	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES		(FORM): 07/05/2017 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DAT). 0938-0391 TE SURVEY MPLETED
		495315	B. WING_		06	/21/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	2017
CONSUL	ATE HEALTH CARE	OF WOODSTOCK		803 SOUTH MAIN ST WOODSTOCK, VA 22664		
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F 000	INITIAL COMMENT	rs	F 00			
F 155 SS=G	survey was conduct Significant correction compliance with 42 Term Care required survey/report will for The census in this 8 at the time of the succonsisted of 13 cur (Residents 1 through reviews (Residents 483.10(c)(6)(8)(g)(1) REFUSE; FORMULT 483.10 (c)(6) The right to rediscontinue treatment to participate in explanation of the survey	CFR Part 483 Federal Long nents. The Life Safety Code llow. 88 certified bed facility was 80 revey. The survey sample rent Resident reviews h 13) and 6 closed record 14 through 19). 2), 483.24(a)(3) RIGHT TO ATE ADVANCE DIRECTIVES request, refuse, and/or nt, to participate in or refuse erimental research, and to be directive.	F 15			
	construed as the rig the provision of med	paragraph should be ht of the resident to receive lical treatment or medical edically unnecessary or				
	(g)(12) The facility n requirements specif subpart I (Advance I	ed in 42 CFR part 489,				
	inform and provide v residents concerning medical or surgical t	nts include provisions to written information to all adult the right to accept or refuse reatment and, at the mulate an advance directive.				
BORATORY	DIRECTOR'S OR PROVIDE	PISUPPLIER REPRESENTATIVE'S SIGN	,, /	TITLE		(X6) DATE
IMIAN)	w+ 17 - X	uso the		EXECUTIVE RESECTION		712-17

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

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	MENT OF HEALTH	AND HUMAN SERVICES & MEDI() SERVICES			C	FORM	0: 07/05/2017 MAPPROVED 0: 0938-0391
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F 155	facility's policies to and applicable State (iii) Facilities are perentities to furnish the legally responsible frequirements of this (iv) If an adult indivitime of admission and information or articulas executed an admay give advance of individual's resident with State law. (v) The facility is not provide this information or she is able to recomprove the information to the information to the information to the information to the information of the information to the information of	written description of the implement advance directives e law. rmitted to contract with other is information but are still for ensuring that the section are met. dual is incapacitated at the nd is unable to receive plate whether or not he or she wance directive, the facility directive information to the representative in accordance at relieved of its obligation to tion to the individual once he eive such information. The endividual directly at the povide basic life support, resident requiring such for to the arrival of emergency and subject to related the resident's advance. It is not met as evidenced to the individual directly at the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of the support is not met as evidenced to the weight of t	F	155	Past noncompliance: no plan	of	
	determined that the a resident's right to	record review, it was facility staff failed to preserve execute an advance directive to followed in the event she		ı	correction required.		

became without heartbeat and not breathing in

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI(**D SERVICES** OMB NO. 0938-0391 STATEMENT OF DEF!CIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4] ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY F 155 Continued From page 2 F 155 the facility. Resident #14 had signed an advance directive stating she wanted all resuscitative efforts to be undertaken for her. In accordance with this advance directive, the physician had written an order that the resident would be a full code. On 12/4/17, Resident #14 was discovered to be without pulse and without respirations. The facility staff failed to honor the advance directive and follow the physician's order by immediately beginning CPR and calling for emergency medical assistance, and Resident #14 subsequently expired. The findings include: Resident #14 was admitted to the facility on 11/24/16 with diagnoses including, but not limited to: ovarian cancer which had spread, diabetes, nausea, and vomiting. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 12/1/16, Resident #14 was coded as being severely cognitively impaired for making daily decisions, having scored only three out of 15 on the BIMS (brief interview for mental status). A review of the admission nursing assessment dated 11/24/16 revealed that Resident #14 was alert and oriented to person only.

ALERT: FULL."

A review of Resident #14's clinical record revealed a page with the title "FIRST ALERT." This page contained the following: "CODE

Further review of the clinical record revealed the document "[Name of state] Advance Directive for

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

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F 155	Continued From pa	age 3	F 1	55			
	[name Resident #1 make known my w incapable of makin my health care, as Care Instructions instructions in the edetermines that my and medical treatments possible within the health care standar receive treatment t comfortable." This one individual to se another individual t	document stated, in part: "I 4] willingly and voluntarily ishes in the event that I am g an informed decision about follows:Section II: My Health I provide the following event my attending physician of death is imminent (very close) tent will not help me recoverI to prolong my life as long as limits of generally accepted rds. I understand that I will o relieve pain and make me document listed the names of erve as primary agent, and o serve as secondary agent. Is signed by Resident #14 and					
	document with the Discussion Docum part: "Please indiction following: Cardiope PROVIDE. Please the following documed decision-maker." I check mark beside directive and health continued: "I have policies on Advance given a chance to a rights to make decicare. I understand or accept medical at the right to formula concerning my heachoices requires present indices in the standard of the right to formula concerning my heachoices requires present indices in the standard or accept medical at the right to formula concerning my heachoices requires present indices in the standard or accept medical at the right to formula concerning my heachoices requires present in the standard or accept medical at the right to formula concerning my heachoices requires present in the standard or accept medical at the right to formula concerning my heachoices requires present in the standard or accept medical at the right to formula concerning my heachoices requires present in the standard or accept medical at the right to formula concerning my heachoices requires present in the standard or accept medical at the right to formula concerning my heachoices requires present in the standard or accept medical at the right to formula concerning my heachoices requires present in the standard or accept medical at the right to formula concerning my heach of the standard or accept medical at the right to formula concerning my heach or accept medical at the right to formula concerning my heach or accept medical at the right to formula concerning my heach or accept medical at the right to formula concerning my heach or accept medical at the right to formula concerning my heach or accept medical at the right to formula concerning my heach or accept my h	ne clinical record revealed a title "Advance Directives ent." The document stated, in ate your wishes regarding the ulmonary Resuscitation (CPR): indicate if you possess any of ments or have primary he document contained a the categories of advance of care agent. The document received a copy of the facility's endicated and have been ask questions regarding my sions regarding my medical that I have the right to refuse and/or surgical treatment, and the advance directives lith care. Honoring resident oviding appropriate did I understand that I am					

	TMENT OF HEALTH	AND HUMAN SERVICES & MEDIQ SERVICES			(FORM	07/05/2017 APPROVED
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F 155	Continued From pa	ge 4	: F <i>*</i>	, 155			
	necessary and/or le appropriate for Adva document was sign	ance Directives." The ed by Resident #14 and by the nated in the Advance					
	#14 revealed the fol	sician's orders for Resident lowing order, dated 11/24/16 hysician on 12/1/16: "Code -					
	plan dated 11/24/16	t #14's comprehensive care revealed no information ce directive or code status.					
	revealed, in part, the - 12/3/16 - 12/4/16 through 7:00 a.m. or quietly. [Arrow poin (body temperature). No SOB (shortness bell in reach. Will column - @ (at) 130 (1:30 a assistant) went into	"7p - 7a (7:00 p.m. on 12/3/16 n 12/4/16) - Resident resting ting up] (increased) temp No c/o (complaint of) pain. of breath)/cough noted. Call ont (continue) to monitor. m.), CNA (certified nursing take resident's temp and		** (1784.5) m.			
	around lips and nail director of clinical set this incident the curr services, administra position of assistant and Dr. (doctor) noti were signed by LPN #10. - "12/4/16 0245 (2:4 respiration, no apical	alse and not breathing. Blue beds. ADCS (assistant bervices [*note at the time of the time the time of the time					

time. 2nd (second) nurse verified. CPR initiated.

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F 155	Continued From pa	ge 5	F 1	55			
	EMS (emergency m (medical doctor [ph (responsible party).	nedical services) called. MD ysician]) made aware and RP "This note was signed by e staff member) #2, the		55			
	following order, date ASM #3, the nurse	e clinical record revealed the ed 12/4/16 and was signed by practitioner, on 12/7/16: gency room) for eval at (treatment)."		1			
	Service) record for revealed, in part, the	S (Emergency Medical Resident #14 dated 12/4/16 e following: "Dispatched to n in cardiac arrest. On scene,		•			
	(year old female) lyi staff performing CP	oom number], found a 72 YOF ng supine on the bed with R on the pt and was (sic) valve mask. Staff was asked	:				
	if there were a DNR advised that she is cardiac arrest while	(do not resuscitate) and they a full code. Pt was found in the nurse was doing rounds. e. CPR was started and 911		: :			
	called. General impunresponsive. Pt w unstable. Pt was lo	oression was poor. Pt was as not mobile. Pt was gged rolled (sic) onto a		:			
	machine) was place CPR. Care was tra	Lucas device (automatic CPR and was initiated to take over nsferred to [name of EMS hx (history) was obtained	:				

from staff. Pt allergies are unknown...Pt was picked up and carried out to the cot and placed on it and secured...Pt had no signs of life. Pt was transported to [name of local hospital]...On arrival

A review of the records from the local hospital

to [name of local hospital], pt was still unresponsive and not breathing."

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIQ OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 155 Continued From page 6 F 155 dated 12/4/16 revealed, in part, the following: "Emergency History and Physical Exam: "[Name of Resident #14] is a 72 y.o. (year old) female who presents by EMS. Apparently the patient was found on the floor unresponsive in (sic) cyanotic around at the nursing home...unknown how long she had been down...Differential diagnosis considered includes: Dead on arrival...The patient was pronounced dead at 3:43 a.m. Death certificate completed. Clinical Impression: Dead on arrival." A review of the report sent to the state agency dated 12/6/16 revealed, in part, the following: "[Name of Resident #14] was a 72 year old female admitted to this facility on 11/24/16...Her advanced directive requested full code status. On 12/4/16 at 0130 (1:30 a.m.), [Resident #14] presented as unresponsive to the on shift CNA. The CNA reported this to LPN Charge Nurse [name of LPN #10], who noted the resident as having no pulse, no breathing and presenting with blue lips and nail beds. [LPN #10] phoned [ASM #2] and requested that she come to the facility and pronounce death. On arrival, [ASM #2] also noted [Resident #14] to be absent of vital signs: but identified [Resident #14] as a full code and initiated the facility CPR policy and transferred [Resident #14] via EMS to the local emergency department...After facility investigation, neglect has been substantiated. [LPN #10's] employment with this facility has been terminated and required

Professions."

reporting will occur to the Department of Health

A review of the facility's investigation file about this incident revealed the following statement written by LPN #3 and dated 12/5/16: "On December 4, 2016, [LPN #10] asked me to come

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F 155	lungs nothing heard nonchalant with the had been declining (cancer). This lead patient was comfort time." Further review of th revealed the following #10 dated 12/4/16: CNA to take temp of temp of 100.1. CNA room. Found reside and very pale and to been checked on an called another nurse sounds. At this poin director of clinical seand she returned the was unaware the residence.	ge 7 with her. Listened to heart and I (sic). [LPN #10] was situation told (sic) me patient and had hx (history) of CA (sic) me to believe that the and expecting to go any e facility's investigation file and expecting to go any e facility's investigation file and statement written by LPN "At 0130 (1:30 a.m.) I sent fresident. Earlier she had a called me to the resident's ent without resp (respirations) urning cold. (Resident had a hour prior.) At this point I esto listen for heart rate/breath at I texted the ADCS (assistant ervices) and left a message es called (sic). At this point, I sident was a full code. When the began CPR and called the	F 155			
	When asked what s reported to her that been found without prespirations, LPN #5 code blue." She stanurses to check the the physician's order code, "somebody stamakes the calls and	stated: "I would page a ted the process is for two resident's chart and clarify. If the resident is a full arts CPR and somebody else does the paperwork." She wides frequent training and				
	On 6/20/17 at 2:40 p When asked what sl	.m., LPN #4 was interviewed.				

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F 155	Continued From pa	ge 8	F	155			
	been found without respirations, LPN # chart to see whether stated if the resident assess the resident no vital signs. She staff members to care and physician. On 6/20/17 at 3:40 practitioner, was intresident has an ord resident ceased her should be done, AS should be coded." A underlying diagnosi middle of the night a we must start CPR she is aware that the	a resident under her care had pulse and without 4 stated: "I would grab the or or not they are a DNR." She at was not a DNR, she would and start CPR if there were stated she would get other all the rescue squad, family, p.m., ASM #3, the nurse erviewed. When asked if a er to be a full code, and if that art rate and respirations, what M #3 stated: "The resident ASM #3 stated: "The s doesn't matter. If it's the and the resident is a full code, and call 911." She added that e facility practices this code blue drills frequently.					
:	Resident #14 on the 12/4/16. She stated earlier in the shift, a her to re-check the #1 stated when she "it looked like she w	a.m., CNA#1 was atted that she was assigned to a night of 12/3/16 through the resident had a fever and that LPN #10 had asked resident's temperature. CNA entered the resident's room, was dead. She was gray."					
	called for LPN #10 stated: "[LPN #10] She immediately ye help her. They both checked [Resident remembered the nu	to come to the room. CNA #1 never looked at the chart. lled for LPN #3 to come and went in the room and #14]." She stated she arses talking to each other call for the facility to pronounce					

death, and that neither of them discussed the

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F 155	Continued From pa	аае 9	F	155	•		
	•	tus. She stated one of the	: ' ·	100			!
		#2, the director of clinical					
		was "a good while" before	:				
		the facility. CNA #1 stated					
		and pronounced [Resident	İ				!
		stated ASM #2 went to do			:		
	-	esk, and discovered that	!		1		
•	Resident #14 was a	a full code. CNA#1 stated					
	ASM #2 started CP	R and other staff called					
	emergency services	s.					
:	0-0/04/47 -+ 7.40	- I DNI #0 intentioned	İ				
		a.m., LPN #3 was interviewed.	.		•		
		was working on my side and					!
		r me to go help her. We went dent #14] was gray and cold.					į
		the resident had cancer, and					
		. She told me the resident had			:		
:		I thought she was on comfort			•		
		essed her." LPN #3 stated			1		
		s of life, and there was no					
		esident's code status. LPN #3					
		led ASM #2. ASM #2 arrived					
		hey started CPR. I really don't					
		ed after that because I went	i		'		ĺ
:	back to work on my	/side."					
	On 6/04/47 at 7:00	ACM #0 (the dispetance					
		a.m., ASM #2, (the director of	į				
		no at the time of this incident	İ				İ
		of assistant director of clinical viewed. ASM #2 stated during	_				
		ours of 12/4/16, she received	J		•		!
		D. She did not remember the	!				
		ted LPN #10 left a voicemail	İ				
		ated: "At some point I woke					
		e voicemail. I came in, went in					
		ed [Resident #14] was not					1
		, and no blood pressure. I					
		esk and started to write the					
		reen spine on the chart." ASM	i .				

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PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC) SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ΙD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE OATE TAG TAG DEFICIENCY) F 155 Continued From page 10 F 155 #2 stated a green spine indicates that a resident has a physician's order for a full code. She stated when she checked the chart for the physician's order, she discovered that Resident #14 was a full code, and she went and "started CPR on her (Resident #14)." ASM #2 stated the EMS arrived, took over the CPR and transported the resident to the emergency room. She stated she called ASM #4, the attending physician, later in the morning and told him what had happened. On 6/21/17 at 7:35 a.m., ASM #4 was interviewed. He stated he did not remember being called by LPN #10 to inform him that Resident #14 had been discovered in her room without signs of life. He stated he remembered ASM #2 calling him later to inform him of what had happened. When asked what process was to be followed when a resident who has a full code order is discovered without signs of life, ASM #4 stated: "We should immediately call a code and call 911, and we should immediately begin resuscitative efforts." The administrator and director of nursing at the time of this incident are no longer employed by the facility. On 6/21/17 at 8:35 a.m., ASM #1, the executive director, and ASM #2 were informed of these concerns. At this time, the survey team informed these staff members of the concern for harm.

A review of the facility policy "Advance Directives - Nursing" revealed, in part, the following: "The facility nursing staff will abide by resident advance-directives, if known, and if those directives are not in conflict with Federal and State regulations. Nursing staff must verify

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

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		495315	B. WING		06/	/21/2017
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLDBE	(X5) CDMPLETION DATE
F 155	advance directive residentNursing advance directive before certain trea intravenous feedir emergency situati breathing or there beat, staff will che order has been er cardiopulmonary radministered imm summon anyone is certified to adminicall emergency pattending physicial A review of the fact Resuscitation (CP following: "Policy: Resuscitation (CP following: "Policy: Resuscitation (CP residents who are unless such residents who are unless such residents who are unless such residents who are unless are to main Procedure: In the immediately call for members are to v for code status. L'Code Blue' to Root times (or location until life support sibe discontinued if physician orders CC contact the physician contact the physician contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact the physician orders and the contact th	o determine whether or not any is have been issued by the graff must be aware of other is regarding residents' wishes atments are initiated (i.e. ing). Follow these steps in an ion: If a resident stops is an absence of pulse or heat ick to determine whether a DNR order, resuscitation (CPR) must be ediately. Page 'Code Blue' to in the facility who has been ster CPR. At the same time, aramedic support. The in must also be notified." Cardiopulmonary in the Cardiopulmonary in the cardiac arrest ent has a DNR order. The interest and in certification for CPR. The interest is a performed only ified in CPR. All licensed in the cardiac arrest, or assistance. Two staff erify the current physician order is the paging system and call	F1	55		

the Code Blue Documentation Form."

		AND HUMAN SERVICES				o: 07/05/2017 MAPPROVED
		SERVICES			OMB NO	<u>0. 0938-0391</u>
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		495315	B. WING _		O.E	5/21/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII		
CONSUL	ATE HEALTH CARE	OF WOODSTOCK		803 SOUTH MAIN ST WOODSTOCK, VA 22664		
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F 155	Continued From pa	ogo 12	F 4F	٠.١		
1 100			F 15	5		!
		a.m., ASM #2, the director of				
		resented the survey team with	!			
		ated to these concerns. The				ĺ
		5/16 and documented: le policy and Procedures.				
		status of unresponsive				
		right to self-determination,				
		ce. Step 1 - Evaluation of				
	Systems and Imme					
		Resuscitation was initiated by				-
		and EMS was initiated.	İ			
	Employee suspend	ed until investigation can be				
		ation of the employee having				
		cation status by DCS (director				
		/Designee. Completion of				
		ED/Designee regarding				
		wed through the grievance				
		on by DCS/Designee that ent ready and available. How				
		sident at Risk. Social				
		o contact Residents/RP with				
		verify continued desire for		•		
	this status. Review					
		of current resident records to	:			İ
		entation is consistent to				
	include most currer		i			•
	doctor)/Physician's	orderand state DNR			1	
		of Licensed Nurse files to				
	verify current CPR	certification present. ED				
		/Designee to review last (5)				
		ensure proper following of				
vi.		g of resident rights with any				
		ed on a grievance form and	İ			
		the grievance process. What				
	measures were put					
		ng staff education by the				
		green light/red light with focus	!			
	on oringing the cha	rt to the code and verifying	!			

that the code status is honored. Training by the

	TMENT OF HEALTH	AND HUMAN SERVICES & MEDI D SERVICES			(FORM	: 07/05/2017 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		(X3) DAT	E SURVEY PLETED
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	PROVIDER OR SUPPLIER ATE HEALTH CARE (OF WOODSTOCK	1	803	EET ADDRESS, CITY, STATE, ZIP O SOUTH MAIN ST DODSTOCK, VA 22664	ODE	1 00/	21/2011
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F 155	resident rights and Code blue drills will DCS/Designee and three months then rworker)/Designee with status reviews and at least quarterly will potential violation of code status will be I grievance process. problem does not reclinical services) an review of the code of grievance logs to id action needed. An Performance Improving (QAPI) has been he POC (plan of correct measures. QA. Rereported to the mon and discussion to en by 12/8/16." The survey team rewell as the credible implementation of the identified no concert implementation. Addreviewed the CPR licompared to the assist the facility. No correlated to the facility duty at all times in the This citation is cited. "CPR is an emerger"	also focus on upholding following Drs. Orders. (sic) be conducted by the ongoing once a week for monthly. ED/SW (social vill continue weekly code ensure that status is reviewed the the Resident/RP. Any for Resident Rights related to ogged/processed through the How to monitor to ensure the eoccur. ED/DCS (director of d SW will complete a weekly drills, code audits and entify any trends or corrective impromptu Quality Assurance wement Committee Meeting and corrective sults of weekly reviews will be the thing of the ensure substantial compliance wiewed this plan of action, as evidence documenting the his plan. The survey team has related to this ditionally, the survey team censes of all nursing staff as worked schedules provided oncerns were identified thaving CPR-licensed staff on	F	155				

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MED(D SERVICES			(FORM	07/05/201 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		4953 15	B. WING_			06/	21/2017
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F 155	breathing until eme	maintain circulation and gency medical help arrives." aken from the website	F 1:	55 157			
	483.10(g)(14) NOT (INJURY/DECLINE	FY OF CHANGES	re	esid	e Posey bopts were discontinued ent #2 on 6/22/17. The physicia	n and	
	consult with the resconsistent with his consistent with the resconsistent with his consistent tely inform the resident; dent's physician; and notify, or her authority, the resident men there is- olving the resident which has the potential for requiring on; unge in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or	po ac 3. no w w	rde . A 1 osey ddit . The otifi arra ill b	ent representative were notified r at this time. 200% Quality review of residents y boots was completed on 7/13/2 ional findings. The policy on physician and resident cation was reviewed and no character at this time. Licensed nurse re-educated on the process of cian and resident representative e 7/14/17.	with 17 with no it nges are ing staff notifying		
	a need to discontinu treatment due to ad commence a new fo	nsfer or discharge the	qı or be to	ualit ne ti e co the	e DCS/designee will complete a 1 y review of all residents with positive fine per month. Any negative fine prected immediately and will be a facilities QAPI meeting monthly his at which time if no further inc	sey boots dings will reported for 3	

physician.

(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that

all pertinent information specified in §483.15(c)(2) is available and provided upon request to the

thereafter.

7/14/17.

noted it will be monitored intermittently

5. Corrective Action will be completed by

	TMENT OF HEALTH	AND HUMAN SERVICES & MED() SERVICES			<u>(</u>	FOR	D: 07/05/2017 RM APPROVED
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
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F 157	Continued From pa	ge 15	F 1	57			
		t also promptly notify the sident representative, if any,	:				
į č	(A) A change in roo as specified in §483	m or roommate assignment 3.10(e)(6); or		•			
		ident rights under Federal or ions as specified in paragraph on.					
:	update the address phone number of th This REQUIREMEN	t record and periodically (mailing and email) and le resident representative(s). NT is not met as evidenced					
	and clinical record r the facility staff faile	rview, facility document review review, it was determined that at to notify the physician of a ratus for one of 19 residents in Resident #2.					
	The facility staff faile when Resident #2 c	ed to notify the physician continued to refuse to wear ces on her bilateral feet for		;			
	The findings include	3 :		:			• • •
	with a readmission	Imitted to the facility on 4/9/10 on 10/31/12 with diagnoses ere not limited to, Parkinson's	!				

depression.

disease (1), a movement disorder, dementia, dysphagia (difficulty with swallowing), anxiety and

Resident #2's most recent MDS (minimum data set) is a quarterly assessment with an ARD

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDI D SERVICES			í	FO	ED: U//U5/2017 RM APPR O V E D
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		PLE CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
		495315	B. WING	÷			06/21/2017
	PROVIDER OR SUPPLIER	OF WOODSTOCK		8	STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664		00/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 157	(assessment refere Resident #2 was co a possible 15 on Se BIMS (brief interview that Resident #2 is in daily decision made A review of Resident in part, the following the nurse practitions member) #3, on 10/boots (a heel offload to protect the heels (bilateral) feet when Further review of Resident order; "5/10/17: Posin bed every shift." A review of Resident notes revealed, in processment and Pla (2)) left heel. The acontinue prevention and pressure relief for Review of Resident Tech Information Kabe completed for Revealed, the care it not checked to be decreased. #9 was asked nurse) #9 was asked a.m. lying in the bed nurse) #9 was asked asked to be decreased.	nce date) of 3/29/17. Indeed as scoring a three out of section C, Cognitive Patterns, we for mental status), indicating cognitively severely impaired king. In #2's clinical record revealed, gorder signed and dated by the staff (4/17 (sic). "4/7/17 Posey ding device worn on the feet from skin breakdown) to bilate in bed. It #2's clinical record print out titled "Physician's the ented, in part, the following they boots to bilateral feet when the staff (4/17 (deep tissue injury they in an easures including skin prepared in the staff (4/17 (deep tissue injury they is now healed. Will measures including skin prepared in the staff (4/17 (deep tissue injury they is now healed. Will measures including skin prepared in the staff (4/17 (deep tissue injury they is facility document "Nurse and they is facility document "Nur		157			

obtained from Resident #2 and the nurse lifted

		AND HUMAN SERVICES				PRIN	TED: 07/05/2017 DRM APPROVED
	RS FOR MEDICARE					OMB	NO. 0938-0391
	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION) DATE SURVEY COMPLETED
		495315	B. WING	i			06/24/2047
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		06/21/2017
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F 157	Continued From pa	ge 17		157			
		I that Resident#2 was not	, F 	137	•		
	nursing assistant) # CNA #5 was asked wound prevention in Resident #2. CNA # every two hours and wounds. When ask special devices order CNA #5 stated that wearing boots on he "They were not on hike them and reque asked to accompany room to observe her permission from Refeet. Resident #2 w CNA #5 stated that so the boots were. A hibed at the time of the she had not seen the weeks. CNA #5 look	onducted with CNA (certified 5 on 6/21/17 at 10:43 a.m. if she was aware of any nterventions being done for #5 stated that she was turned dipositioning to prevent red if Resident #2 had any ered for wound prevention, she was supposed to be er feet, CNA #5 further stated, her this morning, she doesn't rests them off." CNA #5 was by this writer to Resident #2's refeet. CNA #5 obtained sident #2 and uncovered her ras not wearing any boots. She didn't even know where ospice aide was beside the re observation and stated that re boots for about three red in Resident #2's wardrobe red, CNA #5 stated, "I don't er boot is."					
:: .	practical nurse) #9 of was asked what wou Resident #2 was sup #9 stated, "I'm not sup Resident #2's TAR (trecord). LPN #9 star have booties on her that she had not see that morning and she refused to wear then	nducted with LPN (licensed on 6/21/17 at 11:20. LPN #9 und prevention devices oposed to be wearing. LPN ure." LPN #9 was shown treatment administration ted, "She is supposed to bilateral feet." LPN #9 stated on them on Resident #2's feet be believed that Resident #2 n. LPN #9 was asked what uld do if Resident #2 was					

	MENT OF HEALTH	AND HUMAN SERVICES & MEDI D SERVICES			(FOR	D: 07/05/2017 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED
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	they should circle the placement was che their initials to indicate note on the back of to review the TAR at notations regarding the booties. LPN # LPN #9 further state (responsible party) Resident #2's refus When asked if there physician or RP had reviewed the nursin TAR and stated that On 6/21/17 at 11:10 conducted with LPN when the physician #2 stated any time to condition or a change that included refusatified. A review of Resider plan dated 10/31/12 following document has the potential for (related to) immobil Initiated: 6/23/2016 treatments as order effectiveness. Notific condition. Posey both on 6/21/17 at 11:45 conducted with ASN conducted wi	e booties. LPN #9 stated that he date and time the bootie cked on the TAR and circle ate refusal and then write a the TAR. LPN #9 was asked and asked if there were any Resident #2 refusing to wear 9 stated that there were not. Bed that the physician and RP should be made aware of all to wear the bilateral booties. Be was any evidence that the dibeen made aware LPN #9 g notes and the back of the tit had not been done. If a.m. an interview was I #2. LPN #2 was asked or RP would be notified, LPN there was a change in ge in therapy. When asked if I of treatments, LPN #2 stated at #2's comprehensive care the revealed, in part, the lation: "Focus: The resident impaired skin integrity r/t ity and incontinence. Dated and monitor for y physician for change in	F	157			

director of clinical services. ASM #1 and ASM #2 were made aware that the physician and RP had

		AND HUMAN SERVICES		<i>i</i>	FORM	07/05/2017 APPROVED
STATEMENT	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DAT). 0938-0391 TE SURVEY MPLETED
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F 157	to wear the booties asked if the physicial resident refuses a to "Yes." ASM #2 was regarding physician No further information of the survey present the property of the survey present of the survey present asked in the survey present the surv	egarding Resident #2's refusal as ordered. ASM #2 was an should be notified when a treatment, ASM #2 stated, is asked to provide a policy in notification.	F 157			
	movement disorder in the brain don't prochemical called dop obtained from the for https://medlineplus.(2) Deep Tissue Pronon-blanchable deed discoloration Intact of localized area of pered, maroon, purple separation revealing filled blister. This in the following website http://www.npuap.orclinical-resources/ny483.10(e)(2)(i)(1)(i)(SAFE/CLEAN/COMENVIRONMENT) (e)(2) The right to repossessions, including as space permits, unupon the rights or heresidents.	r. It happens when nerve cells roduce enough of a brain pamine. This information was collowing website: gov/parkinsonsdisease.html ressure injury: Persistent repered, maroon or purple or non-intact skin with resistent non-blanchable deep rediscoloration or epidermal regression of a dark wound bed or blood offormation was obtained from receivers/resources/educational-and-puap-pressure-injury-stages/	F 252			

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI) SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER DR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION JX5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY DR LSC IDENTIFYING INFORMATION) TAG TAG CRDSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 252 Continued From page 20 right to a safe, clean, comfortable and homelike environment, including but not limited to receiving F252 treatment and supports for daily living safely. The facility must provide-1. The floor tiles in the front hall, near room 313 and 341 will be replaced by 7/30/17. The small (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or shower on the Rosewood unit and the shower her personal belongings to the extent possible. on the Dogwood unit was scrubbed by Health Care Services using a buffer which resolved the (i) This includes ensuring that the resident can receive care and services safely and that the black to light brown residue on floor tile .The physical layout of the facility maximizes resident bathtub was scrubbed and disinfected independence and does not pose a safety risk. eliminating the dirt, hair, plastic bag, white (ii) The facility shall exercise reasonable care for plastic coat hanger, and red shoes on 6/22/17. the protection of the resident's property from loss The dark black substance noted in the grout in or theft. This REQUIREMENT is not met as evidenced the corner tile will be resolved by having the by: area re-grouted on or before 7/30/17. The Based on observation, staff interview, and facility lower part of the wall under the handrails with document review, it was determined that the facility staff failed to ensure a clean, comfortable. carpet like material will be professionally homelike environment on 2 of 2 facility nursing cleaned by Health care services, the lose/worn units (Dogwood and Rosewood units) and in 2 of edges will be re-attached on or before 7/14/17. 3 facility shower rooms (small shower room on Rosewood unit and Dogwood shower room).

On the Rosewood and Dogwood units, cracks in the tile flooring were observed. In the small shower room on the rosewood unit a black substance was observed on the time. In the Dogwood shower room a black substance was noted on the tile and other debris including hair was observed in the shower stall.

The findings include:

On 6/21/17 an observation of the facility environment was conducted. The following

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI() SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) COMPLETION OATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 252 Continued From page 21 F 252 concerns were observed: 2A 100% quality review was conducted of floor On the front hallway, from the doors to the lobby, tile, shower rooms, bathtubs, and wall running across the hall to the windows of the coverings on 7/13/17. No additional findings dining room was a large crack in the tile of the floor. were noted.

On the Rosewood unit, a large crack was running across the tile floor from the doorway of Room 313, straight across the hall to the doorway of Room 319.

On the front hallway, just outside the conference

room door, running across the hall from the wall

on one side to the wall on the other side was a

large crack in the tile of the floor.

On the Rosewood unit, a large crack in the tile floor was running from approximately 3 feet inside of Room 341, across the hall, and approximately 3/4 of the way across the floor of Room 329.

On the Dogwood unit, a large crack in the tile floor was running from the inside window wall of the Recreation Room, across the hall to the wall on the opposite side. One of the tiles near the wall had 2 chips missing as well. One chipped area was approximately 2 to 3 inches x approximately 1/2 inch; and one chipped area was approximately 1/2 inch x 1/2 inch.

On the Rosewood unit, in the smaller of 2 shower rooms, the shower stall was observed to have a light black to brown colored residue on the floor tile.

On the Dogwood unit shower room, there was a light black substance/residue on the floor just outside the shower room door. Inside the shower

- 3. The maintenance staff and housekeeping staff were educated on 7/14/17 on the proper homelike environment with the policies titled: Maintenance, Maintenance plan, and Hospitality services. A review was conducted of these policies and warranted no change at this time.
- 4. The Maintenance Director/Designee will perform a quality review once a week: floor tile, shower room's tile and grout, 8athtubs, and wall covering beneath the handrails for cleanliness and dexterity. All negative findings will be corrected immediately and reported once a month at QAPI for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter.
- 5. Corrective Action will be completed by 7/30/17.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495315	B. WING		 _	06/	21/2017	
	PROVIDER OR SUPPLIER	OF WOODSTOCK		STREET ADDRESS, C 803 SOUTH MAIN S WOODSTOCK, VA				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION OATE	
	hair on the seat, a process, and seat, and down in the seat, and down in the seat, and shower stall, dark is been the grout of the shower stall, dark is been the grout of the floor, was covered the floor, was covered the floor, was covered the floor, was covered the floor, was covered the floor, was covered the floor stall the floor search of the floor search of the stated this most till floor seams were with the expansion minimize the cracking the floor seams were with the expansion minimize the cracking the floor search of the floor search of the stated that shower rooms, that concerns they see the floor search they see that when houseked if they see anything immediately. She search of the floor that the floor search of the floor search of the floor search of the floor floo	vas observed to have dirt and pair of red rubber shoes on the he tub area was a plastic bag, hanger, and hair. Inside the plack substance was noted to be corner of the tile wall. acility in all hallways, the lower in under the handrail, down to red with a carpet material, acted to contain black and marks, discoloration, worn worn or loose edges ity. 5 a.m., OSM #2 (Other Staff tenance Director, was shown of concerns. He stated that, boring issues, the cement slab is expansion joints, and the chip, and buckle over time. Ity happens in areas where the re not properly installed in line joints, which he said would	F 2	52				
	the carpeted walls i	n the hallways are cleaned and microfiber cloth routinely.					! : :	

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDI D SERVICES			r'	FORM	D: 07/05/2017 M APPR O VED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		495315	B. WING	·		0.6	2/04/004=
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	0	5/21/2017
CONSUI	_ATE HEALTH CARE (OF WOODSTOCK			3 SOUTH MAIN ST OODSTOCK, VA 22664		
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F 252	Continued From page	ge 23	F 2	252			:
	during daily morning maintenance issues is a daily evening m	a.m., OSM #2 stated that meetings, housekeeping and are discussed; and that there eeting as well wherein the sed and updated about what					
	documented, "The E Services will perforn	ty policy, "Maintenance" Director of Environmental daily rounds of the building free of hazards and in dition."					
:	documented, "All eq be maintained in goo member notices an i will complete a work area or item needing staff will review the lo	y policy, "Maintenance Plan" uipment and furnishings will od condition. When a staff tem needing repair, he/she order request defining the repair. The maintenance og and make the appropriate clude:Floor and Carpet					
	cleaning of all interio including, but not limit and public baths, tub	ed, "Standards for routine r spaces will be followed, ited to patient rooms, patient and shower rooms, closets, diet kitchens, storage					
F 282	On 6//21/17 at 11:50 Director of Nursing (A Member) #1 and #2) findings. No further i	a.m., the Administrator and ASM (Administrative Staff were made aware of the information was provided.	F 28	32			

PRINTED: 07/05/2017

CENTERS FOR MEDICARE & MEDIC D SERVICES					(FORM APPROVE OMB NO. 0938-03		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495315	B. WING				06/2	21/2017
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK				803	EET ADDRESS, CITY, STATE, ZIP COL SOUTH MAIN ST ODSTOCK, VA 22664)E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	:	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	ГЕ	(X5) COMPLETION OATE
F 282	Continued From pa	ge 24	i	282				
		ive Care Plans led or arranged by the facility, comprehensive care plan,		to dis	hysicians order was obtained continue the air mattress for ne care plan was updated on	residen	t #10	

(ii) Be provided by qualified persons in accordance with each resident's written plan of

This REQUIREMENT is not met as evidenced bv:

Based on observation, facility staff interview, staff interview, and clinical record review, it was determined that the facility staff failed to follow the written plan of care for two of 26 residents in the survey sample, Residents #10 and #8.

- 1. The facility staff failed to implement an air mattress per the written plan of care for Resident #10.
- 2. The facility staff failed to maintain the bed in a low position, as directed in Resident #8's comprehensive care plan, to promote safety.

The findings include:

1. Resident #10 was admitted to the facility on 5/4/15 and most recently readmitted on 3/31/16 with diagnoses including, but not limited to: intellectual disability, enlarged prostate. Parkinson's disease, and high blood pressure. On the most recent MDS (minimum data set), a quarterly assessment dated 3/15/17, he was coded as being cognitively intact for making daily decisions. He was not coded as having any pressure ulcers.

On the following dates, Resident #10 was

A Physicians order was obtained on 6/26/17 to discontinue the low bed for resident #8 and the care plan was updated at that time.

- 2. A 100% quality review was completed on 7/13/2017 of all residents with physician orders for air mattresses and low beds. No additional findings were noted.
- 3. A review was conducted of the policy entitled "Plans of Care" and no changes are warranted at this time. Nursing staff were re-educated on this policy on or before 7/14/17.
- 4. The DCS/designee will complete a 100% quality review of all residents with low beds and air mattresses one time per month. Any negative findings will be corrected immediately and will be reported to the facilities QAPI meeting monthly for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter.
- 5. Corrective Action will be completed by 7/14/17.

	MENT OF HEALTH	AND HUMAN SERVICES & MEDI() SERVICES				FORM	: 07/05/2017 A PPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ECONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495315	B. WING	i		06/	21/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	ATE HEALTH CARE (DF WOODSTOCK			3 SOUTH MAIN ST OODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE	(X5) COMPLETION DATE
F 282	mattress on the bed 6/20/17 at 7:45 a.m. A review of the physpart, the following: The order was writterecently signed by the 6/12/17. A review of the TAR record) for Resident that the air mattress place each shift during that the air mattress place each shift during the plan dated 3/6/16 arrevealed, in part, the order." On 6/21/17 at 9:55 anurse) #2 accompant #10's room. When was on Resident #1 not sure the exact k mattress was an air "No. It's definitely not stated she needed to because she was not air mattress was con On 6/21/17 at 10:20	th a regular pressure-reducing d: 6/19/17 at 6:25 p.m.; and 6/21 17 at 6:55 a.m. sician's orders revealed, in "Air mattress every shift." en on 5/18/16 and was most the nurse practitioner on the first time of the month of June. (treatment administration at #10 for June 2017 revealed as was signed off as being in ing the month of June. at #10's comprehensive care and updated on 9/21/16 at following: "Air mattress per a.m., LPN (licensed practical hied the surveyor to Resident asked what kind of mattress 0's bed, LPN #2 stated: "I'm ind." When asked if the mattress, LPN #2 stated: ot an air mattress." LPN #2 o check Resident #10's chart of certain that the order for the crect. a.m., LPN #2 and ASM	F	282			
	(administrative staff clinical services, we stated: "You are right the TAR. I'm looking order to discontinue	member) #2, the director of re interviewed. ASM #2 ht. [The air mattress] is on g to see if there was ever an it [the air mattress] that was ." LPN #2 stated: "If it's					

ordered, it should be on there." When asked how

CENTE	RS FOR MEDICARE	& MEDIC) SERVICES			(0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTIO	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER ATE HEALTH CARE (OF WOODSTOCK		803	EET ADDRESS, CITY, STATE, Z SOUTH MAIN ST ODSTOCK, VA 22664		6/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	plan, LPN #2 stated look at the care plan that if I have a quest resident's plan of care #2 stated: "Yes." On 6/21/17 at 10:40 find the order to disc should have been of asked to provide a cregarding following not sure if we have one if I can find it." On 6/21/17 at 10:45 director, was inform	at she follows a resident's care it: "To be honest, I don't really nevery day. I really only do stion." When asked if a are should be followed, LPN o a.m., ASM #2 stated: "I can't continue [the air mattress]. It in the bed." ASM #2 was copy of the facility's policy care plans. She stated: "I'm one. I will look and give you is a.m., ASM #1, the executive	F2	282			
	#8's bed in a low po #8's written plan of of Resident #8 was ad 4/21/17 with diagnos not limited to, the for (low red blood cell of dependence with with	mitted to the facility on ses that included, but were llowing diagnoses; anemia ount), seizures, alcohol thdrawal.		:			
	set) is an admission (assessment referer Resident #8 was co	recent MDS (minimum data assessment with an ARD nce date) of 4/28/17. ded as scoring 12 out of a BIMS (brief interview of mental Cognitive Patterns,					

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		AND HUMAN SERVICES			<i>y</i> *		FORM	บ <i>เก</i> บจก2บ17 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		CONSTRUCTION	I	(X3) DATI	0938-0391 E SURVEY PLETED
		495315	B. WING	i			06/	21/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CO	DDE		21/2011
CONSUL	ATE HEALTH CARE	OF WOODSTOCK			SOUTH MAIN ST ODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
	A review of Resider a physician order d in part, the following position while resid A review of Resider plan dated 4/21/17 documentation; "For potential for injury r. ETOH (ethyl alcohoseizures, anxiety, n bell, impaired insigh awareness, behavious 5/2/17. Revision or low position. Date like A review of Resider "Nurse Tech (technolot to provide direct residents)" revealed documentation; "Sa Resident #8 was oboccasions during the 8:20 p.m., 6/20/17 at revealed that Resider directed and 6/21/17 at revealed that Resider directed in the side of	dent #8 is cognitively intact making. Int #8's clinical record revealed ated 4/24/17 that documented, g; "4/24/17: Bed to be in low ent in the bed." Int #8's comprehensive care revealed, in part, the following icus: The resident has the ft (related to) recurrent falls, gl) abuse, dx (diagnoses) of con-compliant with ringing call int, judgement and safety ors and debility. Date Initiated: in 5/9/17. Interventions: Bed in initiated 5/2/2017." Int #8's facility document ician) Information Kardex (a cition to aides caring for d, in part, the following fety: Other: Low bed." Inserved lying in his bed on four es survey process; 6/19/17 at at 7:45 a.m., 6/20/17 at 12:00 7:30 a.m. Each observation ent #8's bed was not low and	F	282				
:	conducted with CNA #6. CNA #6 was as information on the c she was caring for. Kardex that helps u	ght. a.m. an interview was (certified nursing assistant) ked how she was provided eare needs of the residents CNA #6 stated, "We have the sto know what special needs updates the Kardex." CNA #6						

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDI() SERVICES OMB NO. 0938-0391 (X1) PROVÌDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017

NAME OF PROVIDER OR SUPPLIER

CONSULATE HEALTH CARE OF WOODSTOCK

STREET ADDRESS, CITY, STATE, ZIP CODE

803 SOUTH MAIN ST WOODSTOCK, VA 22664

(X4) ID PREFIX (EAC TAG REGI

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL 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 282 Continued From page 28

was asked if the Kardex followed the resident's care plan. CNA #6 stated that it did. CNA #6 was asked to review Resident #8's Kardex and asked what she was supposed to do for Resident #8 to ensure safety from falls. CNA #6 stated, "He did have fall preventions when he was first admitted, but not anymore." CNA #6 was asked whether or not Resident #8 was to be in a low bed, CNA #6 stated, "No. It was discontinued." CNA #6 was asked who discontinued the order for the low bed. CNA #6 stated, "I couldn't say, it would have had to have been the doctor or nurse practitioner."

On 6/21/17 at 10:30 a.m. an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 was asked what safety preventative measures were in place for Resident #8. LPN #6 stated, "None, they were all taken away." LPN #6 was asked specifically about the order for the low bed. LPN #6 stated, "It was discontinued, fairly recently." LPN #6 was asked to review Resident #8's clinical record and demonstrate where the low bed was discontinued. LPN #6 stated, "We do not have an order to discontinue the low bed. We have not been maintaining a low bed. He is doing so well." LPN #6 was asked the purpose of the care plan. LPN #6 stated the care plan was to direct the care specific to a resident. LPN #6 was shown Resident #8's care plan for safety and the documentation for, "Bed in low position." LPN #6 stated, "(Name of Resident #8's) care plan does not reflect the care we are currently providing. When asked if the care should follow the care plan, LPN #6 stated, "Yes it should. We haven't been doing it. The low bed should still be in place and he has not been on a low bed."

On 6/21/17 at 11:45 a.m. a meeting was conducted with ASM (administrative staff

F 282

	TMENT OF HEALTH	AND HUMAN SERVICES & MEDI* 'D SERVICES			C	FORM	0: 07/05/2017 APPROVED
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F 282	director of clinical so were made aware the been following the was resident #8. His be- low position when have requested at the care plan. The facility documer revealed, in part, the "Policy: An interdisc established for each accordance with starequirements and of Procedure: Direct of the par	Iministrator and ASM #2, the ervices. ASM #1 and ASM #2 hat the nursing staff had not written plan of care for ed was not being kept in the e was in the bed. A policy is time regarding following the not titled, "Plans of Care" e following documentation; ciplinary plan of care will be a resident and updated in the and federal regulatory in an as needed bases.	F	282			
F 309 SS=G	Care." No further information end of the survey properties 483.24, 483.25(k)(l) FOR HIGHEST WEING AND AND AND AND AND AND AND AND AND AND	PROVIDE CARE/SERVICES LL BEING Indiamental principle that and services provided to facility ident must receive and the the necessary care and maintain the highest mental, and psychosocial	F3	309			
	applies to all treatme	re undamental principle that ent and care provided to sed on the comprehensive	,			•	

	MENT OF HEALTH	AND HUMAN SERVICES			(FO	ED: 07/05/2017 RM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) !	NO. 0938-0391 DATE SURVEY COMPLETED
		4953 15	B. WING	i		,	06/21/2017
	PROVIDER OR SUPPLIER ATE HEALTH CARE (DF WOODSTOCK		80	REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST OODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	assessment of a rethat residents receivaccordance with propractice, the compressed plan, and the rout not limited to the (k) Pain Manageme The facility must enprovided to resident consistent with profithe comprehensive and the residents' general terms of practice, the compartice, the compartice, the compartice, the compartice, the compartice, the compartice, the compartice, and the repreferences. This REQUIREMENT by: Based on staff interview, and clinical determined that the to provide care and highest level of well in the survey sample. Resident #14 had significant that the resident that the resid	sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered esidents' choices, including e following: ent. sure that pain management is to who require such services, essional standards of practice, person-centered care plan, to als and preferences. cility must ensure that re dialysis receive such to with professional standards eprehensive person-centered esidents' goals and IT is not met as evidenced exidenced review, facility document record review, it was facility staff failed staff failed services to promote the being for one of 19 residents	F:	309	Past noncompliance: no plan of correction required.	f	

immediately beginning CPR and calling for

		AND HUMAN SERVICES			Ċ		FORM	07/05/2017 APPROVED
	RS FOR MEDICARE		-			<u> </u>	<u>MB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	. '		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER				STF	REET ADDRESS, CITY, STATE, ZIP CODI	Ξ		
CONSUL	ATE HEALTH CARE	OF WOODSTOCK			SOUTH MAIN ST DODSTOCK, VA 22664			
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F 309	Continued From pa	ge 31 I assistance and Resident #14	F 30	09				
	expired.	assistance and Nesident #14						
:	The findings include	ə:	 	•				
;	11/24/16 with diagn to: ovarian cancer we nausea, and vomitin (minimum data set) with an assessmen Resident #14 was of cognitively impaired	admitted to the facility on oses including, but not limited which had spread, diabetes, ng. On the most recent MDS an admission assessment t reference date of 12/1/16, coded as being severely d for making daily decisions,						
:	(brief interview for r	three out of 15 on the BIMS mental status).						1
## 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1 m 1		nission nursing assessment ealed that Resident #14 was person only.						
	revealed a page wit	nt #14's clinical record th the title "FIRST ALERT." d the following: "CODE						
. :	document "[Name of Health Care." This [name Resident #14 make known my with incapable of making	ne clinical record revealed the of state] Advance Directive for document stated, in part: "I 4] willingly and voluntarily shes in the event that I am g an informed decision about follows:Section II: My Health						

Care Instructions...I provide the following instructions in the event my attending physician determines that my death is imminent (very close) and medical treatment will not help me recover...I want all treatments to prolong my life as long as possible within the limits of generally accepted

		AND HUMAN SERVICES				PRINTED FORM): 07/05/2017 APPROVED
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		495315	B. WING	·		06	/21/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		12 1/2011
CONSUL	ATE HEALTH CARE (DF WOODSTOCK		80	3 SOUTH MAIN ST OODSTOCK, VA 22664	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	receive treatment to comfortable." This one individual to set another individual to the another individual to the another individual to the another individual to the another individual to the another individual to the another individual to the another individual to the another individual to the another individual to the another individual to the another individual to anot	ds. I understand that I will or relieve pain and make me document listed the names of rive as primary agent, and of serve as secondary agent. Signed by Resident #14 and et clinical record revealed a little "Advance Directives ent." The document stated, in the your wishes regarding the Imonary Resuscitation (CPR): indicate if you possess any of ents or have primary the document contained a the categories of advance care agent. The document eccived a copy of the facility's Directives and have been sk questions regarding my sions regarding my medical that I have the right to refuse advance directives the care. Honoring resident widing appropriate I understand that I am iding the facility with the gal documentation nee Directives." The ed by Resident #14 and by the nated in the Advance Care. Ician's orders for Resident	F	309			
	#14 revealed the foll	owing order, dated 11/24/16 hysician on 12/1/16: "Code -					

		AND HUMAN SERVICES				PRIN T E FOR	D: 07/05/2017 M APPROVED
	RS FOR MEDICARE					OMB N	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVÌUÉR/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION		ATE SURVEY OMPLETED
		495315	B. WING				6/21/2017
NAME OF PROVIDER OR SUPPLIER			1	STF	REET ADDRESS, CITY, STATE, ZIP COD	E	
CONSUL	ATE HEALTH CARE (DF WOODSTOCK			SOUTH MAIN ST OODSTOCK, VA 22664		
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F 309	Continued From pa	ge 33	F 3	09		•	
	plan dated 11/24/16 related to her advar A review of the nurs revealed, in part, the 12/3/16 - 12/4/16 through 7:00 a.m. o quietly. [Arrow poin (body temperature). No SOB (shortness bell in reach. Will c - @ (at) 130 (1:30 a assistant) went into found her with no puaround lips and nail	at #14's comprehensive care is revealed no information ince directive or code status. The seed in the status of t					
	this incident the curservices, administration of assistant and Dr. (doctor) not were signed by LPN #10 "12/4/16 0245 (2:4 respiration, no apical (patient) expired, pt time. 2nd (second) EMS (emergency medical doctor [phy (responsible party)."	rent director of clinical tive staff member #2, held the director of clinical services]) ified." Both of these notes (licensed practical nurse) 5 a.m.) Pt (patient) without al heart rate present. Pt identified as full code @ this nurse verified. CPR initiated. edical services) called. MD (scician]) made aware and RP This note was signed by a staff member) #2, the					
		e clinical record revealed the ed 12/4/16 and was signed by	:				

ASM #3, the nurse practitioner, on 12/7/16: "Send to ER (emergency room) for eval (evaluation) and treat (treatment)."

		AND HUMAN SERVICES			FOR	J. UTIUSIZUTT MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROL ASUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		495315	B. WING		06	6/21/2017
	PROVIDER OR SUPPLIER ATE HEALTH CARE	OF WOODSTOCK	803	EET ADDRESS, CITY, STATE, ZIP (SOUTH MAIN ST OODSTOCK, VA 22664	CODE	JE 1720 17
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	IX5) COMPLETION DATE
F 309	Continued From pa	age 34	F 309			
	Service) record for revealed, in part, the [facility] for a person in [Resident #14's record for exercised for a person in [Resident #14's record for a person in [Resident #1	S (Emergency Medical Resident #14 dated 12/4/16 the following: "Dispatched to an in cardiac arrest. On scene, from number], found a 72 YOF ing supine on the bed with PR on the pt and was (sic) evalve mask. Staff was asked R (do not resuscitate) and they a full code. Pt was found in the nurse was doing rounds. The energy was poor. Pt was reas not mobile. Pt was regged rolled (sic) onto a Lucas device (automatic CPR and was initiated to take over ansferred to [name of EMS hx (history) was obtained the pression was poor. Pt was read out to the cot and placed Pt had no signs of life. Pt was a e of local hospital]On arrival registrial, pt was still not breathing."				
	dated 12/4/16 revea "Emergency History of Resident #14] is a who presents by EN was found on the flocyanotic around at thow long she had be diagnosis considere arrivalThe patient	aled, in part, the following: and Physical Exam: "[Name a 72 y.o. (year old) female als. Apparently the patient bor unresponsive in (sic) the nursing homeunknown the dincludes: Dead on the pronounced dead at 3:43 the completed. Clinical				

Impression: Dead on arrival."

	MENT OF HEALTH	AND HUMAN SERVICES & MEDI () SERVICES			·	FORM	0: 07/05/2017 1APPROVED 0: 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495315	B. WING			06	/21/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	ATE HEALTH CARE (DF WOODSTOCK			SOUTH MAIN ST OODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	i	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 35	F	309			
	dated 12/6/16 revea "[Name of Resident female admitted to advanced directive On 12/4/16 at 0130 presented as unres The CNA reported t [name of LPN #10], having no pulse, no blue lips and nail be #2] and requested t and pronounce dea noted [Resident #14] but identified [Resident #14] via EdepartmentAfter f. has been substantia with this facility has	ort sent to the state agency aled, in part, the following: #14] was a 72 year old this facility on 11/24/16Her requested full code status. (1:30 a.m.), [Resident #14] ponsive to the on shift CNA. his to LPN Charge Nurse who noted the resident as breathing and presenting with eds. [LPN #10] phoned [ASM hat she come to the facility th. On arrival, [ASM #2] also 4] to be absent of vital signs; lent #14] as a full code and CPR policy and transferred EMS to the local emergency acility investigation, neglect ated. [LPN #10's] employment been terminated and required to the Department of Health					
	this incident revealed written by LPN #3 and December 4, 2016, and check patient will lungs nothing heard nonchalant with the had been declining (cancer). This lead	ity's investigation file about of the following statement and dated 12/5/16: "On [LPN #10] asked me to come with her. Listened to heart and (sic). [LPN #10] was situation told (sic) me patient and had hx (history) of CA (sic) me to believe that the and expecting to go any					
	Further review of the	e facility's investigation file					•

revealed the following statement written by LPN #10 dated 12/4/16: "At 0130 (1:30 a.m.) I sent

		E & MEDIC D SERVICES			Ć.	0	FORM	APPROVED
STATEMENT OF DE AND PLAN OF COR	EFICIENCIES	(X1) PROVR/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION		(X3) DAT	0938-0391 E SURVEY PLETED
		495315	B. WING				06/	21/2017
	DER OR SUPPLIER	OF WOODSTOCK		803	EET ADDRESS, CITY, STATE, ZIP (SOUTH MAIN ST ODSTOCK, VA 22664	ODE	<u> </u>	112011
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CO (EACH CDRRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION OATE
cnA temp room and beer calle sour direct and was the A	o of 100.1. CN n. Found resid very pale and to n checked on a ed another nurs nds. At this poi ctor of clinical s she returned th unaware the re	age 36 of resident. Earlier she had a A called me to the resident's ent without resp (respirations) urning cold. (Resident had n hour prior.) At this point I e to listen for heart rate/breath nt I texted the ADCS (assistant ervices) and left a message he called (sic). At this point, I esident was a full code. When we began CPR and called the	F 30	09				
Whe repo been respi code nurse the p code make state	en asked what some that to her that to her that to found without irations, LPN # blue." She state to check the physician's order, "somebody state the calls and	p.m., LPN #5 was interviewed. The would do if a staff member a resident under her care had pulse and without 5 stated: "I would page a ated the process is for two resident's chart and clarify or. If the resident is a full carts CPR and somebody else it does the paperwork." She ovides frequent training and he staff.					•	
Whe report been respited chartestate asset no vite staff	n asked what s rted to her that found without rations, LPN #4 to see whethe d if the resident ss the resident tal signs. She	b.m., LPN #4 was interviewed. he would do if a staff member a resident under her care had pulse and without 4 stated: "I would grab the r or not they are a DNR." She t was not a DNR, she would and start CPR if there were stated she would get other II the rescue squad, family,		:				
On 6	/20/1 7 at 3:40 p	o.m., ASM #3, the nurse						

PRINTED: 07/05/2017

		AND HUMAN SERVICES				PR	INTED FORM	: 07/05/2017 APPROVED
	***	& MED/ ID SERVICES				ON.	IB NO	0938-0391
STATEMEN' AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PRO\∠R/\$UPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	- 1	(X3) DAT	E SURVEY IPLETED
		495315	B. WING				06/	21/2017
NAME OF	PROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CO	<u></u>		21/2011
CONSUL	ATE HEALTH CARE			8	803 SOUTH MAIN ST WOODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHDULD B	3F	(X5) COMPLETION OATE
F 309	Continued From pa	ae 37	 - 	309				
		erviewed. When asked if a	Г	ous				
	resident has an ord	er to be a full code, and if that	I					
	resident reased he	art rate and respirations, what						
	should be done AS	M #3 stated: "The resident						
		ASM #3 stated: "The	i					
		s doesn't matter. If it's the	l					
	middle of the night	and the resident is a full code,						
	we must start CPR	and call 911." She added that						
,	she is aware that th	e facility practices this			:			
	scenario by way of	code blue drills frequently.						
	On 6/21/17 at 7:05	a m CNA #1 was			÷			
		ated that she was assigned to					:	
	Resident #14 on the	e night of 12/3/16 through						
	12/4/16. She stated	the resident had a fever						ļ
	earlier in the shift, a	nd that LPN #10 had asked						
	her to re-check the	resident's temperature. CNA		1				
		entered the resident's room,						
	"it looked like she w	as dead. She was gray."						
!		ped out of the room and						
		o come to the room. CNA#1		:			ļ	
		never looked at the chart. led for LPN #3 to come and						
!		went in the room and					į	
	checked [Resident #	#14]." She stated she						
	remembered the nu	rses talking to each other						
	about who was on c	all for the facility to pronounce					:	
!	death, and that neith	er of them discussed the						
	resident's code statu	is. She stated one of the					İ	ľ
	nurses called ASM #	[‡] 2, the director of clinical						
		vas "a good while" before						i
		e facility. CNA#1 stated			,		i i	ļ
		d pronounced [Resident						f
		tated ASM #2 went to do						
		sk, and discovered that						l
		full code. CNA#1 stated						
	ASIVI #2 Started CPF emergency services	R and other staff called						
	CITICING CHOV SELVICES	•						1

		AND HUMAN SERVICES			(FOF	ED: 07/05/2017 RM APPROVED
STATEMENT	RS FOR MEDICARE T OF DEFICIENCIES DEFICIENCIES OF CORRECTION	& MED(D SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) E	IO. 0938-0391 DATE SURVEY COMPLETED
		495315	B. WING_			· ,	06/21/2017
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE,		30/21/2011
CONSIII	ATE HEALTH CARE (DE WOODSTOCK		803	SOUTH MAIN ST		
CONSUL	ALE REALIN CARE (DF WOODSTOCK		Wo	ODSTOCK, VA 22664		
(X4).ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	IX5I COMPLETION DATE
⊏ 200		00		! 			
F 309		-	F 30	09			1
		a.m., LPN #3 was interviewed.					
		as working on my side and					1
		me to go help her. We went					†
		ent #14] was gray and cold. he resident had cancer, and					
		She told me the resident had					
		I thought she was on comfort		,			
	care. We both asse	essed her." LPN #3 stated	:				İ
		of life, and there was no					
		sident's code status. LPN #3					
	stated LPN #10 call	ed ASM #2. ASM #2 arrived					
		ney started CPR. I really don't	:				
		ed after that because I went	i :				
	back to work on my	side."					i
	: On 6/04/47 at 7:00	0 m					
		a.m., ASM #2, (the director of o at the time of this incident		:			
		of assistant director of clinical		:			į I
		viewed. ASM #2 stated during			•		-
:		ours of 12/4/16, she received	:				
		. She did not remember the					
		ed LPN #10 left a voicemail					i L
		ated: "At some point I woke	:				
		voicemail. I came in, went in					İ
		ed [Resident #14] was not	:				!
		and no blood pressure. I		:			1
		esk and started to write the		:			
	•	een spine on the chart." ASM	:				
		oine indicates that a resident	!				1
		der for a full code. She stated the chart for the physician's	! 				
		ed that Resident #14 was a					
		ent and "started CPR on her					
		SM #2 stated the EMS arrived.					
		and transported the resident to					

the emergency room. She stated she called ASM #4, the attending physician, later in the morning and told him what had happened.

	MENT OF HEALTH	AND HUMAN SERVICES & MEDI() SERVICES			Č	F O RM	: U//U5/2017 IAPPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495315	B. WING			06	/21/2017
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	ATE HEALTH CARE	OF WOODSTOCK			SOUTH MAIN ST ODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION OATE
E 300	Continued From pa	ao 20	: - /	1			
1 000	· · · · · · · · · · · · · · · · · · ·	_	r v	309			
	On 6/21/17 at 7:35						
		ated he did not remember					
		V #10 to inform him that					
		een discovered in her room He stated he remembered			-		1
	0	later to inform him of what	ļ				
		nen asked what process was					:
		a resident who has a full	: 				
		vered without signs of life,	İ				
		e should immediately call a			•		
		and we should immediately					
	begin resuscitative						
	time of this incident	and director of nursing at the are no longer employed by					
	the facility.						· · · · · · · · · · · · · · · · · · ·
	On 6/21/17 at 9:25	a.m., ASM #1, the executive		İ			
		#2 were informed of these	1	i			
		me, the survey team informed	i				
		s of the concern for harm.		:			
	. A	11 11 11 A 1 - 12 11	•				İ
		ity policy "Advance Directives	!				
		, in part, the following: "The					
		will abide by resident					:
		if known, and if those conflict with Federal and	:				
		Nursing staff must verify					
		determine whether or not any					
		have been issued by the		-			
		staff must be aware of other					į
		regarding residents' wishes					
		ments are initiated (i.e.	!				!
		g). Follow these steps in an	•				
		n: If a resident stops					
		s an absence of pulse or heat	i				ļ
		k to determine whether a DNR					:
		ered. If there is no DNR order,					İ

cardiopulmonary resuscitation (CPR) must be

	MENT OF HEALTH	AND HUMAN SERVICES & MED['D SERVICES		÷	Ć		FORM	U//U5/2017 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		(X3) DATE	0938-0391 E SURVEY PLETED
		495315	B. WING				06/:	21/2017
	PROVIDER OR SUPPLIER ATE HEALTH CARE (OF WOODSTOCK		803	EET ADDRESS, CITY, STATE, ZIP COD S OUTH MAIN S T ODSTOCK, V A 22664	ΣE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
	summon anyone in certified to administ call emergency parattending physician. A review of the facil Resuscitation (CPR following: "Policy: Resuscitation (CPR residents who are id unless such resident Cardiopulmonary reby individuals certifinarses are to maint Procedure: In the elimmediately call for members are to ver for code status. Us 'Code Blue' to Roor times (or location of until life support system (or location of until life support system of action relaplan was dated 12/8 - "PROBLEM: Code Verification of code patient. Residents is standards of practic Systems and Immediately paratters are to verification of code patient. Residents in standards of practic Systems and Immediately paratters are to verification of code patient. Residents in standards of practic Systems and Immediately paratters are to verification of code patient. Residents in standards of practic Systems and Immediately paratters are to verification of code patient. Residents in standards of practic Systems and Immediately paratters are to verification of code patient. Residents in standards of practic Systems and Immediately paratters are to verification of code patient. Residents in the control of the code standards of practic Systems and Immediately paratters are to verification of code patient.	diately. Page 'Code Blue' to the facility who has been ter CPR. At the same time, amedic support. The must also be notified." ity policy "Cardiopulmonary and ity policy "Cardiopulmonary and ity policy "Cardiopulmonary and ity policy "Cardiopulmonary and ity policy "Cardiopulmonary and ity policy "Cardiopulmonary and ity policy "Cardiopulmonary and ity policy "Cardiopulmonary and ity policy an		309				

the Licensed Nurse and EMS was initiated.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC O SERVICES

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495315	B. WING			06	/21/2017
	PROVIDER OR SUPPLIER	OF WOODSTOCK		80	TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	completed. Verifical current CPR certification of clinical services), grievance form by Eresident rights follow process. Verification crash carts/equipm to Identify other Reservice/Designee to full code status and this status. Review Director/Designee of ensure that docume include most current doctor)/Physician's document. Review verify current CPR (executive director) in-house deaths to orders and honoring concerns to be note addressed through measures were put recurrence? Ongoi DCS/Designee on goon bringing the chart the code status DCS/Designee will resident rights and Code blue drills will DCS/Designee and three months then rworker)/Designee w status reviews and at least quarterly will potential violation or construction of the cons	ed until investigation can be ation of the employee having cation status by DCS (director //Designee. Completion of ED/Designee regarding wed through the grievance on by DCS/Designee that ent ready and available. How sident at Risk. Social contact Residents/RP with verify continued desire for by Social Services of current resident records to entation is consistent to at MD (medical orderand state DNR of Licensed Nurse files to certification present. ED //Designee to review last (5) ensure proper following of g of resident rights with any ed on a grievance form and the grievance process. What	F3	309			

grievance process. How to monitor to ensure the

	TMENT OF HEALTH	AND HUMAN SERVICES & MED! D SERVICES			(FOR	D: 07/05/2017 MAPPROVED
STATEMENT	T OF OEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		CONSTRUCTION	(X3) OA	O. 0938-0391 ATE SURVEY EMPLETEO
		49 5 3 15	B. WING			.01	6/21/2017
	PROVIOER OR SUPPLIER	DF WOODSTOCK		803	REET AOORESS, CITY, STATE, ZIP COOE SOUTH MAIN ST DODSTOCK, VA 22664	1 00	3/2 1/2U17
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULO BE	(X5) COMPLETION DATE
F 314:	clinical services) an review of the code of grievance logs to ideaction needed. An Performance Improving (QAPI) has been heter POC (plan of correct measures. QA. Reserved to the monand discussion to entry 12/8/16." The survey team reviewell as the credible implementation of the identified no concert implementation. Addreviewed the CPR licompared to the assistant of the facility. No concert implementation is cited to the facility duty at all times in the This citation is cited. "CPR is an emergent whose heart has sto breathing. CPR can breathing until emerging the process of the process of the process of the process of the concert implementation is cited. This citation is cited to the facility duty at all times in the thing concern implementation is cited. The citation is cited the process of the process of the concern implementation is cited. The citation is cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility. The cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility. The cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility. The cited to the facility duty at all times in the cited to the facility duty at all times in the cited to the facility.	eoccur. ED/DCS (director of d SW will complete a weekly drills, code audits and entify any trends or corrective impromptu Quality Assurance vement Committee Meeting eld on 12/5/16 to review the etion) and corrective isults of weekly reviews will be the third QAPI meeting for review insure substantial compliance viewed this plan of action, as evidence documenting the his plan. The survey team is related to this ditionally, the survey team is related to this ditionally, the survey team is related to the censes of all nursing staff as worked schedules provided incerns were identified having CPR-licensed staff on the facility. as past noncompliance. The survey team is related to this ditionally, the survey team is related to the survey team is rela	F3	309			
	(b) Skin Integrity -	:					
	(1) Pressure ulcers.	Based on the					

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDI() SERVICES			(1	FORM.	07/05/201 APPR O VE 0938-039
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		K3) DATE	SURVEY PLETED
		495315	B. WING			į	06/3	21 /2 01 7
NAME OF	PROVIDER OR SUPPLIER	***	` I	S	TREET ADDRESS, CITY, STATE, ZIP CO	DE '	00,2	11/2017
CONSUL	ATE HEALTH CARE (DF WOODSTOCK			03 SOUTH MAIN ST /OODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		IX5) COMPLETION OATE
F 314	Continued From pa	_	, F3	, 314				
	(i) A resident receive professional standar	essment of a resident, the that- es care, consistent with rds of practice, to prevent does not develop pressure		resi upo	The Posey boots were discont dent #2 on 6/22/17 and the c lated at that time. A physiciar ained on 6/21/17 to discontin	are plan ns order	was was	
		dividual's clinical condition hey were unavoidable; and	:		ttress for resident #10 and the lated on 6/22/17.	e care pla	an was	5
	necessary treatmen professional standa healing, prevent info from developing.	ressure ulcers receives It and services, consistent with rds of practice, to promote ection and prevent new ulcers IT is not met as evidenced		7/1 for	100% quality review was con 3/17 of all residents with phys air mattresses and Posey book itional findings were noted.	sician or		
	Based on observat document review ar was determined tha implement intervent	ion, staff interview, facility and clinical record review, it the facility staff failed to ions to prevent pressure residents in the survey 2 and Resident #10.		enti "Cli cha	review was conducted of the itled "Nurse tech information nical Guideline Skin and Wournges are warranted at this tim were re-educated on this po	Kardex" nd" and ne. Nursi	and no ing	
:	boots on Resident #	failed to place protective 2's bilateral feet to prevent her heels as ordered by the		4. T qua	ore 7/14/17. he DCS/designee will complet lity review of all residents wit	h Posey	boots	
	2. The facility staff to with a physician-ord	failed to provide Resident #10 ered air mattress.			air mattresses one time per r ative findings will be correcte		•	
	The findings include	:			will be reported to the facilities			

physician.

1. The facility staff failed to place heel protector

boots on Resident #2's bilateral feet to prevent

skin breakdown on her heels as ordered by the

Resident #2 was admitted to the facility on 4/9/10

7/14/17.

intermittently thereafter.

no further incident is noted it will be monitored

5. Corrective Action will be completed by

DEPAR?	FMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 07/05/2017
	RS FOR MEDICARE				(OMB N	M APPROVED O. 0938-0391
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		495315	B. WING				6/21/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP C	ODE	0/2 1/20 17
CONSUL	ATE HEALTH CARE	OF WOODSTOCK			SOUTH MAIN ST ODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 314	Continued From pa	ige 44	F 3	314			
	that included, but w disease (1), a move	on 10/31/12 with diagnoses were not limited to, Parkinson's ement disorder, dementia, y with swallowing), anxiety and					
	set) is a quarterly as (assessment refere Resident #2 was co a possible 15 on Se BIMS (brief interview that Resident #2 is in daily decision ma	recent MDS (minimum data assessment with an ARD ence date) of 3/29/17. Oded as scoring a three out of ection C, Cognitive Patterns, aw for mental status), indicating cognitively severely impaired aking. Section M, Skin reveal any wounds coded on ent.					
	in part, the following the nurse practitions member) #3, on 10/ boots (a heel offload	nt #2's clinical record revealed, g order signed and dated by er, ASM (administrative staff /4/17 (sic). "4/7/17 Posey ding device worn on the feet from skin breakdown) to bilat in bed.					
	revealed a monthly Orders" that docume	esident #2's clinical record print out titled "Physician's ented, in part, the following sey boots to bilateral feet when					
	notes revealed, in pa Assessment and Pla injury) left heel. The	nt #2's physician progress part, the following; "5/17/17 an: 1. DTI (2) (deep tissue a area is now healed. Will measures including skin prep foam booties."					

Review of Resident #2's facility document "Nurse

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CENIE	43 FOR WEDICARE	A MEDIT 'S SERVICES			0	MB NO.	<u>. 0</u> 938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROV/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DAT	E SURVEY APLETED
		495315	B. WING			06/	21/2017
	PROVIDER OR SUPPLIER ATE HEALTH CARE	OF WOODSTOCK	·	803	REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST DODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	be completed for R	ardex" (a list of care items to esident #2 by CNAs), tems "Heel protectors" was	F	314			
	(treatment administ part, the following of Posey Boots to bila shift. 7a (a.m.) - 7p Nursing initials were	nt #2's June 2017 TAR ration record) revealed, in ocumentation: "5/10/17. teral feet when in bed every (p.m.) 7p (p.m.) - 7a (a.m.)." e entered for each date and did not contain any initials.					
		at #2's nursing notes revealed, g documentation; "6/5/17 Heel		:			
	plan dated 10/31/12 following document has the potential for (related to) immobil Initiated: 6/23/2016 treatments as order	/ physician for change in					
	a.m. lying in the bed nurse) was asked if #2's feet under the obtained from Resid	served on 6/21/17 at 8:20 I. LPN #9 (licensed practical she could reveal Resident covers. Permission was dent #2 and the nurse lifted that Resident #2 was not ordered.					
	nursing assistant) # CNA #5 was asked	nducted with CNA (certified 5 on 6/21/17 at 10:43 a.m. if she was aware of any iterventions being done for					

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FORM APPROVED

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARE) SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 314 Continued From page 46 F 314 Resident #2. CNA #5 stated that she was turned every two hours and positioning to prevent wounds. When asked if Resident #2 had any special devices ordered for wound prevention, CNA #5 stated that she was supposed to be wearing boots on her feet, CNA#5 further stated, "They were not on her this morning, she doesn't like them and requests them off." CNA #5 was asked to accompany this writer to Resident #2's room to observe her feet. CNA #5 obtained permission from Resident #2 and uncovered her feet. Resident #2 was not wearing any boots. CNA #5 stated that she didn't even know where the boots were. A hospice aide was beside the bed at the time of the observation and stated that she had not seen the boots for about three weeks. CNA #5 looked in Resident #2's wardrobe and retrieved one boot, CNA#5 stated, "I don't know where the other boot is." An interview was conducted with LPN (licensed practical nurse) #9 on 6/21/17 at 11:20. LPN #9 was asked what wound prevention devices Resident #2 was supposed to be wearing. LPN #9 stated, "I'm not sure." LPN #9 was shown Resident #9's June 2017 TAR (treatment administration record). LPN #9 stated, "She is supposed to have booties on her bilateral feet." LPN #9 stated that she had not seen them on Resident #2's feet that morning and that she believed that Resident #2 refused to wear them.

LPN #9 was asked what the nursing staff should do if Resident #2 was refusing to wear the

booties. LPN #9 stated that they should circle the date and time the bootie placement was checked on the TAR and circle their initials to indicate refusal and then write a note on the back of the TAR. LPN #9 was asked to review the TAR and asked if there were any notations regarding

	MENT OF HEALTH	AND HUMAN SERVICES & MEDI() SERVICES			(FOR	D: 07/05/2017 M APPR O VED <u>D. 0</u> 938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į.		CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		495315	B. WING		<u></u>	۱ ۵	6/21/2017
	PROVIDER OR SUPPLIER ATE HEALTH CARE (DF WOODSTOCK		80 3	REET ADDRESS, CITY, STATE, ZIP CODE SOUTH MAIN ST DODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN DF CORREC' (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	On 6/21/17 at 11:45 conducted with ASM ASM #2, the director and ASM #2 were metaff did not place be as ordered that more heel protection boot breakdown to Residuated "Yes." ASM policy regarding work to further information of the survey proceeding work of the survey procedured from the brain don't prochemical called dopobtained from the following website http://www.npuap.or	g to wear the booties. LPN #9 fre not. is a.m. a meeting was if #1, the administrator and if of clinical services. ASM #1 hade aware that the facility ooties on Resident #2's feet rining. ASM #2 was asked if its were necessary to prevent lent #2's heels. ASM #2 #2 was asked to provide a und prevention. on was provided prior to the rocess. ase (PD) is a type of It happens when nerve cells oduce enough of a brain amine. This information was ollowing website: gov/parkinsonsdisease.html issure Injury: Persistent p red, maroon or purple or non-intact skin with rsistent non-blanchable deep discoloration or epidermal g a dark wound bed or blood formation was obtained from	F	314			

2. The facility staff failed to provide an air

	MENT OF HEALTH	AND HUMAN SERVICES			<u>C</u>	FOR	D: 07/05/2017 M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
		495315	B. WING			0	6/21/2017
	PROVIDER OR SUPPLIER	OF WOODSTOCK		803	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH MAIN ST		
	0111111514074	TELEVIT OF DEFIDIENCIES		WO	ODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 48	 F3	314			
	•	cian's order for Resident #10.	; !				
	5/4/15 and most rewith diagnoses inclinitellectual disability. Parkinson's disease On the most recent quarterly assessment coded as being cog	admitted to the facility on cently readmitted on 3/31/16 uding, but not limited to: y, enlarged prostate, e, and high blood pressure. MDS (minimum data set), a ent dated 3/15/17, he was initively intact for making daily not coded as having any					
	observed in bed, wi mattress on the bed	tes, Resident #10 was th a regular pressure-reducing d: 6/19/17 at 6:25 p.m.; .; and 6/21 17 at 6:55 a.m.					
	part, the following: The order was writt	sician's orders revealed, in "Air mattress every shift." en on 5/18/16 and was most he nurse practitioner on					
	record) for Residen	t (treatment administration t #10 for June 2017 revealed s was signed off as being in ring the month.		i			
	plan dated 3/6/16 a	nt #10's comprehensive care nd updated on 9/21/16 e following: "Air mattress per	:				
	nurse) #2 accompa	a.m., LPN (licensed practical nied the surveyor to Resident asked what kind of mattress					

was on Resident #10's bed, LPN #2 stated: "I'm not sure the exact kind." When asked if the

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES		(FORI	D: 07/05/2017 M APPR O VED
STATEMEN	T OF DEFICIENCIES DE CORRECTION	(X1) PROVICES (X1) PROVICER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO	D. 0938-0391 TE SURVEY MPLETED
		495315	B. WING	·	04	2/24/2047
	PROVIDER OR SUPPLIER ATE HEALTH CARE (DF WOODSTOCK	803	REET ADDRESS, CITY, STATE, ZIP 3 SOUTH MAIN ST DODSTOCK, VA 22664	CODE	6/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	It's definitely not an she needed to chec because she was not air mattress was con On 6/21/17 at 10:20 (administrative staff clinical services, we stated: "You are right the TAR. I'm looking order to discontinue ever transcribed." Lit should be on there On 6/21/17 at 10:40 find the order to discoshould have been or On 6/21/17 at 10:45 director, was informed A review of the facilit Skin and Wound" review: To provid skin at risk, impleme including evaluation at promote skin healt worsening of/preventinginyDevelop indivinterventions and door recordEvaluate the interventions, and prothe care management.	attress, LPN #2 stated: "No. air mattress." LPN #2 stated k Resident #10's chart of certain that the order for the rect. a.m., LPN #2 and ASM member) #2, the director of re interviewed. ASM #2 nt. [The air mattress] is on g to see if there was ever an it [air mattress] that was not PN #2 stated: "If it's ordered, a." a.m., ASM #2 stated: "I can't continue [the air mattress]. It is the bed." a.m., ASM #1, the executive ed of this concern. by policy "Clinical Guideline - vealed, in part, the following: de a system for identifying nting individual interventions and monitoring as indicated th, healing, and decrease idualized goals and cument in the medical effectiveness of ogress towards goals during it meeting and as needed." n was provided prior to exit.	F 314			
! 	n Fundamentals of N Patricia A. Potter and	lursing, 6th edition, 2005, Anne Griffin Perry; Mosby,			:	

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARE **D SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 50 F 314 Inc., Page 419: "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." F 323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT F 323 SS=D HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -(1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are

appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced

Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to

PRINTED: 07/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARE **D SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495315 B. WING 06/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST CONSULATE HEALTH CARE OF WOODSTOCK WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE OATE TAG DEFICIENCY) F 323 Continued From page 51 F 323 implement safety interventions for one of 19 residents in the survey sample, Resident #8. 1. A Physicians order was obtained on 6/26/17 to discontinue the low bed for resident # 8 and The facility staff failed to maintain Resident #8's bed in a low position as a safety measure the care plan was updated at that time. following a fall, as ordered by the physician. The findings include: 2. A 100% quality review was completed on Resident #8 was admitted to the facility on 7/13/2017 of all residents with physician orders 4/21/17 with diagnoses that included, but not limited to, the following diagnoses; anemia (low for low beds. No additional findings were red blood cell count), seizures, alcohol noted. dependence with withdrawal. 3. A review was conducted of the policy entitled Resident #8's most recent MDS (minimum dataset) is an admission assessment with an ARD "Plans of Care" and no changes are warranted (assessment reference date) of 4/28/17. at this time. Nursing staff were re-educated on Resident #8 is coded as scoring 12 out of a this policy on or before 7/14/17. possible 15 on the BIMS (brief interview of mental status) in Section C, Cognitive Patterns. indicating that Resident #8 is cognitively intact 4. The DCS/designee will complete a 100% with daily decision making. quality review of all residents with low beds one time per month. Any negative findings will be A review of Resident #8's clinical record revealed that Resident #8 had fallen in the facility on two corrected immediately and will be reported to occasions, 5/8/17 (a fall from his wheelchair) and the facilities QAPI meeting monthly for 3 5/12/17 (a fall out of bed). There were no injuries months at which time if no further incident is associated with either fall.

A review of Resident #8's clinical record revealed

a physician order dated 4/24/17 that documented, in part, the following: "4/24/17: Bed to be in low

A review of Resident #8's comprehensive care plan dated 4/21/17 revealed, in part, the following documentation; "Focus: The resident has the potential for injury r/t (related to) recurrent falls.

position while resident in the bed."

thereafter.

7/14/17.

noted it will be monitored intermittently

5. Corrective Action will be completed by

		AND HUMAN SERVICES				PKIN F(1ED: 07/05/2017 ORM APPROVED
		& MEDICAID SERVICES					NO. 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PRO∜∜SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		construct) DATE SURVEY COMPLETED
		495315	B. WING				0 6/ 2 1/ 2 017
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	00/21/2017
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F 323	Continued From page	ge 52	F3	123			
		l) abuse, dx (diagnosis of	1 -	123			<u>:</u>
	seizures, anxiety, no	on-compliant with ringing call					:
	bell, impaired insigh	it, judgement and safety					
	awareness, behavio	ors and debility. Date Initiated:					
	5/2/17. Revision on	5/9/17. Interventions: Bed in					:
i	low position. Date In	nitiated 5/2/2017."					
	A rovious of Booidon	t #8's facility document					<i>i</i> !
	"Nurse Tech (techni	cian) Information Kardex (a					
	tool to provide direct	tion to aides caring for					
		, in part, the following					:
!	documentation; "Saf	fety: Other: Low bed."					;
	Deside 170						:
	Resident #8 was ob	served lying in his bed on four					;
:	8.20 n m 6/20/17 a	e survey process; 6/19/17 at t 7:45 a.m., 6/20/17 at 12:00					!
	p.m. and 6/21/17 at	7:30 a.m. Each observation					
	revealed that Reside	ent #8's bed was not low and		:			
	was at a regular heig						1 *
				:			
		a.m. an interview was		÷			
:	conducted with CNA	(certified nursing assistant)					1
		ked how she was provided are needs of the residents					:
		CNA #6 stated, "We have the		!			
	Kardex that helps us	to know what special needs					
	there are. Nursing up	odates the Kardex." CNA#6					
	was asked if the Kar	dex followed the resident's		:			
	care plan. CNA#6 s	tated that it did. CNA#6 was					
		ident #8's Kardex and asked					
		sed to do for Resident #8 to					
	have fall proventions	alls. CNA #6 stated, "He did					
	but not anymore."	when he was first admitted, NA #6 was asked whether or					
		d was to be in a low position,					
	CNA #6 stated. "No	It was discontinued." CNA					
	#6 was asked who di	iscontinued the order for the					1
	low bed. CNA#6 sta	ated, "I couldn't say, it would					
	have had to have bee	en the doctor or nurse					

		AND HUMAN SERVICES			, "	FORM): 07/05/2017 1 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	MEDIQ SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
		495315	B. WING			06	/ 21/2 0 17
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CONSUL	ATE HEALTH CARE	OF WOODSTOCK			SOUTH MAIN ST DODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x !	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa practitioner."	ge 53	F3	23			
	conducted with LPN LPN #6 was asked measures were in p stated, "None, they was asked specificated. LPN #6 stated recently." LPN #6 w #8's clinical record low bed was discond on the have an order we have not been doing so well." LPN the care plan. LPN to direct the care sp was shown Resider the documentation #6 stated, "(Name of does not reflect the providing. When as the care plan, LPN haven't been doing	a.m. an interview was (licensed practical nurse) #6. what safety preventative place for Resident #8. LPN #6 were all taken away." LPN #6 ally about the order for the low d, "It was discontinued, fairly was asked to review Resident and demonstrate where the tinued. LPN #6 stated, "We er to discontinue the low bed. maintaining a low bed. He is 1 #6 was asked the purpose of #6 stated the care plan was pecific to a resident. LPN #6 at #8's care plan for safety and for, "Bed in low position." LPN of Resident #8's) care plan care we are currently sked if the care should follow #6 stated, "Yes it should. We it. The low bed should still be a not been on a low bed."					
	conducted with ASM member) #1, the addirector of clinical swere made aware to been following the value Resident #8. His below position when his	is a.m. a meeting was If (administrative staff Iministrator and ASM #2, the ervices. ASM #1 and ASM #2 hat the nursing staff had not written plan of care for ed was not being kept in the lie was in the bed. A policy lis time regarding following the					

The facility document titled, "Plans of Care" revealed, in part, the following documentation;

	DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM.	07/05/2017 APPROVED
	RS FOR MEDICARE	1	T			01		0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTIÒN			E SURVEY PLETED
	·	495315	B. WING				06/2	21/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZI	IP CODE		<u> </u>
CONSUL	ATE HEALTH CARE (OF WOODSTOCK			ODSTOCK, VA 22664			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 323	established for each accordance with starequirements and or Procedure: Direct of	age 54 ciplinary plan of care will be h resident and updated in ate and federal regulatory on an as needed bases. care staff should be aware, low their Resident's Plan of	F3	323				
	end of the survey price 483.70(i)(1)(5) RES RECORDS-COMPLLE (i) Medical records. (1) In accordance we standards and prace	S LETE/ACCURATE/ACCESSIB	F	514,				
	(i) Complete;(ii) Accurately documents(iii) Readily accessing(iv) Systematically of	ble; and						
	(5) The medical rec	_	:		•			
		ation to identify the resident;		:				
	(ii) A record of the r	esident's assessments;		i				
	(iii) The comprehen provided;	sive plan of care and services						! !

(iv) The results of any preadmission screening

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

PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVÌUÉR/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	495315	B. WING		06/21/2017	
NAME OF PROVIDER OR SUPPLIES CONSULATE HEALTH CARE		8	STREET ADDRESS, CITY, STATE, ZIP CODI 803 SOUTH MAIN ST NOODSTOCK, VA 22664		
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
1		,			

- F 514 Continued From page 55 and resident review evaluations and determinations conducted by the State;
 - (v) Physician's, nurse's, and other licensed professional's progress notes; and
 - (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 19 residents in the survey sample, Resident # 1 and Resident #5.

- 1. The facility staff failed to file the results of a Modified Barium Swallow study in Resident # 1's clinical record.
- 2. The facility staff failed to document Resident #5's daily fluid intake as ordered by the physician.

The findings include:

1. The facility staff failed to file the results of a Modified Barium Swallow study in Resident # 1's clinical record.

Resident # 1 was admitted to the facility on 10/10/16 with diagnoses that included but were not limited to: anemia, hypertension (high blood pressure), Parkinson's disease (1), diabetes (2), arthritis, hypothyroidism (3), and depression (4). Resident # 1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/27/17, coded

F514

- 1. The MBS results were filed on the resident #1's medical record on 6/20/17. The fluid intake documentation prior to 6/21/17 cannot be corrected for resident #5.
- 2.A 100% quality review was completed on 7/11/17 to ensure the results of MBS studies were available on the medical record and fluid intakes were documented per physician orders . There were no additional findings.
- 3. The policies entitled "Clinical/Medical Records" and "Fluid restriction" was reviewed and no changes are warranted at this time. Nursing staff were re-educated on these policies on or before 7/14/17.
- 4. The DCS/designee will perform a quality review of medical records of residents with new orders for MBS and fluid intake monitoring once per week. Any negative findings will be corrected immediately and will be reported to the facilities QAPI meeting monthly for 3 months at which time if no further incident is noted it will be monitored intermittently thereafter.

	TMENT OF HEALTI	HAND HUMAN SERVICES		<i>y</i>	PRINTED: 07/05/20 FORM APPROVI	ΈD
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	91
<u>.</u>		495315	B. WING		06/21/2017	
	PROVIDER OR SUPPLIER ATE HEALTH CARE		80	TREET ADDRESS, CITY, STATE, ZIP COD 03 SOUTH MAIN ST /OODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIO	 NC
	interview for menta was cognitively into was cognitively into During a review of physician order sig documented: "Mod During a further revidocumented result Swallow being com During an interview ASM (administrative) (director of clinical for the missing report of the Modifie completed on 4/4/1 located ASM # 2 state building. During an interview 6:00 p.m. with ASM ASM # 2, this concerning and interview 4:2, this concerning and interview 4:3 missing report of the Modifie completed on 4/4/1 located ASM # 2 state building.	oring a 12 out of 15 on the brief al status, indicting the resident act. Resident # 1's clinical record a ned and dated on 3/29/17 lified Barium Swallow". View of the clinical record the sof the Modified Barium pleted could not be located. View on 6/20/17 at 2:20 p.m. with e staff member) # 2, DCS services), a request was made ort. p.m. the ASM # 2 presented a d Barium Swallow that was 7. When asked where it was atted that the report was not in on 6/20/17 at approximately # 1, the administrator, and ern was reviewed and a copy	F 514			
	documentation: "Cli "Policy:Clinical F accordance with pro- to provide complete each resident for co record shall contain resident clearly; a re assessments; the p results of pre-admis	y policy revealed the following nical/Medical Records" Records are maintained in offessional practice standards and accurate information on ontinuity of care. The clinical information to identify the ecord of the resident's lan of care and services; the sion screening; and progress e change toward achieving the	;			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICOLOGY STATEMENT OF OFFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					F.	RINTE! FOR	D: 07/05/2017 MAPPR O VED
		T	т · · · · · · · · · · · · · · · · · · ·			<u>MB NC</u>). 0938-0391
	OF OFFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CONSUL	ATE HEALTH CARE (OF WOODSTOCK			3 SOUTH MAIN ST DODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 57	 F5	514			
	•	s. In addition, the resident's	i . `				•
		be readily accessible and					
		nized to facilitate retrieving mation The purpose of the					
		document the course of the		!			
	resident's plan of ca	are and to provide a medium	: ! !				
	of communication a						
	professionals involv	'ed in this care,"					
	No further informati	on was provided prior to exit.	 				
	References:		 - - -	:			
	(1) Parkinson's Dise	ease Parkinson's is a	:	÷			
:	older people. It typic	ous system that mostly affects cally begins after the age of					
:		n be very hard to live with restricts mobility and as a		:			i
:		activities increasingly difficult.		:			
	This information wa	s obtained from the following					
	website; https://www.ncbi.nln T0024544/	m.nih.gov/pubmedhealth/PMH		:			
1	(2) Diabetes is a dis	sease in which your blood ugar, levels are too high.					
	Glucose comes from	n the foods you eat. This ained from the following					
	website; https://sear	rch.nih.gov/search?utf8= ate=nih&query=Diabetes&co					:
	(3) Hypothyroidism -	The thyroid gland performs			\$		

a vital function: It produces the hormones that regulate the body's metabolism and keep them in balance. Thyroid hormones direct many of the body's processes. An underactive thyroid does not produce enough hormones. This condition is

	TMENT OF HEALTH	AND HUMAN SERVICES			r.	FORM): 07/05/2017 1APPROVED
STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		LE CONSTRUCTION	(X3) DA	. 0938-0391 FE SURVEY MPLETED
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•	PROVIDER OR SUPPLIER ATE HEALTH CARE (OF WOODSTOCK		8	TREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH MAIN ST WOODSTOCK, VA 22664	1 00	/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	information was obt website: https://www.ncbi.nlmT0022776/ (4) Depression (mai clinical depression) mood disorder. It ca affect how you feel, activities, such as shttps://www.nimh.nii.n/index.shtml 2. The facility staff if #5's daily fluid intake Resident #5 was ad 3/27/17 with diagnos not limited to; heart dementia, asthma a irregular heart rhythin Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17. Resident #5's most (minimum data set) assessment with an date) of 4/3/17 with diagnos minimum data set) assessment with an date) of 4/3/17 with diagnos minimum data set) assessment with an date) of 4/3/17 with diagnos minimum data set) assessment with an date) of 4/3/17 with diagnos minimum data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an data set) assessment with an dat	nypothyroidism. This ained from the following m.nih.gov/pubmedhealth/PMH for depressive disorder or is a common but serious auses severe symptoms that think, and handle daily leeping, eating, or working. h.gov/health/topics/depressio failed to document Resident as ordered by the physician. mitted to the facility on ses that included, but were failure, high blood pressure, and atrial fibrillation (an m). recent comprehensive MDS was an admission ARD (assessment reference sident #5 was coded as a possible 15 indicating that verely impaired with daily esident #5 was also coded in ons, as receiving a diuretic (a eases the production of urine) seven day look back period.	F	514			
	revealed, in part, the 3/29/17. Rec (recon	#5's physician orders following order: "Date: nmendation): 2.0 L (liters)					

centimeters) via dietary. 920 cc via nursing."

	TMENT OF HEALTH	AND HUMAN SERVICES & MEDI			Č.	FOR	D: 07/05/2017 MAPPR O VED <u>O. 0938-0</u> 391
STAT EMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		ONSTRUCTION	(X3) O	O. 0936-0391 ATE SURVEY OMPLETEO
		495315	B. WING		<u> </u>	ر ا	6/21/2017
NAME OF	PROVIOER OR SUPPLIER				EET AOORESS, CITY, STATE, ZIP CO		OE 112011
CONSUL	ATE HEALTH CARE	OF WOODSTOCK			SOUTH MAIN ST ODSTOCK, VA 22664		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AI OEFICIENCY)	SHOULO BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 59	F f	514			
		y ASM (administrative staff urse practitioner, on 4/3/17."	!				
	administration recoin part, the following restriction. 1080 (c nursing." For each June 1 - June 20 nu documented indicat was administered.	nt #5's MAR (medication rd) dated June 2017 revealed, g order: "2.0 Liter fluid c) via dietary - 920 (cc) via date and each shift beginning ursing initials were ting that the fluid restriction However there were no nts for Resident #5's fluid					
	plan dated 3/27/17 documentation: "Fo r/t (related to) h/o (h	at #5's comprehensive care revealed, in part, the following cus: Potential fluid imbalance nistory of) dehydration on		:		,	
	fluid restrictions and	al, use of diuretic, 2000 l (liter) d dx (diagnosis) of CHF ailure). Interventions: Fluid ed."					
	not reveal any docu	esident #5's clinical record did mentation of the amounts of onsumed on each shift.					
	member) #2, the dir approached this wri not been document (name of Resident off on the MAR ack restriction, but they fluid she (Resident)	p.m. ASM (administrative staff rector of clinical services, ter and stated, "The staff have ing the fluid intake amount for #5). They (the staff) signed nowledging there was a fluid did not document how much #5) had consumed each day."					

On 6/21/17 at 11:45 a.m. a meeting was

restriction.

	MENT OF HEALTH	AND HUMAN SERVICES & MEDI SERVICES			Ć.	FORM	D: 07/05/2017 M APPR OVE D
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CDNSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
		495315	B. WING	3		Of	6/21/2017
NAME OF F	PROVIDER OR SUPPLIER		. L		TREET ADDRESS, CITY, STATE, ZIP CODE		NZ 1/2011
CONSUL	ATE HEALTH CARE (OF WOODSTOCK			03 SOUTH MAIN ST OODSTOCK, VA 22664		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATIDN)	PREF TAG		PROVIDER'S PLAN OF CDRREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	[X5] COMPLETION DATE
	ASM #2, the director and ASM #2 were in staff was not documintake for Resident was asked if the am documented on the should. On 6/21/17 at 12:22 conducted with LPN LPN #4 was asked monitoring a fluid re #4 stated that the fluentered into the MA check off and dietar asked if she wrote to resident takes in du "No, we just know, we know not to leave fluigust our shift, we do much fluid intake the asked if she could to the masked if she wrote to the masked in the masked if she wrote to the masked if she wrote to the masked in the masked in the masked in the masked in the masked in the	If #1, the administrator and or of clinical services. ASM #1 made aware that the facility menting the amount of fluid #5 from shift to shift. ASM #2 mount of fluid intake should be MAR, ASM #2 stated that it it it it it it it it it it it it it	F	514			

by the attending physician. Procedure: The

		AND HUMAN SERVICES		F	PRINTED: 07/05/201 FORM APPROVE
	TOF DEFICIENCIES	& MEDI SERVICES	T		<u> </u>
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495315	B. WING	·	06/24/2047
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	06/21/2017
CONSUL	ATE HEALTH CARE (OF WOODSTOCK		803 SOUTH MAIN ST WOODSTOCK, VA 22664	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	D.BE COMPLETION
F 514	Continued From pa	go 61	=		
:	resident will have flu that he/she can hav on resident preferer shift, keep in mind f	uid restrictions calculated so re intake on each shift based nees. In calculating intake per luid required for resident to and desired at mealtimes."	F 514	· 	
: 	No further information end of the survey pr	on was provided prior to the ocess.			
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