PRINTED: 03/29/2018 FORM APPROVED OMB NO 0938-0391

		T TELEVISION OF SERVINGES	т		OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362			R-C
	PROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	03/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
{E 000}	Initial Comments		{E 00	0}	
F 558 SS=D	which following an a conducted on 1/10/conducted 3/14/18 are required for confederal Long Term Uncorrected deficie report. Corrected deficie report. Corrected deficience of the CMS 2567 - B.  The census in this 1/179 at the time of the consisted of 18 currence in the consisted of 18 currence in the consisted of 18 currence in the complaint was involved a complaint was involved in the complaint was involved in the consisted of 18 currence in the currence in the consisted of 18 currence in the currence in the currence in the currence in t	edicare/Medicaid revisit to the conducted on 1/10/18 through ted 3/14/18 through 3/15/18. estigated during the survey. aired for compliance with 42 ral Long Term Care corrected deficiencies are report. Corrected atified on the CMS 2567 - B.  90 certified bed facility was a survey. The survey sample ent resident reviews, ugh #118. Hodations Needs/Preferences of the conduction of the condu	{F 000	F558: Reasonable Accommodation of Needs/Preferences  1. Resident #114 placed within reach 3 continues to remain v residents reach.  2. A quality review of resident rooms con Executive Director	's call bell was 3/15/18 and vithin the of current mpleted by the r (ED)/ g linary Team all bells are

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

Executive Director 4/6/1

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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CENTE	ERS FOR MEDICAR	E & MEDICAID SERVICES					PORM APPROVE 2008-038 NO. 0938
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495362	B. WING	j			R-C 03/16/2018
NAME OF	PROVIDER OR SUPPLIER	`	1	STR	EET ADDRESS,	CITY, STATE, ZIP CODE	1 03/10/2016
ASHLAI	ND NURSING AND RE	EHABILITATION			THOMPSONS HLAND, VA 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOUL FERENCED TO THE APPROP DEFICIENCY)	D.BE COMPLETION
	other residents. This REQUIREMEI by: Based on observa document review a was determined the call bell was within in the survey sampi  The facility staff fail call bell within her r several occasions of The findings include Resident #114 was 11/20/15 with diagn net limited to: diabe dementia, deep veir schizophrenia (any characterized by gro withdrawal from soc of thought, language response) (1).  The most recent ME assessment, a quar assessment referen the resident as havir memory difficulties a impaired to make co Resident #114 was o vision. Resident #11	ENT is not met as evidenced ation, staff interview, facility and clinical record review, it be facility staff failed to ensure a reach for one of 18 residents ole, Resident #114.  Illed to place Resident #114's reach, it was observed on on the floor mat by the bed.  Ite:  Is admitted to the facility on noses that included but were etes, high blood pressure, in thrombosis (blood clot) and a group of mental disorders ross distortions of reality, cial contacts, and disturbances pe, perception and emotional  DS (minimum data set) rerely assessment, with an once date of 12/11/17, coded ing both short and long-term and as being severely ognitive daily decisions. coded as having impaired 14 was coded as requiring the of one staff member for	F 5	i58	4.	Current facility staff by the ED/DON/desi regarding ensuring carwithin the residents remains and the residents residents remains and the residents remains and the residents remains and the residents remains a suring call within the resident	ignee all bells are reach.  nee to ity nock survey l bells are each daily ekly x 2 y x 2 ekly then ed to QAPI and updated monitoring sed on

Observation was made on 3/14/18 at 11:00 a.m. of Resident #114 in her bed; the bed was in low

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 1039 030
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	!	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION	9	TREET ADDRESS, CITY, STATE, ZIP CODE 06 THOMPSON STREET ASHLAND, VA 23005	03/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	LILD BE COMPLETION
	of the bed. The cal Resident #114's real A second observation 9:16 a.m. of Reside mats on each side con the floor out of R. The comprehensive documented in part, the potential for injuring diabetes, gait/balance "Interventions" documented in part, the potential for injuring diabetes, gait/balance "Interventions" documented in gait balance it is the resident to use it when asked where the placed, CNA #1 septiments was concurring assistant) #1 When asked where the call #1 septiments was concurred in the floor, is a "They couldn't reach it."  An interview was compractical nurse) #5 on asked why the resident stated, "So they can asked where the call #5 stated, "Where it of the stated it was a second or stated it."	were fall mats on each side I bell was on the floor, out of ach.  On was made on 3/15/18 at an #114 in her bed with fall of the bed. The call bell was desident #114's reach.  I care plan dated, 1/9/18, "Focus: (Resident #114) has ry r/t (related to) confusion, be problems." The mented in part, "Be sure the swithin reach and encourage to within reach and encourage to make the covers." When asked if a call a problem, CNA #1 stated, it and they could fall trying to an another covers. When asked if a call a problem, CNA #1 stated, it and they could fall trying to an another call bells, LPN #5 call for assistance." When bell should be placed, LPN can be reached by the ed if a call bell on the fall mat	F 558		
7	The facility policy, "Ca noperable" documen	all Bell Systems - ted in part, "Policy: Resident			

must have, at all times, a system to notify staff when assistance is needed." the policy did not

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	. 10 1 011 11 20 107 11 12	T WILLDION NO OLIVIOLO			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	03/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE COMPLETION
{F 607} SS=D	ASM (administrative executive director, and ASM #3, the divervices were made on 3/15/18 at 6:15 p.  No further information of the facility docrecord review, facility docrecord review, in the sign of the facility staff failed.	call bell should be placed.  e staff member) #1, the ASM #2, director of nursing visional director of clinical e aware of the above concern o.m.  on was provided prior to exit.  ary of Medical Terms for the er, 5th edition, Rothenberg and 2.  Abuse/Neglect Policies 1)-(3)  lity must develop and olicies and procedures that:  bit and prevent abuse, eation of residents and resident property,  lish policies and procedures	F 56		at #117's left using Root RCA) by the 5/18 and be a result of p completed as n findings.  of current cent skin eted by the e to ensure an g RCA is dents who or bruising

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORN NAB NIC	// APPROVEI ). 0938-039
STATEMEN	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER			F	TREET ADDRESS, CITY, STATE, ZIP CODE	03	/16/2018
ASHLAN	ID NURSING AND RE	HABILITATION			<sup>06</sup> THOMPSON STREET SHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Resident #117 was 2/9/18 with a recent diagnoses that incluvascular dementia, stroke, diabetes, depressure.  The most recent ME assessment, an adrassessment referent resident rarely under making herself under coded as having both memory difficulties. having the following back period; physical directed towards oth symptoms directed towards of symptom such as hitting, scrative palivocal symptom disruptive sounds. Requiring limited assifor most of her activity.  Observation was mad 3/14/18 at 2:15 p.m. hall. The resident's lebruised and swollen. happened, the residential and symptoms are such as a symptom of the resident's lebruised and swollen.	left eye, to rule out abuse.  admitted to the facility on a readmission on 3/13/18 with uded but were not limited to: abnormal gait and balance, epression, and high blood  DS (minimum data set) mission assessment, with an ace date of 2/16/18 coded the erstanding others and rarely erstood. The resident was the short and long-term Resident #117 was coded as behaviors during the look all behavioral symptoms hers, verbal behavioral sowards other, and other is not directed towards others toking pacing, rummaging or mis like screaming and desident #117 was coded as istance of one staff member ties of daily living.  de of Resident #117 on sitting in a wheelchair in the eft eye was noted to be When asked how it ent stated, "Don't know."	{F 6	07}	Regional Director of Cli Services (RDCS)/design regarding ensuring an investigation using RCA conducted for residents visustain a bruise or bruising follow up as indicated by findings and per regulative Licensed nurses re-educated the DON/designee to ensure sidents who sustain a beare documented on the 2d Report.  Licensed nurse re-educated the ED/designee to ensure ED/DON are called with residents who sustain a bear bruising of unknown origing the time of the occurrence CNAs re-educated to repubruising upon identification supervisor.  DON re-educated by the RDCS/designee regarding notifying the ED with residents who sustain a bruise or broof unknown origin at the time of identification	is who ong with used on on. ated by ture ruise 4 Hour ed by e the ruise or in at e. ort on to	
•	The resident was obs	served on 3/15/18 at 9:43					

a.m. sitting on the side of her bed. The bruise to the left eye was observed and swelling under the

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		495362		AND SECULAR AND A TO MAKE A PART AND	0	R-C 3/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 906 THOMPSON STREET ASHLAND, VA 23005	DE	3/10/2018
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	documented in part, beside her bed. Ask and the roommate sonto the floor. Resilaround on the floor in purplish bruise obseloned (responsible party) a made aware."  A late entry nurse's in 3/11/18 at 7:30 a.m. "Resident's left eye in a.m. when writer did was informed (by the that the resident was 11-7 shift (11:00 p.m. doctor) and RP (responsible was documentation for the conducted nurse) #3, Finurse, on 3/15/18 at #117's bruise to her extend that she got it on the conducted with LPN in the first time when I exam. on 3/11/18. It stand purple on 3/11/18.	lated, 3/11/18 at 11:30 a.m., "Resident sitting on the floor sed her if she fell, she stated stated that she slid off the bed dent was also scooting in her room. Reddish - erved to left eye. RP and MD (medical doctor)  note dated, 3/12/18 for documented in part, was red and swollen at 7:30 arrive at start of shift. Writer enurse of the off going shift) is on the floor several times on to 7:00 a.m.) MD (medical consible party) notified." I record failed to evidence or the 11-7 shift.  Inducted with LPN (licensed Resident #117's regular 1:13 p.m. regarding Resident eye. LPN #3 stated, "I was sunday when she fell."  Induction was was #8, who cared for Resident	{F 60	4. ED/DON/designee to quality monitoring the Morning Clinical Mean residents who sustain bruising to ensure an investigation using Reconducted with followindicated based on finger regulation 3 x weeks, 2 x weekly x weekly x 4 weeks and indicated.  ED/DON/designee to quality monitoring the Morning Clinical Mean 24 Hour report to ensure residents who sustain bruising are investigated. RCA is conducted with as indicated based on an and per regulation 3 x weekly x 4 weeks and indicated.  ED/DON/designee to an and per regulation 3 x weekly x 4 weeks and indicated.  ED/DON/designee to a quality monitoring throw Morning Clinical Meet residents who sustain a bruising of unknown on ensure the ED/DON are	arough eeting of a bruise or cCA is w as addings and eekly x 4 weeks, d PRN as conduct cough eting of the ure a bruise or eed using h follow findings weekly x weeks, PRN as conduct ough ing of bruise or rigin to	

stated she had notified the acting supervisor of all of the occurrences of the day with Resident #117.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, 906 THOMPSON STREET ASHLAND, VA 23005	03/16/2018 ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
- f	statement related to "No, Ma'am."  An interview was co (administrative staff director, on 3/15/18 the bruise investigateye, ASM #1 stated the clinical meeting fallen on Sunday." Vinvestigation initiate stated, "I will have to asked if anyone obtaregarding the bruise check."  Review of the clinical falls on 3/11/18. All of the resident had "Sli The note of 3/12/18 resident had fallen in assessed for a right.  On 3/15/18 at 5:40 pnursing, informed this investigation for the late process followed of unknown origin, Abruise is discovered. Investigation was just bruise of unknown or 3/11/18, ASM #2 stat.  The facility policy docolollowing: "The Administration of the Administrati	was asked to provide a of the bruise, LPN #8 stated, anducted with ASM member) #1, the executive at 2:58 p.m. When asked for tion for Resident #117's left, "I know that it was noted in on Monday and that she had When asked if there was, and for the bruise, ASM #1 of get back with you." When ained statements from staff, ASM #1 stated, "I'll have to all record did not reveal any documentation documented defrom the bed to the floor." at 1:56 p.m. documented the of the hallway and was swollen hand.  I.m. ASM #2, the director of swriter she had started the bruise. When asked about for investigation of bruises SM #2 stated, "When the "When asked if the t starting for Resident #117's igin noted by staff on ed, "Yes, Ma'am."	{F 60	at the time of the or weekly x 4 weeks, 4 weeks, weekly x PRN as indicated. DON and or Unit I review Weekly Ski residents with a bru bruising to ensure i and reporting occur regulation. Mock sto be reviewed by to ensure investigat reporting occur as pr/t Abuse.  Findings to be reported to be reported to ensure investigate reporting to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.  Findings to be reported to ensure investigate reporting occur as pr/t Abuse.	2 x weekly x 4 weeks and  Managers to n Checks for nise or nvestigation r as per urvey rounds the ED/DON tion and per regulation  orted to QAPI y and updated ty monitoring based on

by other residents, visitors or

volunteers...Identification: All reported events

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CENTERS FOR MEDICARE & MEDICAID SERVICES		& MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING	·	R-C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	03/16/2018 E. ZIP CODE
ASHLAN	ID NURSING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	-, -:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
	(bruises, skin tears, behaviors) will be in Clinical Services - conursingInvestigation his/her designee shallegations of abuse and exploitation. A may be offered in the during any question residents. Preliminate upon an allegation of suspect(s) shall be spending the investigual allegation. The nurse Services shall performation and individual in charge conjunction with the abuse. This report is possible in order to predict the abuse coordinate Coordinator and/or Eshall take statement suspect(s) and all produce the properties of the contracted service produced in the abuse, reporting contracted service produced in the preparedReporting contracted service produced in the prepared in the pre	inappropriate or abusive exestigated by the Director of con: The Abuse Coordinator or all investigate all reports or all investigate all reports or an expect, misappropriation social Service representative are role of resident advocate ing of or interviewing of ry Investigation: Immediately of abuse or neglect, the segregated from residents ation resident of the se or Director of Clinical rm and document a thorough and notify the attending ant report shall be filed by the who received the report in person who reported the shall be filed as soon as provide the most accurate ally fashion, and submitted to bor. Investigation: The Abuse Director of Clinical Services are from the victim, the possible witnesses including all the vicinity of the alleged also secure all physical appletion of the investigation, a decorate who witness or has of abuse or an allegation of poloitation or mistreatment,	{F 60	)7}	

immediately, but no later than 2 hours after the allegation is made, if the events that cause the

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		T WEDICAID SERVICES	T			OMB NO	<u>D. 0938-039</u> 1
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		
		495362	B. WING			i	
NAME OF	PROVIDER OR SUPPLIER		<del></del>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	ECTION (X5) IOULD BE COMPLET PROPRIATE DATE	0/10/2016
ΔSHLΔ	ND NURSING AND RE	HARII ITATION		906 T	HOMPSON STREET		
/\text{\tin}\text{\tett{\text{\tetx{\text{\text{\text{\text{\text{\text{\text{\text{\text{\text{\ti}\}\text{\text{\text{\text{\text{\text{\text{\text{\tex{\tex	TO NOTION O AND IL			ASH	LAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	COMPLETION
{F 607}	allegation involve a injury, or not later the cause the allegation not result in serious Administrator and to with State law. One reported, the Executoordinator, is resporting in comple appropriate officials and State regulation Law Enforcement in crime has occurred ASM (administrative executive director, and ASM #3, the divisorvices were made	buse or result in serious bodily han 24 hours if the events that had not involve abuse and do a bodily injury, the coother officials in accordance ce an allegation of abuse is ative Director, as the abuse consible for ensuring that ted timely and appropriately to in accordance with Federal has, including notification of the accordance areason able suspicion of the accordance with Federal has, including notification of the accordance with Federal has a contracted by the accordance with Federal has a contracted	{F 6	)7}			
	provided prior to exi Reporting of Alleged CFR(s): 483.12(c)(1 §483.12(c) In respon neglect, exploitation, must: §483.12(c)(1) Ensur- involving abuse, neg mistreatment, includ source and misappro are reported immedia hours after the allega that cause the allega	on regarding the above was t.  Violations )(4)  nse to allegations of abuse, or mistreatment, the facility  e that all alleged violations	{F 60	9}	F609: Reporting of A  Violations  1. Bruise to resident # eye investigated usi Cause Analysis (RC ED/DON on 3/15/1 determined not to be Abuse.	117's left ng Root (A) by the 8 and	,

the events that cause the allegation do not involve

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	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLETION
(F 609)	the administrator of officials (including to adult protective senter for jurisdiction in lor accordance with Staprocedures.  §483.12(c)(4) Report investigations to the designated represe accordance with Stasurvey Agency, with incident, and if the appropriate correction This REQUIREMENT by:  Based on observatinterview, facility dorecord review, it was failed to report, to the unknown origin for esurvey sample, Resulting and failed to origin for Resident # observed with a reducible facility staff did not with the state age through established.  The findings include Resident #117 was a series.	esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in late law through established administrator or his or her intative and to other officials in late law, including to the State hin 5 working days of the lalleged violation is verified we action must be taken. In which is not met as evidenced ion, resident interview, staff cument review and clinical is determined the facility staff he state agency, an bruise of one of 18 residents in the lident #117.  Treport a bruise of unknown facilities the occurrence of the report the bruise of unknown gency and other officials procedures.	{F 6	2. Quality review of residents most reevaluations by the completed to ensewith a bruise or bunknown origin at timely to the approagency per regulation up based on finding Quality review of in the last 30 days ED/DON completed residents with an aunknown origin at timely to the approagency per regulation based on finding agency per regulation or bruising of unknown are reported timely appropriate state age regulation.  ED and DON re-ed RDCS/designee regulation.	ecent skin the ED/DON ture residents ture residents to ruising of the reported ropriate state tation. Follow the ted to ensure tinjury of the reported to priate state tion. Follow the ted to ensure tinjury of the reported to priate state tion. Follow the ted to the ted to ensure tion to the the ted to ensure to the ted to

diagnoses that included but were not limited to: vascular dementia, abnormal gait and balance, stroke, diabetes, depression, and high blood

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		495362	B. WING		R-C
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE. ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	03/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
{F 609}	Continued From papressure.	ge 10	{F 60	19}	
	assessment, an ada assessment referer resident rarely under making herself under coded as having bounded making herself under coded as having bounded making the following back period; physical directed towards of symptoms directed behavioral symptoms uch as hitting, sor a verbal/vocal symptom disruptive sounds. Frequiring limited assert for most of her actives the code of the	DS (minimum data set) mission assessment, with an accedate of 2/16/18 coded the erstanding others and rarely erstood. The resident was the short and long-term Resident #117 was coded as behaviors during the look all behavioral symptoms hers, verbal behavioral towards other, and other is not directed towards others tching pacing, rummaging or ms like screaming and Resident #117 was coded as istance of one staff member lities of daily living.		timely to the appagency per regule CNAs re-educat DON/designee to upon identification.  4. ED/DON/designee quality monitoring Morning Clinical event reports to with a bruise or unknown origin the appropriate stimely per regulation weekly x 4 weekly weekly, then PR indicated.	lation. ed by the o report bruising on to supervisor.  nee to conduct ng through I Meeting of ensure residents bruising of are reported to tate agency ation 3 times s, 2 times N an as
	hall. The resident's le bruised and swollen. happened, the reside The resident was ob	eft eye was noted to be When asked how it ent stated, "Don't know." served on 3/15/18 at 9:43		ED/DON/design quality monitorin Morning Clinica 24 Hour Report t residents with a b	ng through I Meeting of the to ensure bruise or
	a.m. sitting on the sid the left eye was obse eye was noted.	de of her bed. The bruise to erved and swelling under the eted, 3/11/18 at 11:30 a.m.		bruising of unknoreported to the apagency timely pe times weekly x 4 weekly, then PRI	ppropriate state r regulation 3 weeks, 2 times
: :	documented in part, ' beside her bed. Aske and the roommate st	riced, 3/11/18 at 11:30 a.m.  'Resident sitting on the floor and her if she fell, she stated ated that she slid off the bed ent was also scooting		indicated.	van as

around on the floor in her room. Reddish purplish bruise observed to left eye. RP

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/29/2018

CENTERS FOR MEDICARE &	MEDICAID SERVICES			C	FORMA DMB NO. (	PPROVEI
	PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONS	TRUCTION	(X3) DATE	SURVEY
	495362	B. WING			R-0	5/2018
NAME OF PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
ASHLAND NURSING AND REHA	BILITATION			MPSON STREET ND, VA 23005		
PRÉFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFII TAG	X CF	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D RF (	(X5) COMPLETION DATE
made aware."  A late entry nurse's no 3/11/18 at 7:30 a.m. de "Resident's left eye wa a.m. when writer did a was informed (by the resident was of 11-7 shift (11:00 p.m. that the resident was of 11-7 shift (11:00 p.m. that doctor) and RP (responseview of the clinical response and practical nurse) #3, Resident nurse, on 3/15/18 at 1: #117's bruise to her eye told that she got it on Stated with LPN #8 #117 on 3/11/18, regard Resident #117's eye. It has first time when I en a.m. on 3/11/18. It star and purple on 3/11/18 at stated she had notified of the occurrences of the When asked if she was	d MD (medical doctor)  ste dated, 3/12/18 for occumented in part, as red and swollen at 7:30 rrive at start of shift. Writer nurse of the off going shift) on the floor several times on the floor several times on 7:00 a.m.) MD (medical nsible party) notified."  record failed to evidence the 11-7 shift.  ucted with LPN (licensed esident #117's regular 13 p.m. regarding Resident es. LPN #3 stated, "I was sunday when she fell."  a., an interview was 8, who cared for Resident ding the bruise on LPN #8 stated, "I saw it for tered the room at 7:30 ted to change colors to red at 11:30 a.m. When asked about the bruise, LPN #8 the acting supervisor of all ne day with Resident #117. It is asked to provide a ge bruise, LPN #8 stated,	{F 60	09}	ED/DON/designee to conquality monitoring throughorning Clinical Meeting event reports to ensure rewith an injury of unknow origin are reported to the appropriate state agency to per regulation 3 times we 4 weeks, 2 times weekly, PRN an as indicated. ED/DON/designee to conquality monitoring throughorning Clinical Meeting 24 Hour Report to ensure residents with an injury of unknown origin are report the appropriate state agency timely per regulation 3 times weekly x 4 weeks, 2 times weekly x 4 weeks, 2 times weekly, then PRN an as indicated. DON and or Unit Manager review Weekly Skin Check residents with a bruise or bruising to ensure investigation. Mock survey rounds to be reviewed by the ED/DON to ensure investigation and reporting occur as per regulation occur as per regulation occur as per regulation and reporting occur as per regulation occur as per regulation and reporting occur as per regulation.	gh g of sidents imely ekly x then duct gh s of the ted to ey es s to as for	

director, on 3/15/18 at 2:58 p.m. When asked for the bruise investigation for Resident #117's left eye, ASM #1 stated, "I know that it was noted in

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES						D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUC		(X3) DA	TE SURVEY MPLETED
		495362	B. WING				I	R-C
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION		906		ESS, CITY, STATE, ZIP CO DN STREET 'A 23005	1	3/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH	OVIDER'S PLAN OF COR I CORRECTIVE ACTION : REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	the clinical meeting fallen on Sunday." Vinvestigation initiate stated, "I will have to asked if anyone obtoregarding the bruise check."  Review of the clinicate falls on 3/11/18. All the resident had "SI The note of 3/12/18 resident had fallen in assessed for a right on 3/15/18 at 5:40 pursing, informed the investigation for the the process follower of unknown origin, Abruise is discovered investigation was just bruise of unknown or 3/11/18, ASM #2 states of the facility policy do following: "The Admirecognizes that resid by other residents, volunteersIdentification (bruises, skin tears, behaviors) will be involunteed in clinical Services - dinursingInvestigation his/her designee sha allegations of abuse,	on Monday and that she had When asked if there was, an old for the bruise, ASM #1 to get back with you." When ained statements from staff at a statements from staff at record did not reveal any documentation documented id from the bed to the floor." at 1:56 p.m. documented the number of the hallway and was swollen hand.  D.m. ASM #2, the director of its writer she had started the bruise. When asked about it for investigation of bruises as M #2 stated, "When the st starting for Resident #117's wrigin noted by staff on ted, "Yes, Ma'am."  cumented in part the inistration of the Company dent abuse can be committed isitors or ation: All reported events inappropriate or abusive vestigated by the Director of	{F 60	)9}	5.	Findings to be rep committee monthl as indicated. Qual schedule modified findings. Date of Complian	ly and updated ity monitoring I based on	i

may be offered in the role of resident advocate during any questioning of or interviewing of

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPR	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	OMB NO, 0938 (X3) DATE SURV COMPLETED	/EY
		495362	B. WING		R-C	
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP 906 THOMPSON STREET ASHLAND, VA 23005	03/16/20 CODE	18
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CI (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE COMPL BE APPROPRIATE DA	(5) LETION ATE
	residents. Prelimina upon an allegation of suspect(s) shall be pending the investig allegation. The nurse services shall performance on ursing evaluation, physician. An incide individual in charge conjunction with the abuse. This report information in a time the abuse coordinate Coordinator and/or Eshall take statement suspect(s) and all poother employees in the abuse. He/she shall evidence. Upon condetailed report shall preparedReporting contracted service performation of a president, is obligated immediately, but no lease the allegation involve abunjury, or not later that cause the allegation of the coordinator and to evith State law. Once eported, the Executive	of abuse or neglect, the segregated from residents pation resident of the se or Director of Clinical rm and document a thorough and notify the attending ent report shall be filed by the who received the report in person who reported the shall be filed as soon as provide the most accurate ely fashion, and submitted to port. Investigation: The Abuse Director of Clinical Services is from the victim, the possible witnesses including all the vicinity of the alleged also secure all physical inpletion of the investigation, a be provide who witness or has of abuse or an allegation of coloitation or mistreatment, anknown source and the events that cause the the events that cause the tise or result in serious bodily in 24 hours if the events that do not involve abuse and do	{F 60	9}		

reporting in completed timely and appropriately to

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 906 THOMPSON STREET ASHLAND, VA 23005	03/16/2018 ODE
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
(F 609) F 610 SS=D	appropriate officials and State regulatio Law Enforcement i crime has occurred ASM (administrative executive director, and ASM #3, the diservices were madion 3/15/18 at 6:15 No further informatiprovided prior to extend to extend the extended prior to extended prior to extended the extended prior to extend the extend the extended prior to extend the extended prior to extend the extend the extended prior to extend the extend the extend the extended prior to extend the extended prior to extend the extended	s in accordance with Federal ns, including notification of n a reason able suspicion of t."  e staff member) #1, the ASM #2, director of nursing visional director of clinical e aware of the above concerno.m.  ion regarding the above was it.  //Correct Alleged Violation	{F 609}	F610:  Investigate/Privestigate/Privestigate  1. Bruise to reside eye investigate Cause Analysis ED/DON on 3 determined not	edent #117's left  ed using Root  s (RCA) by the  3/15/18 and  t to be a result of  v up completed as
	§483.12(c)(3) Preveneglect, exploitation investigation is in professional strategy of the secondary of the designated represer accordance with Stasurvey Agency, with incident, and if the appropriate corrective This REQUIREMENT by:  Based on observational preventions are the secondary of the sec	ent further potential abuse, , or mistreatment while the ogress.		<ol> <li>A quality revier residents most evaluation com ED/DON/design investigation us conducted for resustained a bruing Follow up base</li> <li>ED/DON re-ed Regional Direct Services (RDCS regarding ensurinvestigation us conducted for resustained a bruing with follow up a based on finding regulation.</li> </ol>	recent skin upleted by the gnee to ensure an sing RCA is residents who ise or bruising. d on findings. lucated by the tor of Clinical S)/designee ring an sing RCA is residents who se or bruising as indicated

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		F	RINTED: 03/29/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE 0MB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C
	PROVIDER OR SUPPLIER  ND NURSING AND REF	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	03/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO  ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 610	record review, it was failed to investigate for one of 18 resides Resident #117.  The facility staff faile Resident #117's left  The findings include	s determined the facility staff an bruise of unknown origin nts in the survey sample, ed to investigate a bruise on eye.	F 6	Licensed nurses re-ed the DON/designee to residents who sustaine are documented on the Report. Licensed nurse re-edu the ED to ensure the ED/DON/designee are with residents who sus bruise or bruising of u	ensure ed a bruise e 24 Hour cated by called stain a nknown

diagnoses that included but were not limited to: vascular dementia, abnormal gait and balance, stroke, diabetes, depression, and high blood pressure.

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/16/18 coded the resident rarely understanding others and rarely making herself understood. The resident was coded as having both short and long-term memory difficulties. Resident #117 was coded as having the following behaviors during the look back period; physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards other, and other behavioral symptoms not directed towards others such as hitting, scratching pacing, rummaging or verbal/vocal symptoms like screaming and disruptive sounds. Resident #117 was coded as requiring limited assistance of one staff member for most of her activities of daily living.

Observation was made of Resident #117 on 3/14/18 at 2:15 p.m. sitting in a wheelchair in the

occurrence. 4. ED/DON/designee to conduct quality monitoring through Morning Clinical Meeting of residents who sustain a bruise to ensure an investigation using RCA is conducted with follow up as indicated based on findings and per regulation 3 x weekly x 4 weeks, 2 x weekly x 4 weeks, weekly x 4 weeks and

PRN as indicated.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 03/29/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				RM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) D	O. 0938-039 PATE SURVEY OMPLETED
		495362		ING		R-C 3/16/2018
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CO	DE I	3/10/2018
401114	(D. 181901)			906 THOMPSON STREET		
ASHLAN	ND NURSING AND RE	HABILITATION		ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD BE	(X5) COMPLETION DATE
F 610	Continued From pa	ige 16	F 6	310		
	bruised and swoller	left eye was noted to be n. When asked how it dent stated, "Don't know."				
	a.m. sitting on the s	bserved on 3/15/18 at 9:43 side of her bed. The bruise to served and swelling under the		ED/DON/designee to co quality monitoring throu Morning Clinical Meeti 24 Hour Report to ensur residents who sustain a	ugh .ng of the re	
	documented in part beside her bed. Asl and the roommate onto the floor. Res around on the floor purplish bruise obse	dated, 3/11/18 at 11:30 a.m.  "Resident sitting on the floor ked her if she fell, she stated stated that she slid off the bed ident was also scooting in her room. Reddisherved to left eye. RP and MD (medical doctor)		unknown origin are involusing RCA is conducted follow up as indicated be findings and per regulat weekly x 4 weeks, 2 x v 4 weeks, weekly x 4 weeks, weekly x 4 weeks, as indicated.  DON and or Unit Mana review Weekly Skin Ch	estigated d with based on tion 3 x weekly x beeks and	
	3/11/18 at 7:30 a.m "Resident's left eye a.m. when writer did was informed (by the that the resident was 11-7 shift (11:00 p.m doctor) and RP (reseview of the clinical any documentation."	note dated, 3/12/18 for documented in part, was red and swollen at 7:30 darrive at start of shift. Writer enurse of the off going shift) s on the floor several times on the to 7:00 a.m.) MD (medical ponsible party) notified." all record failed to evidence for the 11-7 shift.  Inducted with LPN (licensed Resident #117's regular		residents with a bruise of bruising to ensure invest and reporting occur as pregulation.  Mock survey rounds to reviewed by the ED/DC ensure investigation and reporting occur as per ref. Abuse.  Findings to be reported committee monthly and as indicated. Quality me	or stigation oer  be ON to d egulation  to QAPI l updated onitoring	
	nurse, on 3/15/18 at #117's bruise to her	: 1:13 p.m. regarding Resident eye. LPN #3 stated, "I was n Sunday when she fell."		schedule modified base findings.	d on	

On 3/15/18 at 2:02 p.m., an interview was conducted with LPN #8, who cared for Resident #117 on 3/11/18, regarding the bruise on

5. Date of compliance 4-15-18.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES  STAIR MENT OF DEFICIENCES AND PLAN OF CORRECTION  (X1) PROVIDER SUPPLIER:  A 95362  NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 610 Continued From page 17  Resident #117"s eye. LPN #8 stated, "I saw it for the first time when I entered the room at 7:30 a.m. on 3/11/18. It started to change colors to red and purple on 3/11/18 at 11:30 a.m. When asked if she notified anyone about the bruise, LPN #8 stated she had notified the acting supervisor of all of the occurrences of the day with Resident #117. When asked if she was asked to provide a statement related to the bruise, LPN #8 stated, "No, Ma'am."  An interview was conducted with ASM (administrative staff member) #1, the executive director, on 3/15/18 at 2:58 p.m. When asked for the bruise investigation for Resident #117: beft eye, ASM #1 stated, "I know that it was noted in the clinical meeting on Monday and that she had fallen on Sunday." When asked if there was, an investigation intitated for the bruise, ASM #1 stated, "I will have to get back with you." When asked if anyone obtained statements from staff regarding the bruise, ASM #1 stated, "I'll have to check."  Review of the clinical record did not reveal any	(X3) DA	ATE SURVEY OMPLETED					
		495362	B. WING			i	R-C 3/16/2018
		HABILITATION		906	THOMPSON STREET		<i>3</i> /10/2016
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
F 610	Resident #117's eye the first time when I a.m. on 3/11/18. It and purple on 3/11/ if she notified anyor stated she had notified of the occurrences. When asked if she statement related to "No, Ma'am."  An interview was co (administrative staff director, on 3/15/18 the bruise investigatelye, ASM #1 stated the clinical meeting fallen on Sunday." Vinvestigation initiate stated, "I will have to asked if anyone obtategarding the bruise	e. LPN #8 stated, "I saw it for entered the room at 7:30 started to change colors to red 18 at 11:30 a.m. When asked he about the bruise, LPN #8 fied the acting supervisor of all of the day with Resident #117. was asked to provide a the bruise, LPN #8 stated, and the bruise, LPN #8 stated, and the different was noted in the different was noted in the different was, and for the bruise, ASM #1 of get back with you." When asked statements from staff	F6	10			
	falls on 3/11/18. All of the resident had "Sli The note of 3/12/18	documentation documented d from the bed to the floor." at 1:56 p.m. documented the national the hallway and was					
	nursing, informed the investigation for the the process followed	.m. ASM #2, the director of s writer she had started the bruise. When asked about for investigation of bruises SM #2 stated, "When the " When asked if the					

investigation was just starting for Resident #117's bruise of unknown origin noted by staff on

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		<del></del>	<u> </u>	MID MO. 0930-039
STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	[()	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
	495362	B. WING		R-C <b>03/16/2018</b>
NAME OF PROVIDER OR S	UPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHLAND NURSING	AND REHABILITATION	l	906 THOMPSON STREET ASHLAND, VA 23005	
PREFIX (EACH D	MARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

F 610 Continued From page 18 3/11/18, ASM #2 stated, "Yes, Ma'am."

F 610

The facility policy documented in part the following: "The Administration of the Company recognizes that resident abuse can be committed by other residents, visitors or volunteers...Identification: All reported events (bruises, skin tears, inappropriate or abusive behaviors) will be investigated by the Director of Clinical Services - director of nursing...Investigation: The Abuse Coordinator or his/her designee shall investigate all reports or allegations of abuse, neglect, misappropriation and exploitation. A Social Service representative may be offered in the role of resident advocate during any questioning of or interviewing of residents. Preliminary Investigation: Immediately upon an allegation of abuse or neglect, the suspect(s) shall be segregated from residents pending the investigation resident of the allegation. The nurse or Director of Clinical Services shall perform and document a thorough nursing evaluation, and notify the attending physician. An incident report shall be filed by the individual in charge who received the report in conjunction with the person who reported the abuse. This report shall be filed as soon as possible in order to provide the most accurate information in a timely fashion, and submitted to the abuse coordinator. Investigation: The Abuse Coordinator and/or Director of Clinical Services shall take statements from the victim, the suspect(s) and all possible witnesses including all other employees in the vicinity of the alleged abuse. He/she shall also secure all physical evidence. Upon completion of the investigation, a detailed report shall be prepared...Reporting/Response: Any employee or contracted service provide who witness or has

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	TIDLE CONCERNATIO		JIVID INO. 0936-039
	OF CORRECTION	IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTIO	IN.	(X3) DATE SURVEY COMPLETED
		40 7000				R-C
		495362	B. WING			03/16/2018
ASHLA	PROVIDER OR SUPPLIER  ND NURSING AND REI			STREET ADDRESS 906 THOMPSON S ASHLAND, VA		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CO	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOUL FERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 610	abuse, neglect or e- including injuries of misappropriation of resident, is obligate immediately, but no allegation is made, allegation involve at injury, or not later th cause the allegation not result in serious Administrator and to with State law. Once reported, the Execu coordinator, is responsed appropriate officials and State regulation	t of abuse or an allegation of exploitation or mistreatment, unknown source and resident property, to a d to report such information later than 2 hours after the fif the events that cause the buse or result in serious bodily an 24 hours if the events that do not involve abuse and do	F	510		
	executive director, A and ASM #3, the div	staff member) #1, the SM #2, director of nursing isional director of clinical aware of the above concern m.				
{F 656} SS=E	provided prior to exit	Comprehensive Care Plan	{F 65	6}		
	implement a compre care plan for each re	cility must develop and hensive person-centered sident, consistent with the the at §483.10(c)(2) and				

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			T		ONID NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C
		1 433302	13. 11.110		03/16/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
A C LII A A	ID NUDSING AND DE	HARILITATION		906 THOMPSON STREET	
ASTLAN	ID NURSING AND RE	HABILITATION	i	ASHLAND, VA 23005	
(X4) (D)	SUMMARY STA	TEMENT OF DEFICIENCIES			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
{F 656}	Continued From pa	ae 20	{F 65	6)	
,	•	frames to meet a resident's	η σο	o,	
	medical, nursing, a needs that are iden assessment. The c describe the followi (i) The services tha	nd mental and psychosocial tified in the comprehensive omprehensive care plan must		F656: Development/Implement Comprehensive Care Plan  1. Resident #111 received laboratory services per physician order on 03/08/2018.	1
or ph re (ii ur	physical, mental, ar	nd psychosocial well-being as 3.24, §483.25 or §483.40; and		Resident #116 oral status evaluation completed 3/22/18.	
	(ii) Any services that	it would otherwise be required 3.25 or §483.40 but are not		Resident #116 received dental services per the plan of care on	
		resident's exercise of rights		3/28/18.	
	under §483.10, incli	uding the right to refuse		Care plan updated to reflect the	
	treatment under §48			care needs of resident #110's	
		services or specialized		Peripherally Inserted Central	
		es the nursing facility will		Catheter (PICC) on 3/24/18.	
	provide as a result of	of PASARR		Resident #116 heels floated per	
	recommendations.	If a facility disagrees with the		the plan of care.	
	findings of the PASA	ARR, it must indicate its		Resident #114's call bell was	
	rationale in the resid	dent's medical record.		placed within reach 3/15/18 per	
	(iv)In consultation w	ith the resident and the		the plan of care and continues to	
	resident's represent			remain within the residents	'
	(A) The resident's g	oals for admission and		reach.	
	desired outcomes.			reacii.	
		reference and potential for		2 Quality raviant of assess	
		cilities must document		2. Quality review of current	ata d
		t's desire to return to the		resident's care plan compl	
		essed and any referrals to		by the DON/Unit Manager	·
		es and/or other appropriate		(UM)/designee to ensure	
	entities, for this purp			laboratory services are pro	
		in the comprehensive care		per physician order. Follo	w <sub>_</sub> up
		, in accordance with the		based on findings.	
		th in paragraph (c) of this			
	section.				
		T is not met as evidenced			
	by:				İ
		on, resident interview, staff cument review and clinical			

record review, it was determined the facility staff

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CENTE'	RS FOR MEDICARE	E & MEDICAID SERVICES			(	OMB NO. 0938-039
STATEMENT	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING	;		R-C 03/16/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010
ASHLAN	ND NURSING AND REI	HARII ITATION		1	06 THOMPSON STREET	
	10 1101101110	IADICITATION		Α	ASHLAND, VA 23005	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
{F 656}	Continued From pa	04				
i ocoj			{F 65	56}		
	failed to develop and					
	in the survey sample 104 and 114.	re plan for five of 18 residents le, Residents # 111, 116, 110,				
					Quality review of	fcurrent
		failed to implement/follow the			resident's care pl	lan completed
		e plan to obtain laboratory			by the DON/UM/	/designee to
	specimens as order	red for Resident #111.			ensure residents r	receive routine
:	2. The facility staff f	inited to implement fallow the			dental services an	nnually and/or
	2. THE facility stan to	ailed to implement/follow the eplan to notify the doctor if			upon change in co	ondition.
	the resident's teeth	were missing, cracked or			Follow up based	on findings.
	decayed for Resider				Quality review of	f current
					resident's care pla	an completed
	3. The facility staff fa				by the DON/UM/	
	comprehensive care	e plan to address the care			ensure oral status	
		#110's peripherally inserted			completed per pol	licy. Follow up
	central catheter (PIC	CC).			based on findings	
	4. The facility staff for	ailed to float Resident #116's			Quality review co DON/UM/designe	impleted by the
	heels per the compre	shensive care plan			care plan reflects	the care needs
	Hoors por are comp.	siterisive care plan.			of resident's with	a PICC
	5. The facility staff fa				Follow up based of	
	comprehensive care	plan to ensure Resident			Quality review of	Current
	#114's call bell was v	within reach.			resident's care pla	an completed
	The findings include:	:			by the DON/UM/o ensuring resident'.	designee's call bells are
	1. Resident #111 was	s admitted to the facility on			within reach. Foll on findings.	low up based
	7/10/15 with diagnose	ses that included but were not			Quality review of	
İ	limited to: diabetes, h	heart failure, chronic lung			resident's care pla	current
1	disease, irregular hea	artbeat, high blood pressure			by the DON/UM/o	
i	and falls.				ensuring residents	
	The most recent MD	C/minimum data ast)			floated per the plan	n of care
	annual assessment,	S (minimum data set), an with an ARD (assessment				n or care.

reference date) of 12/14/17 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	D. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING		
		495362	B. WING		03	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	e-educated by to ensure the educated by Director the care plan ing residents e-educated by Director the care plan ing residents e-educated by to ensure the ed regarding ach. re-educated DS Director the care plan ing residents e-educated by to ensure the ed regarding ach. re-educated DS Director the care plan the resident's e-educated by to ensure the resident's e-educated by to ensure the educated by to ensure the resident's e-educated by	
ASHI AN	ID NURSING AND RE	HARII ITATION		906 THOMPSON STREET		
	ID NOROMO AND RE	TABLETATION		ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
	The resident was of from staff for all act exception of eating perform after the trace revised on 1/9/18 diresident is at risk for cardiac outputInterview of the clinical resident is at risk for cardiac outputInterview of the clinical resident had a complete (1) on 3/8/18.  Review of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical physician's order of the physical	ct to make daily decisions.  oded as requiring assistance ivities of daily living with the which the resident could ay was set up.  plan initiated on 1/30/17 and ocumented, "Focus. The releeding and decreased erventions. Monitor labsens) as ordered and notify the elete metabolic panel (CMP)  cian's orders did not evidence for a CMP on that date.  Inducted on 3/15/18 at 10:45 ansed practical nurse) #7, the shead practical nurse) #7, the shead off the resident's pehaviors." When asked who LPN #7 stated, "Pretty much team plays a role in the care of staff were expected to LPN #7 stated, "I would say anducted on 3/15/18 at 11:00 the resident's nurse. When cess staff follow to obtain	{F 65	3. Licensed nurses rethe Division MDS Director/designee to care plan is followed laboratory services. Licensed nurses re-Division MDS Director/designee to ensure is followed regarding services. Licensed nurses rethe Division MDS Indesignee to ensure is followed regarding with a PICC. Licensed nurses rethe Division MDS Director/designee to care plan is followed call bells within read MDS Coordinator response to the Division MDS regarding ensuring the accurately reflects the current status. Licensed nurses rethe Division MDS Director/designee to care plan is followed the Division MDS Director/designee to care plan is followed.	o ensure the ed regarding educated by ector the care plan ing dental educated by Director the care plan ing residents educated by o ensure the d regarding ch. e-educated S Director the care plan in the care plan in the care plan in the care plan in the care plan in the care plan in the care plan in the care plan in the care plan in the resident's educated by the ensure the	
	follow the care plan, yes."  An interview was cora.m. with LPN #5, th asked about the productions aboratory specimen	LPN #7 stated, "I would say nducted on 3/15/18 at 11:00 e resident's nurse. When		Director/designee to	ensure the I regarding	

a laboratory test without a physician's order LPN

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·				. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495362	B. WING	i		[	R-C / <b>16/2018</b>
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STR	REET ADDRESS, CITY, STATE, ZIP CODE	1	10/2010
ASHLAN	ND NURSING AND REI	HABILITATION			THOMPSON STREET HLAND, VA 23005		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
{F 656}	laboratory specime time. LPN #5 stated CMP for 3/19/18 bu When asked if she wanted the CMP dr she had not. When care plan, LPN #5 so f care we provided if staff were expecte #5 stated, "it should An interview was coa.m. with ASM #2, to a guide for caring for When asked who ustated, "It helps to be a guide for caring for When asked who ustated, "The whole is asked if staff were explan, ASM #2 stated aware of the finding On 3/15/18 at 6:15 plan, ASM #2, the #3, divisional director made aware of the facility Care" documented, person-centered plate by the interdisciplinare sident and/or resident and/or resident and/or resident practicable a with state and feder. Develop a comprehend	request for the 3/8/18 CMP en order was requested at that d, "The doctor ordered the at I got it drawn on 3/8/18." had asked the doctor if he rawn on 3/8/18, LPN #5 stated asked why a resident has a stated, "Basically it's what kind d for the patient." When asked ed to follow the care plan, LPN d be."  onducted on 3/15/18 at 11:05 the director of nursing. When it's had care plans, ASM #2 direct their care. It's kind of like or them. It's individualized." used the care plan, ASM #2 interdisciplinary team." When expected to follow the care d, "Yes." ASM #2 was made gs at that time.  p.m. ASM #1, the executive ne director of nursing and ASM or of clinical services were	{F 6	56}	ensuring residents he floated per the plan of MDS Coordinator residents and Envision MDS regarding ensuring linurses and CNA's are and understand their development of the reare plan.  4. MDS Coordinator/DON/deconduct quality monthrough morning climeeting to ensure call intervention(s) accurate resident's currentimes weekly x 2 we weekly x 4 weeks, the weekly and PRN as MDS Coordinator/DON/deconduct quality monthrough morning climeeting to ensure the is followed regarding services 5 times weekly x 4 we	of careeducated S Director censed re aware of role in resident's resident'	ct

timetables to meet the resident's medical, nursing, mental and psychosocial needs that are

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CENTE	45 FOR MEDICARE	& MEDICAID SERVICES	<del></del>		O	<u>MB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING			R-C 03/16/2018
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE	1 03/10/2018
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	THE FIRST CONTROL OF LICEN				THOMPSON STREET	
ASHLAN	D NURSING AND REI	HABILITATION				
				ASI	ILAND, VA 23005	
(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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
{F 656}	Continued From pa	ae 24	{F 65	56)		
,	·	prehensive assessment.	(, 00	30)	MDS	
		d /or revise the comprehensive			Coordinator/DON/des	ionee to
	plan of care based				conduct quality monitor	
		eds of the resident and in			through morning clinic	
	response to current				meeting to ensure the	care nlan
	interdisciplinary tea	m shall ensure the plan of			is followed regarding	dental
		resident needs and that the			services 5 times weekl	v x 2
		ard attaining or maintaining			weeks, 3x weekly x 4	weeks.
		ble physical, mental and			then 2 x weekly and Pl	RN as
		eing. The individualized			indicated.	
		an of care may include but is lowing: Resident's strengths			MDS	
		s to attain or maintain the			Coordinator/DON/desi	ignee to
		racticable physical, mental,			conduct quality monito	
		ell-being as required by state			through morning clinic	
	and federal regulator				meeting to ensure the c is followed regarding r	esidents
	No further information	on was provided prior to exit.			with a PICC 5 times weeks, 3x weekly x 4 v	eekly x 2 weeks,
		mentals of Nursing Lippincott			then 2 x weekly and PF	₹N as
	Williams and Wilkin				indicated.	
		ten care plan serves as a			MDS	1
		among health care team			Coordinator/DON/desi	gnee to
		ensure continuity of			conduct quality monito	ring
		are plan is a vital source of			through morning clinic	al
		e patient's problems, needs, ns detailed instructions for			meeting to ensure the c	are plan
		established for the patient			is followed regarding e	nsuring
		careexpect to review,			residents call bells with	
		ne care plan regularly, when			5 times weekly x 2 wee	ks, 3x
		condition, treatments, and			weekly x 4 weeks, then weekly and PRN as ind	∠ x icated.
		Nursing Lippincott Williams incott Company Philadelphia				

(1) CMP -- The comprehensive metabolic panel

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CENTERS FOR MEDICAL	RE & MEDICAID SERVICES	<del></del>		OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION UNITED TO THE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495362	B. WING		R-C <b>03/16/2018</b>	
NAME OF PROVIDER OR SUPPLIE  ASHLAND NURSING AND R			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	, 00.1012010	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	ULD BE COMPLETION	
that provides info of a person's met the kidneys and I balance as well a blood proteins. The from: https://labtestsontabolic-panel-cmp.  2. The facility state comprehensive of the resident's teed decayed for Resident #116 was 10/20/15 with diagnot limited to: strong diabetes, depress.  The most recent I with an ARD of 2/having short-term problems and as The resident was from staff for all and Review of the annoyer 10/27/17 in Section documented, "D. broken natural teed."  An observation was a.m. of Resident #3.	ently ordered panel of 14 tests rmation about the current status tabolism, including the health of iver, electrolyte and acid/base is levels of blood glucose and this information was obtained line.org/tests/comprehensive-me of the state of	{F 65	DON/UM/IDT to conduct quality monitoring through mock survey rounds to ensuresidents heels are floated p the plan of care 5 times weed 2 weeks, 3x weekly x 4 weethen 2 x weekly and PRN as indicated.  Findings to be reported to Committee monthly and upd as indicated. Quality monito schedule modified based on findings.  5. Date of Compliance 4-15-18	er ekly x eks, s QAPI ated oring	

and his mouth was open. In the lower jaw, there were two teeth broken to the gum line. There

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FC	RM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
		495362	B. WING			R-C
	PROVIDER OR SUPPLIER  ND NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STAT 906 THOMPSON STREET ASHLAND, VA 23005	E, ZIP CODE	03/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
{F 656}	debris, a greenish/g the teeth and the te that.	r seven teeth, which had food gray substance at the base of eth had black decay above	{F 65	56}		
	and revised on 11/7, (Name of resident) Inutrition r/t (related the ProblemResident Interventions, Monitor (medical doctor) PR and symptoms) of orattention, Pain (gum Abscess, Debris in name of the problem.	plan initiated on 10/27/16 /17 documented, "Focus. has potential for imbalanced to)Chewing has poor dentition. or/document/report to MD N (as needed) s/sx (signs ral/dental problems needing s, toothache, palate), nouth, Lips cracked or sing, loose, broken, eroded,				
;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;;	a.m. with LPN #4, the asked about the prochas dental issues, LF they can verbalize if it teeth were checked, when mouth care is conursing assistant) wo what types of issues #4 stated, "If they're leasked what staff did it had obvious cavities, the chart for the RP (rithe doctor." When as having decayed and by as asked to look in Fresident had no upper	nducted on 3/15/18 at 9:30 be resident's nurse. When cess staff follows if a resident PN #4 stated, "If they're vocal it hurts." When asked how LPN #4 stated, "Normally done. The CNA (certified build tell me." When asked the CNA would report, LPN coose or painful." When if the teeth were broken or LPN #4 stated, "I'd check responsible party) and call ked if there were risks to broken teeth, LPN #4 stated, her health issues." LPN #4 Resident #116's mouth. The reeth, one tooth in the left deep black center, two				

broken teeth in the front of the lower jaw and

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CENTE	35 FUR MEDICARE	& MEDICAID SERVICES	<del></del>		OMR NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495362	B. WING		1	R-C / <b>16/2018</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		10/2010
				906 THOMPSON STREET		
ASHLAN	D NURSING AND REI	HABILITATION		ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
{F 656}	#4 stated, "Yes."  An interview was coa.m. with LPN, (lice MDS coordinator. Vocare plans, LPN #7 the resident's care. comprehensive and general diagnoses, included on the care "Generally we would impaired communic status." When asked of the annual MDS, was asked to review	ge 27 e was decay in the teeth, LPN enducted on 3/15/18 at 10:45 nsed practical nurse) #7, the When asked why residents had stated, "The care plan drives They're individualized, I based off the resident's behaviors." When asked was e plan, LPN #7 stated, d discuss cognitive function, eation, nutritional status, dental d who completed Section AL LPN #7 stated, "I do." LPN #7 of Section L of the annual MDS eation and the dental care plan.	{F 65			
	the MDS, LFN #7 s (interdisciplinary teal about the risks of hateeth, LPN #7 states. When asked who ustated, "Pretty much plays a role in the cowere expected to fo stated, "I would say had followed Reside stated they had not.  An interview was coal.m. with ASM #2, til	nducted on 3/15/18 at 11:05 ne director of nursing. When				
	stated, "It helps to d a guide for caring fo When asked who us stated, "The whole i	s had care plans, ASM #2 irect their care. It's kind of like ir them. It's individualized." sed the care plan, ASM #2 interdisciplinary team." When ald do if they identified dental				

issues for a resident, ASM #2 stated, "I would

# DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME OF	DDOVIDED OD GUDDUED	495362	B. WING		R-C 03/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 906 THOMPSON STREET ASHLAND, VA 23005	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	every day when ass care." When asked follow the care plan. #2 was asked to exist ASM #2 stated, "Ummade aware of the following for the fol	ified on admission and then isting the resident with mouth if staff were expected to ASM #2 stated, "Yes." ASM amine Resident #116's mouth, hmm, I see." ASM #2 was findings at that time.  O.M. ASM #1, the executive edirector of nursing and ASM or of clinical services were indings.  On was provided prior to exit.  Itiled to develop a plan to address the care 110's peripherally inserted C).  Idmitted to the facility on es that included but were not abscess (1), high blood epsis, difficulty walking and  S, an admission ARD of 2/25/18 coded the ored 15 out of 15 on the esident was cognitively ecisions. The resident was sistance from staff for all gexcept for eating which the nafter the tray was set up	{F 656	6}	

intravenously medications.

Review of the physician's orders dated and

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	···			OMB NO	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		TE SURVEY MPLETED
		495362	B. WING	Mark constraints			R-C 3/ <b>16/2018</b>
NAME OF E	PROVIDER OR SUPPLIER	V-10-70-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1-12-0-1			REET ADDRESS, CITY, STATE, ZIP CODE		110/2010
ASHLAN	D NURSING AND REI	HABILITATION			THOMPSON STREET HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	per SASH (saline, a (3)). Monitor IV (intr (signs and sympton Review of the Marc "Flush Per SASH P centimeters) NS (no 10 cc NS 5 cc Hepa documentation regasigns of infection.  Review of the care indocumentation regasigns of infection.  Review of the care indocumentation regasigns of infection.  Review of the care indocumentation regasigns with LPN, (lice MDS coordinator. We care plans, LPN #7 the resident's care. comprehensive and general diagnoses, resident had a PICC the care plan, LPN #7 that it should probabasked why, LPN #7 them at an increase asked who used the	ocumented, "Flush Pic (sic) (2) entibiotic, saline and heparin ravenous) site daily for s/s ens) of infection."  th 2018 MAR documented, rotocol twice daily 10 cc (cubic ormal saline) ABT (antibiotic) erin." There was no ending monitoring the site for plan did not evidence	{F 6	56}			
	a.m. with LPN #5, th asked why a residen stated, "Basically it's provided for the patie	nducted on 3/15/18 at 11:00 e resident's nurse. When it has care plan, LPN #5 what kind of care we ent." When asked if staff low the care plan, LPN #5					-

stated, "It should be." When asked if a PICC line would be care planned, LPN #5 stated, "Yes

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	10. 0938-039°
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		DATE SURVEY COMPLETED
		495362	B. WING				R-C 03/16/2018
	PROVIDER OR SUPPLIER  D NURSING AND RE	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP COD THOMPSON STREET HLAND, VA 23005	)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 656}	go septic and die."  An interview was coa.m. with ASM #2, to asked why resident stated, "It helps to coa guide for caring for When asked who ustated, "The whole  On 3/15/18 at 6:15 director, ASM #2, the #3, divisional director made aware of the No further information."  1. Intraspinal situs or introduced into the specially the vertel was obtained from: https://www.merrian.pinal Abscess: a I surrounded by inflar was obtained from: https://www.merrian.ess  2. PICC a device treatments, including blood transfusions. Into a vein in the upp (threaded) into a largethe heart called the information was obtained was obtained from the upp (threaded) into a largethe heart called the information was obtained was obtained from the upp (threaded) into a largethe heart called the information was obtained was obtained was obtained the information was obtained was obtained the information was obtained was obtained the information was obtained was obtained the information was obtained was obtained the information was obtained was obtained the information was obtained was obtained the information was obtained th	on keep it clean or they could on ducted on 3/15/18 at 11:05 he director of nursing. When is had care plans, ASM #2 direct their care. It's kind of like or them. It's individualized." sed the care plan, ASM #2 interdisciplinary team."  p.m. ASM #1, the executive me director of nursing and ASM for of clinical services were findings.  on was provided prior to exit.  ated within, occurring within, me spinal column and foral canal. This information in-webster.com/medical/intrassocalized collection of pusing med tissue. This information in-webster.com/dictionary/abscursed to draw blood and give grintravenous fluids, drugs, or a thin, flexible tube is inserted for arm and guided gree vein above the right side of superior vena cava. This	{F 6	56}			

ancer-terms/def/picc

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OWR MC	<i>).</i> 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	СО	TE SURVEY MPLETED
		495362	B. WING		l l	R-C 8 <b>/16/2018</b>
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		7 10/2016
14.00E 01.	THE THE ENGLISH CONTROL OF THE CONTR			906 THOMPSON STREET		
ASHLAN	D NURSING AND REI	HABILITATION	i	ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
(F 656)	Continued From pa	ne 31	{F 65	561		
[1 000]	•	<u>-</u>	{m 0;	50}		
		n injection is an anticoagulant. se the clotting ability of the				
		rent harmful clots from				
		vessels. This information was				
	obtained from:	vectore, time imerimation was				
		n.nih.gov/pubmedhealth/PMH				
	T0010545/					
	4. The facility staff failed to float Resident #116's					
	heels per the comp	rehensive care plan.				
	Resident #116 was admitted to the facility on					
	2/21/18 with diagnoses that included but were not					
	•	clerosis [1], difficulty walking,				
		h blood pressure, pain to left				
		arged prostate), paraplegia,				
		ce of toes. Resident #116				
		ninimum data set) was a nt with ARD (assessment				
		ed 2/21/18. Resident #116				
		cognitively intact in the ability				
		ons scoring 15 out of 15 on				
	the BIMS (Brief Inte	rview for Mental Status)				
		16 was coded as requiring				
		n most ADLs (activities of				
		nt #116 was coded as being				
	unit.	alking in his room and on the	-			
	Review of Resident	#116's clinical record				
		n dated 10/12/16 that				
		owing information: "(Name of				
		otential for impaired skin				
		o) incontinence, external				1
		allergies, Cardiovascular of) Eczema-Psoriasis,				
		eft foot drop(Name of				l
		nave intact skin, free of				
		discoloration through next				

review...interventions: ... Float heels."

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C 03/16/2018
	PROVIDER OR SUPPLIER  ID NÜRSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, 906 THOMPSON STREET ASHLAND, VA 23005	ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
{F 656}	Continued From pa	ge 32	{F 65	56}	
	for CNAs [certified i	#116's care kardex (care plan nursing assistant]) lowing: "Float heels."			
	On 3/15/18 at 8:45 a.m. and 9:56 a.m., observations were made of Resident #116. Resident #116 was lying in bed. His heels were not floated.				
	conducted with Res his heels were eleva #116 stated that sta that and he could do	a.m., an interview was ident #116. When asked if ated on a pillow, Resident ff hadn't been telling him to do it himself. Resident #116 k his heels needed it.			
	Predicting Pressure his last assessment	#116's Braden Scale for Sore Risk [3] revealed that was completed on 4/5/17, coded as being at risk for sores.			
	conducted with RN (on the unit. When a plan, RN #2 stated the plan was to serve as resident. RN #2 stated the care plan should should be made to the cannot be followed. also updated with an conditions. When as updating the care plan should the care plan should be made to the cannot be followed.	a.m., an interview was registered nurse) #2, the RN sked the purpose of the care nat the purpose of the care a guide of care for each ed that the care plan was he resident. RN #2 stated be followed or changes he care plan if interventions RN #2 stated the care plan is y change in the resident's ked who was responsible for an, RN #2 stated that unit urses on the unit (floor)			

nurses can update the care plan. RN #2 stated

the care kardex was also updated to

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	RS FUR MEDICARE	& MEDICAID SERVICES	<del> </del>		ON	<u> MB NO. 09</u>	938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495362	B. WING			R-C <b>03/16</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY	STATE ZIP CODE	03/10	72010
				906 THOMPSON STRE			
ASHLAN	D NURSING AND REI	ABILITATION		ASHLAND, VA 2300			
	CHIMALANDV	TEMENT OF PERIORNOIS		<del></del> -			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD I NCED TO THE APPROPR DEFICIENCY)	BE C	(X5) OMPLETION DATE
{F 656}	assistants) any cha nursing aides are al RN #2 was not fami	he CNAs (certified nursing nges. RN #2 stated the so made of changes verbally. liar with Resident #116.	{F 6	56}			
	conducted with CNA #5, Resident #116's CNAs would know will place for each resident measures, CNA #5 a piece of paper or what each resident Resident #116 need protect his skin, CN. have heel boots but When asked the pur #5 stated, "So the histated that she didn' attempted or offered heels that day, CNA #5, was shown Resi confirmed that it inst When asked if Resident rould go check. CNA #5 to Resident observed flat on the On 3/15/18 at 11:00 conducted with LPN Resident #116's nurs of floating heels, LPN to prevent skin break	a.m., an interview was a (certified nursing assistant) aide. When asked how what interventions to put into ent such as skin preventive stated that each resident had kardex that alerted them on needed. When asked if red anything in place to A #5 stated that he used to that they were discontinued. Pose of floating heels, CNA reels don't get red and asked if Resident #116 was a heels floated, CNA #5 think so. When asked if she is to float Resident #116's #5 sated, "No." When CNA dent #116's Kardex, CNA #5 ructed to float his heels. This writer accompanied #116's room. His heels were bed.  a.m., an interview was (licensed practical nurse) #3, see. When asked the purpose of the skin asked if Resident #116 was sated the purpose of the skin asked if Resident #116 was sated the purpose waskdown and to prevent the skin nen asked if Resident #116					

pillow while in bed, LPN #3 stated that his heels

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B WING			0	R-C <b>3/16/2018</b>
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET HLAND, VA 23005		5/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	II D BE	(X5) COMPLETION DATE
	asked if Resident # heels, LPN #3 state floated and I know I nurse." LPN #3 als out of bed often by heels were floated a she was not sure. I check his heels that Resident #116 shou float heels on his cawas on the care plabe followed.  On 3/15/18 at 11:05 Resident #116's hee #3. His heels were On 3/15/18 at 3:19 p conducted with LPN asked if staff were eplan, LPN #7 stated reasons why staff were eplan, LPN #7 stated that if problematic, such as intervention, then the updated to reflect the No further informatic [1] multiple sclerosis nervous system dise	illow if he was in bed. When 116 ever refused to float his ed, "No, his heels are usually because I am the treatment of stated that the resident gets himself. When asked if his at that time, LPN #3 stated LPN #3 stated she did not at day. When asked if all still have an intervention to are plan, LPN #3 stated if it in than the intervention of els was conducted with LPN intact and normal in color.  D.m., an interview was #7, the MDS nurse. When expected to follow the care that they were. When asked ould not follow the care plan, f an intervention becomes a resident refusing an exare plan should be	{F 65	i6}			
	nerve cells. This dan messages between y	rounds and protects your nage slows down or blocks your brain and your body, oms of MS. This information		-			

Health.

was obtained from the National Insitutes of

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OWR NO	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495362	B. WING		į	R-C 3/ <b>16/2018</b>
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40	DANIDONIO AND DEI	LIADU ITATION		906 THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION		ASHLAND, VA 23005		į
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR: X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
(F 656)	Continued From pa	nge 35	{F 65	561		
(1 000)		.gov/multiplesclerosis.html.	\1 OC	,0)		
	to raise the front pa or paralysis of the r result, individuals walong the ground or foot higher than use causes what is called can be unilateral (a (affecting both feet) obtained from The https://www.ninds.m /Foot-Drop-Informa [3] The Braden Sca Sore Risk is a clinionurses and other he score a patient/clier pressure ulcers. 5. The facility staff f	ele for Predicting Pressure cally validated tool that allows ealth care providers to reliably nt's level of risk for developing failed to follow the e plan to ensure Resident				
	11/20/15 with diagn not limited to: diabed dementia, deep vein schizophrenia (any characterized by growithdrawal from sociof thought, language response) (1).  The most recent MI assessment, a quarassessment reference.	admitted to the facility on oses that included but were tes, high blood pressure, in thrombosis (blood clot) and group of mental disorders oss distortions of reality, cial contacts, and disturbances e, perception and emotional OS (minimum data set) rerly assessment, with an ince date of 12/11/17, codeding both short and long-term				

memory difficulties and as being severely

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			D. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495362	B. WING	~ = =======			R-C
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET ILAND, VA 23005	1 0.	3/16/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
	Resident #114 was vision. Resident #11 extensive assistance moving in the bed at The comprehensive documented in part, the potential for injudiabetes, gait/balance "Interventions" documented in part, the potential for injudiabetes, gait/balance "Interventions" documented in part, the potential for injudiabetes, gait/balance "Interventions" documented to use in Observation was made of Resident #114 in the position. There of the bed. The call Resident #114's reach a second observation 9:16 a.m. of Resident mats on each side of on the floor out of Resident was confursing assistant) #1 When asked where a be placed, CNA #1 shed, attached to the light on the floor, is an "They couldn't reach it." When asked plan, CNA #1 stated, the proper care." What to the care plan, CNA #1 stated, the proper care."	ognitive daily decisions. coded as having impaired 14 was coded as requiring e of one staff member for nd transfers.  care plan dated, 1/9/18, "Focus: (Resident #114) has ry r/t (related to) confusion, ce problems." The mented in part, "Be sure the s within reach and encourage t."  ade on 3/14/18 at 11:00 a.m. her bed; the bed was in low were fall mats on each side bell was on the floor, out of	{F 65				

"Yes."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	· ·		DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B. WING			R-C 03/16/2018	
	(EACH DEFICIENC)	HABILITATION  ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	906 TI ASHL	ET ADDRESS, CITY, STATE, ZIP CODE HOMPSON STREET LAND, VA 23005  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
{F 656}	practical nurse) #5 asked why the resistated, "It tells us we provide to the resicular plan should be follow.  An interview was comply marked the care plan is to "Yes." When asked the care plan should stated, "There should stated, "There should stated, and ASM (administrative executive director, and ASM #3, the displacement of the residual provides the care plan should stated.	onducted with LPN (licensed on 3/15/18 at 1:50 p.m. When dents have care plans, LPN #5 that kind of care we are to lents." When asked if the care bwed, LPN #5 stated, "Yes."  onducted with LPN #7, the 5/18 at 3:17 p.m. When asked be followed, LPN #7 stated, if there were any reasons why d not be followed, LPN #7 uld not be."  e staff member) #1, the ASM #2, director of nursing visional director of clinical e aware of the above concern	{F 6	56}			
	Services Provided CFR(s): 483.21(b)(3) Com The services provided as outlined by the comust- (i) Meet professional This REQUIREMED by: Based on observation interview, facility do record review, it was failed to follow professional processional processional professional professio	prehensive Care Plans ded or arranged by the facility, comprehensive care plan, al standards of quality. NT is not met as evidenced ction, resident interview, staff comment review and clinical s determined the facility staff dessional standards for one of survey sample, Resident #110	F 6	58	F658: Services to Pro Professional Stance  1. PICC care and trea obtained 3/15/18 fo #110.  2. Quality review of control resident's with a PIcc completed by the DON/UM/designee physician orders are and followed regard with a PICC withou Follow up based on	tment orders or resident  urrent CC to ensure obtained ling residents t omission.	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0	FORM APPROV 3-0938 NO. 0938	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CO	NSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495362	B. WING				R-C	
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		906 TH	T ADDRESS, CITY, STA IOMPSON STREET AND, VA 23005	ATE, ZIP CODE	03/16/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD D TO THE APPROPE DIENCY)	BE COMPLETI	ON
	order for the care as inserted central cath change the dressing for Resident #110.  The findings include Resident #110 was a 2/17/18 with diagnos limited to: intraspina pressure, diabetes, sknee surgery.  The most recent MD admission assessment referenthe resident as having the BIMS (brief intendicating the resident make daily decisions requiring assistance daily living except for could perform after the resident was coded a medications.  Review of the physicistic signed on 3/7/18 doc per SASH (saline, and). Monitor IV (intravosigns and symptoms and other orders for the PICC.	ed to obtain a physician's and treatment of a peripheral neter (PICC) and failed to g as per professional standard as a per professional standard admitted to the facility on ses that included but were not I abscess (1), high blood sepsis, difficulty walking and as (minimum data set), an	F6	58	physician order and followed with a PICC v.  4. DON/UM/dest quality monitor Morning Clinensure physic obtained and tresidents with omission 5 times weeks, 3x weeks, 3x weeks indicated. Findings to be committee more and followed with the properties of the propertie	I/designee to ensers are obtained regarding reside without omission signee to conductoring through ical Meeting to ian orders are followed regarding a PICC without ness weekly x 2 ekly x 4 weeks, ally and PRN as the reported to QA onthly and updat Quality monitori ified based on	nts  tot  PI ed	

"Flush Per SASH Protocol twice daily 10 cc (cubic centimeters) NS (normal saline) ABT (antibiotic)

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1	TIPLE CONSTRUC	(X3) D	ATE SURVEY OMPLETED	
		495362	B. WING				R-C <b>3/16/2018</b>
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		STREET ADDR 906 THOMPS ASHLAND, N			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUI.L SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EAC	ROVIDER'S PLAN OF COR CH CORRECTIVE ACTION S-REFERENCED TO THE A DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 658	Review of the nurse 3/15/18 did not evice regarding the PICC Review of the notes PICC line site was I symptoms of infection. An interview was coal a.m. with LPN #5, tasked if staff were eplan, LPN #5 stated if a PICC line would stated, "Yes, becauthey could go seption. An observation was Resident #110. A reresident's PICC dregauze with an occlue edges of the occlus detached from the sonot be visualized and dressing. Resident and dressing. Resident and been of stated, "Maybe som remember." LPN #5 resident's PICC dredressing was dated asked when the last changed, LPN #5 stated.	arin." There was no arding monitoring the site for there was no documentation the PICC dressing.  es' notes from 3/4/18 through lence documentation dressing being changed. It is did not evidence that the being monitored for signs and ons on nine occasions.  Inducted on 3/15/18 at 11:00 the resident's nurse. When expected to follow the care It, "It should be." When asked be care planned, LPN #5 se we have to keep it clean or	F	558			

can't help it. No one will wrap it up for me."

A request was made to ASM (administrative staff

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES				——————————————————————————————————————						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) E	DATE SURVEY OMPLETED				
		495362	B. WING			<b>,</b>	R-C				
	PROVIDER OR SUPPLIER  D NURSING AND REI	ABILITATION		906	REET ADDRESS, CITY, STATE, ZIP CODE  THOMPSON STREET  HLAND, VA 23005		3/16/2018				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE				
	1:00 p.m.for evident been changed. ASI evidence that the dr ASM #2 was asked they used.  An interview was co p.m. with LPN #4, they was wasked when I changed, LPN #4 st asked what day LPN When asked how of be changed, LPN #4 why the dressing was "In case it has drains would obtain an order and treatment of a P should. When asked should be noted on it record, LPN #4 state how staff knew wher PICC dressing, LPN On 3/15/18 at approximate the divisional director the facility used Lipp standard.  On 3/15/18 at 6:15 p director, ASM #2, the	cetor of nurses on 3/15/18 at ce that the PICC dressing had what the PICC dressing had what stated there was no essing had been changed, what professional standards and cetor of old control of the picture of clinical services were director of nursing and ASM ctor of clinical services were desired that the professional control of the professional control of the picture of clinical services were cetor of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of clinical services were control of the picture of the pictur	F	558							
(	Catheter Dressing Cl	s policy titled, "Midline nange" documented, he catheter insertion site is a									

potential entry site for bacteria that may cause a catheter-related infection. 2. A transparent

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FORM APPROVED 2039-039 OMB NO.		
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		495362	B. WING	*************			R-C	
	PROVIDER OR SUPPLIER  ID NURSING AND RE	HABILITATION		906	EET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET ILAND, VA 23005		03/16/2018	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE	
F 658	When a transparen sterile gauze dressing and is charpost-insertion or up days. 2.3 If the integrompromised (wet, Assessment of the performed: 5.4 At lein use. 6. Assessment industrial infusion related commot limited to, the all Erythema (redness) or induration, 6.4 Cl site. 6. 5 Tendernes tract. 6.6 Integrity of Numbness or tinglin Procedure: 1. Verify independent practiti	t dressing. Guidance: 2. It dressing is applied over a ing it is considered a gauze anged: 2.1 24 hours on admission. 2.2 Every two grity of the dressing has been loose or soiled). 5. It wascular access site is east once every shift when not ent of entire arm with access device (VAD) for applications is to include, but is posence or presence of: 6.1 In 6.2 Drainage. 6.3 Swelling mange in skin temperature at a state site or along vein at the site or along vein fransparent dressing. 6.7 In physician/license	F 6	58				
	or introduced into the especially the verteb was obtained from: https://www.merriampinal Abscess : a I surrounded by inflan was obtained from: https://www.merriamess	uated within, occurring within, e spinal column and oral canal. This information a-webster.com/medical/intras ocalized collection of pushed tissue. This information a-webster.com/dictionary/abscused to draw blood and give						

treatments, including intravenous fluids, drugs, or blood transfusions. A thin, flexible tube is inserted

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<u> </u>	. to t of t the end to the	T CANAL OF TANAL OF T			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495362	B. WING_		R-C 03/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 658	(threaded) into a lar the heart called the information was obt	per arm and guided rge vein above the right side of superior vena cava. This ained from: gov/publications/dictionaries/c	F 65	i8	
	It is used to decreas blood and help prev developing in blood obtained from:	n injection is an anticoagulant, se the clotting ability of the ent harmful clots from vessels. This information was n.nih.gov/pubmedhealth/PMH	{F 684	1. Resident #117	1:1
	§ 483.25 Quality of care  Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in			discontinued per ph on 3/15/18. Resident #117 r per physician o 3/15/18.	coom changed
	accordance with propractice, the comprecare plan, and the reaction of the reac	fessional standards of shensive person-centered esidents' choices.  T is not met as evidenced on, staff interview, facility d clinical record review, it facility staff failed to provide in accordance with d of practice and the on-centered care plan for		2. Quality review residents complete DON/UM/design ensure physicial followed for reservations 1:1 sure Follow up based Quality review of residents complete DON/UM/design ensure physicial followed for reservations a room	letted by the gnee to n orders are sidents upervision. d on findings. of current letted by the gnee to n orders are sidents

Follow up based on findings.

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CENTE	RS FOR MEDICARE	FORM APPROVIDED OMB NO. 0938-0						
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1 ' '	TIPLE CONSTRUCT			(X3) DATE SURVEY COMPLETED	
		495362	B. WING				R-C 03/16/2018	
	PROVIDER OR SUPPLIER  ND NURSING AND REI			906 THOMPSOI	N STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH	OVIDER'S PI CORRECT REFERENC	LAN OF CORRECTION IVE ACTION SHOULD IVED TO THE APPROP FICIENCY)	DBE COMPLETION	
	and failed to have F prescribed room.  The findings include Resident #117 was 2/9/18 with a recent diagnoses that incluvascular dementia, stroke, diabetes, depressure.  The most recent ME assessment, an adrassessment referent resident rarely undemaking herself undecoded as having both memory difficulties. having the following back period; physical directed towards oth symptoms directed the symptoms directed towards oth symptoms directed towards oth symptoms directed towards oth symptoms directed towards oth symptoms directed towards oth symptoms directed towards oth symptoms directed towards oth symptoms directed towards oth symptoms directed towards other activity of the physician order "Place resident on 1: moved to (room #) B.  There were no further	exision per the physician order Resident #17 in a physician  e:  admitted to the facility on a readmission on 3/13/18 with uded but were not limited to: abnormal gait and balance, expression, and high blood  DS (minimum data set) mission assessment, with an accedate of 2/16/18 coded the exstanding others and rarely erstood. The resident was of sheaviors during the look all behavioral symptoms hers, verbal behavioral towards other, and other as not directed towards others atching pacing, rummaging or oms like screaming and Resident #117 was coded as sistance of one staff member rities of daily living.	{F 68	34}	4. DO conthro Mee orde rega a roo	censed nurses reached the DON/UM/garding ensuring ders are followed garding resident the DON/UM/garding ensuring ders are followed garding resident garding resident garding resident garding resident goom change.  ON/UM/designed and the properties are followed arding residents supervision 5 x weeks, 3x weekly leks, then 2 x weeks, th	designee g physician ed ts requiring e-educated designee g physician ed s requiring e to conitoring Clinical physician d s requiring t weekly x y x 4 eekly and eto nitoring clinical physician requiring weekly x	

back to (room #) A.

one to one and no order to move Resident #117

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES						D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495362	B. WING			ļ	R-C <b>3/16/2018</b>
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		906 TH	T ADDRESS. CITY, STATE, ZIP CO HOMPSON STREET LAND, VA 23005	ODE 1 US	5/10/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	dates and times. A process was Reside one to one supervis made of the resider - 3/14/18 at 2:15 p. observed in the hall - 3/14/18 at 4:30 p. observed in the hall by a friend 3/15/18 at 8:08 a. observed walking in wearing a shirt and intervened) 3/15/18 at 9:43 a. observed sitting on - 3/15/18 at 10:00 a wheelchair being pu activities staff member wheelchair to ou (room #A) 3/15/18 at 10:20 a bed. LPN (licensed observed talking to to cautioning her to not was wet (floor had ju housekeeping) 3/15/18 at 12:58 pobserved in her roor #117 was in a wheel The nurse's note dat documented in part, roommate racial rem Resident and roomm Residents were imm	observed at the following to no time during the survey ent #117 observed to be on ion. All observations were at being in (room #) A.  m. Resident #117 was in a wheelchair.  m. Resident #117 was in a wheelchair being pushed ent.  m. Resident #117 was in a wheelchair being pushed ent.  m. Resident #117 was the hall, very unsteady and briefs. (staff member ent. Resident #117 was in a shed by another resident. An over pushed Resident #117 in the side the door to her room ent.  m. Resident #117 was in her practical nurse) #7 was the resident from the doorway it get up because her floor ist been cleaned by  m. Resident #117 was in her practical nurse) #7 was the resident from the doorway it get up because her floor ist been cleaned by  m. Resident #117 was in Nesident #117 was in Nesident #117 was in Nesident #117 was in Resident #117 was in R	{F 68	34}	weeks, then 2 x PRN as indicate Findings to be re QAPI committe and updated as Quality monitor modified based 5. Date of Complia	ed. eported to ee monthly indicated. ring schedule on findings.	

Resident became aggressive pushing writer, hitting writer and pulling clothes of writer. MD

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CENTE	42 LOK MEDICAKE	& MEDICAID SERVICES				OMR M	<u>0. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION		OATE SURVEY OMPLETED
		495362	B. WING			0	R-C <b>3/16/2018</b>
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STR	EET ADDRESS, CITY, STATE, ZIP CODE		0/10/2010
				906	THOMPSON STREET		
ASHLAN	D NURSING AND RE	HABILITATION		ASF	HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
{F 684}	made (aware) of th	nd RP (responsible party) is."	{F 68	34}			
	The nurse's note dated, 3/11/18 at 4:00 p.m. documented in part, "Resident continues on 1:1."						
	The nurse's note dated, 3/11/18 at 10:00 p.m. documented in part, "Continue 1:1."						
		11:00 p.m. to 7:00 a.m.) tietly. No c/o (complaints of) tinues."					
	There was no furthenurse's notes of the	er documentation in the 1:1 supervision.					
	treatment administr	ministration record and the ration record for March 2018 ocumentation of the 1:1					
	revised on 3/15/18, Potential for impaire r/t (related to) diagn AEB (as exhibited by wandering, throwing to floor, and combaryelling, exit seeking meet her parents, no assistive devices, rewithout needed sup documented in part, underlying medical in psychosocial state. Encourage resident appropriate manner	e care plan dated, 2/21/18 and documented in part, "Focus: ed or inappropriate behaviors to sis anxiety and depression by): yelling, screaming, crying, g self backward on bed, sliding tive at times punching, asking for rides so she can oncompliant with use of esident desired to leave facility ervision." The "Interventions" and assess behaviors for causes. Assess for changes us and/or environment. To express feelings in a fresident, is violent, give resident time to calm					

down. Do not approach until resident is calmer.

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			FORM APPROVE
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	
ASHLAN	ND NURSING AND RE	HABILITATION		906 THOMPSON STREET	
				ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLETION ED TO THE APPROPRIATE DATE ICIENCY)
	behavior and report Provide calm, quiet agitation or violent to inappropriate behave sources of agitation resident from the area. An interview was controlled practical nurse, asked if Resident #1 supervision, LPN #3 was shown the purpose when asked why should have to check the was on one to one with her roommate." She was in on Monday, to one asked me wholl would have to check the was on one to one with her roommate. The was in on Monday on duty, LPN #3 state was told by administration the one to one any lower was an order to discourse.	e in behaviors or unsafe to physician prn (as needed). environment during periods of pehavior. Redirect viors as needed. Remove as possible. Remove the ea."  Inducted with LPN (licensed on 3/15/18 at 1:13 p.m. When 17 was on one to one stated, "Right now, no." LPN hysician order dated 3/11/18, he was not on one to one, as off the weekend and when I the aide assigned to the one o was relieving her. I told her ext. The night nurse told me ne because she got into it When asked which room any morning when she came ed, "She was in (room #) A. I ration that she didn't need onger." When asked if there ontinue the one to one or a	{F 68	4}	
,	able to come off one stated, "I don't see or a physician order to le her original room (root I haven't seen one."  An interview was constaff member (ASM) is	lains why and when she was to one supervision, LPN #3 ne." When asked if there was et Resident #117, go back to om #) A, LPN #3 stated, "No, ducted with administrative #2, the director of nursing, n. When asked if there is an			

order for one to one supervision and no order to discontinue it, should the resident still be on one to one supervision, ASM #2 stated, "Yes." When asked if there is an order for a resident to be

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OLIVIE.	TO TOTT MEDICALL	E & MEDIO, ND OELLIVIOES			OND NO. 0330-0331
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		405000			R-C
		495362	B. WING	<i>3</i>	03/16/2018
	PROVIDER OR SUPPLIEF  ID NURSING AND RI			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION SHO	ULD BE COMPLETION
{F 684}	change rooms, where in, ASM #2 star written for." When room was Resider "(Room #) A." When Monday, was Ressupervision, ASM of."  During an interview director, on 2:58 psurveyor Resident when she entered approximately 7:30	room and no further orders to nich room should the resident ted, "In the room the order was you came in on Monday, which at #117 in, ASM #2 stated, en asked when she came in on ident #117 on one to one #2 stated, "Not that I'm aware w with ASM #1, the executive .m. ASM #1 informed this #117 was not on one to one the building on 3/12/18 at 0 a.m.	{F 6	684}	
	In "Fundamentals Patricia A. Potter a Inc.; Page 419. "T directing medical tobligated to follow believe the orders clients."  The executive director of divisional director of the state of	"Physician Orders" did not follow the physician orders.  of Nursing" 6th edition, 2005; and Anne Griffin Perry; Mosby, the physician is responsible for reatment. Nurses are physician's orders unless they are in error or would harm of clinical services were made a finding on 3/15/18 at 6:15		F689: Free From and Hazards/Superviol 1. Identified non-power strips remarks the patient vicin 7 feet above and	sion/Devices medical grade moved from hity defined as
		nts.	{F 68	around the resid	lent bed on 3- stic bags on top of

3-14-18

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	E & MEDICAID SERVICES			FORM APPROVE
ICIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
white was a second	495362	B. WING		R-C 03/16/2018
R OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,10,2010
SING AND RE	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
ACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOT	ILD BE COMPLETION
25(d)(1) The e of accident a of accident a of accident a color of	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent.  It is not met as evidenced ion, staff interview and facility as determined the facility staff ver strips were safely installed 11 of 179 occupied beds.  In additional to the patient vicinity, seven feet above the bed and bed.  It is not met as evidenced ion, staff interview and facility staff ver strips were safely installed 11 of 179 occupied beds.  In additional to the patient vicinity, seven feet above the bed and bed.  It is not met as evidenced into 179 occupied beds	{F 68	2. Quality review of the ED/DON/IDT/M Director/designer non-medical grastrips are not used patient vicinity of feet above and 6 the resident bed. based on findings M& M Solutions of Electrical Reconcurrent residents' initiated 3-15-18. Quality review conthe ED/DON/IDT/Ma Director/designee objects and plastic not on top of and/opower strips. Follows.	faintenance e to ensure de power d within the efined as 7 feet around Follow up s. Instillation eptacles in rooms empleted by sintenance to ensure bags are or around ow up
	R MEDICARE  R OR SUPPLIER  SING AND RE  SUMMARY STA ACH DEFICIENCY GULATORY OR L  Dued From pa 25(d)(1) The re of accident  25(d)(2) Each vision and assents. EQUIREMEN  d on observat rentation, it was rentation, it was rentation, it was rentation and assents. EQUIREMEN  dion observat rentation and assents. EQUIREMEN  dion observat rentation was rentation in rentation rentation was rentation in rentation rentation was rentation in rentation rentation was rentation was rentation in rentation rentation was rentation was rentation was rentation was rentation was rentation was rentation was rentation was rentation in rentation rentation in rentation rentation was rentation in rentation rentation in rentation rentation in rentation rentation in rentation rentation in rentation rentation in rentation rentation in rentation rentation rentation in rentation rentati	R MEDICARE & MEDICAID SERVICES  ICIENCIES  I	R MEDICARE & MEDICAID SERVICES  ICIENCIES ICIE	R MEDICARE & MEDICAID SERVICES  ICIENCIES  I

connected to it.

resident's telephone charger and phone were

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING			R-C <b>03/16/2018</b>
NAME OF I	PROVIDER OR SUPPLIER			STRE	EET ADDRESS. CITY, STATE, ZIP CODE	
ASHLAN	ND NURSING AND REI	HABILITATION			THOMPSON STREET ILAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
{F 689}	p.m. with OSM (oth director of maintenaresidents have powers can't, we can only of a patient area." Vootained that inform fire Marshall." OSM getting more outlet building was built was available room was power strip in room OSM #2 stated it was struggle because was When asked what power strips vootated, "We have a weekly so the whole month." When asked what power strips, OSM # inventory them but the became aware the power strips had to bed, OSM #2 stated, "Dedid not pass the first "No." When asked vnon-medical grade ponder strips when asked vnon-medical grade ponder strips had to bed, OSM #2 stated, "Dedid not pass the first "No." When asked vnon-medical grade ponder strips had to be when the osm #2 stated, "Dedid not pass the first "No." When asked vnon-medical grade ponder strips had to be when the osm #2 stated, "Dedid not pass the first "No." When asked vnon-medical grade ponder the whole was the first "No." When asked vnon-medical grade ponder the was the first "No." When asked vnon-medical grade ponder the was the first "No." When asked vnon-medical grade ponder the was the first "No." When asked vnon-medical grade ponder the was the first "No." When asked vnon-medical grade ponder the was the first "No." When asked vnon-medical grade ponder the was the first "No." When asked vnon-medical grade ponder the was the was the first "No." When asked vnon-medical grade ponder the was the first "No." When asked vnon-medical grade ponder the was the	age 49 conducted on 3/14/18 at 4:00 her staff member) #2, the hance. When asked could wer strips, OSM #2 stated, "We use the hospital grade ones. hes we can use within six feet When asked where he mation, OSM #2 stated, "The M #2 stated, "We're working on he space because when this he had the crank beds."  conducted on 3/14/18 at 4:05 and two surveyors. Each he had two surveyors. Each he had the crank beds."  conducted on 3/14/18 at 4:05 and two surveyors. Each he had the crank beds."  conducted on 3/14/18 at 4:05 and two surveyors. Each he have families bring them in." he process they had to check to he have families bring them in." he program that we do (a unit) he building is done each he how they were tracking he be six feet from the resident's he fire marshal came back. he fire marshal came back, he cember." When asked if they have tinspection, OSM #2 stated, he what could be plugged into he power strips, OSM #2 stated, he what could be plugged into he vices could be plugged into	{F 68	39}	3. ED and Mainter educated by the regarding ensur medical grade pare not utilized vicinity defined above and 6 fee resident bed.  Current staff rethe ED/DDCS/I Director/design non-medical grastrips are not ut patient vicinity feet above and the resident bed notification to tet ED/Maintenance the time observed Current staff rethe ED/DDCS/I Director/design objects and plast not on top of an power strips.	ing non- cower strips in the patient I as 7 feet et around the  -educated by Maintenance ade power tilized in the defined as 7 6 feet around I with the the Director at ededucated by Maintenance ee to ensure

non-medical grade power strips, OSM #2 stated, "No." When asked what was considered a medical device, OSM #2 stated, "The bed,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405000				R-C	
		495362	B. WING			03/16/2018	
	PROVIDER OR SUPPLIER  D NURSING AND RE	\ HABILITATION		ĺ	RESS, CITY, STATE, ZIP CODE  SON STREET  VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EA	ROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
{F 689}	When asked if ther trash bags or clothe OSM #2 stated, "M were any other haz response.  The following room and the two surveyor power strips within medical devices plus 103 A non-medic plugged into it. Nex 107 B non-medic clear trash bag part was laying on top or 109 A a non-medic plugged into another strip with the bed plugged into another strip with the bed plugged into it. 117 A a bag of clemedical grade power 118 B a non-medical bed plugged into it. 123 A non-medical bed plugged into it, 127 B tube feedin non-medical power 129 A -	ors, tube feeding machines." e was any hazard to having as on top of a power strip, oisture." When asked if there ards, OSM #2 didn't have a swere observed by OSM #2 ors to have non-medical grade the patient care vicinity and agged in to some of them:  all grade power strip with bed to the bed. all grade power strip with a ially filled with white objects it. Next to the bed. ical grade power strip was er non-medical grade power sugged into it. Next to the bed. of extension cord with the echarger plugged into it. Next othes was lying on top of a er strip. Next to the bed. ical grade power strip with the Next to the bed. all grade power strip next to the bed. all grade power strip next to all grade power strip next to all grade power strip with the behind the bed. g pump plugged into bed A's	{F 6		ED/DON/IDT/designee conduct random quality monitoring through mod survey rounds ensuring medical grade power strare not used within the pricinity defined as 7 fee above and 6 feet around resident bed daily x 4we 5 times weekly x 2 weeks twice weekly then PRN indicated. ED/DON/IDT/designee conduct random quality monitoring through mod survey rounds ensuring objects and plastic bags not on top of and/or around power strips daily x 4we 5 times weekly x 2 weeks twice weekly x 2 weeks twice weekly x 2 weeks times weekly x 2 weeks twice weekly then PRN indicated. Findings to be reported QAPI committee month updated as indicated. Quantitoring schedule mobased on findings.	ck non- ips patient t the eeks, ks, 4 then as to ck are und eeks, ks, 4 then as to ly and jality	
	the bed. 214 A non-medica	al grade power strip with the connected to it. Next to the		5	. Date of compliance 4-1	5-18.	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) C	DATE SURVEY COMPLETED
		495362	B. WING	3		R-C 03/16/2018
	PROVIDER OR SUPPLIER  ID NURSING AND REI	HABILITATION		STREET ADDRESS, CITY, STATE, 906 THOMPSON STREET ASHLAND, VA 23005	, ZIP CODE	33/10/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
{F 689}	An interview was cop.m. with LPN (licer When asked what of strip, LPN #5 stated When asked what president had a non-their room, LPN #5 know." They can't bonly medical things, strip could not be us it hasn't been tested any hazard to leaving	edical grade power strips were	{F 68	89}		
	a.m. with ASM (adm the executive director nursing, ASM #3, the services and OSM # maintenance. ASM # came in October and strips." ASM #1 state accepted the plan of completed in October this surveyor an emathe corporate director stated that non-medible used in the reside devices as long as the care vicinity that was inches above the bed. A request for a device the corporate of the care vicinity that was inches above the bed.	inducted on 3/15/18 at 8:50 inistrative staff member) #1, or, ASM #2, the director of elivisional director of clinical 2, the director of #1 stated, "The fire marshal dive didn't clear on the powered the fire marshal had correction, which would be en of 2018. OSM #2 showed will dated February 2018 from or of maintenance. The email cal grade power strips could ent's room for resident ney were not in the patient defined as seven feet six d and six feet around the copy of the email was made not received. OSM #2 stated,				

"Families bring them in all the time. So we don't have enough plugs in the rooms for all of the

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B. WING				R-C <b>3/16/2018</b>
NAME OF	PROVIDER OR SUPPLIER		1	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	!	3/10/2010
A CI II A N	ID NII IDGING AND DE				THOMPSON STREET		
ASHLAN	ID NURSING AND RE	HABILITATION		ASF	HLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 689}	asked since he was power strips what p implement to preve within six feet of the response. When as developed and imp devices were plugg strips, OSM #2 had there was any haza clothes on the power "Fire."  Review of the life sid dated 12/20/17 doc Life Safety Code reconducted on 10/30 12/20/17The facili	so we use power strips." When a ware that families brought in all of the develop and the power strips from being to bed, OSM #2 did not have a sked what plan he had demented to ensure medical ed into medical grade power no response. When asked if ard in having trash bags and the strips, ASM #1 stated,  aftety code initial comments to the standard survey with the standard survey with the standard with the	{F 6	89}			
	Requirements for P Medicald.	articipation Medicare and		-			
	No turther informati	on was provided prior to exit.	-				
	99), (1) NFPA define portion of a health of are intended to be e- equipment intended areas-which include treatment rooms, as	lealth Care Facilities (NFPA es a patient care area as "any are facility wherein patients examined or treated." For to be used within these patient, examining, and well as any similar areas in					
	with electrical device	likely to come into contact es-NFPA specifies that rents should not exceed 300					
	microamperes. (Not from the pre-1993 li However, NFPA doe certain conditions; fo	e that this limit was increased mit of 100 microamperes.) s permit exceptions under or example, leakage currents eres are permitted if the					

leakage current does not represent a hazard to

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING	1	R-C
NAME OF	PROVIDER OR SUPPLIER	13332		STREET ADDRESS, CITY, STATE, ZIP CODE	03/16/2018
				906 THOMPSON STREET	
ASHLAN	ID NURSING AND REI	HABILITATION		ASHLAND, VA 23005	
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{F 689}	remains intact. Also equipment that will 500 microamperes, leakage current red	ge 53 e grounding connection b, when chassis leakage from be used in the area exceeds NFPA permits the use of uction methods, such as transformer or redundant	{F 6	89}	
	requires that any explacement near the requirements. NFPA patient as the patient defines as "a space the examination and extending 6 ft (1.8 not the bed, chair, the patient [and] above the floor." For space, NFPA require between conductive reference grounding (NFPA established the vicinity so that the examination was obtained from: http://www.mdsr.ecrc_id=8286 Laboratory Services CFR(s): 483.50(a) (1) The falaboratory services the residents. The facility and timeliness of the (i) If the facility provides	y(i)  ory Services.  original action of the control	F 7	F770: Laboratory Sec.  1. Resident #113 CM2 per physician order on 2. Quality review of concession of the laboratory of the laboratory to the laboratory to obtained per physician of the laboratory to obtained per physician per physician of the laboratory to obtain the laboratory the laboratory to obtain the laboratory t	P obtained 3/15/18. urrent ast 30 the e to ests are cian order.

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		495362	B. WING	<i>i</i>			03/16/2018		
NAME OF F	PROVIDER OR SUPPLIER			1		CITY, STATE, ZIP CODE			
ASHLAN	ID NURSING AND RE	HABILITATION		1	06 THOMPSON ST SHLAND, VA 23				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ſΧ	(EACH COR	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 770	of this chapter. This REQUIREMENT by: Based on staff intered and clinical record of facility staff failed to the physician orders survey sample, Resident survey sample, Resident facility staff failed (comprehensive me physician for Resident facility staff failed (comprehensive me physician for Resident facility staff failed (comprehensive me physician for Resident facility stroke, contractures pressure, elevated to dementia with behavior and the facility stroke, contractures pressure, elevated to dementia with behavior stroke, contractures pressure, elevated to dementia with behavior stroke, contractures pressure, elevated to dementia with behavior stroke, contractures pressure, elevated to dementia with behavior stroke, contractures pressure, elevated to make daily cognitives to make	boratories specified in part 493  NT is not met as evidenced erview, facility document review review, it was determined the pobtain a laboratory test per so for one of 18 residents in the sident #113.  Ided to obtain a CMP etabolic panel) ordered by the lent #113.  The e:  The admitted to the facility on mission on 2/26/18, with uded but were not limited to:  So diabetes, high blood fats in the blood, and vascular exioral issues.  DS (minimum data set) mission assessment, with an ince date of 2/13/18, coded the both short and long-term and being severely impaired itive decisions. The resident ent on one or more staff his activities of daily living.  In dated, 3/11/18, documented, Metabolic Panel (CMP) is used	-	770	4.	Licensed nurses reby the DON/UM/de ensuring laboratory obtained per physic Licensed nurses reby the DON/UM/de ensuring residents orders for laborator are documented on Hour Report.  DON/UM/designee conduct quality mothrough Morning Conduct qual	esignee y tests are cian ordereducated esignee with ry tests the 24  e to onitoring Clinical aboratory oer x weekly x y x 4 bekly and  to nitoring linical esidents oratory ed on the x weekly x y x 4 ekly and		
		ng tool to evaluate organ				and updated as indic	-		

function and check for conditions such as diabetes, liver disease, and kidney disease. The

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495362	B. WING		R-C
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND RE	HABILITATION		STREET ADDRESS. CITY. STATE, ZIP COD 906 THOMPSON STREET ASHLAND, VA 23005	<b>03/16/2018</b> E
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
conditions, such as people taking specior liver-related side interested in following components, she makes a special section of the components, she makes a special section of the test results for the test results for the test results for the test results for the test results for the test results for the test results for the test results for the test results for the test results for the test results for the laboratory testing.  An interview was compractical nurse) #3 was shown the pand asked to locate she would get back LPN #3 was asked in LPN #3 stated, "I'm now." At 1:07 p.m., I and stated that she had lab results for 3 of birth didn't match for Resident #113. It ordered the lab to be (Immediate)." When performed per the plastated, "No, Ma'am."  The executive direct divisional director of	ordered to monitor known hypertension, and to monitor hypertension, and to monitor ific medications for any kidney-effects. If a doctor is ng two or more individual CMP nay order the entire CMP ore information. (1)  all record failed to evidence he CMP.  care plan dated, 2/6/18, occumentation related to enducted with LPN (licensed on 3/15/18 at 11:30 a.m. LPN hysician order for the CMP the results. LPN #3 stated, with this writer. At 11:40 a.m., f she had found anything, calling the lab (laboratory) LPN #3 returned to this writer had contacted the lab. They /10/18 but the name and date the name and date of birth LPN #3 stated, "We just a completed STAT asked if the test was hysician order, LPN #3	F 7	Quality monitoring s modified based on fi 5. Date of Compliance	ndings.

No further information was provided prior to exit.

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		495362	B. WING		R-C <b>03/16/2018</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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AUTE	D NORSING AND IL.	TABLETATION	/	ASHLAND, VA 23005	
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F 773	Continued From pa	э <b>ае</b> 56	F 773	· · · · · · · · · · · · · · · · · · ·	
	•	an Order/Notify of Results	F 773		
	CFR(s): 483.50(a)(		1 110	ı	
	ordered by a physic practitioner or clinic accordance with Stapractice laws.  (ii) Promptly notify the physician assistant, nurse specialist of the outside of clinical rewith facility policies notification of a prace physician's orders. This REQUIREMEN by:  Based on staff interested and clinical record of facility staff failed to prior to obtaining a law 18 residents in the second of the findings included the findings included Resident #111 was a 7/10/15 with diagnost limited to: diabetes, disease, irregular he and falls.	In laboratory services only when cian; physician assistant; nurse cal nurse specialist in tate law, including scope of the ordering physician, and the ordering physician, and the ordering physician, and the ordering results that fall eference ranges in accordance and procedures for actitioner or per the ordering obtain a physician's order laboratory specimen for one of survey sample, Resident #111.  The ded to obtain a physician's thensive metabolic panel 3/8/18 for Resident #111.		E773: Lab Services/Physician/Notify Results  1. Resident #111 CMP ob per physician order 3/08/13 2. Quality review of curreresidents over the last days completed by the DON/UM/designee to ensure laboratory tests obtained per physician Follow up based on fir  3. Licensed nurses re-edu by the DON/UM/designensuring laboratory test obtained per physician Licensed nurses re-edu by the DON/UM/designensuring residents with orders for laboratory to are documented on the Hour Report.	otained 8. ent 30 s are n order. ndings. ncated gnee sts are n order. ucated gnee h ests

annual assessment, with an ARD (assessment reference date) of 12/14/17 coded the resident as

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CON	(X3) DATE SURVEY COMPLETED	
		495362	B. WING			R-C 03/16/2018
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		906 TH	ADDRESS, CITY, STATE, ZIP CODE OMPSON STREET AND, VA 23005	
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F 773	interview for menta was cognitively inta The resident was of from staff for all act exception of eating perform after the track. Review of the care revised on 1/9/18 d resident is at risk for cardiac outputInterview of the clinic resident had a complysician of results. Review of the clinic resident had a complysician of the physician of the	out of 15 on the BIMS (brief I status) indicating the resident act to make daily decisions. oded as requiring assistance tivities of daily living with the which the resident could ay was set up.  plan initiated on 1/30/17 and ocumented, "Focus. The or bleeding and decreased erventions. Monitor labsens) as ordered and notify the	F 7		4. DON/UM/designee to conduct quality monito through Morning Clinic Meeting ensuring labor tests are obtained per physician order 5 x week 4 weeks, 3x weekly x 4 weeks, then 2 x weekly PRN as indicated. DON/UM/designee to conduct quality monitor through Morning Clinic Meeting ensuring reside with orders for laborato tests are documented or 24 Hour Report 5 x week 2 weeks, 3x weekly x 4 weeks, then 2 x weekly PRN as indicated. Findings to be reported to QAPI committee month and updated as indicated Quality monitoring schemodified based on findings. Date of Compliance 4-1:	cal ratory ekly x and ring cal ents ory the ekly x and to ally d. edule ngs.

On 3/15/18 at 6:15 p.m. ASM #1, the executive director, ASM #2, the director of nursing and ASM #3, divisional director of clinical services were

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED
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		495362	B. WING				03/16/2018
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION				STREET ADDRES 906 THOMPSON ASHLAND, VA	STRE		
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F 773	Continued From pa		F 7	73	T-84	00 7	
	Diagnostic and X-R provide guidance o documenting and rand x-ray results. Porder for laboratory x-ray."  No further informatic Routine/Emergency CFR(s): 483.55(a)( §483.55 Dental seroutine and 24-hour \$483.55(a) Skilled It A facility- §483.55(a)(1) Must outside resource, in §483.70(g) of this p dental services to more sident;  §483.55(a)(2) May additional amount for dental services;  §483.55(a)(3) Must circumstances where dentures is the facilic charge a resident for the services of the facilic charge a resident for the services of the facilic charge a resident for the services of the facilic charge a resident for the services of the facilic charge a resident for the services of the facilic charge a resident for the services of the facilic charge a resident for the services of the services of the facilic charge a resident for the services of the serv	ty's policy titled, "Laboratory, tay" documented, "Policy: To n ordering, obtaining, eporting laboratory, diagnostic procedure: Obtain a physician's work, diagnostic testing, and fon was provided prior to exit. (Dental Srvcs in SNFs 1)-(5)  vices. sist residents in obtaining remergency dental care.  Nursing Facilities  provide or obtain from an accordance with with art, routine and emergency neet the needs of each charge a Medicare resident and routine and emergency have a policy identifying those in the loss or damage of dity's responsibility and may not or the loss or damage of din accordance with facility	F 79	90	2.	Resident #116 de obtained per phys on 3/15/18. Dent scheduled 3/28/18 Quality review of residents complet DON/UM/design ensure residents r dental consult per order. Follow up findings. Quality review of residents complet DON/UM/designe ensure residents of residents complet DON/UM/designe ensure residents complet DON/UM/designe ensure residents complet DON/UM/designe ensure residents of evaluation is curre policy. Follow up findings.  Licensed nurses reby the DON/UM/densuring residents dental consult per order.  Licensed nurses reby the DON/UM/densuring residents evaluation is curre policy. Follow up findings.	ntal consult sician order al visit 8.  current ed by the ee to eccives a physician based on  current ed by the ee to oral status ent per o based on  ceducated designee receive a physician educated designee oral status ent per oral status ent per educated designee receive a physician educated designee oral status ent per

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		495362	B. WING				R-C <b>03/16/2018</b>	
	OVIDER OR SUPPLIER	HABILITATION		906	EET ADDRESS, CITY, STAT THOMPSON STREET HLAND, VA 23005	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPE	BE COMPLETION	
§4 as (i) (iii de §4 re de 3 w an se le tr by de de se TI Re 10 no di Th wi ha	ssist the resident; In making appoin By arranging for ental services local 483.55(a)(5) Must esidents with lost of ental services. If a days, the facility r hat they did to ental drink adequate ervices and the ex d to the delay, his REQUIREMEN estermined that the ental services for curvey sample.  acility staff failed the ervices for Reside the findings include the findings include esident #116 was 0/20/15 with diagn of limited to: stroke abetes, depression the most recent Milith an ARD of 2/5/ eaving short-term a coblems and sever	if necessary or if requested, intents; and transportation to and from the ation; and promptly, within 3 days, refer or damaged dentures for a referral does not occur within must provide documentation of sure the resident could still eatily while awaiting dental itenuating circumstances that NT is not met as evidenced tion, staff interview, facility cal record review, it was a facility staff failed to provide one of 18 residents in the	F	790	ccithe More place with More cuithe More with More cuithe More cuit	weeks, 3x weeks, then 2 x RN as indicated. ON/UM/design on the conduct quality trough Morning to ensure the conduct explainment per police with the committed and the committed dupdated as a lity monitor odified based.	y monitoring ng Clinical sure residents al consult per r 5 x weekly x eekly x 4 x weekly and ed. gnee to y monitoring ng Clinical ure residents uation is icy 5 x eks, 3x eks, then 2 x N as reported to ee monthly indicated. ring schedule	

staff for all activities of daily living.

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		495362	B. WING	<u> </u>	R-C <b>03/16/2018</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	
				906 THOMPSON STREET	
ASHLAN	D NURSING AND RE	HABILITATION		ASHLAND, VA 23005	
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F 790		al MDS with an ARD of	F7	790	
broken natural tee An observation wa	bvious or likely cavity or				
	a.m. of Resident # a recliner in the hal and his mouth was were two teeth brokgums were reddene the area. There we which had food debt	s made on 3/14/18 at 10:40 116. The resident was lying in way. His eyes were closed open. In the lower jaw, there een to the gum line and the ed and slightly swollen around re approximately seven teeth, ris, a greenish/gray substance eeth, and the teeth had black			
	and revised on 11/7 (Name of resident) nutrition r/t (related ProblemResident Interventions. Monit (medical doctor) PF and symptoms) of cattention. Pain (gum Abscess, Debris in				
	a.m. with LPN (licen resident's nurse. WI follow if a resident h stated, "If they're vo hurts." When asked LPN #4 stated, "Nor done. The CNA (cer	nducted on 3/15/18 at 9:30 sed practical nurse) #4, the nen asked the process staff as dental issues, LPN #4 cal they can verbalize if it how teeth were checked, mally when mouth care is tified nursing assistant) would d what types of issues the			

CNA would report, LPN #4 stated, "If they're loose

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	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C 03/16/2018
		HABILITATION  TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005 PROVIDER'S PLAN OF CORRECT	ION (VS)
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION OPRIATE DATE
F 790	or painful." When a were broken or had stated, "I'd check th (responsible party) asked if there were broken teeth, LPN # other health issues. Resident #116's mo upper teeth, one too with a deep black of front of the lower jay the front of the lower	sked what staff did if the teeth obvious cavities, LPN #4	F 7	90	
	a.m. with CNA (certi resident's aide. Whe conducted, CNA #8 to make sure they're I try to wet his mouth When asked what si	nducted on 3/15/18 at 10:45 fied nursing assistant) #8, the en asked how oral care was stated, "First of all you have e not NPO (nothing by mouth). In first and brush his teeth." taff look for while doing e stated, "If the teeth are			

An interview was conducted on 3/15/18 at 11:05 a.m. with ASM #2, the director of nursing. When asked what was expected of staff regarding dental issues, ASM #2 stated, "What I would expect is it to be identified on admission and then everyday when assisting the resident with mouth care." When asked how residents obtained dental services, ASM #2 stated, "This would an all depends situation. We would ask the family if they had a dentist. If not we would work with them

to find a dentist." ASM #2 was asked to examine

broken, if the teeth are rotting." When asked if Resident #116 had broken and rotting teeth, CNA #8 stated, "Yes. I told them. They told me they were aware and to make sure to still perform oral

care on him."

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		495362	B. WING		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005	
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F 790	hmm, I see." ASM a consult or a corphysician about the ASM #2 stated, "I on consult." Whe documentation at #2 stated, "No."  On 3/15/18 at 6:1 director, ASM #2, #3, divisional director and a ware of the consult.	mouth, ASM #2 stated, "Um M #2 was asked if there was ever oversation with the family or the care of Resident #116's teeth. Let me look into that."  15 p.m. ASM #2 stated, "There's in asked if there was any pout the resident's teeth, ASM in the director of nursing and ASM into the ctor of clinical services were the findings.	F 7	Procurement/Store Prepare/Serve  1. Identified OSM educated by the regarding how to wear a hair net food form the so Identified CNA educated by the regarding serving residents in a sa manner. Resident identified 2567 did not su	#1 re- ED to properly when serving team table. #10 re- ED ng food to unitary fied in the ffer any
	Food Procurement CFR(s): 483.60(i) Food some facility must see \$483.60(i) (1) - Properties of local authority from local product and local laws or (ii) This provision facilities from using gardens, subject safe growing and (iii) This provision from consuming from consuming from consuming from facilities from using safe growing and (iii) This provision from consuming from consumi	cafety requirements.  ocure food from sources idered satisfactory by federal, norities. de food items obtained directly ers, subject to applicable State	F8	adverse effects served in the di 3/15/18.  2. Quality review kitchen/steam t meal service co the ED/Dietary (DM)/ designed hair nets are wo when serving fo steam table. Fo indicated. Quality review service comple ED/DON/IDT/ensuring food i residents in a sa manner. Follow indicated.	of the able during mpleted by Manger to ensure orn properly bod from the able was of meal ted by the designee is served to enitary

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI B. WING	1.	X3) DATE SURVEY COMPLETED R-C
	493302	D. WING		03/16/2018
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHLAND NURSING AND REHABILITATION			906 THOMPSON STREET ASHLAND, VA 23005	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	

#### F 812 Continued From page 63

standards for food service safety.
This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review, and in the course of a complaint investigation, the facility staff failed to serve food in a sanitary manner for one of two dining rooms (the main dining room).

- 1. The facility staff failed to wear hair restraints properly while serving food from the steam table.
- 2. The facility staff failed to serve food to the residents in a sanitary manner in the main dining room.

#### The findings include:

1. Or, 3/15/18 at 11:55 a.m., an observation of the main dining room was conducted. OSM (other staff member) #1, the dietary aide was observed at the steam table dishing out food and placing them on resident plates. OSM #1 had a one-inch piece of hair coming out of the front of her hair net. Her strand of hair was covering an eyebrow piercing.

On 3/15/18 at 12:20 p.m., the regional dietary manager (OSM #3) was observed walking by OSM #1. When asked how his staff should be wearing hairnets, OSM #3 stated that dietary staff should have all of their hair tucked underneath the net. When asked the purpose of the hairnet, OSM #3 stated that it was an infection control issue if hair were to get into the food. When asked if OSM #1 was wearing her hair net properly, OSM # 3 stated that she wasn't. OSM #3 then instructed OSM #1 to fix her hairnet.

F 812

- 3. Dietary staff re-educated by the DM/ED/designee regarding ensuring hair nets are worn properly while in the kitchen when serving food from the steam table. CNAs re-educated by the ED/DON/IDT/designee regarding ensuring food is served to residents in a sanitary manner.
- 4. ED/DM/designee to conduct random quality monitoring of the kitchen to ensure hair nets are worn properly when serving food from the steam table 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. DON/UM/IDT/designee to conduct random quality monitoring of meal service to ensuring food is served to residents in a sanitary manner 5 x weekly x 4 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
- 5. Date of Compliance 4-15-18.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495362	B. WING			- 1	R-C <b>3/16/2018</b>
	PROVIDER OR SUPPLIER  D NURSING AND REI	HABILITATION		906	REET ADDRESS, CITY, STATE, ZIP COD THOMPSON STREET HLAND, VA 23005		3/10/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 812	Continued From pa	ge 64	F	312			
	staff member) #1, t	p.m., ASM (administrative he executive director and ASM tor of Nursing) was made concerns.					
	in part, the following their hair off their sh	led, "Staff Attire;" documents g: "All staff members will have noulders, confined in a hair net air properly restrained."					
	No further informati	on was presented prior to exit.					
		ailed to serve food to the ary manner in the main dining					
	main dining room w CNA (certified nursicobserved taking a p serving it to a reside gloves, and her fing plate. CNA #10 had 11:56 p.m., CNA #16 hands and then graf	a.m., an observation of the as conducted. At 11:55 p.m., ng assistant) 10 was late from the steam table and ent. CNA #10 was not wearing ers were on the edge of the livery long, fake nails. On D was observed sanitizing her obing another plate with her edge of the plate. This plate a resident.	.* -				
	holding a plate close not touching her clot hair was resting on t #1 then proceeded t	p.m., CNA #1, was observed to her body. The plate was thes but a long strand of her op of the breaded okra. CNA o serve this plate, also with ching the edge of the plate, to					

the resident.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	1	495362	B. WING			1	R-C <b>3/16/2018</b>
	PROVIDER OR SUPPLIER  D NURSING AND REF	HABILITATION		906 T	ET ADDRESS, CITY, STATE, ZIP CODE THOMPSON STREET LAND, VA 23005	<u>,</u>	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 812	received the plate for percent of the bread	0 p.m., the resident who from CNA#1 had eaten 100 ded okra.	F 8	112			
	conducted with CNA maintain infection or residents in the dinition she should hold the her body. When as food a few inches a stated, "So hair could when asked how sit transporting a residuable to the resident holding a plate by a demonstrated that hedge of the plate. I have her thumbs or #1 quickly removed clipboard and state bare thumbs should plate, CNA #1 state hands could touch that fake nails, CNA When asked if they while serving-food, everybody has fake	p.m., an interview was A #1. When asked how to control while serving food to ing room, CNA #1 stated that a food a few inches away from sked why she should hold the away from her body, CNA #1 uldn't get into it, that's nasty." she should hold a plate while dent's meal from the steam of, CNA #1 demonstrated using a clipboard. CNA #1 her thumbs would be on the When asked if she should in the edge of the plate, CNA d her thumps from the ed, "Oh no." When asked why d not be on the edge of the ed that something on her the food. When asked if she A #1 stated that she did. I were allowed to be worn CNA #1 stated, "I don't know, a nails." CNA #1 stated she he observations made while					
	staff member) #1, ti	p.m., ASM (administrative the executive director and ASM stor of Nursing) was made concerns.					
	The facility policy tif	tled, "Staff attire" documents in				-	

part, the following: "Fingernails will be kept clean and neat. Nail polish and/or acrylic nails are not

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CLIVILI	13 I ON MEDICANE	A MILDIONID SERVICES				ONID NO. 0936-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DESCRIPTION AT TON A STREET		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
					R-C	
		495362	B. WING			03/16/2018
NAME OF I	PROVIDER OR SUPPLIER		1	STREET	ADDRESS, CITY, STATE. ZIP COL	DE
ASHLAN	ID NURSING AND RE	HARBITATION	1	906 THO	MPSON STREET	
AOHEAN		TADICIA TOA		ASHLAI	ND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI ROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 812	Continued From pa	ıge 66	F8	12		
	documents in part, transported to the o that ensure proper	cy titled, "Meal Distribution," the following: "Meals are dining locations in a manner temperature maintenance, ntamination, and are delivered urate manner"			F813: Persona	al Food Policy
No further informati  Complaint deficience		ion was presented prior to exit.			Identified for nourishment room	ood items Unit 2
		cy -			discarded 3/16/	
F 813	Personal Food Poli	cy	F 8	13		ood items Unit 3
SS=E	CFR(s): 483.60(i)(3	(i)			nourishment roo	
		CADO CO(i)(O) Have a palicy appending use and			discarded 3/16/	
	§483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.					gerator cleaned
	This REQUIREMEN	NT is not met as evidenced			2. Quality revi	
	by: Based on observation, staff interview, and facility document review, it was determined that facility staff failed to store residents' food in a sanitary manner for two of three nourishment rooms (Unit 2 and Unit 3).			the DM/I to ensure food item		nt room s completed by N/UM/designee sident personal here labeled dated ed per policy.
		ed to label and date food that amily/visitors for resident use			Follow up b	pased on findings.
		ishment rooms. (Unit 2 and			Quality revi	ew of
	Unit 3).	Simon rooms. (Sim 2 and			nourishment	t room
	,				refrigerators	s completed by
	The findings include	);				JM/designee to
	observation was connourishment room.	eximately 8:30 a.m., an and and and and and and and and and			refrigerators spillage and	ishment room s are free from /or soiling. ased on findings.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495362	B. WING			R-C 03/16/2018
NAME OF F	PROVIDER OR SUPPLIER		L	STR	REET ADDRESS, CITY, STATE, ZIP CODE	03/16/2018
ASHLAN	D NURSING AND RE	HABILITATION		906	THOMPSON STREET HLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
	number. There we indicating when it w Three of the bowls bowl contained Okr On 3/15/18 at approinterview was conditioned assistant) asked the process from an outside sou food should be date later. When asked were to find the bowdates on them, CN/the nurse for further that the family actual nurse so that the nuitems. CNA #2 statesponsible for datin was responsible for CNA #2 stated a diecleans out the refrig determine how often if she knew how long refrigerator, CNA #2 on unit 2 and could On 3/15/18 at 9:45 a conducted with RN was asked about the family brings in food she would first have and if it matches with #1 stated she would food was prepared at the conducted was prepared at the con	resident's name and room re no dates on the bowls was brought into the facility. contained rice and the other ra.  Description of the contained rice and the other ra.  Description of the contained rice and the other ra.  Description of the contained rice and the contained rice and the contained rice, a contained rice	F	313	3. Current staff re the DON/UM/ensuring reside food items are and discarded Current staff re the DON/UM/ensuring staff pitems are not re nourishment re Current staff re the DON/UM/ensuring nouris refrigerators are spillage and/or  4. ED/DON/UM/E to conduct rand monitoring of nor room refrigerators are sident personal are labeled dated discarded per poweekly x 4 weekly x 4 weekly x 4 weekly and PRN indicated.	designee ent personal labeled dated per policy. e-educated by designee personal food efrigerated in frigerators. e-educated by designee chment room e free from soiling.  DM/designee om quality ourishment prs to ensure al food items d and plicy 5 x cs, 3x cs, then 2 x

the resident's name and/or room number. RN #1 did not have a key to the nourishment room. RN

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		,	OMB NO. 0938-039
	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495362	B. WING		R-C 03/16/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010
ASHLAN	ID NURSING AND REI	HABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D.BE COMPLETION
	to open the nourish confirmed the food should be discarded shift nurses are sup refrigerator. LPN # Resident #116 were #1 confirmed that the were rice and okra.  On 3/15/18 at 10:00 2 nourishment room box containing a bar bag of grapes, a box container full of what was found in the refibelonged to one restresident's name and things labeled on the substance was also refrigerator shelf.  On 3/15/18 at 10:03 #2 confirmed the aborefrigerator were not	ment room. LPN #1 items were not dated and d. LPN #1 stated the 11-7 items do clean out the 1 stated the family for always bringing in food. LPN ine food contained in the bowls  a.m., observation of the Unit is was conducted. A take out con cheeseburger, a plastic ix of pizza, and a Tupperware it appeared to be egg salad rigerator. All food items ident in room 224. The is room number were the only ite food items. A red sticky observed stuck on  a.m., RN (registered nurse)	F8	ED/DON/UM/DM/o to conduct random o monitoring of nouri room refrigerators to staff personal food i not stored in nourisl room refrigerators 5 weekly x 4 weeks, 3 weekly x 4 weeks, to weekly and PRN as indicated. ED/DON/UM/DM/o to conduct random o monitoring of nouris room refrigerators to nourishment room refrigerators are free spillage and/or soillin weekly x 4 weeks, th	quality shment o ensure tems are nment

dietary usually cleans the refrigerators in the nourishment rooms. On 3/15/18 at approximately 4:45 p.m., an interview was conducted with OSM (other staff member) #4, the dietary manager. OSM #4 stated a dietary aide will clean out the

refrigerators every morning at 6:30 a.m. OSM #4 stated it is not the same aide every time. OSM

would throw out all items because she was not

sure when the food was brought into the facility.

substance on the refrigerator's shelf was and stated that she would clean it. RN #2 stated that

RN #2 could not determine what the red

modified based on findings. 5. Date of Compliance 4-15-18.

weekly and PRN as

Findings to be reported to

QAPI committee monthly

and updated as indicated.

Quality monitoring schedule

indicated.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C 03/16/2018
NAME OF	PROVIDER OR SUPPLIER		S1	FREET ADDRESS, CITY, STATE, ZIP CODE	03/10/2018
ASHLAN	ID NURSING AND REI	HABILITATION	į	96 THOMPSON STREET SHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION
F 813	they notice a spill. of the red sticky subshelf, OSM #4 state juice. The cleaning room refrigerator's of On 3/15/18 at 6:15 staff member) #1, the (administrative staff)	f are responsible to help if When OSM #4 was informed ostance on the refrigerator at it was probably cranberry schedule of the nourishment was requested.  p.m., ASM #1 (administrative ne executive director and ASM member) #2, the DON	F 813		
		) were made aware of the ne cleaning schedule could			
	Foods from Visitors following: "Resident storing and safely of the facility for reside. The facility staff will in food, and/or reside notify a member of the departments. 2. The member will determ for immediate consulater use 4. When later consumption, the member will: -Ensur separate or easily different foods Ensure that it container to prevent foods with the reside date5. Refrigerate brought in by visitors.	led, "Fcod: Safe Handling for "documents in part, the swill be assisted in properly consuming food brought into ents by visitors. Procedures: request that visitors bringing ents that receive food, must he nursing or activities e responsible facility staff ine whether the food item is imption or to be stored for a food items are intended for the responsible facility staff e that the food is stored stinguishable from the facility foods are in a sealed cross contamination. Label ent's name and the current of freezers for storage of foods will be properly maintained			
	duration and discard	ing for refrigerated storage of any food items that have ter or equal to 7 days.			

-Cleaned weekly."

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STATEMENT OF DEFICIENCIES AND PROVIDER SUPPLIER LIAD NUMBER  495362  8 WING  STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 2014  SUMMARY STATEMENT OF DEFICIENCIES PREFIX LEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCIES IN PROVIDER PREPAY LEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES TAG SHAND, VA 2014 T	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
ASHLAND NURSING AND REHABILITATION    MAIL DID   SUMMARY STATEMENT OF DEFICIENCIES   10			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED
ASHLAND NURSING AND REHABILITATION  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 813 Continued From page 70 F 813 No further information was presented prior to exit.  (F 840) Use of Outside Resources \$483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in paragraph (g)  (2) of this section.  \$483.70(g)(2) Arrangements as described in section 1861(w) of the Act or an agreement described in paragraph (g)  (2) of this section.  \$483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility and (ii) The timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record  **STRET ADDRESS, CITY, STATE, ZIP CODE  **ASHLAND, VA 23005  **ASHLAND, VA 23005  **CHACHORAGOR SPRETION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE CORNECTION S			495362	B. WING		R-C 03/16/2018
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG			HABILITATION		906 THOMPSON STREET	03/10/2018 CODE
No further information was presented prior to exit.  (F 840) SS=D  No further information was presented prior to exit. Use of Outside Resources  \$483.70(g)(1) (If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)  (2) of this section.  \$483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-  (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and  (ii) The timeliness of the services.  This REQUIREMENT is not met as evidenced by:  Based on resident interview, staff interview, facility document review and clinical record  RE840: Use of Outside  Resources  1. Dental contract obtained 3/26/18.  2. Quality review completed by the ED/designee to ensure outside vendors requiring a contract is current and accessible. Follow up based on findings.  3. ED re-educated by the Divisional Director of Clinical Services  (DDCS)/designee regarding ensuring vendors requiring a contract is current and accessible.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLETION
\$483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)  (2) of this section.  \$483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for-  (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility, and  (ii) The timeliness of the services.  This REQUIREMENT is not met as evidenced by:  Based on resident interview, staff interview, facility document review and clinical record  F840: Use of Outside  Resources  1. Dental contract obtained  3/26/18.  2. Quality review completed by the ED/designee to ensure outside vendors requiring a contract is current and accessible. Follow up based on findings.  3. ED re-educated by the Divisional Director of Clinical Services  (DDCS)/designee regarding ensuring vendors requiring a contract is current and accessible.  4. ED/DDCS/designee to conduct random quality	{F 840}	No further informati Use of Outside Res	on was presented prior to exit.			
review, it was determined the facility staff failed to maintain a contract for dental services for one of 18 residents in the survey sample.  The facility staff failed to maintain a contract for dental services for Resident #116. Resident #116 had broken and decaying teeth.  The findings include:  monitoring of outside vendors requiring a contract to ensuring contracts are current and accessible 2 x		§483.70(g)(1) If the qualified profession service to be provid must have that serv person or agency or arrangement descrit Act or an agreement (2) of this section.  §483.70(g)(2) Arran section 1861(w) of the pertaining to service resources must speciassumes responsible (i) Obtaining service standards and principrofessionals provid and (ii) The timeliness of This REQUIREMEN by:  Based on resident in facility document revreview, it was determinated and the services for Richard services for Richard services for Richard broken and decared.	facility does not employ a al person to furnish a specific ed by the facility, the facility ice furnished to residents by a utside the facility under an bed in section 1861(w) of the t described in paragraph (g)  gements as described in he Act or agreements is furnished by outside cify in writing that the facility lity forst hat meet professional iples that apply to ing services in such a facility; the services.  This not met as evidenced interview, staff interview, iew and clinical recordined the facility staff failed to or dental services for one of urvey sample.  It is maintain a contract for esident #116. Resident #116		Resources  1. Dental contract 3/26/18. 2. Quality revies the ED/design outside vended contract is curaccessible. From findings. 3. ED re-educated Divisional Directional Directional Directional Directional Servity (DDCS)/design ensuring vended contract is curaccessible. 4. ED/DDCS/design conduct random monitoring of vendors requirection to ensuring contraction.	ct obtained w completed by mee to ensure ors requiring a ment and follow up based ed by the irector of ices gnee regarding dors requiring a ment and signee to om quality outside ring a contract entracts are

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<b>~</b>		OMB NO. 0938-039	11
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495362	B WING		R-C 03/16/2018	
NAME OF I	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIF	P CODE	_
ACUI AN	ID NITIDEING AND DE	JADII ITATION		906 THOMPSON STREET		
ASIILAN	D NURSING AND RE	IABILITATION		ASHLAND, VA 23005		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE	1
{F 840}	Continued From pa	ge 71	{F 84	40}		
,	Resident #116 was 10/20/15 with diagr not limited to: strok	admitted to the facility on oses that included but were e, Alzheimer's disease, and difficulty swallowing.	Į, o	,		
	with an ARD of 2/5/having short-term a problems and seve resident was coded staff for all activities. Review of the annu 10/27/17 in Section documented, "D. O broken natural teeth An observation was a.m. of Resident # a recliner in the hall and his mouth was were two teeth brok gums were reddened the area. There wer which had food deb	al MDS with an ARD of L – Oral/Dental Status ovious or likely cavity or		weekly x 2 wee 2 weeks, and th and PRN as ind Findings to be r QAPI committe and updated as Quality monitor modified based 5. Date of Complia	en monthly licated. eported to ee monthly indicated. ring schedule on findings.	
	decay above that.  A review of the care and revised on 11/7 (Name of resident) I nutrition r/t (related in ProblemResident Interventions. Monit (medical doctor) PR and symptoms) of o attention. Pain (gum	plan initiated on 10/27/16 /17 documented, "Focus. nas potential for imbalanced to)Chewing				

bleeding, Teeth missing, loose, broken, eroded,

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AND PLANOF CORRECTION  A95362  A95362  ASHLAND NURSING AND REHABILITATION  IXA   ID   SUMMARY STATEMENT OF DEFICIENCIES   PRECIDENCIES   PRECIDENCY   PREFIX   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY   CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391						
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION  IX4) ID SUMMARY STATEMENT OF DEFICIENCIES (ACCH CORRECTIVE ACTION SHOULD BE (EACH DEPICENCY MUST BE PRECEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION)  (F 840) Continued From page 72 decayed"  An interview was conducted on 3/15/18 at 9:30 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked the process staff follow if a resident has dental issues, LPN #4 stated, "If they're vocal they can verbalize if it hurts." When asked how teeth were checked, LPN #4 stated, "Normally when mouth care is done. The CNA (certified nursing assistant) would tell me." When asked what test was tasteff did for the teeth were broken or had obvious cavities, LPN #4 stated, "If check the chart for the RP (responsible party) and call the doctor." When asked if there were risks to inaving decayed and broken teeth, LPN #4 stated, "Decay can cause other health issues." LPN #4 was asked to look in Resident #116's mouth. The resident had no upper teeth, one tooth in the left back lower jaw with a deep black center, two broken teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw and seven decayed teeth in the resident's aide. When asked how oral care was conducted, CNA #8 stated, "Terst of all you have to make sure they're not INPO (nothing by mouth).							X3) DATE SURVEY COMPLETED		
ASHLAND NURSING AND REHABILITATION  (X3) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)  (F 840) Continued From page 72 (EACH DEFICIENCY WAS 16 PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  An interview was conducted on 3/15/18 at 9:30 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked the process staff follow if a resident has dental issues, LPN #4 stated, "If they're vocal they can verbalize if it nurts." When asked how teeth were checked, LPN #4 stated, "Normally when mouth care is done. The CNA (certified nursing assistant) would tell me," When asked what staff did if the teeth were broken or had obvious cavities, LPN #4 stated, "If check the chart for the RP (responsible party) and call the doctor." When asked if there were risks to having decayed and broken teeth, LPN #4 stated, "Decay can cause other health issues." LPN #4 stated, "Decay can cause other health issues." LPN #4 stated, "The resident had no upper teeth, one tooth in the left back lower jaw with a deep black center, two broken teeth in the front of the lower jaw and seven decayed teeth in the front of the lower jaw when asked if there was decay in the teeth, LPN #4 stated, "Yes."  An interview was conducted on 3/15/18 at 10.45 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked how oral care was conducted, CNA #8 stated, "First of all you have to make sure they're not NPO (nothing) by mouth).			495362	B. WING					
FREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE ON THE APPROPRIATE				906 THOMPSON STREET	IP CODE	00/10/2010			
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When asked what staff look for while doing mouth care, CNA #8 stated, "If the teeth are broken, if the teeth are rotting." When asked if Resident #116 had broken and rotting teeth, CNA #8 stated, "Yes. I told them. They told me they		a.m. with LPN (licer resident's nurse. W follow if a resident h stated, "If they're vo hurts." When asked LPN #4 stated, "Not done. The CNA (certell me." When asked CNA would report, Lor painful." When as were broken or had stated, "I'd check the (responsible party) a asked if there were broken teeth, LPN # other health issues.' Resident #116's moupper teeth, one too with a deep black cefront of the lower jav the front of the lower was decay in the teeth an interview was cora.m. with CNA (certif resident's aide. Whe conducted, CNA #8 to make sure they're I try to wet his mouth When asked what st mouth care, CNA #8 broken, if the teeth a Resident #116 had b	in interview was conducted on 3/15/18 at 9:30 m. with LPN (licensed practical nurse) #4, the isident's nurse. When asked the process staff Illow if a resident has dental issues, LPN #4 ated, "If they're vocal they can verbalize if it jurts." When asked how teeth were checked, PN #4 stated, "Normally when mouth care is one. The CNA (certified nursing assistant) would ll me." When asked what types of issues the NA would report, LPN #4 stated, "If they're loose painful." When asked what staff did if the teeth ere broken or had obvious cavities, LPN #4 ated, "I'd check the chart for the RP esponsible party) and call the doctor." When aked if there were risks to having decayed and oken teeth, LPN #4 stated, "Decay can cause her health issues." LPN #4 was asked to look in esident #116's mouth. The resident had no oper teeth, one tooth in the left back lower jaw that deep black center, two broken teeth in the ent of the lower jaw and seven decayed teeth in the ent of the lower jaw and seven decayed teeth in the ent of the lower jaw. When asked if there has decay in the teeth, LPN #4 stated, "Yes."  Interview was conducted on 3/15/18 at 10:45 m. with CNA (certified nursing assistant) #8, the sident's aide. When asked how oral care was inducted, CNA #8 stated, "First of all you have make sure they're not NPO (nothing by mouth). You wet his mouth first and brush his teeth."  Then asked what staff look for while doing both care, CNA #8 stated, "If the teeth are other, if the teeth are rotting." When asked if						

were aware and to make sure to still perform oral

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495362	B. WING		R-C <b>03/16/2018</b>
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE.  906 THOMPSON STREET  ASHLAND, VA 23005	ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION OF THE APPROPRIATE DATE
{F 840}	Continued From page	ge 73	{F 84	40}	
	asked what was expedental issues, ASM expect is it to be ide everyday when assi care." When asked services, ASM #2 st depends situation. Very they had a dentist. If to find a dentist. ASR esident #116's monhmm, I see." ASM # a consult or a converge physician about the ASM #2 stated, "Let On 3/15/18 at 1:05 p	o.m. ASM #2 stated, "There's			
	documentation about #2 stated, "No."  A request for the fact made on 3/15/18 at executive director. A verbal contract with (everyone on Medical	sked if there was any at the resident's teeth, ASM iiity's dental contract was 1:10 p.m. of ASM #1, the SM #1 stated, "We have a (name of dentist). He takes re and Medicaid. I just got a pum a mobile dental unit and getting approved."		F908: Essential Equipment/Safe ( Condition  1. Identified area: water drained/clea: 3/14/18.  Identified miss replaced by 4/15/1 Garbage dispose 4/15/18.	s of standing ned/dried sing tiles/grout 8.
	director, ASM #2, the	.m. ASM #1, the executive e director of nursing and ASM r of clinical services were ndings.	-	Identified leaki fixed by 4/15/1 Identified food towels and deb	18. items, wet

No further information was provided prior to exit.

F 908 Essential Equipment, Safe Operating Condition

F 908

removed/areas identified

cleaned 3/16/18.

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		495362	B. WING		R-C <b>03/16/2018</b>			
NAME OF I	PROVIDER OR SUPPLIER	L.,	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/10/2018			
ASHLAND NURSING AND REHABILITATION				906 THOMPSON STREET ASHLAND, VA 23005				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION			
SS=C	and patient care eq condition. This REQUIREMEN by: Based on observat document review, a complaint investigat facility staff failed to operating condition The kitchen floor wastanding water from connected to a brok and dishwasher. Oddirector, stated that been acting up in the that the pipe was lead to a staff member) #3, the At 10:35 a.m., approwas observed on the kitchen's sink and gaunderneath this sink dishwasher was also saturated cardboard floor folded up flat with this sink was also saturated cardboard floor folded up flat with this sink was also saturated cardboard floor folded up flat with this sink was also saturated cardboard floor folded up flat with this sink was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor folded up flat with the pipe was also saturated cardboard floor floo	tain all mechanical, electrical, uipment in safe operating of the properties of a staff interview, and facility and in the course of a sion it was determined that maintain equipment in safe in the facility kitchen.  The secovered in half an inch of a leaking pipe that was en garbage disposal, sink of some parbage disposal, sink of the garbage disposal had be beginning of January and aking.	F 90	2. Quality review complete ED/designee to enthe kitchen is free from standing water. Followased on findings. Quality review complete ED/designee to enthe kitchen is free from missing tile/grout. Four based on findings. Quality review complete the ED/designee to ensemble the ED/designee to ensemble the kitchen is free from leaking pipe(s). Follow based on findings. Quality review complete the ED/designee to ensemble the	eted by sure m llow eted by sure n llow eted by sure n w up ted by ure and e ly per d on eed by ure posal er. lings.			
	asked OSM #3 what stated that there app water. When asked	was going on, OSM #3 eared to be a lot of standing why the box was on the loved the box and revealed 6		ensure kitchen equipmen in good working order. Follow up based on findi				

missing tiles underneath the box. The area where

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NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP COD 906 THOMPSON STREET ASHLAND, VA 23005	E
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(	OULD BE COMPLETION
F 908		ge 75 ng were full of water. Soggy o observed on the floor	F	908 3. Maintenance D re-educated by	

the tiles were missing were full of water. Soggy food debris was also observed on the floor underneath the garbage disposal. Rolled up saturated towels were observed on the floor underneath the dishwasher. When asked OSM #3 where the leak was coming from, OSM #3 stated that he would ask the dietary manager because he had just started on Monday.

On 3/14/18 at 10:36 a.m., an interview was conducted with OSM #4, the dietary manager. When asked where the leak was coming from. OSM #4 stated that the leak was coming from the garbage disposal. When asked how long the garbage disposal/sink had been leaking, OSM #4 stated that it had been leaking for "about two months." OSM #4 stated that she was told the leak was "In the works" from maintenance. When asked where all the food debris came from, OSM #4 stated that it was from breakfast. OSM #4 stated that staff still used the area to clean off the trays. This writer then observed food debris inside the garbage disposal. When asked if the garbage disposal was still functioning, OSM #4 stated that it didn't work. When asked how long food debris was inside the garbage disposal, OSM #4 stated that the food debris inside the garbage disposal was also from breakfast. OSM #4 stated that her staff still rinse off the trays and then take a glove and sweep out the garbage disposal with their hands. When asked the clean up time after breakfast, OSM #4 stated that breakfast clean up was usually started at about 9 a.m.

On 3/14/18 at approximately 5 p.m., a second observation was made of the kitchen. The standing water had been drained. The floor underneath the garbage disposal/sink was still

ED/designee regarding ensuring the kitchen is free from standing water, the kitchen is free from missing tile/grout, the kitchen is free from leaking pipe(s), food items, wet towels and debris in the kitchen are removed/cleansed timely per policy, the kitchen garbage disposal is in good working order, kitchen equipment is in good working order and reporting items needing repair to the ED at the time observed.

ED re-educated by the DDCS/designee regarding ensuring the kitchen is free from standing water, the kitchen is free from missing tile/grout, the kitchen is free from leaking pipe(s), food items, wet towels and debris in the kitchen are removed/cleansed timely per policy, the kitchen garbage disposal is in good working order, kitchen equipment is in good working order and

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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE
ASHLAN	D NURSING AND REI	ABILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE COMPLÉTION
	On 3/15/18 at 9:25 conducted with OSI was that much stan garbage disposal/si that the dishwasher pipe as the sink and stated that every timis a large amount of floor. OSM #3 stated standing water drainfew hours. OSM #3 finished using the diclean-up, before this observation. When standing water on the #3 stated, "No." When standing water on the #3 stated, "No." When ever be standing water on the #3 stated, "No." When ever be standing water on the wind was in the same displayed in the some time. When a months to fix this prowas not sure, but the some documentation OSM #3 was asked On 3/15/18 at approximated that OSM #4 was morning but would be #3 stated that he could be #3 stated that he could be with the could be #3 stated that he could be with the could be w	is had been cleaned up, and the floor had been removed.  a.m., an interview was with #3. When asked why there ding water underneath the risk on 3/14/18, OSM #3 stated was connected to the same of garbage disposal. OSM #3 the the dishwasher runs, there is water that leaks onto the dishwasher runs, there is water that leaks onto the dishwasher for breakfast is writer made the above asked if there should ever be the floor in the kitchen, OSM then asked why there should eater on the floor of the sted that is was an infection itself that is was an infection itself in the area with the esposal had been broken for sked why it was taking 2 oblem, OSM #3 stated that he brught OSM #4 may have had in regarding repair requests. Its provide this information.  Eximately 11:00 a.m., OSM #3 was not in the building that the back in the evening. OSM uld not access her emails, the maintenance director may	F 9	reporting item repair to the R President of O the time obser Dietary staff repair the DM regard the kitchen is free from mitile/grout, the I from leaking pitems, wet tow in the kitchen a removed/clean policy, the kitch disposal is in good workin reporting items repair to the DM/Maintenant the time observed Maintenance with the Maintenance with the mitigate of the Stand Up meets.	degional Vice operations at ved. e-educated by ding ensuring free from r, the kitchen issing kitchen is free oipe(s), food rels and debris are used timely per chen garbage cood working equipment is ng order and a needing nce Director at red. rork orders to Morning

On 3/15/18 at 3:30 p.m., an interview was conducted with OSM #2, the maintenance

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 093				
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		495362	B. WING	i		R-C 03/16/2018	
NAME OF I	PROVIDER OR SUPPLIER		1	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 03/10/2010	
ASHLAN	D NURSING AND REI	HABILITATION			THOMPSON STREET HLAND, VA 23005		
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F 908	about the garbage of #2 stated that the gacting up in the beg pipe was leaking. Or research the part be was so old, the serithe part that he need guess it doesn't wor. "They told me today today, OSM #2 stat working." When as garbage disposal at knowledge of the instated that it was fix that he was going to and look at the leak that the kitchen stafthe area if it was lead asked to provide all or evidence that he in January. OSM #2 from to fix the garbaform was dated 3/15 OSM #2 could not prinformation.  On 3/15/18 at 5:30 pstaff member) #1, the #2, the DON (Direct aware of the above	disposal in the kitchen, OSM arbage disposal had been pinning of January and that the DSM #2 stated that he had to ecause the garbage disposal al numbers were worn off on ided. OSM #2 stated, "Now I rk at all. OSM #2 stated, "Now I rk at all. OSM #2 stated, "When asked who told him ed, "Weil you are saying it isn't ked if he had ever fixed the had pipe after having itial leak in January, OSM #2 stated to have someone come out tomorrow. OSM #2 stated if should not have been using aking water. OSM #2 was maintenance requests sheets had fixed the initial leak back 2 then presented a proposal fage disposal. The proposal form, ASM (administrative ne executive director and ASM or of Nursing) were made	F	908	4. ED/DM/Maintenance Director/designee to corrandom quality monitor to ensure the kitchen is from standing water 5 x weekly x 4 weeks, 3x weekly x 2 weeks, week 4 weeks, then twice morand PRN as indicated. ED/DM/Maintenance Director/designee to corrandom quality monitor to ensure the kitchen is from missing tile/grout: weekly x 4 weeks, 3x weekly x 2 weeks, week 4 weeks, then twice morand PRN as indicated. ED/DM/Maintenance Director/designee to corrandom quality monitor to ensure the kitchen is from leaking pipe(s) 5 x weekly x 4 weeks, 3x weekly x 2 weeks, week 4 weeks, then twice morand PRN as indicated. ED/DM/Maintenance Director/designee to conrandom quality monitori to ensure food items, we towels and debris in the	ing free  cly x  nthly  nduct  ing free 5 x  cly x  nthly  nduct  ing free  ly x  nthly  duct  ing free	
	Complaint Deficienc	у			kitchen are removed/clea	aned	

timely per policy 5 x weekly

x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks. then twice monthly and PRN as indicated. ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure the kitchen garbage disposal is in good working order 5 x weekly x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated. ED/DM/Maintenance Director/designee to conduct random quality monitoring to ensure kitchen equipment is in good working order 5 x weekly x 4 weeks, 3x weekly x 2 weeks, weekly x 4 weeks, then twice monthly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Compliance Date 4-15-18