH   | AND HUMAN SERVICES   |              |                              | OMB NO.           | 0938-0391          |
|--|--|--|--------------|------------------------------|-------------------|--------------------|
| DEPARTO  | E FOR MEDICARE   | & MEDICAID SERVICES  |              |                              | TAG (EX)          | E SURVEY           |
| гитемекії С  | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | A. BUILD     | TIPLE CONSTRUCTION<br>ING    | 1                 | PLETED<br>C        |
| AD LENK OF   |  |  |              |                              | 1                 | 11/2017            |
|  |  | 495147   | B, WING      | STREET ADDRESS, CITY, STATE, |                   |                    |
| NAME OF PI   | ROVIDER OR SUPPLIER  |  |              | 1221 ROSSER AVE              |                   |                    |
|  |  |  | •            | WAYNESBORO, VA 22980         |                   |                    |
| AVANTE   | AT WAYNESBORO  |  | iD.          | DROVIGED'S DI AN C           | F CORRECTION      | (XS)<br>COMPLETION |
| X41 ID<br>PREFIX<br>TAG  | The second secon | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREF<br>TAG  | ANNOG DESERVENUEU II         | D THE APPROPRIATE | DATE               |
|  |  |  | _            |                              |                   |                    |
| F 225  | Continued From P   | age 2  | . F          | 225                          |                   |                    |
|  | : .  | ENT is not met as evidenced  |              |                              |                   |                    |
|  | review, and clinic   | terview, facility documentation<br>al record review, the facility sta<br>egations of abuse for two of 19<br>urvey sample, Resident # 2 an  | 9            |                              |                   | *                  |
|  | allegation of a hotoward Resident Protective Service failed to report the State Survey working days of   |  | ult<br>O     |                              |                   |                    |
|  | an allow   | aff failed to report to the state<br>ation of abuse/neglect toward<br>orn two personal caregivers th<br>ivate home.  | at           |                              |                   |                    |
| THE PROPERTY OF THE PROPERTY O | The findings inc   | duded:   |              |                              |                   |                    |
|  | 12/22/15. Diag<br>but are not limit<br>anemia (decrea<br>(abnormal bloo<br>Minimum Data<br>Reference Data  | is admitted to the facility on moses for Resident #2 included ted to dementia, depression, assed red blood cells), and diabled sugar levels). Resident #2's Set (MDS) with an Assessmer e (ARD) of 9/20/16 coded Resident #2's | etës<br>nt   |                              | ECEIVED           | j                  |
| The state of the s | #2 with no cog   | nitive impairment.<br>Minimum Data Set coced<br>quiring no assistance only<br>om staff-for Activities of Daily L   |              |                              | DH/OLC            |                    |
| Average and the second   | •  | esident #2's clinical record was   | s<br>vierral |                              |                   |                    |

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| EPART            | MENT OF HEALTH                | AND HUMAN SERVICES  |            |                      | OMB N   | <u>0. 0938-039</u>                  |
|------------------|-------------------------------|---|------------|----------------------|---|-------------------------------------|
|                  |                               | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA                 | (X2) MUL   | TIPLE CONSTRUCTION   | (X3) D:   | ATE SURVEY                          |
| EMENT<br>PLAN CI | OF DEFICIENCIES<br>CORRECTION | IDENTIFICATION NUMBER:  |            | ING                  |   |                                     |
|                  |                               | ,   | 5 17016    |                      |   | RRECTION (XS) I SHOULD BE COMPLETIC |
|                  |                               | 495147  | B. WING    | STREET ADDRESS, COY. |   |                                     |
| AR OF F          | ROVIDER OR SUPPLIER           | 2   |            | 1221 ROSSER AVE      |   |                                     |
| ANTE             | AT WAYNESBORD                 |   |            | WAYNESBORD, VA       | 22980   |                                     |
| (4) (D<br>REFIX  | SUMMARY ST                    | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL         | ID<br>PREF | (EACH CORREC         | PLAN OF CORRECTION<br>OTIVE ACTION SHOULD BE<br>NOED TO THE APPROPRIATE | COMPLETIC                           |
| TAG              | REGULATORY OR                 | LSC IDENTIFYING INFORMATION)                                    | IAS        |                      | DEFICIENCY)   |                                     |
| COOE             | Continued From p              | nage 3  | F          | 225                  |   |                                     |
| - 223            | comparaing a with             | essed act of verbal abuse from                                  |            |                      |   |                                     |
|                  | a staff member to             | Resident #2 on Tu/Zo/To. Tills                                  | :          |                      |   |                                     |
|                  | referral read, two            | Adult Protective Service stall                                  |            |                      |   |                                     |
|                  | members witness               | sed facility staff state, "stop                                 |            |                      |   |                                     |
|                  | complaining" in a             | ruce tone to Resident #2. Also 2 does not remember the          | ī          |                      |   |                                     |
|                  | Line Ident but state          | ed that she would be upset if                                   |            |                      |   |                                     |
|                  | comeane told be               | r to stop complaining. Notice of                                |            |                      |   |                                     |
|                  | - this incident of VA         | erhal mental abuse and  |            |                      |   |                                     |
|                  | investigation by A            | APS was received in the state                                   | 3          |                      |   |                                     |
|                  | Office of Licensu             | ire and Certification on 12/06/16                               | <i>).</i>  |                      |   |                                     |
|                  | On 1/11/17 at ap              | proximately 10:00 a.m., the                                     |            |                      |   |                                     |
|                  | Administrator Wa              | as interviewed. The Administrat                                 | U          |                      |   |                                     |
|                  | explained that the            | ne incident of verbal abuse had 28/16 at approximately 11:35 a. | m.         |                      |   |                                     |
|                  | nor a notification            | i letter and a visit from two Ar ⊃                              |            |                      |   |                                     |
|                  | workers to the fa             | acility on 11/1/16. Immediately                                 |            |                      |   |                                     |
|                  | following this no             | tification on 11/1/16, the state                                |            |                      |   |                                     |
|                  | member involve                | id was suspended pending an                                     |            |                      |   |                                     |
|                  | internai investig             | ation. As a result of the                                       |            |                      |   |                                     |
|                  | investigation an              | d in collaboration with APS, the as terminated on 11/7/16 for   |            |                      |   |                                     |
|                  | verbal abuse of               | Resident #2.  |            |                      |   |                                     |
|                  |                               |   |            |                      |   |                                     |
|                  | A facility docum              | nentation review was conducted                                  |            |                      |   |                                     |
|                  | on 4/11/17 The                | , facility staff member in question                             | 11         |                      |   |                                     |
|                  | was hired on 7/               | 14/15 and a criminal backgrout                                  | iu         |                      |   |                                     |
|                  | check was proc                | cessed on 7/6/15, This staff irable with no barrier crimes on   | the        |                      |   |                                     |
|                  | tibing of broads              | ion, the staff member signed w                                  | ·O         |                      |   |                                     |
|                  | atatements that               | tishe had read and received ure                                 | 7          |                      |   |                                     |
|                  | Abuse/Neglect                 | Policy dated 7/10/15 and 9/6/10                                 | 5.         |                      |   |                                     |
|                  |                               | approximately 12:20 p.m., the                                   |            |                      |   |                                     |
|                  | A deministrator s             | <sub>stated</sub> "I snould have reported t                     | his        |                      |   |                                     |
|                  | tahuse allecati               | on and investigation; to your on                                | ce         |                      |   |                                     |
|                  | N/irginia Dehall              | rtment of Health: Office of                                     |            |                      |   |                                     |
|                  | Licensure and                 | Certification] but I thought APS                                |            |                      | the works with  | on sheet Page 4                     |

FORM CM5-2567(02-59) Frevlous Versions Obsolete

Event ID: PNKL11

Facility ID: VA0019

If continuation sheet Page 4 of 54



PRINTED: 01/20/2017 FORM APPROVED

| DEFAR                       | OF CONTROL OF THE CON | * MEDICAID SERVICES   |                            |                    | <u>ON</u>  | <u>ив NO. 0938-039</u> |
|-----------------------------|--|---|----------------------------|--------------------|--|------------------------|
|                             |  | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE CONSTRUCTION |                    |  | (X3) DATE SURVEY       |
| STATEMENIT (<br>AND PLAN OF | OF DERICIENCIES<br>CORRECTION  | IDENTIFICATION NUMBER.  |                            | NG                 | Annual responses and   | COMPLETED              |
|                             |  |   |                            |                    |  | C                      |
|                             |  | 495147  | B. WING                    |                    |  | 01/11/2017             |
| MAME OF P                   | ROVIDER OR SUPPLIER  |   |                            | STREET ADDRESS CIT | Y, STATE, ZIP CODE   |                        |
|                             |  |   |                            | 1221 ROSSER AVE    |  |                        |
| AVANTE /                    | AT WAYNESBORO  |   |                            | WAYNESBORO, VA     | A-18-MINE  |                        |
| X4) ID<br>PREFIX<br>TAG     | /EACH DESIGNERIC   | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION:  | ID<br>PREFI<br>TAG         | Z ZEACH CORR       | 'S PLAN OF CORPECTION<br>ECTIVE ACTION SHOULD<br>ENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE            |
| F 22 <b>5</b>               | Continued From pay   | age 4<br>hould have reported on behalf<br>Administrator also agreed that  | F 2                        | 25                 |  |                        |
|                             | the follow-up resul  | ts from the investigation should d to the State agency.   | *                          |                    |  |                        |
|                             | Unknown Origin P 09/16 documented violations involving exploitation, include misappropriation of photographs or mathis policy are to be always report to Agency and follow reporting." Also, dithe following state investigations must day to the Admin accordance with leading the state agency)."  | ct, Exploitation and Injuries of olicy with a revision date of a time following: "All alleged a abuse, neglect, or ling injuries of unknown source, of resident property, or taking aking recordings in violation of the reported immediately to State Survey and Certification of Federal guidelines for ocumented in this policy was ement: "The results of all st be reported within 5 working distrator and other officials in ocal, state and federal law e survey and certification." |                            |                    |  |                        |
|                             | findings during a language finding a language findi | briefing on 1/11/17 at<br>30 p.m. The facility did not<br>er information about the findings   | i.                         |                    |  |                        |
|                             | abuse/neglect to<br>17 regarding two<br>had at his persor  | aff failed to report an allegation of<br>the state agency for Resident #<br>personal caregivers the resider<br>hal home residence.  |                            |                    |  |                        |
|                             | Resident # 17 wa   | as admitted to the facility   |                            |                    |  |                        |

TAKENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/20/2017 FORM APPROVED

|  |   | AND HUMAN SERVICES  |                    |   | MB NO. 0938-0391                   |
|--|---|---|--------------------|---|------------------------------------|
| STATEMENT OF CO  | DEFICIENCIES  | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/DLIA IDENTIFICATION NUMBER:   |                    | TIPLE CONSTRUCTION NG   | (X3) DATE SURVEY<br>COMPLETED<br>C |
|  |   | 495147  | B. WING            |   | 01/11/2017                         |
|  | VIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1221 ROSSER AVE<br>WAYNESBORO, VA 22980                                | ON (X5)                            |
| (X4110)<br>PREFIX<br>TAG   | JEACH DEFICIENCE  | ATÉMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENT.FYING INFORMATION)  | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CORRECTIV<br>X (EACH CORRECTIVE ACTION SHOUL<br>DROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | DEE COMPTERIOR                     |
| Distriction of the control of the co | at were not limited addripted and infect age 4 pressure us the most current for assessment as naving a pairment, with a section making a sessed as requisest one person forming a complaint esident # 17's class (SW (social work 7/08/16 documents). | ses for Resident # 17 included, of to: atrial fibrillation, organic bladder, history of UTI's tions), anxiety disorder, and after.  MDS (minimum data set) was a ent with an ARD (assessment 09/06/16, which assessed the short and long term memory evere impairment in daily kills. The resident was also ring total assistance from at or all ADL's (activities of daily it investigation on 01/11/17, inical record was reviewed. | F 2                | 225   |                                    |

resident...much better spirits and lucid today...talked about upcoming discharge from facility. When asked how he felt about leaving he stated "Honestly I don't fee: ok" When asked why he stated "My 2 caregivers [name of caregiver] and [name of caregiver] are the worst...doesn't do anything- he gets me in and out of bed and that's it. [name of other caregiver] cooks and that's it...I'm paying them \$9/hr to do nothing and they live with me...Reassured resident that if he didn't feel safe discharging next week that we could definitely postpone discharge. Resident in agreement and thankful for conversation...notified resident's RP [responsible party]...also called [name] with APS [adult protective services, administrator made aware of situation..."

Facility ID: VA0019

if continuation sheet Page | 6 of 54

FORM CMS-2967(62-99) Previous Versions Obsolete

JAN 27 2017

RECEIVED

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| DEFAR IN   | MENI OF HEALIN                            | - P MATHICAID CERVICES   |                   |         | (  | OMB NO.                           | 0938-039                         |
|--|---|--|-------------------|---------|--|-----------------------------------|----------------------------------|
|  |   | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MUI          | TIPLE C | CONSTRUCT ON   | (X3) DATE                         | SURVEY                           |
| STATEMEN I C<br>AND PLAN OF  | F DEF CI <b>ENCIE</b> 3<br>CORRECTION     | IDENTIFICATION NUMBER  |                   |         |  |                                   |                                  |
|  |   |  |                   |         |  | RECTION (X5)<br>SHOULD BE COMPLET | -                                |
|  |   | 495147   | B WING            |         |  | 01/                               | 11/2017                          |
| NAME OF PR   | OVIDER OR SUPPLIER                        |  |                   | i       | EET ADDRESS, CITY, STATE, ZIP CODE   |                                   |                                  |
| AVABITE A  | T WAYNESBORO                              |  |                   | 1       | I ROSSER AVE<br>YNESBORO, VA 22980   |                                   |                                  |
| MUMINIA. M   |   |  |                   | L       |  | ACAN I                            |                                  |
| (X4) ID<br>PREFIX<br>TAG   | reach DEFICIENC                           | ATEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG | ΊX      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                             | COMPLETION<br>COMPLETION<br>DATE |
|  | Continued From pa                         |  | F                 | 225     |  |                                   |                                  |
| (  | On 01/11/17 at app                        | proximately 12:50 p.m., the SW   |                   |         |  |                                   |                                  |
| ,  | was interviewed re                        | garding the above information the was aware of the resident                    |                   |         |  |                                   |                                  |
|  | and was asked it s<br>having his credit c | ards used without his  |                   |         |  |                                   |                                  |
|  | permission by the                         | 2 personal care staff at his   |                   |         |  |                                   |                                  |
|  | home. The SW di                           | d not recall the later, but stated   |                   |         |  |                                   |                                  |
|  | that she did report                       | to APS and the administrator   |                   |         |  |                                   |                                  |
|  | what the resident i<br>in his home.       | had said about his 2 caregivers  |                   |         |  |                                   |                                  |
|  | m ma nome.                                |  |                   |         |  |                                   |                                  |
|  | At 2:00 p.m., the \$                      | SW presented a letter from APS   |                   |         |  |                                   |                                  |
|  | cated 08/25/16. T                         | he letter in summary was   |                   |         |  |                                   |                                  |
| Average and a second a second and a second a | notifying the facility                    | y that the investigation was<br>not have any specific                          |                   |         |  |                                   |                                  |
|  | information or wha                        | at the outcome of the  |                   |         |  |                                   |                                  |
|  | investigation deter                       |  |                   |         |  |                                   |                                  |
|  |   |  |                   |         |  |                                   |                                  |
|  | The SW stated the                         | at she did not about the<br>ards until after AP\$ got involved                 |                   |         |  |                                   |                                  |
|  | and she had bear                          | d about it. The SW was asked   |                   |         |  |                                   |                                  |
|  | if this was someth                        | ing that she would report to the   |                   |         |  |                                   |                                  |
|  | state agency. The                         | e SW stated that she did not   |                   |         |  |                                   |                                  |
| gli-   | know, but would fi                        | ind out.   |                   |         |  |                                   |                                  |
| T. C.  | At aggroy'mately                          | 2:45 p.m., the SW and  |                   |         |  |                                   |                                  |
| And the second s | administrator were                        | e again interviewed, the   |                   |         |  |                                   |                                  |
| and the same of th | administrator state                       | ec that they (the facility) did not  |                   |         |  |                                   |                                  |
|  | think this was son                        | nething they needed to report to   |                   |         |  |                                   |                                  |
|  | the state agency                          | since this was not an event that<br>in the facility, the administrator         |                   |         |  |                                   |                                  |
|  | stated that it was                        | reported to APS and the local  |                   |         |  |                                   |                                  |
|  | authorities were in                       |  |                   |         |  |                                   |                                  |
|  |   |  |                   |         |  |                                   |                                  |
|  | No further informa                        | ation or documentation was<br>the exit conference on 01/11/17                  | 7                 |         |  |                                   |                                  |
| and the state of t | presented prior it<br>at 4:15 p.m.        | THE GYIL POINGLEHOO ON CHAILITH  |                   |         |  |                                   |                                  |
| F 226  | 483 12(5)(1)-(3)                          | 483.95(c)(1)-(3)   | F                 | 226     |  |                                   |                                  |
| SS=D   | DEVELOP/IMPL                              | MENT ABUSE/NEGLECT, ETC  |                   |         |  |                                   |                                  |

FORM CMS-2567(C2-99) Previous Versions Obsolete

Evant (0: PNKL1)

Facility ID: VA0019

If continuation sheet Page 7 of 54



PRINTED: 01/20/2017 FORM APPROVED OMB NO. 0938-0391,

| CENTERS FOR MEDIC         | ARE & MEDICAID SERVICES  |                   |   | 'OVEN TATE EL          | mv:=v                     |
|---------------------------|--|-------------------|---|------------------------|---------------------------|
| STATEMENT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MUL          | MPLE CONSTRUCTION   | (X3) DATE SU<br>COMPLE |                           |
| AND PLAN OF CORRECTION    | DENTIFICATION NUMBER:  | A. BUILD          | NG  |                        |                           |
|                           |  |                   |   | C                      |                           |
|                           | 495147   | B. WING           |   | 01/11/:                | 2017                      |
| NAME OF PROVIDER OR SUFF  | PUER   |                   | STREET ADDRESS, CITY, STATE, ZIP COD  | E                      |                           |
| NAME DE PROVIDEIR DICEON  |  |                   | 1221 ROSSER AVE   |                        |                           |
| AVANTE AT WAYNESBOI       | RO   |                   | WAYNESBORO, VA 22980  |                        |                           |
| FACH DEEK                 | RY STATEMENT OF DEFICIENCIES<br>CIENCY MUST BE PRECEDED BY FULL<br>Y OR LSC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG | PROVIDER'S PLAN OF CORRE<br>X (EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE 🗀             | (X5)<br>OMPLETION<br>DATE |
|                           |  | E                 | 226 1) Employee was suspen  | dēd on 2/8             | 3/2017                    |

### F 226 Continued From page 7 POLICIES

483,12

- (b) The facility must develop and implement written policies and procedures that:
- (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.
- (2) Establish policies and procedures to investigate any such allegations, and
- (3) Include training as required at paragraph \$483.95.

483 95

- (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-
- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.
- (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property
- (c)(3) Dementia management and resident abuse prevention.

This REQUIREMENT is not met as evidenced bv:

Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to follow the abuse policy and procedures for reporting an abuse allegation and the results

11/1/2016 upon receiving notification from Adult Protective Services (APS) regarding alleged verbal abuse towards Resident #2. On 11/7/2016, employee was terminated based on final investigation outcome.

A Facility Reportable Incident (FRI) along with the five day follow up investigation was submitted to VDH for reporting purposes on resident #2 and #17.

- 2) The Administrator completed an audit of residents here during the year of 2016 to current. Any issues/ concerns identified or Adult Protective Services (APS) contacted either internally or externally on any in-house resident, will have a FRI along with the 5 day follow up investigation submitted as deemed appropriate.
- 3) In-service provided to current employees on the Abuse and Neglect Policy and procedure. All incidents reported regarding any form of abuse towards residents will have a Facility Reportable Incident (FRI) completed as well as a five day follow up report from the investigation from the facility Administrator and/ or designee.
- 4) On-going monitoring will be conducted through resident interviews and care planning meetings.

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| DEPART                   | MENT OF HEALTH   | AND HUMAN SERVICES   |                   |       | C   | MB NO | . <b>0938</b> -039        |
|--------------------------|--|--|-------------------|-------|---|-------|---------------------------|
| TATEMENT                 | OF DEFICIENCIES  | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA   |                   |       | CONSTRUCTION  |       | E SURVEY<br>MPLETED       |
| ID PLAN O                | FCORRECTION  | IDENTIFICATION NUMBER:   | A. BUILE          | ING _ |   |       | С                         |
|                          |  | 495147   | B. WING           |       |   | 01.   | /11/2017                  |
|                          | ROVIDER OR SUPPLIER  |  |                   | 122   | REET ADDRESS, CITY, STATE, ZIP CODE<br>21 ROSSER AVE<br>AYNESBORO, VA 22980                                 |       |                           |
| (X4) ID<br>FREFIX<br>TAG | SUMMARY ST   | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | EIX   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LOBE  | (X5)<br>COMPLETIO<br>DATE |
| F 226                    | Continued From p<br>of the investigation<br>residents, (Residents)   | age 8<br>n to the State agency for 2 of 19<br>ent #2 and Resident # 17).   | •                 | 226   | The results of this audit will be b<br>to monthly Quality Assuranc<br>Performance Improvement (             | e and |                           |
|                          | Neglect, Exploitat<br>Origin Policy with<br>report a verbal ab<br>housekeeping sta<br>Also, the facility s | If failed to follow the Abuse, ion and Injuries of Unknown a revision date of 09/16 to use allegation of a siff member toward Resident #2 taff failed to follow the policy to of the investigation to the State fication Agency within 5 workingent. | ;                 |       | meeting for review and revision necessary.  | ns as |                           |
|                          | policies and proc<br>reporting for Res<br>the facility SW (s<br>personal caregiv                           | aff failed to implement written<br>ledures for abuse/neglect<br>ident # 17; Resident reported to<br>ocial worker) that his two<br>ers at his home residence were<br>f him appropriately, this<br>not reported to the state agenc                     | <b>)</b>          |       |   |       |                           |
|                          | The findings incl  | udedt  |                   |       |   |       |                           |
|                          | 12/22/15. Diagn<br>but are not limite<br>anemia (decreas<br>(abnormal blood                                | s admitted to the facility on loses for Resident #2 included and to dementia, depression, sed red blood cells), and diabet sugar levels). Resident #2's Set (MDS) with an Assessment (ARD) of 9/20/16 coded Resident                                 |                   |       |   |       |                           |

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#2 with no cognitive impairment. In addition, the Minimum Data Set coded Resident #2 requiring no assistance only

care (eating, dressing).

supervision from staff for Activities of Daily Living

On 1/10/17, Resident #2's clinical record was reviewed. The reviewed revealed an APS referral concerning a witnessed act of verbal abuse from

Event ID: PNKL11

Facility ID: VA0019

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| DEPART   | MENT OF HEALTH                  | AND HUMAN SERVICES   |                 | (  | OMB NO. 0938-0391            |
|--|---------------------------------|--|-----------------|--|------------------------------|
|  |                                 | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA                                       | (X2) MULTIPLE C |  | (X3) DATE SURVEY COMPLETED   |
| STATEMENT<br>AND PLAN CO   | OF DEFICIENCIES<br>FICORRECTION | DENTIFICATION NUMBER:  | A. BUILDING     |  |                              |
|  |                                 |  |                 |  | 01/11/2017                   |
|  |                                 | 495147   | B. WING         | EET ADDRESS, CITY, STATE, ZIP CODE   | 1 01/11/2017                 |
| NAME OF F  | ROVIDER OR SUPPLIER             |  | 1               | 1 ROSSER AVE   |                              |
| AVANTE   | AT WAYNESBORO                   |  |                 | YNESBORO, VA 22980   |                              |
| 7474,***   |                                 | TOT DEDICIONOIS  | 10              | PROVIDER'S PLAN OF CORRECT   | TON (XS)                     |
| (X4) ID<br>PREFIX<br>"AG   | SEACH DEFICIENC                 | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | JELF LIL                     |
| £ 226  | Continued From p                | age 9  | F 226           |  |                              |
| 1 225  | a staff member to               | Resident #2 on 10/28/16. The   |                 |  |                              |
|  | referral read, two a            | Adult Protective Service staff   |                 |  |                              |
|  | members witness                 | ed facility staff state, "stop<br>rude tone to Resident #2. Also,                      |                 |  |                              |
|  | noted Resident #2               | 2 does not remember the  |                 |  |                              |
|  | incident but stated             | that she would be upset if   |                 |  |                              |
|  | someone told her                | to stop complaining. Notice of rbal, mental abuse and                                  |                 |  |                              |
|  | investigation by A              | PS was received in the State   |                 |  |                              |
|  | Office of Licensur              | re and Certification on 12/06/16.  |                 |  |                              |
|  | A alakis 7 ot one               | proximately 10:00 a.m., the  |                 |  |                              |
|  | Administrator was               | s interviewed. The Administrato  | r               |  |                              |
|  | art that baniclava              | incident of verbal abuse had   |                 |  |                              |
| Action Community Com   | occurred on 10/2                | 8/16 at approximately 11:35 a.m<br>etter and a visit from two APS                      | 1.              |  |                              |
|  | workers to the far              | cility on <b>11</b> /1/16. Immediately   |                 |  |                              |
|  | following this not              | ification on 11/1/16, the stair  |                 |  |                              |
| A STATE OF THE STA | member involved                 | I was suspended pending an tion. As a result of the                                    |                 |  |                              |
|  | investigation and               | Lin collaboration with APS, the  |                 |  |                              |
| Boundary Control of the Control of t | staff member wa                 | is terminated on 11/7/16 for   |                 |  |                              |
| The control of the co | verbal abuse of f               | Resident #2.   |                 |  |                              |
|  | A facility docume               | entation review was conducted  |                 |  |                              |
| MI (MI (MI (MI (MI (MI (MI (MI (MI (MI (   | on 1/11/17 The                  | facility staff member in question  |                 |  |                              |
|  | was hired on 7/1                | 4/15 and a criminal background<br>essed on 7/6/15. This staff                          |                 |  |                              |
|  | mamber was hir                  | able with no barrier crimes on tr  | ne              |  |                              |
| ı<br>İ   | record in addition              | on, the staff member signed two  |                 |  |                              |
|  | statements that                 | she had read and received the<br>Policy dated 7/10/15 and 9/6/16.                      |                 |  |                              |
|  |                                 |  |                 |  |                              |
| Vivo contains  | On 1/11/17 at ap                | pproximately 12:20 p.m., the   | ia              |  |                              |
|  | Administrator 5t                | ated, "I should have reported thin and investigation] to your office                   | e<br>e          |  |                              |
| - The second sec | Mirginia Depart                 | ment of Health: Office of  |                 |  |                              |
| Manager - Will Address   | Liconcure and (                 | Partification   but I thought APS  | ıτ              |  |                              |
| Management of the Control of the Con | would report it                 | I should have reported on beha   | Π               |  | -tip, -tip, cheet Page 10 of |

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Event (D) FNKL11

Fachity ID: VA0019

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OMB NO 0938-0391

| DEEMICE NET  | ALOF DEVIL   | * MEDICAND CEDVICES  |                   |      | L.   | MR NO. 0930-039               |
|--|--|--|-------------------|------|--|-------------------------------|
| ATEMENT OF D   | EFICIENCIES i  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   |      | ONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |
| D PLAN OF COI  | RRECTION   | 495147   | a. WING           |      |  | C<br>01/11/2017               |
| IAME OF PROV   | IDER OR SUPPLIER   | 4901+1   |                   | 1221 | ET ADDRESS, CITY, STATE, ZIP CODE<br>ROSSER AVE  |                               |
| AVANTE AT V  | VAYNESBORO   |  |                   | WAY  | NESBORO, VA 22980  |                               |
| X4MD<br>PREFIX<br>TAG  | THE SALE INCIDENCE.  | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FUIL<br>SCIDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORRECTIVE<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | DBE COMPLETO                  |
| of the had The Ur of the of th | e follow-up resultive been reported to been reported to be a reported to b | Acministrator also agreed that its from the investigation should do the State agency.  In Exploitation and Injuries of the following: "All alleged grabuse, neglect, or ding injuries of unknown source, or resident property, or taking aking recordings in violation of the reported immediately to state Survey and Certification of the Federal guidelines for documented in this policy was ement: "The results of all list be reported within 5 working histrator and other officials in local, state and federal law the survey and certification with survey and certification."  In the facility did not the information about the finding and the fi |                   | 226  |  |                               |
|  | abuse/neglect to<br>17 regarding two<br>had at his perso<br>Resident # 17 v  | raff failed to report an allegation of the state agency for Resident to personal caregivers the resident and home residence.  yas admitted to the facility (24/16 and discharged on noses for Resident # 17 include  | ent               |      |  |                               |

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but were not limited to: atrial fibrillation,

Event ID: PNKL11

Facility ID: VA0019

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| DEFFECT                   | -acao umbicade  | O MEDICAID SERVICES  |                   |                                 | OMB NO   | <u>), 0938-0391</u>        |
|---------------------------|---|--|-------------------|---------------------------------|--|----------------------------|
|                           |   | & MEDICAID SERVICES  | 1/2/10/1          | TIPLE CONSTRUCTION              | (X3) DA  | TE SURVEY                  |
| STATEMENT                 | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1                 |                                 | CO   | MPLETED                    |
| AND PLAN C                | F SUKKESTUM   | ELICE POLICION CONTROL   | A. BUILD          | NG                              |  | С                          |
|                           |   |  | B. WING           |                                 |  | 1/11/2017                  |
|                           |   | 495147   | B. WING           |                                 |  | 1711/2017                  |
| NAME OF I                 | PROVIDER OR SUPPLIER  |  |                   | STREET ADDRESS, CITY.           | SIMIE, ZIP CODE  |                            |
|                           | ለም ነጻለል/አህሮ ሶ <b>ቨ ሲ</b> መረን  |  |                   | 1221 ROSSER AVE                 | 10 pp  |                            |
| AVANTE                    | AT WAYNESBORO   |  |                   | WAYNESBORO, VA                  |  |                            |
| (x4; ID<br>PREF.X)<br>TAG | /FACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | X (EACH CORREC<br>CROSS-REFEREN | PLAN DE CORRECTION<br>ITIVE ACTION SHOULD BE<br>ICED TO THE APPROPRIATE<br>(EFICIENCY) | (X5)<br>COMPLETION<br>EATE |
| F 226                     | (ur.nary tract infect<br>stage 4 pressure u<br>The most current to<br>quarterly assessment<br>reference date) of  | ogenic bladder, history of UTI's tions), anxiety disorder, and   |                   |                                 |  |                            |
|                           | impairment, with sidecision making sidecision making sides as required as to the person formation.  During a complain   | evere impairment in daily kills. The resident was also iring total assistance from at or all ADL's (activities of daily at investigation on 01/11/17. inical record was reviewed.  |                   |                                 |  |                            |
|                           | 07/08/16 documer residentmuch be todaytalked abo facility. When ask stated "Honestly he stated "My 2 cand [name of care anything- he gets it. [name of other itI'm paying ther live with meReafeel safe discharg definitely postpon agreement and tresident's RP [resident's RP [resident's RP]]. | etter spirits and lucid at upcoming discharge from ed how he felt about leaving he don't feel ok." When asked why aregivers [name of caregiver] egiver] are the worstdoesn't dome in and out of bed and that's caregiver] cooks and that's assured resident that if he didn't ging next week that we could be discharge. Resident in mankful for conversationnotifies consible party]also called [adult protective strator made aware of | d                 |                                 |  |                            |
|                           | On 01/11/17 at a  | pproximately 12:50 p.m., the SV  | ٧                 |                                 |  |                            |

was interviewed regarding the above information

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| CENTER                   | S FOR MEDICARI                        | E & MEDICAID SERVICES   |                   |     |  | ONB NO | . 0 <u>938-03</u> 91 |
|--------------------------|---------------------------------------|---|-------------------|-----|--|--------|----------------------|
| TATEMENT                 | OF DEFICIENCIES                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                   | , ,               |     | NSTRUCTION   |        | E SURVEY<br>IPLETED  |
| AD PLANT OF              | CORRECTION                            | IDENTIFICATION NOTICE   | A. EUILJ          | ING |  |        | С                    |
|                          |                                       | 495147  | B. WING           |     |  | 1      | 11/2017              |
|                          |                                       |   | J. 11.10          |     | ET ADDRESS, CITY, STATE, ZIP CODE  | 1 017  |                      |
| AME OF P                 | ROVIDER OR SUPPLIER                   | ι   |                   | i . | ROSSER AVE   |        |                      |
| AVANTE A                 | AT WAYNESBORO                         |   |                   | ľ   | NESBORO, VA 22980  |        |                      |
|                          |                                       |   | (F                |     | PROVIDER'S PLAN OF CORRECT   | iON    | (X(5)                |
| (XA; ID<br>PREF.X<br>TAG | TEACH DEFICIENC                       | (AYEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC (DENTIFYING INFORMATION) | ID<br>PREF<br>TA3 |     | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE  | COMPLETION<br>DATE   |
| F 226                    | Continued From p                      | page 12   | F                 | 226 |  |        |                      |
|                          |                                       | she was aware of the resident   |                   |     |  |        |                      |
|                          | having his credit of                  | ards used without his   |                   |     |  |        |                      |
|                          | permission by the                     | 2 personal care staff at his  |                   |     |  |        |                      |
|                          | home. The SW d                        | id not recall the later, but stated to APS and the administrator                        |                   |     |  |        |                      |
|                          | that she did report                   | had said about his 2 caregivers   |                   |     |  |        |                      |
|                          | in his home.                          | Hay you about the   |                   |     |  |        |                      |
|                          |                                       |   |                   |     |  |        |                      |
|                          | At 2:00 p.m., the                     | SW presented a letter from APS  |                   |     |  |        |                      |
|                          | dated 08/25/16.                       | The letter in summary was<br>ty that the investigation was                              |                   |     |  |        |                      |
|                          | complete, but did                     | not have any specific   |                   |     |  |        |                      |
|                          | information or wh                     | at the outcome of the   |                   |     |  |        |                      |
|                          | investigation dete                    | rmined.   |                   |     |  |        |                      |
|                          | The SW etated th                      | at she did not about the  |                   |     |  |        |                      |
|                          | resident's credit of                  | ards until after APS got involved   |                   |     |  |        |                      |
|                          | and she had near                      | d about it. The SW was asked  |                   |     |  |        |                      |
|                          | if this was someth                    | ning that she would report to the   |                   |     |  |        |                      |
|                          |                                       | e SW stated that she did not  |                   |     |  |        |                      |
|                          | know, but would f                     | and out.  |                   |     |  |        |                      |
|                          | The facilities police                 | cy, "The Abuse, Neglect,  |                   |     |  |        |                      |
|                          | Exploitation and I                    | injuries of Unknown Origin Policy   | 1                 |     |  |        |                      |
|                          | with a revision da                    | ite of 09/16" documented the  |                   |     |  |        |                      |
|                          | following: "All alle                  | eged violations involving abuse,  |                   |     |  |        |                      |
|                          | neglect, or exploi                    | tation, including injuries of misappropriation of resident                              |                   |     |  |        |                      |
|                          | property, or takin                    | g photographs or making   |                   |     |  |        |                      |
|                          | recordings in viol                    | ation of this policy are to be  |                   |     |  |        |                      |
|                          | reported immedia                      | ately to :always report to State  |                   |     |  |        |                      |
|                          | Survey and Certi<br>Federal guideline | fication Agency and follow  |                   |     |  |        |                      |
|                          | rederal guideline                     | затоптерогину.  |                   |     |  |        |                      |
|                          | At approximately                      | 2:45 p.m., the SW and   |                   |     |  |        |                      |
|                          | administrator we                      | re again interviewed, the   |                   |     |  |        |                      |
| ı                        | administrator sta                     | ted that they (the facility) did not  |                   |     |  |        |                      |

think this was something they needed to report to the state agency since this was not an event that

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

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| CENTER   | (S FOR MEDICARE  | S MEDICAID SEKVICES  | ·                   |   | ANID MO. 0300-035             |
|--|--|--|---------------------|---|-------------------------------|
| STATEMENT  | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 '                 | IPLE CONSTRUCTION  4G   | (X3) DATE SURVEY<br>COMPLETED |
|  |  | 495147   | B. WING_            |   | C<br>01/11/2017               |
| NAME OF F  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                               |
| AVANTE   | AT WAYNESBORO  |  |                     | 1221 ROSSER AVE<br>WAYNESBORO, VA 22980   |                               |
|  |  |  |                     |   |                               |
| (X4) ID<br>PREFIX<br>TAG   | FACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | OBE COMPLETION                |
| F 226  | Continued From pa  | age 13   | F 22                | 26  |                               |
|  |  | n the facility. the administrator  |                     |   |                               |
|  | stated that it was re<br>authorities were in   | eported to APS and the local   |                     |   |                               |
|  |  |  |                     |   |                               |
|  |  | tion or documentation was<br>the exit conference on 01/11/17   |                     |   |                               |
| F 279  | 483.20(d);483.21(t   | o)(1) DEVELOP  | F 27                | 79  |                               |
| \$\$=D   | COMPREHENSIV   | É CARE PLANS   |                     | 45 m  |                               |
| -01  | 483.20<br>(d) Use, A facility  | must maintain all resident<br>pleted within the previous 15  |                     | <ol> <li>Care plan on resident #1 we<br/>reviewed and updated to reflect curre<br/>care for colostomy.</li> </ol>   |                               |
|  | months in the residence results of the asset and revise the residence.   | dent's active record and use the<br>essments to develop, review<br>ident's comprehensive care  |                     | Care plan on resident #4 was reviewed and updated to reflect current care for communication.  |                               |
|  | plan.  |  |                     | 2) 100% audit of all current residen  | . 7.0                         |
| Annual designation of the control of | 483.21<br>(b) Comprehensive  | e Care Plans   |                     | with colostomy care required we conducted by MDS Coordinators ensure current care plan accuracy. Nother issues identified.  | as<br>to                      |
| NAME OF THE PARTY  | comprehensive per<br>each resident, con-<br>set forth at §483.1<br>includes measural<br>to meet a resident<br>and psychosocial | st develop and implement a erson-centered care plan for hisistent with the resident rights $O(c)(2)$ and §483.10(c)(3), that ble objectives and timeframes its medical, nursing, and mental needs that are identified in the essessment. The comprehensive |                     | 100% audit of all current residents will communication deficits was conducted by MDS Coordinator or designee ensure current care plan accuracy. Nother issues identified. | ed<br>to                      |
| reduced to the second s | care plan must de  | scribe the following -   |                     | 3) In-service provided by Director<br>Clinical Reimbursement/ MDS and/  | oı                            |
|  |  | at are to be furnished to attain sident's highest practicable  |                     | designee regarding accurate assessments and revisions of care pla   |                               |
| Annual designation of the second   | physical, mental, a  | and psychosocial well-being as 83.24, §483.25 or §483.40; and  |                     |   | nd                            |
|  |  | nat would otherwise be required  |                     |   | •                             |

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Event ID: PNKL11

Facility ID: VA0019

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PRINTED: 01/20/2017 FORM APPROVED DEPAR TMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMEN T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01/11/2017 8 WING 495147 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1221 ROSSER AVE AVANTE AT WAYNESBORO WAYNESBORO, VA 22980 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D TEACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE: CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 279 F 279 Continued From page 14 4) Weekly care plan audits for all under §483.24, §483.25 or §483.40 but are not residents with colostomy and will provided due to the resident's exercise of rights continue weekly for 6 weeks to ensure under §483.10, including the right to refuse care plans remain accurate then treatment under §483.10(c)(6). randomly thereafter. (iii) Any specialized services or specialized The results of this audit will be brought rehabilitative services the nursing facility will to monthly Quality Assurance and provide as a result of PASARR recommendations, If a facility disagrees with the Performance Improvement (QAPI) meeting for review and revisions as findings of the PASARR, it must indicate its rationale in the resident's medical record. necessary, (iv)In consultation with the resident and the resident's representative (s)-(A) The resident's goals for admission and cestred outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced Based on staff interview and clinical record review, the facility staff failed to develop a

communication difficulties.

comprehensive care plan for two of 19 residents in the survey sample. Resident #1 nad no care plan developed regarding care for a colostomy. Resident #4 had no care plan to address

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| TO SOT                   | MENT OF HEALTH   | AND HUMAN SERVICES   |                     | (  | FORM APPROVED<br>_MB NO. 0938-0391_ |
|--------------------------|--|--|---------------------|--|-------------------------------------|
| CENTER                   | S FOR MEDICARE<br>OF DEFICIENCIES<br>F CORRECTION  | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE C     |  | (X3) DATE SURVEY<br>COMPLETED       |
| NE PLAN OI               | - CORRECTION   | 495147   | 5. WING             |  | 01/11/2017                          |
| NAME OF F                | ROVIDER OR SUPPLIER  |  | 1221                | EET ADDRESS, CITY, STATE, ZIP CODE<br>I ROSSER AVE                           |                                     |
| AVANTE                   | AT WAYNESBORO  |  |                     | YNESBORO, VA 22980<br>PROVIDER'S PLAN OF CORRECT                             | 1ON (X5)                            |
| (X4) ID<br>PREFIX<br>TAG | and the same property of the same of the s | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION:                                   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD 8c                               |
| F 279                    | Continued From p   | age 15   | F 279               |  |                                     |
| i Ela                    | The findings inclu   |  |                     |  |                                     |
|                          | 1. Resident #1 na<br>regarding a colos   | d no care plan developed<br>tomy.  |                     |  |                                     |
|                          | Diagnoses for Redysphagia, colon (chronic obstruction and history of both The minimum datassessed Reside cognitive skills.  Resident #1's cliphysician's orderesident's colostic emptied each shreatm documented the each shift as orderesident #1's plant and the each shift and the | lan of care (revised 12/20/16)   | ih <del>e</del>     |  |                                     |
|                          | regarding care to care plan listed for rectal cance colostomy.  On 1/11/17 at 8 nurse (LPN #3)   | the resident had "recent surger" but made no mention of the state a.m. the licensed practical caring for Resident #1 was | ery<br>a            |  |                                     |
|                          | La stance Co   | ncerning the care plant, LFN m<br>5 nurses were responsible for (  | U                   |  |                                     |

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On 1/11/17 at 3:50 a.m. the unit manager (LPN #2) was interviewed about a care plan for Event ID: PNKL11

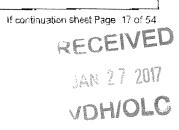
Facility ID. VA0019

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|                          |  | I AND HUMAN SERVICES<br>& MEDICAID SERVICES  |                     |   | PR:NTED: 01/20/2017<br>FORM APPROVED<br>OMB NO: 0938-0391 |
|--------------------------|--|--|---------------------|---|---|
| E'A'EMENT                | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 '                 | IPLE CONSTRUCTION  NG   | (X3) DATE SURVEY<br>COMPLETED<br>C                        |
|                          |  | 495147   | B. WING _           |   | 01/11/2017  |
|                          | PROVIDER OR SUPPLIER<br>AT WAYNESBORO  |  |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>1221 ROSSER AVE<br>WAYNESBORO, VA 22980               | ODE   |
| (X4: ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRÉCEDED BY FULL<br>SC (DENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE COMPLETION                                    |
| F 279                    | Resident #1's color MDS nurses were development and the resident's plan On 1/11/17 at 8:55 MDS coordinator (if a plan of care regal After reviewing the don't see anything stated care for the part of the care plan | stomy. LPN #2 stated the responsible for care plan he colostomy should be part of of care.  a.m. the registered nurse RN #2) was interviewed about ording Resident #1's colostomy. care plan, RN #2 stated, "I He has a colostomy." RN #2 colostomy should have been                 | ' F 27              | '9  |   |
|                          | edition on page 65 "surgically created and the abdominal elimination" This standards of care colostomy to include output each shift, paystem to avoid less skin from fecal ma  | 9 describes a colostomy as a opening between the colon wall to allow fecal a reference documents guidelines for patients with a de monitoring the colostomy periodically changing the pouch akage, protecting surrounding terial and encouraging patient is about body image changes |                     |   |   |
|                          | administrator and omeeting on 1/11/17  (1) Nettina, Sandra Nursing Practice.   | re reviewed with the director of nursing during a 7 at 2:30 p.m.  M. Lippincott Manual of Philadelphia: Wolters Kluwer Villiams & Wilkins, 2014.   |                     |   |   |
|                          | 7 Resident #4 did  | I not have a comorehensive   |                     |   |   |

care plan to include communication.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES | IXI) PROVIDER/SUPPLIER/CLIA | IDENTIFICATION NUMBER: | A BUILDING | B. WING | |

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

PRINTED: 01/20/2017 FORM APPROVED

C 01/11/2017

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

1221 ROSSER AVE

WAYNESBORO, VA 22980

AVANTE AT WAYNESBORO
(X410 SUMMARY S
PREFIX (EACH DEFICIEN

TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 279 Continued From page 17

F 279

Resident #4 was admitted to the facility on 2/26/16 with a readmission on 10/3/16 with diagnoses including post traumatic stress disorder, dysphasia (speech impairment) secondary to stroke.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 11/11/16. Resident #4 was assessed as being cognitively intact.

On 1/10/17 at 2:30 p.m. Resident #4 conversed with a survey team member regarding some concerns. During the conversation Resident #4 verbalized that he becomes frustrated when talking with staff and staff does not understand due to speech impairment, resulting in Resident #4 talking louder and staff verbalizing (to Resident #4) that he is being rude.

Resident #4's electronic record was reviewed on 1/10/17 and evidenced, via most recent MDS dated 11/11/16, section "B" that Resident #4 had triggered for "Unclear speech" "usually understood- difficulty communicating some words [...]"

Review of the facilities "Roster/Sample Matrix" (CMS form 802) triggered Resident #4 for "communication." Section "V" of Resident #4's MDS did not trigger a care plan for communication.

On 1/11/17 at 8:00 a.m. the speech therapist's (other staff, OS #3 and #4) was interviewed concerning Resident #4's speech impairment. Both therapist verbalized Resident does not speak clear and can become frustrated at times

Facility ID: VA0019

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|--|---|---|-------------------|---|--------------------------------|-----------------------|
| CENTERS  | FOR MEDICARE  | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MUL          | TIPLE CONSTRUCTION                          |                                | ATE SURVEY  OMPLETED  |
| STATEMENT OF<br>AND PLAN EDGE  | CERTION<br>CORRECTION   | IDENTIFICATION NUMBER:  | A BJILC           | ING   |                                | C                     |
|  |   |   |                   |   | CODE  S. CITY, STATE, ZIP CODE | 1/11/2017             |
|  |   | 495147  | B. WING           |   |                                | 11/11/2017            |
| NAME OF FRO  | OVIDER OR SUPPLIER  |   |                   | 1221 ROSSER AVE                             | OSE                            |                       |
| *  | WAYNESBORO  |   |                   | WAYNESBORO, VA 22980                        |                                |                       |
| AVANTE AL  |   |   | _                 | ]   | ORRECTION                      | (3.5)                 |
| (X4) ID<br>PREFIX<br>TAG   | CACU DESIGNATION  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION;   | ID<br>PREF<br>TAG | (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T | ON SHOULD BE<br>HE APPROPRIATE | COMPLÉTION<br>DATE    |
| 9<br>F<br>F  | speech therapy ha<br>Resident #4 to spe<br>scondunce words  | age 18 staff. OS #4 verbalized that ad been provided and instructed eak loud as this helps him to more clearly. OS #3 also atation evidencing this  |                   | 279   |                                |                       |
|  | nursing assistant regarding commu Resident #4 is ha con't understand first time he (Resident #4 is ha was presented to (registered nurse most recent MDS aware of Resider agreed that a car | D a.m., Resident #4's certified (CNA#4) was interviewed nication. CNA#4 verbalized rd to understand and if staff what he (Resident #4) said the ident #4) gets upset and loud.  5 a.m. the above information the MDS coordinator, RN#2). RN#2 reviewed the and verbalized that she was at #4 speech impairment and e plan should be in place. RN the social worker is responsib | ìe                |   |                                |                       |
|  | for the MDS asset<br>On 1/11/17 at 8,4<br>was interviewed<br>SW reviewed the<br>verbalized that s   | essment under section "B."  45 a.m. the social worker (SW) concerning Resident #4. The e information provided and he (SW) was able to understand 4 was saying and felt that a care  | d                 |   |                                |                       |
| Account of the second of the s | was provided to<br>nursing during a   |   | ıf                |   |                                |                       |
| F 280<br>SS=D  | conference on 1   | ation was provided prior to exit<br>/11/17.<br>iv,v)(3),483.21(b)(2) RIGHT TO<br>LANNING CARE-REVISE CP   |                   | F 280                                       |                                |                       |

FORM CMS-2567(0%-99) Previous Versions Obsolete

Event ID: PNKL11

Facility ID: VA0019

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DEPAR TMENT OF HEALTH AND HUMAN SERVICES DRINGDICAGE & MEDICAID SERVICES

PRINTED: 01/20/2017 FORM APPROVED OMB NO. 0938-0391

| CENTE RS FOR MEDICAR         | E & MEDICAID SERVICES  |                     | -  | 1               | ere Caracina Africa        |
|------------------------------|--|---------------------|--|-----------------|----------------------------|
| STATEMENT OF DEFICIENCIES    | IX11 PROVIDER/SUPPLIER/CLIA  | £ 1                 | IPLE CONSTRUCTION  | (X3) DAT<br>CON | E SURVEY<br>MPLETED        |
| AND PLAN OF CORRECTION       | IDENTIFICATION NUMBER:   | A. BUILDIN          | NG   |                 | С                          |
|                              | 495147   | B. WING             |  |                 | /11/2017                   |
|                              |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |                 |                            |
| NAME OF PROVIDER OR SUPPLIER | ₹  |                     | 1221 ROSSER AVE  |                 |                            |
| AVANTE AT WAYNESBORO         |  |                     | WAYNESBORO, VA 22980   |                 |                            |
| FACH DEFICIEN                | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRÉCEDED BY FULL<br>(LSC IDENTIFYING INFORMATION) | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REPERENCED TO THE APP<br>DEFICIENCY) | OULD BE         | (XS)<br>COMPLETIÓN<br>DATE |
| F 280 Continued From (       | page 19  | F 2                 | 80   | ŗ               |                            |

483.10

- (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:
- (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.
- (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.
- (iv) The right to receive the services and/or items included in the plan of care.
- (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.
- (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-
- (i) Facilitate the inclusion of the resident and/or resident representative.
- (ii) Include an assessment of the resident's strengths and needs.
- (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

1) Care plan on resident #5 was reviewed regarding the fall mat and wanderguard. It was clinically determined by the IDT Team that the fall mat and wanderguard were not needed and was removed from the residents care plan.

Care plan on resident #10 was reviewed and revised by the IDT Team with appropriate interventions for weight loss now included. Also, Speech consult was completed on 1/12/17 for resident #10.

2) 100% care plan audit was completed for all resident who have fall interventions to include fall mats and wander guards to confirm care plan accuracy. No additional changes were required for update.

100% audit was completed for all residents who trigger for weight loss to ensure appropriate interventions are in place and confirmed with physician promptly. No additional changes were required for update.

3) In-service training was provided by the Corporate Director of Clinical Reimbursement/ MDS accurate assessments and revisions of care plans to all MDS coordinators and interdisciplinary team.

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Event ID: FNKL11

Facility ID: VA0019

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#### PRINTED: 01/20/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-D391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING\_ B. WING 01/11/2017 495147 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PECVIDER OR SUPPLIER 1221 ROSSER AVE AVANTE AT WAYNESBORO WAYNESBORO, VA 22980 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 0.4)10 (EACH CORRECTIVE ACTION SHOULD BE PREEN (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REPERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 F 280 Continued From page 20 4) Weekly care plan audits for all 483.21 residents with fall interventions, (b) Comprehensive Care Plans wanderguard and triggers for weight loss will continue weekly for 6 weeks (2) A comprehensive care plan must beto ensure care plans remain accurate (i) Developed within 7 days after completion of then randomly thereafter. the comprehensive assessment. The results of this audit will be brought (ii) Prepared by an interdisciplinary team, that to monthly Quality Assurance and includes but is not limited to--Performance Improvement (CAPI) meeting for review and revisions as (A) The attending physician. necessary. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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

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assessments.

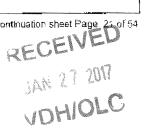
or as requested by the resident.

comprehensive and quarterly review

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the

Event f0: PNKL11

Facility ID: VA0019



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| DEPARTMENT OF HEALT  | H AND HUMAN SERVICES   |                     |  | FORM APPROVED<br>OMB NO. 0938-0391_ |
|--|--|---------------------|--|-------------------------------------|
| CENTERS FOR MEDICAR<br>STATEMENT OF DEFICIENCES<br>AND PLAN OF CORRECTION  | (x1; PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 - '               | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED<br>C  |
|  | 495147   | B. WING             |  | 01/11/2017                          |
| NAME OF PROVIDER OF SUPPLIE  AVANTE AT WAYNESBORO  | Ę  | 122                 | REET ADDRESS, CITY, STATE, ZIP CO<br>21 ROSSER AVE<br>AYNESBORO, VA 22980                        | DE                                  |
| EACH DEFICIEN  | TATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETION                |
| by: Based on staff in review, facility star comprehensive of residents in the staff of the remove placing and use of a Ward 2. Facility staff of Resident #10's Content on the remove placing and use of a Ward an | ENT is not met as evidenced afficial record afficial to review and revise a care plan (CCP) for two of 19 survey sample, Resident #5 and lid not update Resident #5's CCF of floor mat when resident in bed not not update weight loss.  CCP to include weight loss of the cotton of the c | P<br>d<br>a,        |  |                                     |

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Resident #5's electronic medical record (EMR) was reviewed on 01/10/17 at approximately 2:15 p.m. The CCP for this resident included an

Event ID PNKLT1

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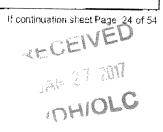
PRINTED: 01/20/2017 FORM APPROVED

| DEPART MENT OF HEALTH AND HUMAN SERVICES  CENTERS FOR MEDICARE & MEDICAID SERVICES  (X2) MULTIPLE CONSTRUCTION  | OMB NO. 0938-0391 |
|---|-------------------|
|   | (X3) DATE SURVEY  |
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING   | COMPLETED         |
| To MINIO  | 01/11/2017        |
| 495 147 CTP-ET ADDRESS CITY, STATE, ZIP CO  |                   |
| NAME OF PROVIDER OR SUPPLIER 1221 ROSSER AVE  |                   |
| AVANTE AT WAYNESBORO WAYNESBORO, VA 22980   |                   |
| DOOMBERS OF AN OF CORE  | RECTION (X5)      |
| (X41 D SUMMARY STATEMENT OF DEPICIENCIES ID PROVIDERS FISHON (EACH CORRECTIVE ACTION S PREFIX FEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE A TAG REGULATORY OR LSC IDENTIFYING INFORMATION) |                   |
| F 280   |                   |
| E 28O Continued From page 44  |                   |
| intervention under fall care plan that stated, "fall  |                   |
| mat on floor at bedside when resident In bed., Date Initiated: 11/30/2015Revision on:   |                   |
| 44/20/2015 "Included in her behavior care plan  |                   |
| woo as intervention that stated, " wander gualius"  |                   |
| (Noma) will remove wander ouard at timesDate  |                   |
| Initiated: 01/10/2016 Created on: 01/10/2016"   |                   |
| Resident #5 was observed ambulating in the  |                   |
| between the an aide on 07/70/7 (at 2.20 p.m. 190  |                   |
| worder quart was in place. This resident was  |                   |
| the second in heal at approximately 3.50 p.m. The   |                   |
| fall mat was in place at the bedside. Resident #5   |                   |
| was observed in bed on 01/11/17 at 7:55 a.m. Again no fall mat was in place at the bedside.   |                   |
| Again no fail that was in place at a second   |                   |
| LPN #4 (licensed practical nurse) was   |                   |
| 1 interviewed on 01/11/17 at 8:20 a.m. regarding  |                   |
| use of a fall mat with Resident #5 when in beu.   |                   |
| LPN #4 stated, "No, it would be a trip hazard for   |                   |
| her."   |                   |
| The survey team met with the Administrator and  |                   |
| DON (director of aursing) on 01/11/17 at  |                   |
| approximately 3:00 p.m. The DON was   |                   |
| interviewed regarding use of a fall mat and a   |                   |
| wander guard for Resident #5. The DON stated, "She doesn't have a fall mat. That would be more  |                   |
| -t - fall hazard for her than a nelb. She has n   |                   |
| fetter out of the hed in a long time. She goes out  |                   |
| have a wander quard in place. Regarding who   |                   |
| undates care plans the DON States, MDS  |                   |
| updates the care plans. We need to inservice  |                   |
| and educate."   |                   |
| No further information was received by the survey team prior to the exit conference on 01/11/17.  |                   |



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|--|---|---|---------------------|---|---|-------|----------------------------|
|  | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '               |   | CONSTRUCTION  |       | E SURVEY<br>IPLETED        |
| Maria de la companya del companya de la companya de la companya del companya de la companya del la companya del la companya de |   | 495147  | B. WING             | *************************************** |   | 1     | C<br><b>11/2017</b>        |
| NAME OF I  | PROVIDER OR SUPPLIER  |   | <u>'</u>            | STRI                                    | EET ADDRESS, CITY, STATE, ZIP CODE  | 1 017 | 11/2011                    |
| AVANTE   | AT WAYNESBORO   |   |                     | 1221                                    | ROSSER AVÉ  |       |                            |
| AVANTE   | AI WATNESDUKU   |   | į                   | WAY                                     | YNESBORO, VA 22980  |       |                            |
| ().4: 'D<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENT FYING INFORMATION)   | ID<br>PREFII<br>TAĞ | x                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE    | (ME)<br>COMPLETION<br>DATE |
| F 280  | Continued From page   | age 23  | F 2                 | 80                                      |   |       |                            |
|  | <ol> <li>The facility staff</li> <li>CCP (comprehens</li> <li>for weight loss in</li> </ol>   | failed to review and revise the ive care plan) for Resident# nterventions.  |                     |   |   |       |                            |
|  | Resident # 10 had<br>lbs (pounds) in one  | a significant weight loss of 9 emonth.  |                     |   |   |       |                            |
|  | Findings include:   |   |                     |   |   |       |                            |
|  | 09/23/97, with the : 07/01/08. Diagnos but were not limited disability, anxiety di  | admitted to the facility on<br>most current readmission on<br>les for Resident # 10 included,<br>d to: moderate intellectual<br>isorder, DM (diabetes<br>with behavioral disturbance,<br>sphasia.   |                     |   |   |       |                            |
|  | set) with an ARD (a<br>10/21/16 assessed<br>score of "0", indica<br>impaired cognitivel<br>skills. The residen<br>requiring extensive<br>for all ADL's (activit           | puarterly MDS (minimum data assessment reference date) of the resident with a cognitive ting the resident was severely in daily decision making twas also assessed as to tota: assistance from staffies of daily living) except for esident was assessed as et up help only.  |                     |   |   |       |                            |
|  | approximately 1:30 record was reviewed form dated 12/08/1 documented, "we ab from 11/1 [16] to stable. Recommented BID [twice dails ST [speech therapy texture" This form | rd review on 01/10/17 at p.m. Resident # 10's clinical ed. A dietary communication 6 was reviewed. The form ight seems to have dropped 9 12/01 [16] Previously weight ed: 1. reweigh 2. nutritionally] due to poor oral intake 3, of for most appropriate diet in had a hand written entry that rentered speech made aware. |                     |   |   |       |                            |



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| DEPARTME                 | NT OF HEALTH  | AND HUMAN SERVICES   |                    |           |  |   | D. 0938-0391         |
|--------------------------|---|--|--------------------|-----------|--|---|----------------------|
| CENTERSE                 | FOR MEDICARE  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULT          | TIPLE CON | STRUCTION  | (X3) DA   | ITE SURVEY           |
| STATEMENT OF D           | DEFICIENCIES  | DENTIFICATION NUMBER:  |                    |           |  | "   | ı                    |
| AND MORA OF O            | 210(2010)   |  |                    |           |  | (X3) DA COO  ATE, ZIP CODE  980  AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE | C                    |
|                          |   | 495147   | B. WING            |           |  |   | 1/11/2017            |
| AMERICA DECI             | VIDER CR SUPPLIER   |  |                    |           | TADORESS, CITY, STATE, ZIF   | - CODE  |                      |
|                          |   |  |                    |           | COSSER AVE   |   |                      |
| AVANTE AT                | WAYNESBORO  |  |                    | WAYN      | NESBORO, VA 22980  | NAMOCOTICAL   | (X5)                 |
| (X4) ID<br>PREF X<br>TAG | A A PART OF THE REPORT OF THE | 4TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |           | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENCE | ON SHOULD BE<br>HE APPROPRIATE  | COMPLETIÓN<br>DATE   |
| E 230 C                  | ontinued From p   | age 24   |                    | 280       |  |   |                      |
| a:                       | nd was signed by  | the DON (director of nursing).   |                    |           |  |   |                      |
|                          | evealed a progremed 5:04 p.m., varegistered dietitial los]5.0 % changes5.0 % changes6.0)Resident's vareviously stable reweigh to rule our recommend nutrinatake is poor. Respropriatesignsi   | nature of RD."  The resident being re-weighed in the clinical record.  ST consult or evaluation could be   | æ                  |           |  |   |                      |
|                          | p.m., document<br>Weight note: va<br>discussedher<br>from 12/9 to 12<br>started 12/12<br>recommendation<br>done. If not, plu<br>current diet app<br>RD."  | dated 12/15/16 and timed 2:11 ed: "RD [registered dietitian] alue: 156Resident weight decreased additional 2 li /12. Nutritional treat BID was ju Unclear if previous RD ins re: ST evaluation has been ease have ST screen to ensure propriatesignature of temporar is current CCP (comprenensive | io.                |           |  |   |                      |
|                          | love / 14/50  | reviewed and documented,<br>ent is at risk for weight loss with  | out                |           | IEE JOY MAGONI   | If continuation   | n sheet Page 25 of 5 |

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

Event ID PNKL11

Fadlity ID: VA0019

If continuation sheet Page 25 of 54



PRINTED: 01/20/2017

| DEPARTMENT OF HEALTH   | AND HUMAN SERVICES   |                                 |  | OMB NO.   | APPROVED<br>0938-0391      |
|--|--|---------------------------------|--|-----------|----------------------------|
| CENTERS FOR MEDICARE TATEMENT OF DEPICIENCIES NO PLAN (OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                | 3                               | TIPLE CONSTRUCTION<br>ING  | COM       | ESURVEY<br>IPLETED<br>C    |
| •  | 495147   | B. W NG                         |  |           | /11/2017                   |
| NAME OF PROVIDER OR SUPPLIER   |  |                                 | STREET ADDRESS, CITY, STATE, ZIP CC<br>1221 ROSSER AVE<br>WAYNESBORO, VA 22980 |           |                            |
| :X4).D SUMMARY STA   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | ID<br>PREF<br>TAG               |  | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| consume at least to maintenance and of [10/24/16]adapt orderedencourage strawsprovide did timeprovide fing liquids" Of the amost recent revision adaptive equipme implemented.  At approximately approximately percentages were January 2017. It resident at e0-25 it was documented for lunch that day January 1st through the resident at e0-35 it was documented for lunch that day January 1st through the resident at e0-35 it was documented for lunch that day January 1st through the resident at e0-35 it was documented and at e0-35 it was documented for lunch that day January 1st through the resident at e0-35 it was documented and looked The DON further a world for Resident at e0-35 it was documented at e0-35 it was documented and looked the DON further a world for Resident at e0-35 it was documented and looked the DON further a world for Resident at e0-35 it was documented at e0-35 it was documented and looked the DON further at world for Resident at e0-35 it was documented and looked the DON further at world for Resident at e0-35 it was documented and looked the DON further at world for Resident at e0-35 it was documented and looked the DON further at world for Resident at e0-35 it was documented at e0-35 it was documented and looked the DON further at world for Resident at e0-35 it was documented at e0- | tn) intake [06/11/15]will<br>50%to promote weight<br>optimal nutritlon               | nd<br>at<br>at<br>an<br>a<br>ek | 280  |           |                            |

know why the supplement for Resident # 10 did not get implemented until four days after the recommendation. The DON was informed that the resident's CCP had not been updated to reflect any of the above information.

The DON and administrator were made aware of concerns regarding Resident # 10 and that the resident's CCP had not been updated with any interventions since 08/01/16, in a meeting with

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| AET MIX T         | ~ EAD MEDICADE   | P MCDICAID SERVICES                                   |             |   |                              | MO: 0820-0331                           |
|-------------------|--|---|-------------|---|------------------------------|---|
|                   |  | & MEDICAID SERVICES                                   | (X2) MIH    | TIPLE CONSTRUCTION                          | (X3)                         | DATE SURVEY                             |
| TATEMENT          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVICER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |             | ING   | <b>,</b>                     | COMPLETED                               |
| AND PLAN CH       | - CORRECTION   |   | A point     |   |                              | С                                       |
|                   |  | 405447  | a. WING     |   |                              | 01/11/2017                              |
|                   |  | 495147  |             | STREET ADDRESS, CITY, STATE, Z              | IP CODE                      | ***                                     |
| NAME OF P         | ROVIDER OR SUPPLIER  |   |             | 1221 ROSSER AVE                             |                              |   |
|                   |  |   |             | WAYNESBORD, VA 22980                        |                              |   |
| AVANTE            | AT WAYNESBORD  |   |             |   |                              |   |
|                   | SUMMARY ST   | ATEMENT OF DEFICIENCIES                               | ID          | PROVIDER'S PLAN OF<br>X (EACH CORRECTIVE AC | CORRECTION<br>TION SHOULD BE | (XS)<br>COMPLETION                      |
| (X4) ID<br>PREFIX | JERON DEFICIENC  | V MUST BE PRECEDED BY FULL                            | PREF<br>TAG | " ANACC DECEDENCED TO                       | THE APPROPRIAT               | E DATE                                  |
| TAG               | REGULATORY OR I  | LSC IDENTIFYING INFORMATION)                          | 7,10        | DEFICIENC                                   | (Y)                          |   |
|                   |  |   |             |   |                              |   |
| E 280             | Continued From p   | ane 26  | F           | 280   |                              |   |
| F Z0U             |  | -g  |             |   |                              |   |
|                   | 3:30 p.m.  |   |             |   |                              |   |
|                   | No further informa   | ition or documentation was                            |             |   |                              |   |
|                   | presented prior to   | the exit conference on 01/11/1                        | 7           |   |                              |   |
|                   | at 4:15 b.m:   |   |             |   |                              |   |
| = 300             | 483.24, 483.25(k)  | (I) PROVIDE CARE/SERVICES                             | S F         | 309   |                              |   |
| SS=D              | The same of the sa | ÉLL BEING   |             | 1) Physician order for res                  | ident #1 was                 | 2/8/2017                                |
| JU-12             |  |   |             | reviewed and clarified                      | to include                   | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
|                   | 483.24 Quality of  | life  |             | defined clinical para                       | meters for                   |   |
|                   | Ou ality of life is a  | fundamental principle that                            |             | physician notification.                     |                              |   |
|                   | annlies to all care  | and services provided to facili                       | ty          | -   |                              |   |
|                   | residents. Each r  | esident must receive and the                          |             | 2) 100% audit was com                       | pleted on all                |   |
|                   | facility must provi  | de the necessary care and                             |             | residents with folly cath                   | neters. No                   |   |
|                   | services to attain   | or maintain the highest                               |             | other issues identified.                    |                              |   |
|                   | practicable physic   | cal, mental, and psychosocial                         |             |   |                              |   |
|                   | well-being, consis   | stent with the resident's                             |             | 3) In-service instruction                   | and maining                  |   |
|                   | comprehensive a  | ssessment and plan of care.                           |             | was initiated on 1/12/17                    | for licensed                 |   |
|                   | 404 OF   |   |             | nurses regarding orders                     | that require                 |   |
|                   | 483.25<br>(k) Pain Manager   | ment  |             | physician notification                      | of a result                  |   |
| <b>Q</b>          | The facility must  | ensure that pain management                           | is          | outside the ordered paran                   | leter.                       |   |
| 40110             | provided to reside   | ents who require such services                        | 3,          |   |                              |   |
|                   | consistent with p  | rofessional standards of practic                      | ce,         | 4) The DON or designe                       | te will review               | T                                       |
|                   | the comprehensi  | ve person-centered care plan,                         |             | all future admissions                       | with residents               | 3                                       |
|                   | and the residents  | s' goals and preferences.                             |             | who have catheters i                        | or to assure                 | ,                                       |
|                   |  |   |             | compliance with ord                         | lered chinical               | 1                                       |
|                   | (i) Dialysis. The  | facility must ensure that                             |             | parameters. Clinica                         | l team wii                   | L                                       |
|                   | residents who re   | quire dialysis receive such                           |             | continue to monitor                         | the output of                | I<br>~                                  |
|                   | services, consist  | ent with professional standard                        | 5<br>.a.    | residents with folly cath                   | eters at least 3             |   |
|                   | of practice, the c   | omprehensive person-centere                           | u           | times a week for 6 wee                      | ks and as the                | 11                                      |
| 1                 | care plan, and th  | e residents' goals and                                |             | randomly thereafter.                        |                              |   |
| Į.                | preferences.   | emple to mot mot as suidespead                        |             |   |                              |   |
|                   |  | MENT is not met as evidenced                          |             | The results of this audit                   | will be brough               | JE.                                     |
|                   | by:  | -tiou and allabal vacard                              |             | to monthly Quality                          | Assurance an                 | d<br>n                                  |
|                   | Based on staff t   | nterview and clinical record                          |             | Performance Improve                         | ement (QAP)                  | 1)                                      |
|                   | review, the facilit  | ty staff failed to follow a                           |             | meeting for review as                       | nd revisions                 | 18                                      |
| •                 | physician's orde   | r for one of 19 residents in the                      | _           | 7.5.78000YV                                 |                              |   |

survey sample. Resident #1, with a physician's

necessary.

Facility ID: VA0019

PRINTED: 01/20/2017 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOR MEDICARE                                |  | & MEDICAID SERVICES  |                     |  | OMB NO.                       | OMB NOT Case-osa:            |  |
|---|--|--|---------------------|--|-------------------------------|------------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF DORRECTION |  |  |                     | (X2) MULTIPLE CONSTRUCTION A. SUILDING           |                               | (X3) DATE SURVEY COMPLETED C |  |
|   |  | 495147   | B. WING             |  | 01/                           | C<br>/11/2017                |  |
|   | FROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP 1221 ROSSER AVE | CODE                          |                              |  |
| AVANTE  | AL WATRESDORO  |  |                     | WAYNESBORD, VA 22980                             |                               |                              |  |
| (X4110<br>FREFIX<br>TAG                             | FACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | IU<br>PREFII<br>TAĞ |  | IN SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETION<br>DATE   |  |
| F 30 <b>9</b>                                       | Continued From p<br>order to alert the d<br>output, had three t<br>no notification to the  | octor of diminished urinary<br>shifts of lower urine output with   | F3                  | 309  |                               |                              |  |
|   | The findings inclu   | de:  |                     |  |                               |                              |  |
|   | 6/10/16 with a re-<br>Diagnoses for Re-<br>dysphagia, colon-<br>(chronic obstructive<br>and history of bow<br>The minimum dat  | admitted to the facility on admission on 12/8/16. sident #1 included pneumonia. cancer, bladder cancer, COPD ve pulmonary disease), stroke vel resection with colostomy. a set (MDS) dated 12/9/16 at #1 with severely impaired  |                     |  |                               |                              |  |
|   | resident had a product to a history of documented a phostating, "Record for MD (physician) of  | ical record documented the<br>escribed Foley urinary catheter<br>f bladder cancer. The record<br>ysician's order dated 12/8/16<br>oley out put QS [each shift] Aler<br>any S/S [sign/symptoms] of<br>ished output." (sic)  | t                   |  |                               |                              |  |
|   | 1/10/17 documer from the catheter ranged from 100 with the exception shift on 1/7/17 do on 1/8/16 an output of 80 cc/s nursing notes do regarding the de 1/7/17, 1/8/17 an notification to the | atment record for 1/1/17 throughted the resident's urinary output each shift. Output by shift to 450 cubic centimeters (cc's) in of three shifts. The evening ocumented an output of 80 cc's, out of 60 cc's and 1/9/17 and The clinical record including cumented no interventions creased output assessed on ad 1/9/17. There was no ephysician or any further arding the lower than usual urine |                     |  | -                             |                              |  |

FORM CMS-2587(02-99) Frevious Versions Dissolete

Event ID PNKL1"

Facility ID: VA0019

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| DEPARTMENT OF HEALTH   | AND HUMAN SERVICES   |         | OMB NO 0938-039                         |                    |  |  |
|--|--|---------|---|--------------------|--|--|
| ENTERS FOR MEDICARE  | 8 MEDICAID SERVICES  | V0.1027 | IPLE CONSTRUCTION                       | (X3) DATE SURVEY   |  |  |
| ATEMENT OF DEFICIENCIES<br>DIPLAN OF CORRECTION  | (X1) PROVICER/SUPFLIER/CLIA<br>IDENTIFICATION NUMBER:  |         | NG                                      | COMPLETED          |  |  |
|  | 495147   | B. WING |   | 01/11/2017         |  |  |
| AME OF PROVIDER OR SUPPLIER  |  |         | STREET ADDRESS, CITY, STATE             | , ZIP CODE         |  |  |
| VANTE AT WAYNESBORD  |  |         | 1221 ROSSER AVE<br>WAYNESBORO, VA 22980 |                    |  |  |
|  |  | l       | DOMESTIC DI ANI                         | DE CORRECTION (X5) |  |  |
| (2001) The second of the secon | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREF    |   | CITHE APPROPRIATE  |  |  |
| ≤ 30 <b>9</b> Continued From p   | ene 28   | F       | 309                                     |                    |  |  |
| On 1/11/17 at 8-49   | a mithe licensed practical   |         |   |                    |  |  |
| (LDN #3) cc  | ring for Resident #1 Was   | NI.     |   |                    |  |  |
| internioused about   | the urine output amounts. LPN<br>dent usually had from 150 to  | •       |   |                    |  |  |
| ann ach an chift   | and accasionally had outputs y   | र्ग     |   |                    |  |  |
| 400 cele par shift   | Regarding the lower outputs t  | الي:    |   |                    |  |  |
| 20 and 20 cc's   | DM #3 stated those occurred or   | 1       |   |                    |  |  |
| the evening shifts   | and she cid not know if any done in response to the lower  |         |   |                    |  |  |
| cutputs.   | done in respanse   |         |   |                    |  |  |
| ·  | a met  |         |   |                    |  |  |
| On 1/11/17 at 8:5  | io a.m. the unit manager (LPN  |         |   |                    |  |  |
| #2) was interview  | ved about any notification<br>ver urine outputs recorded on  |         |   |                    |  |  |
| autiat through 1/  | /g/17. LPN #2 stated arry  |         |   |                    |  |  |
| interpretings red  | arding the lower upine amounts   | 5       |   |                    |  |  |
|  | ad in the nursing notes. LEN m   | t-      |   |                    |  |  |
| stated there show  | uld have been communication to<br>out the lower amounts since  |         |   |                    |  |  |
| the physician activities was a physician activities was a physician activities and the control of the control o | sician's order for an alert.   |         |   |                    |  |  |
|  |  | 1       |   |                    |  |  |
| On 1/11/17 at 10   | 0:05 a.m. the director of nursing viewed about any alert or  | d .     |   |                    |  |  |
| (DON) was inter  | e physician regarding the  |         |   |                    |  |  |
| regident's reduc   | ed urine output amounts. The   |         |   |                    |  |  |
| now stated she   | was not sure if the lower  |         |   |                    |  |  |
| amounts were c   | tue to aides working over and  | ne      |   |                    |  |  |
| LEE THA DOWN   | atout at different times during the reviewed the record and  |         |   |                    |  |  |
| annontrid on Gi  | vidence of any interventions lar   | cen     |   | ,                  |  |  |
| in ronnings to t   | the lower than askid unite other   | <b></b> |   |                    |  |  |
| associate for Re   | eident#1 (Jn 1/ 1/17 at 10.40  | ,       |   |                    |  |  |
| turi ili don ropo  | stated she reviewed the activity ords and the urine output amounts and the same as the sam | His     |   |                    |  |  |
| gaily living reco  | esident #1 were the same as th   | iose    |   |                    |  |  |

administrator and director of nursing during a CORM CMS-2567,02-99 r Provious Versions Obsolets

listed on the treatment record.

These findings were reviewed with the

Eveni ID: PNKL11

Facility ID. VA0019

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

PRINTED: 01/20/2017 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   |  | (X1) PROVIDER SUPPLIER CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   | ,X3) DATE SURVEY<br>COMPLETED |  |  |  |
|---|--|---|--|-------------------------------|--|--|--|
|   | !  | 495147  | ß WING   | C<br>01/11/2017               |  |  |  |
| NAME OF PROVIDER OR SUPPLIER  AVANTE AT WAYNESBORO  (X4) 'D SUMMARY STATEMENT OF DEFICIENCIES |  | ATEMENT OF DEFICIENCIES   | STREET ADDRESS, CITY, STATE, ZIP CODE  1221 ROSSER AVE  WAYNESBORD, VA 22980  ID PROVIDER'S PLAN OF CORRECTION   | N (X5)                        |  |  |  |
| PREFIX<br>TAG   |  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX (EACH CORRECTIVE ACTION SHOULD<br>TAG CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | BE COMPLÉTION                 |  |  |  |
| F 325   | UNLESS UNAVOID   | 7 at 2:30 p.m.<br>MNTAIN NUTRITION STATUS<br>DABLE  | F 309 F 325  1) Resident #10 has was placed on 12/0/16 to monitor.   | 2/8/2017                      |  |  |  |
|   | both percutaneous<br>percutaneous endo<br>enteral fluids). Base<br>comprehensive ass<br>ensure that a reside   | stric and gastrostomy tubes,<br>endoscopic gastrostomy and<br>escopic jejunostomy, and<br>ed on a resident's<br>sessment, the facility must<br>ent-   | for any continued weight changed.  |                               |  |  |  |
|   | status, such as usu body weight range at the resident's clinicath this is not possible a indicate otherwise;  (3) Is offered a them nutritional problem a orders a therapeutic This REQUIREMEN   | rapeutic diet when there is a and the health care provider  | current interventions in place.  3) Any resident who triggers for weight gain/ loss will be discussed during weekly weight meeting to ensure appropriate interventions are in place with timely follow up. If a weight loss or gain is noted, appropriate notification will be provided to the physician and RD.   |                               |  |  |  |
|   | record review, the faceptable parametre prevent a significant residents in the survival Resident # 10 had a lbs (pounds) in one Findings include:  Resident # 10 was a 09/23/97, with the maceptable parameter in the survival resident # 10 was a control of the survival resident # 10 was a | tion, staff interview, clinical facility staff failed to ensure sters of nutritional status to at weight loss for one of 19 evey sample. Resident # 10. a significant weight loss of 9 month.  admitted to the facility on most current readmission on es for Resident # 10 included, | 4) On-going monitoring will continue through facility weekly and monthly clinical weight meetings held with the Director of Nursing, clinical managers, Certified Dietary Manager, and Registered Dietician.  The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary. |                               |  |  |  |

T OF DEALTH AND BUILDAN SERVICES

PRINTED: 01/20/2017 FORM APPROVED

| 2938-033<br>SURVEY<br>LETED<br>1/2017<br>COMPLETION<br>DATE |
|---|
| (ZS)  |
| 1/2017 (X5) COMPLETION                                      |
| (XS)<br>COMPLETION  |
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FORM CMS-2587(02-99) Previous Versions Obsolete

previously stable from 160-168 lb...recommend reweigh to rule out errors in measuring. Also recommend nutritional treat BID as her meal

Event ID: PNKL10

Facility ID: VA0019

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| CENTERS FOR MEDICARE & MEDICAID SERV                                  |   | & MEDICAID SERVICES   |                    | OMB NO. 0938-0391              |   |
|---|---|---|--------------------|--------------------------------|---|
| CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1 ' '              | TIPLE CONSTRUCTION<br>NG       | (X3) DATE SURVEY<br>COMPLETED                     |
|   |   | 495147  | B. WING            |                                | C<br>01/11/2017                                   |
| NAME OF   | PROVIDER OR SUPPLIER  | 430.41  |                    | STREET ADDRESS, CITY, STATE, Z |   |
|   |   |   |                    | 1221 ROSSER AVE                |   |
| AVANTE  | AT WAYNESBORD   |   |                    | WAYNESBORO, VA 22980           | A PROPERTY OF                                     |
| (X4) (O<br>PREFIX<br>TAG  | /EACH DEFICIENC   | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC (DEMTIFY)NG INFORMATION)  | ID<br>PREFI<br>TAG |                                | TION SHOULD BE COMPLETION<br>THE APPROPRIATE DATE |
| F 325   | Continued From pa<br>intake is poor. Re<br>ensure finger food<br>appropriatesigna   | commend ST evaluation to<br>s diet still  | F3                 | 325                            |   |
|   | No evidence of the could be located in  | e resident being re-weighed<br>In the clinical record.  |                    |                                |   |
|   | No evidence of ST located in the clini  | consult or evaluation could be cal record.  |                    |                                |   |
| Republika ka k                       | The nutritional trea<br>12/12/16, four day  | et BID was initiated on<br>a safter the recommendation.   |                    |                                |   |
|   | p.m., documented Weight note: valudiscussedher winder 12/9 to 12/12 started 12/42Unrecommendations done. If not. plea   | ated 12/15/16 and timed 2:11 i: "RD [registered dietitian] ie: 156Resident eight decreased additional 2 lb 2. Nutritional treat BID was just iclear if previous RD is re: ST evaluation has been se have ST screen to ensure priatesignature of temporary   |                    |                                |   |
|   | observed in her be The resident was resident stated, "is and in the hallway was a meal tray of Resident # 10's to ticket with the resinct uded, two piet of sausage on or of melted cheese of the toast had the plate guard was | 30 a.m., Resident # 10 was ed, covered with oxygen on. asked if she had breakfast, the no." This surveyor left the room youtside the resident's room art, the can was opened and ray was identified by a meal sident's name. The meal tray ces of toast (open) with a piece to side, the sausage had a piece on top. The crust of one piece wo small pieces (missing/eaten a observed, along with a cup of cup of juice (full/thickened). | €                  |                                |   |

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

Event ID: PNKL11

Facility ID: VA0019

If continuation sheet Page 32 of 54



PRINTED: 01/20/2017 FORM APPROVED

| CENTERS FOR MEDICARE &                              |  | & MEDICAID SERVICES   |   |       | (  | OMB NO. 0938-0391             |  |  |
|---|--|---|---|-------|--|-------------------------------|--|--|
| TATEMENT OF DEFICIENCIES<br>INDIPLANT OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X3) MULTIPLE CONSTRUCTION  A. BUILDING |       |  | (X2) DATE SURVEY<br>COMPLETED |  |  |
|   |  | 495147  | B. WING                                 |       |  | 01/11/2017                    |  |  |
| NAME OF F   | ROVIDER OR SUPPLIER  |   | .1                                      | STREE | ET ADDRESS, CITY, STATE, ZIP CODE  | •                             |  |  |
|   |  |   |   |       | ROSSER AVE   |                               |  |  |
| AVANTE.   | AT WAYNESBORO  |   |   | WAY   | NESBORO, VA 22980  |                               |  |  |
| (K4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG                       |       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | CD BE COMPLETION              |  |  |
| F 325   | Continued From pa  | age 32  | F                                       | 325   |  |                               |  |  |
|   | interviewed and wa information on Resconsult or evaluation on Resconsult or evaluation of the screens are do automatically (on eact of automatically (on eact of an order. The that the last speed in March of 2016, resident was reconsult in the would include with your fingers, anything you can each of the therapy of communicated to stated that the nut to the therapy deposite of the therapy has the doesn't normally the communication. | S a.m., the rehab director was as asked to provice any sident # 10 regarding a speech on in the last 3 months.  30 a.m., the rehab director erly screen that was completed the rehab director stated that one every three months, everyone) and there is no need rehab director further stated in consult for Resident # 10 was nothing since and that time the mended to have finger foods lude anything you can pick up a sandwich, french fries, eat with your hands.  335. the DON was interviewed consults/screenings are ensure completion. The DON reses would send the information for they (nurses) would swarded to therapy. The DON and it takes to complete, once are order. The DON stated that ake long, maybe a couple of eithe ST person is here 5 days | s<br>t<br>it                            |       |  |                               |  |  |
| diament of  | observed again in<br>bedside table in fi<br>whole, chopped o<br>roasted potatoes<br>liquid. A cup of ju  | 12:40 p.m., Resident #10 was<br>her room. in bed with her<br>ront of her. The resident had<br>hicken, carrot slices, cubed<br>and small cup of cubed pears<br>lice and a cup of coffee<br>resident had a fork eating the  |   |       |  |                               |  |  |

PRINTED: 01/20/2017 FORM APPROVED

| DEPART | MENT OF HEALTH   | AND HUMAN SERVICES   |         | (  | OMB NO. 0938-039           |
|--------|--|--|---------|--|----------------------------|
| CENTER | S FOR MEDICARE<br>OF DEFICIENCIES<br>CORRECTION  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:  |         | E CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |
| 1,0    |  | 495147   | B. WING |  | 01/11/2017                 |
|        | ACKNOWNERSON   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   |         | TREET ADDRESS, CITY, STATE, ZIP CODE  1221 ROSSER AVE  WAYNESBORO, VA 22980  PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOULD CROSS-REPERENCED TO THE APPRODEFICIENCY) | LD BE COMPLETION           |
| F 325  | 2-3 cubes in the bitems did not look. The resident was her chicken, the resident was askeresident stated, "Noffee" and then was observed bla | lifficulty and left approximately owl. The remainder of the food to have been touched or eaten, asked if she was going to eat asident stated, "No." the id about the carrots, the No." the resident stated, stated, "Cream." The coffee ok. No type of milk or creamer the resident's tray. This |         | ō  |                            |

it was documented that the resident ate 26-50% for lunch that day. The remaining of the month January 1st through 10th, it was documented that the resident are 0-25 % for 18 out of 30 meals and ate 26-50 % for 12 out of 30 meals.

Resident # 10's current CCP (comprehensive care plan) was reviewed and documented, "Name of resident is at risk for weight loss without proper po [by mouth] intake [06/11/15]...will consume at least 50%...to promote weight maintenance and optimal nutrition. [10/24/16]....adaptive equipment as ordered...encourage...to eat at meal time....no straws...provide diet as ordered...provide extra time...provide finger foods...provide thickened liquids..." Of the above listed interventions, the Event i0: PNKL11

PRINTED: 61/20/2017 FCRM APPROVED CMB NO. 0938-0391

|   | CONTRACTOR  | ⇒ MEDICAID SERVICES   |                   |  | CIVID  | 140. 0000-000              |  |
|---|---|---|-------------------|--|--|----------------------------|--|
| ATEMENT O   | F DEFICIENCIES  | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MUL          | TIPLE CONSTRUCTION   | į.   | ) DATE SURVEY<br>COMPLETED |  |
| ND PLAN OF CORRECTION   |   | IDENTIFICATION NUMBER:  | A BUILDING        |  |  | С                          |  |
|   |   |   | B. WING           |  | _  | 01/11/2017                 |  |
|   |   | 495147  | B. Willo          | STREET ADDRESS, CITY STA   | TE, ZIP CODE   |                            |  |
| VAME OF PE  | DVIDER OR SUPPLIER  |   |                   | 1221 ROSSER AVE  |  |                            |  |
| AVANTE A  | T WAYNESBORO  |   |                   | WAYNESBORO, VA 229   | 80   |                            |  |
| AMPONIE   |   |   |                   |  | N OF CORRECTION  | (X5)                       |  |
| X4 ID<br>PREFIX<br>TAG  | JEACH DESIGNERS   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | X (EACH CORRECTIVE<br>CROSS-REFERENCED   | E ACTION SHOULD BE   | COMPLETION<br>TE DATE      |  |
|   | O-minus d Erroro D  | one 34  | . F               | 325  |  |                            |  |
| F 325   | Continued From pa   | on was on 08/01/16 for the  |                   |  |  |                            |  |
|   | Tast recent revisit   | nt- no new interventions  |                   |  |  |                            |  |
|   | implemented.  |   |                   |  |  |                            |  |
|   | the ST evaluation done and looked at The DON further size weigh for Residuant after the recomme know why the support get implement recommendation.  The DON and additional concerns regarding weight loss and the recommendations completed, in a fixed one and some completed. | 2:15 p.m., the DON stated that for Resident # 10 had not been as if the "ball had dropped." stated that she could not find a tent # 10 until 12/15/16 (a week endation) and that she did not piement for Resident # 10 did ted until four days after the ministrator were made aware of ng Resident # 10's significant he fact that the RD's is for Resident # 10 had not been eeting with the survey team on eximately 3:30 p.m. | n                 |  |  |                            |  |
|   | No further inform presented prior to  | ation or documentation was<br>o the exit conference on 01/11/1  | 7                 |  |  |                            |  |
| r 257   | at 4:15 n m.  | FICIENT FLUID TO MAINTAIN   |                   | = 327  |  |                            |  |
| F 327   | HYDRATION   |   |                   |  |  |                            |  |
| SS= <u>+</u>  | (g) Assisted nutri<br>(Includes naso-g<br>both percutaneous<br>percutaneous en<br>enteral fluids). B<br>comprenensive a<br>ensure that a res  |   |                   | 1) A tracking form was put into place to monito fluid intake for resident #14. Daily totals will to 11-7 nurse for the previous fluid intake and to more with fluid restriction. | or the total daily and resident and resident be tallied by the dous day's totals oth PCC and the resident's daily nitor compliance | 2/8/201                    |  |
| management of the state of the | proper hydration  | fficient fluid intake to maintain<br>a and health.<br>MENT is not met as evidenced  |                   | Physician reviewed be<br>and #14 with no negative  | oth resident #1  |                            |  |

FORM CMS-2567(02-93) Previous Versions Obsolete

Event ID: PNKL13

Facility ID: VA0019

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PRINTED: 01/20/2017 FORM APPROVED

| DEPARTMENT OF HEALTH         | AND HUMAN SERVICES  |                            |   |                  | 0638-0381                  |
|------------------------------|---|----------------------------|---|------------------|----------------------------|
| Lacution & FOR MEDICARE      | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                 | (X2: MULTIPLE CONSTRUCTION |   | (X3) DATE<br>COM | ESURVEY<br>PLETED          |
| AND FEMALE                   | 495147  | B. WING                    | REET ADDRESS, CITY, STATE, ZIP CODE   |                  | 11/2017                    |
| NAME OF PROVIDER OR SUPPLIER |   | 123<br>W/                  | 21 ROSSER AVE<br>AYNESBORO, VA 22980  |                  |                            |
|                              | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION! | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRE<br>EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE          | 1X5)<br>COMPLETION<br>DATE |
|                              |   |                            |   |                  |                            |

#### Continued From page 35 F 327

Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to follow physician orders for 1500 cc fluid restrictions. The facility staff did not monitor the total fluid intake per day for two of 19 residents, Resident #11 and Resident #14.

- 1. The facility staff did not monitor the total amount of fluid provided to Resident #11 to ensure a physician order for 1500 cc fluid restriction was met.
- 2. The facility staff failed to monitor the total amount of cally fluid provided to Resident #14 to ensure a physician ordered 1500 ml (mililiter) per day fluid restriction for cardiac and renal diagnoses was met from 8/24/16 through 1/11/17.

### Findings were:

 Resident #11 was originally admitted to the facility on 06/18/2013. Her diagnoses included but were not limited to: Type II diabetes mellitus, chronic kidney disease (Stage 4), hypertension, peripheral vascular disease, and arteriosclerotic heart disease.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/01/2016. Resident #11 was assessed as being cognitively intact with a cognitive summary score of "15".

On 01/10/2017 at approximately 2:00 p.m., Resident #11 was observed lying subine watching television in her room. Observed on her bedside

#### F 327

- 2) Any current residents that are placed on fluid restrictions as well as future admissions with fluid restrictions will have a tracking form put into place to monitor their daily intake of fluid as well as compliance with fluid restrictions.
- 3) On 1/11/17 in-service education was provided to licensed nurses regarding procedure for monitoring residents with fluid restrictions.
- 4) All residents with fluid restrictions will be reviewed during facility morning clinical meeting by the DON and/or designee to ensure compliance is maintained for 6 weeks and then randomly thereafter.

The results of this audit will be brought to menthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.

Facility ID: VA0019

If continuation sheet Page 36 of 54

FORM C#MS-2567 (02-99) Previous Versions Obsolete

Evant ID: PNKL11



| m⊏o•DT <b>N</b>          | ACNT OF HEALTH   | AND HUMAN SERVICES   |  |            |   | FORM A          | 01/20/2017<br>APPROVED<br>0938-0391 |
|--------------------------|--|--|--|------------|---|-----------------|-------------------------------------|
| CENTER                   | S FOR MEDICARE<br>DE DEFICIENCIES  | & MEDICAID SERVICES  |  | TIPLE CONS |   | COMP            | E SURVEY<br>PLETED                  |
| PO PAJE GNA              | CORRECTION   | IDENTIFICATION NUMBER:   |  | ING        |   | 1               | 11/2017                             |
|                          |  | 495147   | B. WING                                  | erocet:    | ADDRESS, CITY, STATE, ZIP CODE  |                 |                                     |
|                          | ROV.DER OR SUPPLIER  |  |  | 1221 RO    | SSER AVE<br>SBORO, VA 22980   |                 |                                     |
| AVANTE                   | AT WAYNESBORO  | and the second s |  |            | CONVERTED DE AN OF CORREC   | CTION           | COMPLETION                          |
| (X4) ID<br>PREF X<br>TAG |  | ATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION)  | ID<br>PRES<br>TAS                        | ix.        | (EACH CORRECTIVE ACTION SHO<br>(EACH CORRECTIVE ACTION SHO<br>(EACH CORRECTIVE ACTION SHO<br>(EACH CORRECTION SHOW) | سانته لينيوان ا | DATE                                |
|                          |  | 2008 36  | F  | 327        |   |                 |                                     |
| F 32/                    | Continued From particle table was a white straw.   | Styrofoam cup with a lid and a   | ì  |            |   |                 | : .                                 |
|                          | o1/10/2017. The following three or 08/24/2016: "1500 ml (millilite meals and 600 mgive 240 cc 3-11 give 60 cc every comply with rest meals and 600 mgive 240 cc 3-11 give 60 cc every resident to com "1500 ml (millilite meals and 600 give 240 cc 3-1 give 60 cc every to comply with the comply with the comply with the comply with the complex co | er) fluid restriction. (300 million) from the million provided by nursing) 7-3 = Nillion provided by nursing 7-3 = Nillion provided by nursing) 7-3 = Nillion provided by nursing) 7-3 = Nillion provided by nursing) 7-3 = Nillion provided by nursing 7-3 = Nillion provided by nurs | i<br>Jay<br>to<br>n<br>May<br>May<br>ent |            |   |                 |                                     |
|                          | record) was ret<br>by shift per day<br>ranged from "6<br>cc". There wer<br>evening shift. (<br>available to ret<br>ranged from "2  | y. For day shift (7-3) totals entropy. For day shift (7-3) totals entropy control on the MAR (3-11) nor was there and area cord them. Night shift (11-7) to 40 cc" to "120 cc".  | ies<br>500<br>for<br>otais               |            |   |                 |                                     |
|                          | Resident #11 eating breakfa  | v, at approximately approximately was observed sitting up in her ast. On her tray was a cup of jund a white Styrofoam contained in her bedside table.  |  |            |   |                 |                                     |

PRINTED: 01/20/2017 FORM APPROVED OMB NO 0938-0391

| YEND OF HEALTH  | AND HUMAN SERVICES                                    |                  |  | WR NO. 0830-0331              |
|---|---|------------------|--|-------------------------------|
| DEPARTMENT OF HEALTH<br>CENTERS FOR MEDICARE  | & MED CUID ART.                                       | (X2) MULT        | TIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
| ETATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENT/FICATION NUMBER: | A. BUILDI        |  | С                             |
| AND ENGLISHED   | 495147  | B. WING          | STREET ADDRESS, CITY STATE, ZIP CODE   | 01/11/2017                    |
| NAME OF PROVIDER OR SUPPLIER  |   |                  | 1221 ROSSER AVE<br>WAYNESBORO, VA 22980  |                               |
| AVANTE AT WAYNESBORO  (X4: 10 SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |   | D<br>PREF<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>EACH CORRECTIVE ACTION SHOU<br>CORRES DEFERENCED TO THE APPRO | LD DE                         |
| TAG REGULATION  |   |                  |  |                               |

#### F 327 Continued From page 37

#2 was interviewed at approximately 8:15 a.m. about Resident #11's orders for her fluid restrictions. She was asked about the documentation on the electronic MAR regarding fluid intake and what all was captured in that total. She stated, "That's the total of everything she had on day shift." The unit manager was asked about the entries of greater than 500 cc and what that meant. She stated, "I will need to look at that." The unit manager left the nurse's station. LPN # 7 entered the nurses station and was asked if a resident was on fluid restrictions what would she as a nurse document on the MAR. She stated, "We only put down what nursing gives on the MAR. All the other fluid comes from dietary. The CNAs (certified nursing assistants) enter the tray totals on the ADL (activities of daily living) sheets. The unit manager then returned to the nurse's station. She stated, "I spoke with the nurse who wrote the greater than 500 down. [Name of Resident #11] is noncompliant. The nurse writes that down because she isn't sure how much she is getting." The unit manager was asked fithe white Styrofoam cup on Resident #11's bedside table is what was used by the facility to pass water. She stated, "Yes." The unit manager was then asked if residents on fluid restrictions normally have water cups at their becsides. She stated, "No."

At approximately 8:30 a.m. CNA #2 was interviewed. CNA #2 stated that she was caring for Resident #11. CNA #2 was asked about the ADL sheets. She stated, "I write down what she drinks from her tray on there. That's it." CNA #2 was asked if she knew Resident #11 was on fluid restrictions. She stated, "I don't know how many cc of fluid she is suppose to get a day." CNA#2 was asked if she had a Kardex care plan to

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

| CES  | -                          | OMB NO. 0938-039 |
|------|----------------------------|------------------|
| ES   |                            | (X3) DATE SURVEY |
| CLIA | (X2) MULTIPLE CONSTRUCTION | COMPLETED        |
| BER: | A. BUILDING                | С                |
|      |                            | 04/44/2017       |

| & MEDICA:D GETGTOGS  | (X2) MULTIPLE CONSTRUCTION            | COMPLETED  |
|--|---------------------------------------|------------|
| AND DESCRIPTION OF THE PROPERTY OF THE PROPERT | A. BUILDING                           | l c        |
| DEMINION   |                                       | 01/11/2017 |
| 105447   | B. WING                               | 01/11/2011 |
| 495147   | STREET ADDRESS, CITY, STATE, ZIP CODE |            |

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

1221 ROSSER AVE

AVANTE AT WAYNESBORD

WAYNESBORO, VA 22980

(X4) 1D PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)

103 PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

(X5) COMPLETION DATE

F 327 Continued From page 38

review for her residents. She stated, "Yes." The Kardex was obtained and reviewed. Under the section "Fluids" the entry "Fluid Restriction" was not checked, and beside the entry "Other" was written 'Encourage." The care plan was last updated "3/4/15".

LPN #7 was then Interviewed regarding her entries on the MAR of greater than 500 cc of fluid intake on day shift. She stated, "I did that because I am not sure what all she has gotten...1 go in the room and there are cups there. I cant record how much she had if I don't know how full the cups were from the beginning."

The care plan was reviewed. A focus area "...has a nutritional problem -/t [related to] being over IBW [ideal body weight] (145#) and diabetic ulcers. Interventions included "1500 cc FLUID RESTRICTION ORDER". There were no entries on the care plan regarding Resident #11 being noncompliant with the 1500 cc restriction

Resident #11 was interviewed on 01/11/2017 at approximately 10:00 a.m. Her breakfast ray had been removed. A white Styrofoam cup remained on her bedside table. Resident #11 was asked about the cup. She stated, "It's water. They bring it in here for me."

The DCN (director of nursing) was interviewed on 01/11/2017 at approximately 1:00 p.m. She was asked about fluid restrictions for Resident #11. She stated, "I have inserviced the staff...the nurses are suppose to write only what they give to the resident on the MAR...the CNAs write the intake totals from the trays on the ADL sneets." The DON was asked if there was any place to look to see what Resident #11's totals were per

PRINTED: 01/20/2017

| en en A en m   | MONT OF HEALTH  | AND HUMAN SERVICES  |                     |  | FORM<br>OMB NO | 1APPROVED<br>1. 0938-0391 |
|--|---|---|---------------------|--|----------------|---------------------------|
| ENTER  | S FOR MEDICARE<br>OF DEFICIENCIES<br>FOORRECTION  | & MEDICAID SERVICES   |                     | TIPLE CONSTRUCTION<br>NG                               | 'AG (EX)       | TE SURVEY<br>MPLETED<br>C |
|  |   | 495147  | B. WING_            |  |                | /11/2017                  |
| ME DF P  | ROVIDER OF SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP CC<br>1221 ROSSER AVE | DE             |                           |
| ANTE   | AT WAYNESBORO   |   |                     | WAYNESBORO, VA 22980                                   | DECTION        | (X5)                      |
| X4; D<br>REFIX<br>TAG  | and the same property and the first   | (ATEMENT OF DEFICIENCIES<br>OY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG |  | SHOULU DE      | COMPLETION<br>DATE        |
| F 327  | are paper. The Easked how the fagetting over the 1 stated. "There is totals." The DON should have a wistated, "No." The Resident #11] is anymore. She can fuild restrictions bringing fluids in the above informeeting with the 01/11/2017 at a | s electronic and the ADL sheets DON stated, "No." The DON was cility knew if Resident #11 was 500 cc allotment per day. She no one piace to look at those N was asked if Resident #11 ater cup at her bedside. She e DON also stated, "[Name of unable to get up on her own annot be noncompliant with her unless she has help by someone to her."  mation was discussed during a e administrator and the DON on pproximately 2:30 p.m. |                     | 327  |                |                           |
|  | amount of daily<br>ensure a physiday fluid restric<br>day fluid restric<br>diagnoses was  | staff failed to monitor the total<br>y fluid provided to Resident #14 to<br>ician ordered 1500 ml (milliliter) p<br>ction for cardiac and renal<br>s met from 8/24/16 through 1/11/   | ,,,,                |  |                |                           |
| The same of the sa | 8/24/16. Diag   | ncluded:<br>was admitted to the facility on<br>proses for Resident #14 included<br>nited to heart failure, diabetes (hig<br>press), chronic kidney disease,   | gh                  |  |                |                           |

PRINTED: 01/20/2017

|   | DEPARTMENT OF HEALTH   | AND HUMAN SERVICES   | y comment of   | FORM APPROVED<br>OMB NO. 0938-0391 |
|---|--|--|--|------------------------------------|
|   | CENTERS FOR MEDICARE   | 8 MEDICAID SERVICES  | (X2) MULTIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED      |
|   | TATEMENT OF DEFICIENCIES<br>NO PLAN OF CORRECTION                            | DENTIFICATION NUMBER.  | A. BUILDING  | С                                  |
| <i>P</i>  | AP : Date of a second  |  | e wing   | 01/11/2017                         |
|   |  | 495147   | STREET ADDRESS, CITY, STATE, ZIP CO  | D€                                 |
| ŀ   | NAME OF PROVIDER OR SUPPLIEF   |  | 1221 ROSSER AVE  |                                    |
| 1   |  |  | WAYNESBORO, VA 22989   | DECTION (X5)                       |
|   | AVANTE AT WAYNESBORO  (X4): D PREFIX PREFIX SUMMARY S (EACH DEFICIENT PREFIX | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION) | PROVIDER'S PLAN OF COR<br>PREFIX (EACH CORRECTIVE ACTION<br>TAG CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE COMPLETION               |
| Table Street, Square, | TAG REGULATORS OF  | -  |  |                                    |

#### F 327 Continued From page 40

edema (swelling) and chronic respiratory failure with hypoxia (deprived of oxygen). Resident #14's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/21/16 coded Resident #14 with no cognitive impairment. In addition, the Minimum Data Set coded Resident #14 requiring limited and extensive assistance for Activities of Daily Living care (transfers.cressing, hygiene). Resident #14 was observed on 1/11/17 at approximately 1:15 p.m. The resident was observed to be well groomed.

On 1/11/17 at approximately 1:15 pm., Resident #14 was observed during lunch drinking two cups of lemonade (8 fluid ounces each) and with the ability to eat on her own.

On 1/11/17, Resident #14's clinical record was reviewed. The reviewed showed a physician order dated 8/29/16. The order read, Resident #14 was to have a 1500 milligrams (mi) fluid restriction Every shift for fluid overload. The instructions included: 900 ml with meals and 600 ml provided by nursing); 7-3 (shift nursing staff) may give 240 cc, 3-11 shift nursing staff may give 300 cc and 11-7 shift nursing staff may give 60 cc. This order was discontinued on 1/11/17. The new order with a start date of 1/12/17 was documented on the MAR (Medication Administration Record). This order read, Resident #14 was to have a 1500 ml fluid restriction: (900 ml with mea's and 600 ml provided by nursing. It was written with this instruction; 7-3= May give 240 cc, 3-11= May give 300 cc, and 11-7= May give 60 cc every shift encourage resident to comply with restriction.

Each MAR was reviewed from admission on

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#### CEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICA: D SERVICES (X1) PROVIDER/SUPPLIER/CLIA

OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING . C 01/11/2017 B. WING

495147 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER

DENTIFICATION NUMBER:

1221 ROSSER AVE WAYNESBORO, VA 22980

AVANTE AT WAYNESBORD (3/4) [0]

PREFIX TAG

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

#### F 327 Continued From page 41

8/24/16 through 1/11/17 (the date of the survey when Resident #14's record was reviewed). The MAR was where the nursing staff recorded the fluid intake. The results of this reviewed: Each month had blank spaces indicating no measurement of fluid intake. Each month had amounts greater and less than the prescribed amount for the nursing staff. There was not one month were the nursing staff recorded a consistent amount of fluid as prescribed.

For example, the most current month 1/1/17 through 1/31/17 recorded on the MAR : On 1/5/17 Resident #14 received 1,110 cc of fluid per nursing documentation on the MAR. On 1/5/17 and per the ADL sheets where the CNAs (Certified Nursing Assistant) record fluid intake for meals, Resident #14 received an additional total of 640 cc of fluid from breakfast and dinner. The total documented fluid intake for Resident #14 on 1/5/17 was 1,750 cc for the day.

The unknown factors for Resident #14 on 1/5/17 for fluid intake included lunch because she was LOA (leave of absence) and the amount she had in between meals. The total amount of fluid for Resident #14 was unknown for 1/5/17. The clinical notes for 1/5/17 added no additional information about fluid intake. This scenario was repeated throughout the record review. Also, Resident #14 had days where she was under the fluid restriction per documentation and could have more fluid if desired.

Resident #14's most current careplan did not report a refusal to comply with fluid restrictions.

On 1/11/17 at approximately 1:15 p.m. Resident #14 was interviewed. Resident #14 explained that

| EPARTMENT OF HEALTH  | AND HUMAN SERVICES   | ar a   |  | PRINTED: 01/20/2017<br>FORM APPROVED<br>OMB NO. 0938-0391 |
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| NTERS FOR MEDICARE   | & MEDICAID SETTING   |  | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                             |
| EMENT OF DEFICIENCIES<br>PLAN OF CORRECTION  | DENTIFICATION NUMBER:  | A. BUILDI  | NG   | C<br>01/11/2017   |
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| WEET OF SUPPLIER   |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE                        |   |
| ME OF PROVIDER OR SUPPLIER   |  |  | 1221 ROSSER AVE<br>WAYNESBORO, VA 22980                      |   |
| IANTE AT WAYNESBORD  | and the second s |  | OCOUPLED'S PLAN OF CORRECT                                   | CTDN (X5)   |
|  | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG  | X (EACH CORRECTIVE ACTION SHU<br>CROSS REFERENCED TO THE APP | JULU BE   |
| surrounding her hat I don't get ento time she added container of ice whout I don't like the Dn 1/11/17 at 1.3 Supervisor) was the CNAs record sheets and the rand if anything is occumented on explained that C sheets to keep I shift and when the record (MAI LPN #5 also ad in-service a new large cups to the them.  On 1/11/17 at 1 and added, "Trifluids." LPN #6 nights and day often when I can the resident's On 1/11/17 at Nursing Assistated that shiftom 7 a.m. the know she is on sheets) in the sident in the sident's in the si | striction because of the fluid heart. Resident #14 stated, "I follow the fluid heart. Resident #14 stated, "I follow the fluid have a large white water placed on my bedside table water that much."  30 p.m. LPN #5 (the Unit interviewed, LPN #5 stated that fluid intake for meals on the Alburses document on the MARs of different or a change that is clinical notes. LPN #5 also that are amounts are documented in the fluid intake throughout the amounts are documented in the tally sheets are shreade mitted that sometimes she will writted that sometimes she will writted that sometimes she will correct the fluid intake throughout in the resident and she will correct (worked with Resident #14 on its shifts) added "at times but no shifts) added times and times and times added times and times and times added times and times and times and times and times and times and  | eel ne ble at NDL fly the not the ved on the rin at #14 d, "! n ADL d dent | 327  |   |

300 cc each." CNA#3 does not record dinner

| 27. 27. 2017 12:1324<br>EPARTMENT OF HEALTH  | AND HUMAN SERVICES  |   |  | PRINTED: 01/20/2017<br>FORM APPROVED<br>OMB NO. 0938-0391 |
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| PLAN OF CORRECTION   | IDENTIFICATION TO THE   | A. BOILESI                              | Company and Compan | 01/11/2017  |
|  |   | B. WING                                 |  | 01/11/2017  |
|  | 495147  | 1                                       | STREET ADDRESS, CITY, STATE, ZIP CODE  |   |
| AME OF PROVIDER OF SUPPLIER  |   |   | 1221 ROSSER AVE  |   |
|  |   |   | WAYNESBORO, VA 22980   |   |
| VANTE AT WAYNESBORO  |   |   | TOWN OF CORRECT  | TION X51  |
| SLMMARY ST   | ATEMENT OF DEFICIENCIES<br>LY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      | X (EACH CORRECTIVE ACTION SHO<br>COOSS_REFERENCED TO THE APPL  |   |
| her but! have not think the girs forg cups of water who resident's room  On 1/11/17 at 1:0 Nursing) was into that the nursing regarding the prothe survey team: (1/10/17) and ide total the amount resident. The Dinot get totaled five was tracking the "there is no ream one was add DON now has with the in-serv.  The Administration policy to present any full findings during approximately present any full for SPECIA (b)(2) For SPECIA (c)(2) Foot caproper treatment good for the sident of the service | e big Styroloum er big Styroloum ficed she had the cups and I get." CNA #3 said she takes the en she sees them in the maybe once a week.  OD p.m. the DON (Director of erviewed. The DON explained staff was in-serviced (1/11/17) pocess of monitoring fluids after identified the inconsistencies entified the lack of a process to of fluid intake per day per ON stated, "it [fluid intake] does for the day." When asked how see fluid in-take, DON responded I tracking sheetup to this poinding up the total fluid per day." a plan to change this that begind in staff.  Section and DON did not have a factor and DON did not have a factor.  The facility did not the fine of the process of the facility did not urther information about the fine of the fine of the process of the facility did not urther information about the fine of the process of the fine of the fine of the fine of the fine of the process of the fine of the | o sishe at The as cility e dance adding | F 328  1) Resident #12s oxygen immediately re-applied at prescribed flow rate of 4liters. Chewas re-educated on resident #12s for oxygen while in bed as when up in wheelchair. Resident kardex was updated to reflect or requirements.  | reil as<br>nr #12s  |

CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION

495147

(K2) MULTIPLE CONSTRUCTION A. BUILDING \_

1221 ROSSER AVE

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

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01/11/2017

NAME OF PROVIDER OR SUPPLIER

AVANTE AT WAYNESBORO

PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG

B. WING\_

WAYNESBORO, VA 22980 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION

#### F 328 Continued From page 44 medical condition(s) and

- (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments
- (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterestomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
- (h) Parenteral Fluids. Parenteral fluids must be administerec consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483,65 of this subpart.

#### F 328

2). A 100% kardex sudit was completed on all current residents who require oxygen to ensure correct documentation of oxygen need is in place as well as liter flow for review by staff members caring for residents.

STREET ADDRESS, CITY, STATE, ZIP CODE

- 3) In-service education was started on 1/13/17 for licensed nurses and certified nursing assistants regarding appropriate oxygen information needed on resident's kardex in order to ensure appropriate care is provided to each individual resident in accordance with their specific plan of care.
  - 4) Kardex's will be reviewed on any resident who has a new order for oxygen as well as on all new admissions to ensure that they include the appropriate information for staff to provide care for the resident as ordered. Audits will be completed twice weekly for 6 weeks and as uni! γď thereafter needed managers/DON/ and/or designee.

The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as recessary

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| DEPARTMENT OF HEALTH   | AND HUMAN SERVICES        |                     | C!   | MB NO. 0938-0391              |
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| CENTERS FOR MEDICARE   | WILL CROWDER/SUPPLIER/CUA | (X2) MULTIPLE C     | ONSTRUCTION  | (X3) CATE SURVEY<br>COMPLETED |
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | IDENTIFICATION NUMBER:    | A BULDING           | Takak de ser para antique de la companya de la comp | С                             |
|  | 495147                    |                     | ALL AND  | 01/11/2017                    |
| List per   |                           | 1                   | EET ADDRESS, CITY, STATE, ZIP CODE   |                               |
| NAME OF PROVIDER OR SUPPLIER   | \$                        |                     | 1 ROSSER AVE   |                               |
| AVANTE AT WAYNESBORO   |                           | WA                  | YNESBORO, VA 22980   | N (X5)                        |
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| TA5 REGULATORY OF  |                           |                     |  |                               |
|  | nage 45                   | F 323               |  |                               |

F 328 Continued From page 45

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.

This REQUIREMENT is not met as evidenced

Based on observation, staff interview and clinical record review the facility staff failed to ensure that physician preered oxygen was in place for one of 19 residents, Resident #12.

Resident #12 did not have her oxygen on as ordered while in the aining room from approximately 11:10 a.m. until 1:20 p.m.

Findings were:

Resident #12 was admitted to the facility on 04/01/2016. Her diagnoses included but were not timited to: Pneumonia, urinary tract infection, dysphagia, unspecified heart failure and dementia.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/2/2016. Resident #12's cognitive status was assessed as "moderately impaired" with a summary score of "9".

On 01/11/2017 at approximately 8:30 a.m. Resident #12 was observed lying in bed. A nasal cannula was in place with oxygen running at 4 liters.

The electronic clinical record was reviewed. The

| DEPARTMENT OF HEALTH<br>CENTERS FOR MEDICARE      | N N  | IEDICAID BEITTIES                              |
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| STATEMENT OF DEPICIENCIES STATEMENT OF CORRECTION | (X1° | PROVIDER/SUPPLIER/CUA<br>DENTIFICATION NUMBER: |

495147

(X2) MULTIPLE CONSTRUCTION A BUILDING.

OMB NO. 0938-039\* (X3) DATE SURVEY COMPLETED

PRINTED: 01/20/2017 FORM APPROVED

01/11/2017

NAME OF PROVIDER OR SUPPLIER

AVANTE AT WAYNESBORO

STREET ADDRESS CITY, STATE, ZIP CODE 1221 ROSSER AVE

WAYNESBORO, VA 22980

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X41 ) REGULATORY OR USC DENTIFYING INFORMATION) PREFIX TAG

PREFIX TAG

B. WING

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION CATE

F 328 Continued From page 46

physician order sheet contained the following order: "Cxygen 4 LPM [liters per minute] per nasal cannula every shift related to HEART FAILURE, UNSPECIFIED."

On 01/11/2017 at approximately 11:10 a.m., Resident #12 was observed sitting in her wheelchair in the dining room. She was not wearing her oxygen.

At approximately 12:10 p.m., Resident #12 was fed her lunch in the dining room by a staff member. She was not wearing her oxygen. An oxygen tank was observed on the back of her wheelchair but there was no gasal cannula attached nor was the tank on.

At approximately 1:20 p.m., Resident #12 was wheeled back to her room. CNA#1 was in the room getting Resident #12 to lie back down. Resident #12 was pleasant and chatting with this surveyor. She was asked if she was breathing okay. She stated, "Yes." Resident #12 was askec why she was not wearing her oxygen. CNA #1 stated, "I was told she only needs it in bed."

CNA #1 assisted Resident #12 back to bed and reapplied the oxygen.

The Kardex and care plan were reviewed. Under the area "Respiratory" on the Kardex oxygen was checked but there was no mention of the amount of oxygen ordered or when Resident #12 was to wear it.

During an end of the day meeting on 01/11/2017 at approximately 2:30 p.m., the DON (Director of Nursing) and the administrator were informed of

| EPART <b>V</b>           | IENT OF HEALTH                      | AND HUMAN SERVICES   | به چاپ شانو این                         | 0  | FORM APPROVED<br>MB NO. 0938-0391 |
|--------------------------|-------------------------------------|--|---|--|-----------------------------------|
| ENTERS                   | FOR MEDICARE                        | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:          |   | TIPLE CONSTRUCTION<br>ING  | (X3) DATE SURVEY<br>COMPLETED     |
| PLAN OF                  | CORRECTION                          |  | B. WING                                 |  | 01/11/2017                        |
|                          |                                     | 495147   |   | STREET ADDRESS, DITY, STATE, ZIP CODE  |                                   |
|                          | OVIDER OR SUPPLIER                  |  |   | 1221 ROSSER AVE<br>WAYNESBORO, VA 22980  |                                   |
| VANTE A                  | T WAYNESBORO                        |  |   | PROVIDED'S PLAN OF CORRECTION  | ON (X3)                           |
| (X4) ID<br>PREFIX<br>TAG |                                     | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING (NFORMATION) | ID<br>PREF<br>TAG                       | (EACH CORRECTIVE ACTION SHOULD BE | UBC                               |
|                          | Control Control                     | 200e 47  | F                                       | 328  |                                   |
| F 328                    | Continued From p                    | ation and that Resident #12 ha   | ıd                                      |  |                                   |
|                          | the above months                    | oxygen for over two hours  |   |  |                                   |
|                          | earlier that day (0                 | 1/11/2017)-  |   |  |                                   |
|                          | No further inform                   | ation was obtained prior to the  | <b>;</b>                                |  |                                   |
|                          | evit conference 0                   | on 01/11/2017.   |   | 406  |                                   |
| F 406                    | 483.65(a)(1)(2) F                   | PROVIDE/OB AIN   |   | 1) Speech consult was completed on   | 2/0/2011                          |
| SS=D                     | SPECIALIZED                         | EHAB SERVICES  |   | 1/12/17 for resident #10 with no new   | 2/8/201                           |
|                          | (a) Provision of 9                  | services. If specialized   |   | changes to current medical orders.   |                                   |
|                          | bullitations = ===                  | vines such as but not miniou "   | 0                                       | _  | _                                 |
|                          | - L. minal thorany                  | enench-landijace paulology,  |   | 2) An audit of the past 3 months of  | <u> </u>                          |
|                          | a motional the                      | rany respiratory therapy, and  |   | Registered Dientian notes was  | 5                                 |
|                          | طحم مثلما المساعية والمساح          | vices for mental illness and vices for mental illness and vices of a lesser      |   | completed with no other issues   | <i>t</i>                          |
|                          |                                     | SERIE OF SAME TANDELL OF STREET  | red                                     | concerned noted.   |                                   |
|                          | in the resident's                   | comprehensive plan of care,  | the                                     | 3) All residents who have speed  | h                                 |
|                          | facility must-                      |  |   | 3) All residents who have speces therapy consult recommendations from  | L7                                |
|                          |                                     | . d . ne isons of  |   | the Registered Dietician will have   | a                                 |
|                          | (1) Provide the                     | required services; or  |   | therapy referral form completed b  | Ý                                 |
|                          | (a) In accordan                     | ce with §483.70(g), obtain the   |   | Director of Nursing or designee  | io .                              |
|                          | and the second second second second | as troin an intibide (bacares  | . —                                     | ensure timely evaluation and treatmen  | al.                               |
|                          | and the state of the                | remainsed tellanilitative activities   | es                                      | Director of Nursing and clinic   | aı                                |
|                          | dia ant ovelt                       | HEAT from DarticiDation in any   |   | managers were in serviced.   |                                   |
|                          | federal or state                    | health care programs pursual nd 1156 of the Act.                                 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 4) The Director of Nursing and/  | or                                |
|                          | section 1125 at                     | MENT is not met as evidence  | ed                                      | designee will monitor at   | ny                                |
|                          | r                                   |  |   | recommendations from the Register  | ed<br>,                           |
|                          | ri dementati                        | f interview and clinical record  | of 19                                   | Dietician for 6 weeks and random   | ılÿ                               |
| No.                      | equipus the fac                     | lity staff talled to ensure one v  | J1 10                                   | thereafter.  | •                                 |
|                          | and offer                           | ived specialized rehabilitative a physical decime and to ensu                    | ire                                     | The results of this audit will be broug  | ≅hī                               |
| suate gave controls      | services after a                    | further decline; Resident # 10.  |   | to monthly Quality Assurance a   | ınd                               |
| decrease and the second  |                                     |  |   | Performance Improvement (QA  | PI)                               |
|                          | The facility fail                   | led to complete a physician or   | gered<br>er a                           | meeting for review and revisions   | as                                |
|                          | or (Canach T                        | herapy) consult/evaluation afte<br>ight loss of 9 lbs (pounds) in o              | L                                       | necessary.   |                                   |

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

(X2) MULTIPLE CONSTRUCTION A. BUILDING \_

FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

COMPLETED

PRINTED: 01/20/2017

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01/11/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

(21) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:

> B. WING 495147

STREET ADDRESS, CITY, STATE, ZIP CODE

1221 ROSSER AVE

WAYNESBORD, VA 22980

PREFIX TAG

AVANTE AT WAYNESBORD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY DR LSG IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

XS) DATE

F 406 Continued From page 48 month for Resident #10.

Findings include:

Resident # 10 was admitted to the facility on 09/23/97, with the most current readmission on 07/01/08. Diagnoses for Resident # 10 included, but were not limited to. moderate intellectual disability, anxiety disorder, DM (diabetes mellitus), demeritia with behavioral disturbance, depression and dysphasia.

The most current quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 assessed the resident with a cognitive score of "0" indicating the resident was severely impaired cognitively in daily decision making skills. The resident was also assessed as requiring extensive to total assistance from staff for all ADL's (activities of daily living) except for eating, where the resident was assessed as independent with set up help only.

During clinical record review on 01/10/17 at approximately 1:30 p.m., Resident # 10's clinical record was reviewed. A dietary communication form dated 12/08/16 was reviewed. The form documented, "...weight seems to have dropped 9 lb from 11/1 [16] to 12/01 [16] Previously weight stable. Recommend: 1. reweigh 2. nutritional treat BID (twice daily) due to poor oral intake 3. ST [speech therapy] for most appropriate diet texture..." This form had a hand written entry that documented, "order entered speech made aware" and was signed by the DON (director of nursing).

Further review of the resident's clinical record revealed a progress note dated 12/08/16 and timed 5:04 p.m., which documented: 'RD

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|  | DEPARTMENT OF HEALTH<br>CENTERS FOR MEDICARE       | & MEDICA OF THE                                       | (X2) MULTIPLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
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|  | CENTENS OF DEFICIENCIES AND PLAN OF CORRECTION     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: | A BUILDING   | С                             |
|  | AND PLAN OF CONTRACT TO ST                         | 495147  | B. WINGSTREET ADDRESS, CITY, STATE ZIP CODE  | 01/11/2017                    |
| Decision for the last of the l | NAME OF PROVIDER OR SUPPLIER  AVANTE AT WAYNESBORO |   | 1221 ROSSER AVE WAYNESBORO, VA 22980   | on (X5)                       |
| - Contraction of the Contraction | SLMMARY ST   | ATEMENT OF DEFICIENCIES  Y MUST BE EVEN INFORMATION)  | PROVIDER'S PLAN OF COME PREFIX (EACH CORRECTIVE ACTION SHOUL) PREFIX CROSS-REFERENCED TO THE APPROFI TAG DEFICIENCY; |                               |
|  | PREFX REGULATORY OR                                | LSC IDENTIFY NG INFORMATION)                          |  |                               |

#### F 406 Continued From page 49

[registered dietitian] Weight note: value: 155 [lbs]...5.0 % change over 30 days (5.5%. 9.0)...Resident's wt [weight] appears to have dropped 9 lb from Nov 1 to Dec 1. Weight previously stable from 160-168 lb., recommend reweigh to rule out errors in measuring. Also recommend nutritional treat BID as her meal intake is poor. Recommend ST evaluation to ensure finger foods diet still appropriate...signature of RD."

No evidence of ST consult or evaluation could be located in the clinical record.

A progress note dated 12/15/16 and timed 2:11 p.m., documented: "RD [registered dietitian] Weight note: value: 156...Resident discussed...her weight decreased additional 2 lb from 12/9 to 12/12. Nutritional treat BID was just started 12/12...Unclear if previous RD recommendations re: ST evaluation has been done. If not, please have ST screen to ensure current diet appropriate...signature of temporary RD."

On 01/11/17 at 8:55 a.m., the rehab director was interviewed and was asked to provide any information on Resident # 10 regarding a speech consult or evaluation in the last 3 months.

At approximately 9:30 a.m., the rehab director presented a quarterly screen that was completed in October 2016. The rehab director stated that the screens are done every three months, automatically (on everyone) and there is no need for an order. The rehab director further stated that the last speech consult for Resident # 10 was in March of 2016, nothing since and that time the resident was recommended to have finger foods

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION A. BUILDING ,

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

PRINTED: 01/20/2017 FORM APPROVED

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01/11/2017

B. WING

SYREET ADDRESS, CITY, STATE, ZIP CODE 1221 ROSSER AVE

NAME OF PROVIDER OR SUPPLIER

AVANTE AT WAYNESBORO

0341 D

PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

495147

PREFIX

WAYNESBORO, VA 22980 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION

F 406 Continued From page 50

and that would include anything you can pick up with your fingers, a sandwich, french fries, anything you can eat with your hands.

At approximately 9:35, the DON was interviewed and how therapy consults/screenings are communicated to ensure completion. The DON stated that the nurses would send the information to the therapy department or they (nurses) would give it to a unit manager or to herself (DON) and then it would be forwarded to therapy. The DON was asked how long it takes to complete, once the therapy has the order. the DON stated that it doesn't normally take long, maybe a couple of days max because the ST person is here 5 days a week.

Resident # 10's current CCP (comprehensive care plan) was reviewed and documented, "Name of resident is at risk for weight loss without proper po [by mouth] intake [06/11/15]...will consume at least 50%...to promote weight maintenance and optimal nutrition... [10/24/16]....adaptive equipment as ordered...encourage...to eat at meal time....no straws...provide diet as ordered...provide extra time...provide finger foods...provide thickened liquids as ordered by physician/ST..." Of the above listed interventions, the most recent revision was on 08/01/16 for the adaptive equipment- no new interventions implemented.

At approximately 2:15 p.m., the DON stated that the ST evaluation for Resident # 10 had not been done and it looked as if the "ball had dropped,"

The DON and administrator were made aware of concerns regarding Resident # 10's ST evaluation not being completed after a significant weight

F 406

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

Event ID: PNKL11

Facility ID: VA0019

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|   | AND THINKIN SERVICES   |                   |   | OMB NO.                        | 0938-0391          |  |
|---|--|-------------------|---|--------------------------------|--------------------|--|
| EPARTMENT OF HEALTH   | AND HUMAN SERVICES   |                   | TO CTOUCTON   | VSI DATI                       | F SURVEY           |  |
| CENTERS FOR MEDICARE<br>ATEMENT OF DEFICIENCIES<br>ID PLAN OF CORRECTION      | (X2) ML  |                   | INFLE CONSTRUCTION  |                                | C 01/11/2017       |  |
| ND PLAN OF CURRENTON  | 495147 B. WIN  |                   |   |                                |                    |  |
|   |  |                   | STREET ADDRESS, CITY, STATE, ZIP CODE   |                                |                    |  |
| NAME OF PROVIDER OR SUPPLIER  |  |                   | 1221 ROSSER AVE   |                                |                    |  |
| AVANTE AT WAYNESBORO  |  |                   | WAYNESBORO, VA 22980 PROVIDER'S PLAN OF C   | DEBECTION                      | (X5)               |  |
| SUMMARY ST  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | EX (EACH CORRECTIVE AUTO  | HE APPROPRIATE                 | COMPLETION<br>DATE |  |
|   | The state of the s | E                 | 406   |                                |                    |  |
| 01/11/17 at appn  | oximately 3:30 p.m.  | r                 | 400   |                                |                    |  |
| No further inform<br>presented prior t  | nation or documentation was<br>to the exit conference on 01/11   | ./17              | F 431   |                                |                    |  |
| F 431 483.45(b)(2)(3)(<br>SS=0 LABEL/STORE                                    | g)(h) DRUG RECORDS,<br>DRUGS & BIOLOGICALS   |                   | The bottle of open hemocoult solution of approach to the control of the cont | of Lantus                      | 2/8/2017           |  |
| drugs and biolo   | st provide routine and emergen<br>gicals to its residents, or obtain   |                   | insulin were discarded on 1/  | 12/1/                          |                    |  |
| them under an §483.70(g) of to unlicensed per law permits, but supervision of | agreement obtaining may perm<br>his part. The facility may perm<br>sonnel to administer drugs if S<br>ut only under the general<br>a licensed nurse.   | rit               | <ol> <li>100% audit was complemedication carts and medic<br/>to ensure no other<br/>medications were present<br/>issues were found.</li> </ol>  | unlabeled                      |                    |  |
| pharmaceutic<br>that assure th<br>dispensing, a<br>biologicals) to            | <ul> <li>A facility must provide</li> <li>al services (including procedure</li> <li>accurate acquiring, receiving</li> <li>administering of all drugs are</li> <li>meet the needs of each reside</li> </ul>  | nd                | <ol> <li>In-service education state<br/>with licensed nurses staff (<br/>labeling of all opened manadication carts and in<br/>recorn.</li> </ol>  | on the proper<br>edications on |                    |  |
| employ or ob<br>pharmacist v  | onsultation. The facility must tain the services of a licensed who—  |                   | 4) Medication cart an room audits will be con   | mpleted twice<br>nd as needed  |                    |  |
| disposition of detail to ena  | ies a system of records of rece<br>of all controlled drugs in sufficie<br>note an accurate reconciliation;   | and               | thereafter by Director of<br>Managers/ and/or design<br>facility remains in cor   | nee to ensure                  |                    |  |
| that an accommaintained   | nes that drug records are in ord<br>ount of all controlled drugs is<br>and periodically reconciled.  | jer and           | state regulations.  The results of this audit to monthly Quality  | Assurance and                  |                    |  |
| (g) Labelin<br>Drugs and<br>Jabeled in  | g of Drugs and Biologicals.<br>biologicals used in the facility r<br>accordance with currently acce  | nust be<br>pted   | Performance Improve meeting for review as necessary.  | nd revisions 33                | ation sheet Page   |  |

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NO. ZVV.

| DEPARTMENT OF HEALTH                                   | AND HUMAN SERVICES  |            | <u> </u>   | MB NO. 0938-0391<br>(X3) DATE SURVEY          |
|--|---|------------|--|---|
| CENTERS FOR MEDICARE                                   | & MEDICAID SERVICES  (X1) PROVIDENSUPPLIER/CLIA   | (X2) MULT  | IPLE CONSTRUCTION                                      | COMPLETED                                     |
| TATEMENT OF DEFICIENCIES<br>NO FLANCE CORRECTION       | DENTIFICATION NUMBER  | A BUILDI   | NĞ   | 01/11/2017                                    |
| 147 - 71 - 6   | 495147  | B WING     | STREET ADDRESS, CITY, STATE, ZIP CODE                  | 01/11/2017                                    |
| NAME OF PROVIDER OF SUPPLIER                           |   |            | 1221 ROSSER AVE<br>WAYNESBORO, VA 22980                |   |
| AVANTE AT WAYNESBORO                                   | TATEMENT OF DEFICIENCIES  | ID<br>PREF | PROVIDERS PLANOF CORRECT  (FACH CORRECTIVE ACTION SHOU | ION (X5)<br>NLD BE COMPLETION<br>DPRIATE DAYS |
| (X4) 'D SUMMARY 5 (EACH DEFICIENT PREFIX REGULATORY CR | TATEMENT OF SET | TAG        | CROSS-RÉPÉRENCED 10 11 EV                              |   |
|  |   |            |  |   |

F 431 Continued From page 52

professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

- (ii) Storage of Drugs and Biologicals.
- (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.
- (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced

Based on observation and staff interview, facility staff failed to ensure drugs and biologicals were stored properly in one of two medication rooms, the B-Wing.

Facility staff failed to date an open bottle of Lantus insulin and an open bottle of Hemoccult developer upon initial use.

Findings included:

The medication room on the B-Wing was observed 01/11/17 at 12:45 p.m. by this surveyor and LPN #4 (licensed practical nurse). During this observation a bottle of Hemoccult developer was discovered as opened and not dated. LPN

F 431

FORM CMS-2557(C2-99) Previous Versions Obsidere

Evant :D: PNKL11

Facility ID: vA0019

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| EPARTN  | MENT OF HEALT                        | HAND HUMAN SERVICES  |                   |  |  |                              | . 0938-0391<br>= SURVEY       |  |
|---|--------------------------------------|--|-------------------|--|--|------------------------------|-------------------------------|--|
| DEPARTMENT OF TILALTY DENTERS FOR VEDICARE FATEMENT OF DEFICIENCIES |                                      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   | (x2) MULTIPLE CONSTRUCTION A, BUILDING |  |                              | (X3) DATE SURVEY<br>COMPLETED |  |
| ND PLAN OF CORRECTION   | (DEIVE SWALLE)                       | B, WING  |                   |  | 01/11/2017   |                              |                               |  |
|   |                                      | 495147   | B. W145           | STREET ADDRE                           | ESS, CITY, STATE, ZIP (  | CODE                         |                               |  |
| ME OF PI  | ROVIDER OR SUPPLIEF                  | ₹  |                   | 1221 ROSSER                            | RAVE   |                              |                               |  |
| VANTE /   | AT WAYNESBORO                        |  |                   | WAYNESBO                               | RO, VA 22980   | ADDECTION:                   | (K5)                          |  |
| (X4) ID<br>PRESIX<br>TAG  | SUMMARY S                            | TATEMENT OF DEFICIENCIES<br>ICY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION) | 'D<br>PREF<br>TAC | XX (EAC                                | ROVIDER'S PLAN OF CO<br>SHICORRECTIVE ACTION<br>S-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | COMPLETION<br>DATE            |  |
|   |                                      | 200 53   | F                 | 431                                    |  |                              |                               |  |
| F 431   | Continued From                       | - t u k-wa a dane dilik. VYS   | e                 |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  | lt                |  |  |                              |                               |  |
|   | of Lantus insulin                    | modication refrigerator. No op   |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      | recent resident in the locality  | Ю                 |  |  |                              |                               |  |
|   |                                      | s SQ (subcutaneously) Qhs<br>LPN #4 stated, "I don't know                                  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  | ton<br>No         |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   | <ul> <li>director of nurs</li> </ul> | sing) and see what she wants   |                   |  |  |                              |                               |  |
|   | to do with it."                      | _ ,  | F 11              |  |  |                              |                               |  |
|   | The Administra                       | tor and DON were informed or   | the               |  |  |                              |                               |  |
|   |                                      | during a meeting with the survival at approximately 3:00 p.m.                              |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   | team prior to the                    | ne exit conference on 01/11/17   | •                 |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      | ,  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              | •                             |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |
| 1   |                                      |  |                   |  |  |                              |                               |  |
|   |                                      |  |                   |  |  |                              |                               |  |

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

Event ID: PNKL11

Facility ID, VA0019

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