Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		LIA		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495349		B. WING		03/0	C 01/2018
	OVIDER OR SUPPLIER	HEVILLE - BIRDMONT	990 HO	RESS, CITY, STA L STON RD VILLE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	survey was conducted. The facility was in sur CFR Part 483.73, Re- Care Facilities.	pergency Preparedness ad 02/26/18 through 03/1 bstantial compliance wit quirement for Long-Terr	h 42		Preparation and/or execution of thi does not constitute admission or agreement by the provider of the treather the facts alleged or conclusions seen the statement of deficiencies. To f correction is prepared and/or exsolely because required.	uth of t forth his plan	
	survey was conducte 03/01/18. Corrections with 42 CFR Part 483 requirements. The L survey/report will folk investigated during the The census in this 13 121 at the time of the consisted of 24 currer closed record reviews	dicare/Medicaid standard 02/26/18 through sare required for complist Federal Long Term Cafe Safety Code ow. One complaint was e survey. 7 certified bed facility was survey. The survey sarnt Resident reviews and is.	ance re	F 000			
SS=D	self-determination, an access to persons and outside the facility, incoming this section. §483.10(a)(1) A facility with respect and digning resident in a manner appropriate or quality of life, recondividuality. The facility or mote the rights of the access to the access to the access to the rights of the access to the rights of the access to the acc	2)(b)(1)(2) Rights. ht to a dignified existence of communication with a discretized services inside and shuding those specified in a must treat each reside the and in an environment the or enhancement of his gnizing each resident's ty must protect and	nt at	F 550	1. For Resident #17, the Foley bag was covered during the survey. 2. Residents that currently residenter with Foley catheters have the pto be affected. Observations have been conducted by the Director of Nursing (Designee to ensure that residents residents facility with Foley catheters have the drainage bags covered. 3. In-Servicing has been conducturent nursing employees by the DON Designee regarding ensuring that Foley catheter bags are covered for resident Foley catheters. Observations will be conducted by the DON/Designee (5) fit times/week for (3) three months for residenter bags are covered.	catheter de in the potential en DON)/ ding in neir cted with N/ s with	04/04/18
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S	SIGNATURE	i.	TITLE		(6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except to have included above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing normes, the above intrings 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.



Executive Director

03/26/18

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		1	C 1/ 2018
	ROVIDER OR SUPPLIER	HEVILLE - BIRDMONT	990 HO	RESS, CITY, STA LSTON RD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 550 Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her		acility s and the r all	F 550	4. The results of the discussed by the Administr Quality Assurance Perform (QAPI) Committee meeting months. The Interdisciplina recommend revisions to the to sustain substantial comp 5. 04/04/2018	ance Improvement monthly for three ary team (IDT) will e plan as indicated		
	The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.						
	free of interference, or reprisal from the facility rights and to be supplexercise of his or her subpart. This Requirement is Based on observation document review the	sident has the right to be opercion, discrimination, ity in exercising his or hearted by the facility in the rights as required under not met as evidenced by staff interview and facifacility staff failed to ensered for 1 of 27 Resider	and er e r this y: sility sure				
	The findings included For Resident #17 the Foley catheter bag wa	facility staff failed to ens	sure				
	Resident #17 was adr 02/28/15 and readmitt included but not limite neurogenic bladder, u diabetes mellitus, Alzh	mitted to the facility on ted on 08/21/16. Diagno d to anemia, hypertensi	on, ntia,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			4	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/01/2018
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE	03/01/2018
CARRING	GTON PLACE AT WYTH	HEVILLE - BIRDMONT		LSTON RD VILLE, VA		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES TBE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 550	Continued From page	2		F 550		
	an ARD (assessment coded the Resident as	i (minimum data set) w reference date) of 02/1 s 8 of 15 in section C, is is a significant chan	3/18			
	approximately 1005. F wheelchair, seated in Resident's Foley cathe attached to the side of covered with a privacy Resident #17 again or 1530. Resident was so wheelchair. Foley cath attached to side of who covered with a privacy The surveyor spoke w nursing) on 02/28/18 a regarding Resident #1 Resident's catheter ba covered. The concern of the Fol covered with a privacy the administrative tean	the dining room. The eter drainage bag was fewheelchair and was not cover. Surveyor observe at approximate and day room, in leter drainage bag was electrain and was not cover. A pool of the book of	ot ved ately			
	02/28/18 at approxima	tely	į			
İ	No further information		xit.			
SS=E	Resident/Family Group CFR(s): 483.10(f)(5)(i)- §483.10(f)(5) The resid and participate in resid (i) The facility must pro group, if one exists, wit reasonable steps, with to make residents and	ent has a right to organent groups in the facility vide a resident or family hyrivate space; and tathe approval of the gro	y. y ike up,	F 565	1. A resident council meeting I conducted on or before 04/04/2018 in follow-up was communicated to the recouncil regarding grievances. The clathe process for resident council was communicated to the council by the Administrator/Designee.	has been n which esident hange to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	495349	B. WING		C 03/01/2018	
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE		
CARRINGTON PLACE AT WYTHEVI		HOLSTON RD HEVILLE, VA	24382		
PREFIX : (EACH DEFICIENCY MUST BE P	ENT OF DEFICIENCIES RECEDED BY FULL REGULATORY YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
upcoming meetings in a tir (ii) Staff, visitors, or other or resident group or family grothe respective group's invit (iii) The facility must provid person who is approved by group and the facility and we providing assistance and requests that result from groups concerning issues or in the facility. (A) The facility must be able response and rationale for (B) This should not be considered in the resident or facility must implement as a request of the resident or facility must implement as a request of the resident or facility member(s) or other representative(s) meet in the family member(s) or other representative(s) meet in the families or resident representative. This Requirement is not member and resident council of interview and resident council of interview and resident council of interview and communicate resident council grievances meetings of the council. The Findings Included: On February 28, 2018, at 1: reviewed the Resident Grouncil grievances meetings of the council.	guests may attend oup meetings only at tation. Ide a designated staff of the resident or family who is responsible for responding to written roup meetings. Ider the views of a red act promptly upon mendations of such of resident care and life of the today of the test	F 565	2. Residents that reside in the have the potential to be affected. A council meeting has been conducted before 04/04/2018 in which follow-up communicated to the resident council regarding grievances. The change is process for resident council was also communicated to the council by the Administrator/Designee. 3. In-servicing has been provided before 04/04/2018 regarding the regarding the regarding requirements for resident council control to the Resident Council Committee and Designee to ensure that follow-up regrievances is communicated to the condocumented each month. 4. Results of the review will be discussed by the Administrator/Designer Designee to ensure that follow-up regrievances is communicated to the condocumented each month. 5. Results of the review will be discussed by the Administrator/Designer Designer of the Polymer of States of St	resident d on or p was cil to the o ided to the on or gulatory mmittee. eeting ninistrator/ esponse to council and e gnee at the months. o the plan	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03	C 3/ 01/2018	
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	ZIP CODE			
CARRING	STON PLACE AT WYT	HEVILLE - BIRDMONT	990 HO	LSTON RD				
				EVILLE, VA 243	382			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		!	 			
PREFIX TAG	(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL REDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 565	Continued From pag	je 4		F 565				
	The surveyor reviewe	ed the Resident Group					j	
	Council minutes from						1	
		January 3, 2018 and						
	February 7, 2018. Th	ne surveyor noted that "(Old					
	Business/Follow-Up"		! i					
		ted on the subsequent						
	Resident Council Gro	oup meeting minutes. T	he i					
	Notes read in part							
	"12/6/17 Old Busines	ss/Follow up- NA. Conce		İ			i	
	1 Room 216 Hole in	Ceiling. 2. Staff not kno	rris okina	İ				
		. 3. Residents going into						
		ugh drawers. 4. Family	,	I				
	members not knockin	ng when entering."		į				
	"12/13/17 Old Busine	ess/Follow up (name of	!					
	resident withheld) par	nts were found. Concerr	ns				!	
		e listed/documented. No) į					
	follow up of the previous			!			· '	
		cerns/grievances were		İ				
	addressed/document						i	
	"1/3/18" No old busing		i					
i	documented, addition	nally no concerns were		:				
!	"2/7/18 Old Business/	/Follow up (name of						
	Resident withheld) co			i				
į		bers (name of resident	}	İ				
	withheld) President, (r	name of Resident withh	eld)	į				
	Vice President, Secre	etary (name of resident	,	: :				
	withheld). Concerns 1	. (name of resident		-				
	withheld) needs bigge	er shoes" (sic)					1	
				1				
	On February 28, 2018	3 at 2 p.m. the surveyor	!	!			i	
	conducted the Reside	nt Council Group meeting	ng					
;	with 6 alert and oriente		1	i				
	surveyor asked what he Resident Council Ground			ļ			i l	
i		up voicea during the meeting. The		i İ				
	group stated that the	Activities Director (AD) s	at	!				
		uncil Group meeting and		į			1	
		red specifically if follow i		!				
İ		speemeany ir lonow (. P					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER				PLE CONSTRUCTION G(X	X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018
1	ROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE	
CARRING	GTON PLACE AT WYT	HEVILLE - BIRDMONT		LSTON RD VILLE, VA	24382	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 565 F 635 SS=D	was ever discussed of Resident Council on the Resident Group's On March 1, 2018 at the Director of Nursin not follow up with the previous Resident Council meet The surveyor pointed addressed the grieval Resident Council meet With the Administi Minimum Data Set (M Compliance Nurse (C The surveyor notified (AT) that the facility di Resident Council Group No additional informat exiting the facility as to follow up with the Remeeting grievances/co. Admission Physician (CFR(s): 483.20(a)	or addressed with the the subsequent meeting thated, "No." 8 a.m. the surveyor not g (DON) that the facility Resident Council on the facility resident Council on the facility resident that the facility had not that the facility had not that the facility had not that the facility had not council on the etings. 9:45 a.m. the survey team of the facility had not follow up with voice the Administrative Team of not follow up with voice up grievances/concernstation was provided prior to why the facility staff facesident Council Group oncerns. Orders for Immediate Called Team of the Immediate C	ified / had e I the OON. not am ional ate rator. n ced b. do ailed	F 635	F 635 Admission Physician Orders for Immediate Care 1. For Resident #378, the medica and orders have been reviewed by the physician on or before 04/04/2018.	04/04/18
	immediate care. This Requirement is r Based on staff intervie review, the facility staff	not met as evidenced by	sion		2. Residents that are newly admit readmitted to the facility have the potent be affected. Residents that currently rest the facility that have been admitted/read in the previous (30) thirty days have had medical record reviewed by the DON/De to ensure that admission orders were ob upon admission/readmission.	ial to side in mitted their ssignee

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495349		B. WING			C 1/ 2018
	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
CARRING	STON PLACE AT WYTH	HEVILLE - BIRDMONT		STON RD	24200		
(VA) ID	CLIMMADY C	FATCHENT OF DESIGNATION		VILLE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS OR LSC IDE	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Resident #378 was re 2/24/18 with the follow limited to anemia, confibrillation, high blood vascular disease and pulmonary disease. Tadmission MDS (Minirat the time of the surv to person, place and textensive assistance obathing. The surveyor reviewed Resident #378 on 2/26 surveyor noted that the orders signed or given telephone order when readmitted to the facilities ident's medications	eadmitted to the facility ving diagnoses of, but onary artery disease, a pressure, peripheral chronic obstructive. The resident did not harmum Data Set) completely. The resident was a ime and did require of 1 staff member for did the clinical record of 8/18 and 3/1/18. The ere were no physician to staff as a verbal the resident was ty on 2/24/18. However had been reordered as written on the dischargoital on 2/24/18. The director of nursing of dings on 3/1/18 at a cord of the resident are the MD (medical doctors. The nurses' should not obtained a verbal or sident's care. They did the administrative team of findings on 3/1/18 at a cord. Was provided to the w	r, the nd rge of the ng nd no or). I had der in't	F 635	3. In-servicing has been provided Licensed Nurses by the DON/Design before 04/04/18 regarding obtaining readmission orders appropriately. The Designee will conduct a review for (5 admits/readmits per week for (3) threat to ensure that admission/readmission have been obtained appropriately up admission/readmission. 4. The results of the reviews we discussed by the Administrator/Design QAPI committee meeting monthly for months. The IDT Committee will recrevisions to the plan as indicated to substantial compliance. 5. 04/04/18	nee on or admission/ he DON/ i) five new se months orders on vill be gnee at the (3) ommend	

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

JEOY11

If continuation sheet Page 7 of 75



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495349		B. WING			C 1/2018
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	ESS CITY ST	ATE, ZIP CODE		
	STON PLACE AT WYTH	HEVILLE - RIPDMONT		LSTON RD	AL, ZH GODE		
	J. O. L. LAGE AT TITLE	TEVILLE - BIRDWON		VILLE, VA	24382		
(X4) ID PREFIX TAG	, (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
		,		17.0	DEFICIENCY)	RIAIE	
F 641	Continued From page	e 7		F 641	i contract the second contract to the second		
F 641	Accuracy of Assessm	ents	İ	F 641	F 641 Accuracy of Assessments		04/04/18
SS=E	SS=E ⁺ CFR(s): 483.20(g)						
§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This Requirement is not met as evidenced by:) 		1. For Resident #32, a modification completed for the assessment with As Reference Date 12/04/17 for Section Resident #33, a modification was complete assessment with Assessment Ref	ssessment K. For apleted for ference	
	Based on staff intervie		y .		Date 12/05/17 for Section K. For Res	ident #41,	i I
		ff failed to ensure accur	ate		a modification was completed for the		
		set) assessments for fo			assessment with Assessment Referen		: I
		nts #32, #33, #41, and			01/03/18 for Section K. For Resident modification was completed by the Mi Data Set (MDS) Coordinator for the as	nimum	:
	The findings included.				with Assessment Reference Date 01/2 Section I, to include the urinary tract in	24/18 for	
		he facility staff coded th			For current residents residing	g in the	
		t gain when in fact she	was		facility, the most recent MDS assessmeen reviewed on or before 04/04/20		
	a weight loss.						
		ealed that Resident #3	2		K and Section I are accurately coded. In-servicing has been complete.	المالم	
		o the facility 11/17/17.			 In-servicing has been completed the Administrator/Designee with the current 		
	Diagnoses included, b				MDS Coordinators regarding accurate	dy coding	
		netabolic encephalopati	ny,		Section I and Section K. A review will	be	
	pain, Alzheimer's dise hypothyroidism, and h		1		completed by the Administrator/Design	nee for (5)	
	hypothyroidisin, and h	ypertension.			five MDS assessments per week for (3	3) months	
	Section C (cognitive p	atterns) of the Residen um data set) assessme	ts		to ensure that Section I and Section K been coded accurately.	have	
		nent reference date) of	i		4. Results of the reviews will be		
	12/04/17 was coded 1.				discussed by the Administrator/Design QAPI meeting monthly for (3) three mo		
		s with long and short te	rm		The IDT will recommend revisions to the	nuns.	
		erely impaired in cogniti			as indicated to sustain substantial com	ipliance	
:	skills for daily decision				5. 04/04/18	phanoc.	
		status) had been code	d to	İ			
	indicate the Resident v	was 64 inches tall, weig	hed			-	
	109 pounds and was a	weight gain.		į			
		nts MDS assessments				į	
		Significant change MD				1	ł
		RD of 03/08/17 weight					[
:	pounds. Quarterly asse	essment with an ARD o	f				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03	C 5 /01/2018	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	ZIP CODE			
CARRING	STON PLACE AT WYT	HEVILLE - BIRDMONT		LSTON RD VILLE, VA 243	382			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From pag	e 8		F 641				
	06/05/17 weight 127		: 107	1 041				
	dietician provided the Residents weights will circled.	I service manager and surveyor with a copy o th the following weights						
	02/03/17 weight 122 03/03/17 weight 114 05/19/17 weight 127			İ				
	07/06/17 weight 112 09/04/17 weight 107 11/01/17 weight 105.2	20						
	12/01/17 weight 109			į				
	service manager verb	esidents weights, the fo alized to the surveyor t for 12/04/17 should ha ht loss.	hat					
		ssment during a meetin on 02/28/17 at 1:34 p.m						
P	provided to the survey conference.	•	as					
	ensure a complete and Change Minimum Date		47	-				
	The facility staff failed significant weight loss	to accurately code a	17.					
	admitted on 9/18/17. A included, but were not	2 year old female who was admitting diagnoses limited to: encephalopatension, muscle weakne	athy,					

Printed: 03/16/2018 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) DBO)/IDED/CUDD/JED/C		(X2) MULTIPLE	CONSTRUCTION		NO. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	30.1011	(X3) DATE S COMPL	
				<u> </u>		001411 2	C
		495349		B. WING		03	/01/2018
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	I RESS, CITY, STATE,	ZID CODE		70172010
	STON PLACE AT WYTH	HEVILLE - BIRDMONT		LSTON RD	ZIF CODE		
	TON LAGE AT WITH	TEATER - BIKDIMONI	_	EVILLE, VA 243	182		
		· · · · · · · · · · · · · · · · · · ·	******	VILLE, VA 240			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE	GUI ATORY	ID PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE AC		(X5) COMPLETION
TAG		ENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO		DATE
					DEFICIEN	NCY)	
F 641	Continued From page	e 9		F 641			
	dementia without beh	aviors, gout and anxiet	v.	İ			
			,				
		imum Data Set (MDS)		i			i
		n the clinical record was					
		DS with an Assessmen		1			!
	Reference Date (ARD) of 12/27/17. The faci	lity				
;		ent #33 had a Cognitiv		ļ			
		The facility staff also o					
;		uired extensive (3/3) to					
ļ		n Activities of Daily Livir . Swallowing and Nutrit					
į		f coded that Resident #					
		Resident #33 was not					
		g a Significant Weight k					!
i		g = e.gount troignt i					i l
	On February 27, 2018	at 1 p.m., the surveyor	-				
	reviewed Resident #33	3's clinical record. Revi	ew				
		roduced Resident #33's		İ			
	weights since admission	on. Resident #33 weig	ht				
	was documented as w	eighing 198 pounds on	!				
1	admission. The survey	or calculated that Resi	dent	i			
	#33 had a 14.65% wei			!			!
	speak with the MDS N	surveyor requested to					
	Speak with the MDS N	urse.	ĺ	!			
	On February 27, 2018	at 3:45 n m, the MDS					
	Nurse, who was a Red	istered Nurse, approac	hed :				
	the surveyor. The sun	veyor notified the MDS		į			
	Nurse that Resident #3	33 was admitted weighi	ng	!			
	198 pounds and that o	n 12/5/17 Resident #33	3's				
		s. The surveyor notifie	d	1			! [
	the MDS Nurse that Re						
		of 14.65% during the t		:			
		gh 12/5/17. The surve					ļ 1
		that a Significant Cha		:			
		5/17 and that the MDS	did				
	not capture/code Resid			ı			i
	Weight loss of 14.64%.	. The MDS Nurse and sident #33's weights and	_				
i	the Significant Change	MDS with the APD of	u !	i			
	and digrimicant Charige	with the AKD of					

A Marie Tolker

JEOY11

If continuation sheet Page 10 of 75



		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03	C / 01/2018	
	OVIDER OR SUPPLIER	HEVILLE - BIRDMONT	990 HO	RESS, CITY, STATE, LSTON RD WILLE, VA 243				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 641	did not capture Resid loss. The MDS Nurse manager completed S MDS Nurse stated that MDS with the ARD of coded to reflect Resid loss. On February 27, 2018	r pointed out that the Ment #33's Significant We stated that the dietary Section K of the MDS. at the Significant Change 12/5/17 should have beent #33's Significant Wes at 4:30 p.m., the surves	/eight / The ge een /eight	F 641				
	On February 27, 2018 at 4:30 p.m., the surveyor notified the Administrator (Adm), Director of Nursing (DON) and ADON that Resident #33 was receiving Coumadin every day. The surveyor notified the Administrative Team (AT) that Resident #33 had a Significant Weight loss from 9/18/17 through 12/5/17. The surveyor notified the AT that the Significant Weight loss was not coded/captured on the Significant Change MDS with the ARD of 12/5/17.							
	survey team prior to e the facility staff failed to accurate MDS assess 3. For Resident #41 the ensure a complete and Data Set (MDS) assess	d accurate Annual Mini ssment with an Assessr) of 1/3/18. The facility at Resident #41 had a	mum ment					
	admitted on 8/19/15. A included, but were not without behaviors, hyp	limited to: dementia pertension, major Izheimer's, chronic kidr ire to thrive.	:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB			A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495349		B. WING		03	C 3/ 01/2018	
NAME OF PROVIDER OR SUPPLIER	}	STREET ADDR	RESS, CITY, STATE	, ZIP CODE			
CARRINGTON PLACE AT	WYTHEVILLE - BIRDMONT		LSTON RD VILLE, VA 24	382			
PREFIX (EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL RE SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 641 Continued From	page 11		F 641				
record was an A ARD of 1/3/18. Resident #41 ha 6. The facility strequired extensiwith Activities of K. Swallowing a staff coded that pounds. The fac Resident #41 ha in the past 30 da On February 27, reviewed Reside of the clinical recidentified that Recomfort Care.	nnual MDS assessment with The facility staff coded that d a Cognitive Summary Sociaff also coded that Resident ve (3/2) to total nursing care Daily Living (ADL's). In Second Nutritional Status, the fact Resident #41 weighed 113 cility staff additionally coded d a Significant Weight loss of the company of the past 6 more 2018 at 4 p.m., the surveyont #41's clinical record. Resident #41 was receiving comfort Care measures initial centified that the family wanted	ore of t #41 e (4/2) etion cility that of 5% onths. or view eat	F 041				
Further review o that Resident #4 12/3/15 and was obtained since 1 the MDS Nurse to surveyor about F. On February 27, who was a Licentand spoke with the MDS was on Comfort been obtained sit notified the MDS MDS with an AR Resident #41 has surveyor reviewed with the MDS Nurspecifically reviews	the clinical record documer t's weight was obtained on 113. No weights had been 2/3/15. The surveyor reque o come and speak with the	e, came #41 not then I The cord					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495349		B. WING		03	C / 01/2018	
	ROVIDER OR SUPPLIER STON PLACE AT WYTI	HEVILLE - BIRDMONT	990 HO	ADDRESS, CITY, STATE, ZIP CODE HOLSTON RD THEVILLE, VA 24382				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	Resident #41's MDS a a Significant Weight lost stated she did not cor MDS. The MDS Nurs manager completed S (LPN) stated that the inaccurately as Reside weighed since 12/3/15 On February 28, 2018 notified the Administra Nursing (DON) that Rewith the ARD of 1/3/18 surveyor notified the Athat Resident #41 was her weight had not be The surveyor notified Annual MDS with the Afor a Significant Weight No additional informat exiting the facility as to ensure a complete assessment for Reside inaccurately coded that Significant weight loss assessment with the Afor Resident #71 the ensure a complete and Minimum Data Set (MI Assessment Reference The facility staff failed Tract Infection in the latactive Diagnoses.	surveyor pointed out that was inaccurately coded oss. The MDS Nurse (implete Section K of the se stated that the dietar Section K. The MDS Nu MDS was coded ent #41 had not been 5. Set at 9:45 a.m., the surventor (Adm) and Director esident #41's Annual MB was inaccurate. The administrative Team (ATS on Comfort Care and en obtained since 12/3, the AT that Resident #4 ARD of 1/3/18 was code to why the facility staff fained accurate MDS ent #41. The facility staff fained accurate MDS ent #41. The facility staff fained accurate Quarterly DS) assessment with an end accurate Code a Urir list 30 days in Section I.	eyor of IDS Ithat /15. 41's ed to ailed aff	F 641				
	originally admitted on 8	3/8/12 and readmitted of gnoses included, but w	on					

Printed: 03/16/2018 FORM APPROVED

OLIVILIA	OT ON WEDICANE &	VILDICAID SERVICES				OMB	<u>NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE (COMPL	ETED
		495349		B. WING		0.3	C 3/01/2018
NAME OF DE	ROVIDER OR SUPPLIER	L	CTDCCT ADD	DECC OITY STATE	TID OODS		70172010
	STON PLACE AT WYT	HEVILLE DIDDMONT		RESS, CITY, STATE,	, ZIP CODE		
CARRING	STON PLACE AT WITH	HEVILLE - BIKDMON!		LSTON RD EVILLE, VA 24:	382		
0/40/15	CUMMADYO	TATEMENT OF REPORTS					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From pag	e 13		F 641			
	not limited to: cholecy	stitis, chronic kidney					!
		and cerebrovascular					
	accident with left hem	iparesis.	į	į			!
			!	:			
		imum Data Set (MDS)					
		n the clinical record was	-	İ			
		sment with an Assessm 0) of 1/24/18. The facilit					
		lent #71 had a Cognitive					!
		The facility staff also	:	İ			
		71 required extensive (3/2)	ļ			
	assistance with Activit	ies of Daily Living (ADL	's).	İ			
		agnoses, a Urinary Trac	at i	!			
	Infection in the last 30	days was not coded.	:				
İ	On February 27, 2018	at 12 noon, the survey	i	1			
:	interviewed Resident	#71 Resident #71	Or .				
		that he had recently be	en				
ļ	in the hospital with a u	rinary tract infection.					
	0.51		!				
İ	On February 27, 2018	at 1:20 p.m., the surve	yor	ļ			
		1 clinical record. Review duced nurses' notes that					
		dent #71 had been ill ar					;
i		ted that he be sent to a	iu	!			
	local hospital on 1/8/1						<u> </u>
	Continued review of th	ne clinical record reveale	ed a	į			
	Hospital Progress Not	e dated 1/17/18 that		İ			į
į	documented that Resi	dent #71 had a "bacteria	al"	!			
ļ	urinary tract infection a		į				
	indwelling urethral catl	neter. Resident #71 had	d a	ĺ			
	positive urinalysis and	culture and sensitivity a	ınd	·			
	was treated with Zosyr	n and Augmentin		!			
!	(antibiotics).		į	į			1
	On February 27, 2018	at 1:45 p.m., the survey	or !	ĺ			
	spoke with the MDS N	urse, who was a Licenso	ed				
		The surveyor notified t		İ			
	MDS Nurse (LPN) that	Resident #71's Quarter	dy !	:			
ĺ	MDS with the ARD of	1/24/18 was incorrect. T	he	i :			!
				1			· ·

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/O		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		0.3	C 3/01/2018	
	ROVIDER OR SUPPLIER			RESS, CITY, STATE,	ZIP CODE			
CARRING	STON PLACE AT WYTI	HEVILLE - BIRDMONT		LSTON RD EVILLE, VA 243	382			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	with the MDS Nurse (out that Resident #71 to the hospital on 1/8/reviewed Resident #7 that documented a poand sensitivity, treatmand physician diagnosis of the surveyor then review the MDS Nurse (out that Section I did ract infection in the panal Nurse (LPN) stated the matter. The surveyor in the surv	esident #71's clinical red LPN). The surveyor pot had been ill and was so 18. The surveyor then 11's Hospital Progress No esitive urinalysis and cubent with antibiotics and fa urinary tract infection viewed the Quarterly Mil LPN). The surveyor pot not code/capture a urinal ast 30 days. The MDS at she would look into the requested the MDS Nut. Assessment Instruction	ointed sent Notes Iture I a n. DS ointed ary the					
	On February 27, 2018 Nurse, a Registered N surveyor and informed never coded a urinary with a recent hospital a informed the MDS Nur period for a urinary tra and therefore if a Resi infection within a 30 pe assessment it must be regardless of it was du surveyor opened up th	at 3 p.m. a different Miurse (RN), approached the surveyor that she tract infection associated admission. The surveyone (RN) that the lookbed to infection was 30 day dent had a urinary tracteriod of the MDS coded/captured uring a hospital stay. The surveyor's copy of the ved the RAI guidelines	d the had ed ed eack s					
	notified the Administrat Nursing (DON) that Re MDS with the ARD of 1	/24/18 was inaccurate. ne Administrative Team	of					

F 641 Continued From page 15 infection during his recent admission in the hospital (1/8/18 through 1/20/18). The surveyor	AND PLAN (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SU COMPLET	
AMME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT (X4) ID PREFIX TAG OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 15 infection during his recent admission in the hospital (1/8/18 through 1/20/18). The surveyor			495349		B. WING_		03/0	
CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT 990 HOLSTON RD WYTHEVILLE, VA 24382 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 15 infection during his recent admission in the hospital (1/8/18 through 1/20/18). The surveyor	NAME OF PR	OVIDER OR SUPPLIER	R SUPPLIER	STREET ADDR	RESS, CITY, ST	ATE, ZIP CODE	03/0	172016
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 15 Infection during his recent admission in the hospital (1/8/18 through 1/20/18). The surveyor	CARRING	TON PLACE AT WYTH	ACE AT WYTHEVILLE - BIRDMON	990 HOI	LSTON RD			
infection during his recent admission in the hospital (1/8/18 through 1/20/18). The surveyor	PREFIX	(EACH DEFICIENCY MUST	DEFICIENCY MUST BE PRECEDED BY FULL RI		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
notified the AT that the urinary tract infection should have been code/deptured on the MDS assessment with the ARD of 1/24/18. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #71. The facility staff failed to code/capture a urinary tract infection in the past 30 days. F 655 Baseline Care Plan SS=E CFR(s): 483.21(a)(1)-(3) S483.21 Comprehensive Person-Centered Care Planning (ABS) and the facility (ABS)	F 655 SS=E	infection during his red hospital (1/8/18 throughospital (1/8/18 thr	In during his recent admission in the I (1/8/18 through 1/20/18). The survithe AT that the urinary tract infection have been coded/captured on the Minent with the ARD of 1/24/18. Ititional information was provided prior the facility as to why the facility staffers a complete and accurate MDS ment for Resident #71. The facility so code/capture a urinary tract infection to 30 days. In Comprehensive Person-Centered (1/9) In Comprehensive Pers	to failed taff n in Care dent ide sident are. t's	F 655	1. Resident #386 no longer resident facility. Resident #26 no longer resident facility. Resident #172 no longer resident facility. Resident #172 no longer resident facility. For Resident #381, Resident #378, Resident president facility. For Resident #381, Resident #378, Resident president or responsible party. 2. There has been a review concept the Administrator/Designee for currer residents residing in the facility to ensure baseline care plans have been initiated provided/reviewed with the resident and responsible party. 3. In-servicing has been provided Administrator/Designee regarding the requirements for initiating a baseline cand presenting it to the resident or responsity. A review will be completed by the Administrator/Designee for (5) five newly admitted/readmitted residents per week three months to ensure that the baseling plan has been initiated and presented to	sides in esides in esides in esides in has he ducted ent ere that dand d/or d by the ere plan consible e ely c for (3) e care	04/04/18

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1	X2) MULTIPLE CONSTRUCTION A. BUILDING		O. 0938-039 RVEY ED
		495349		B. WING			C 1/ 2018
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
CARRING	TON PLACE AT WYT	HEVILLE - BIRDMONT		LSTON RD			
		i	WYTHE	VILLE, VA	24382		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUS OR LSC ID	T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
	admission. (ii) Meets the requirer (b) of this section (excord this section). §483.21(a)(3) The faresident and their repof the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the facility (iv) Any updated inform of the comprehensive This Requirement is repassed on staff intervied clinical record review at the facility staff failed to summary of the baseli (Resident's #381, #380 and #172). The findings included: 1. The facility staff failed representative with a becomprehensive with a becompleted #381 was add 2/23/18. Resident #381 was add 2/23/18 with the following imited to heart attack, diabetes, congestive here weakness. The residence ompleted MDS (Minimizering admitted to the facility staff failed to the facility staff failed to the facility staff failed the facility st	ments set forth in paragrephing paragraph (b)(2) cility must provide the resentative with a summan that includes but is the resident. The resident resident and personnel activity and personnel activity and personnel activity and personnel activity and personnel activity and personnel activity and facility document reso provide a written ne care plan for 7 of 27 6, #26, #378, #387, #12 and facility document reso provide a written ne care plan for 7 of 27 6, #26, #378, #387, #12 and facility on mitted to the facility on ing diagnoses of, but high blood pressure, eart failure and general num Data Set) due to	mary not and ting tails y. y: eview	F 655	4. Results of the review will be discussed by the Administrator/Dest the QAPI committee meeting month three months. The IDT will recomm revisions to the plan as indicated nesustain substantial compliance. 5. 04/04/18	signee at oly for (3) nend	
			1	i		!	j

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

If continuation sheet Page 17 of 75



	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495349		B. WING		C 03/01/2018			
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STAT	E, ZIP CODE				
CARRING	STON PLACE AT WYTH	HEVILLE - BIRDMONT	990 HOL	HOLSTON RD					
			WYTHE	VILLE, VA 24	4382				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION			
F 655	Continued From page	e 17		F 655					
		resident was alert and	ı	1 055					
	oriented to person, place and time. The resident					;			
	also required extensiv	e assistance of 1 staff		!					
	member for bathing.		!						
	.			i					
	The surveyor conduct	ed a resident interview	with	!					
	Resident #381 on 2/27	7/18 at 2:39 pm. The							
	surveyor asked the re	sident if she had been	given	1					
	a copy of the base line	e care plan when she w	/as	!		:			
	admitted on 2/23/18.	The resident stated, "I	don't	į					
	remember them going Friday when I came in	over this with me last	1	:		ļ			
	r nday when i came in		!	!		!			
i	The surveyor reviewed	the clinical record of	1						
		3/18. During this reviev	i i	i					
		it the baseline care plai		!					
		The baseline care pla							
İ		the last page of the ca							
		natures from the reside		į					
ļ	or representative statir	ng they had received co	ppies	1					
İ		an or that this care plar				;			
1	had been reviewed wit	th them by the facility st	aff.						
ļ	The surveyor notified the findings to the director approximately 1:30 pm stated that she would find been given to the residual to the stated that she would find the stated that she would	of nursing on 2/28/18 a The director of nursing The director of nursing out if this care plan	ng ,						
	The surveyor notified the administrative team of the above documented findings on 2/28/18 at 1:40 pm. The director of nursing stated, "I have talked with staff and they did not go over the information on the baseline care plan with the resident or representative. They said they haven't started that yet."								
İ	At 4 pm, the director of surveyor with the facility Care Plan". Under the	y's policy titled "Baselin	ie						

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE	, ZIP CODE		
CARRING	STON PLACE AT WYT	HEVILLE - BIRDMONT	990 HOL	LSTON RD VILLE, VA 24			
(V 4) ID	CUMMADVC	TATEMENT OF RESIDENCE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 655	Continued From pag	e 18		F 655			
	Explanation and Compolicy stated the following. "4. A written splan shall be provided representative in a large resident/representative in a large summary shall include following: a. The initial b. A summan medications and dietar c. Any service	apliance Guidelines, the wing: summary of the baseline of the to the resident or an anguage that the attaive can understand, e, at a minimum, the goals of the resident, but of the resident's any instructions, the sees and treatments to be	The				
	administrated by the facility and personnel actin on behalf of the facility" No further information was provided to the						
		exit conference on 3/1/1	8.				
	2. The facility staff fail baseline care plan wh admitted to the facility	ed to provide a copy of en Resident #386 was on 2/23/18.	the	!			
	Resident #386 was admitted to the facility on 2/23/18 with the following diagnoses of, but no limited to chronic obstructive pulmonary diseas and oxygen dependent. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey since the resident was admitted to the facility on 2/23/18 According to the admission assessment documentation, the resident was alert and oriented to person, place and time. The reside also required limited supervision of 1 staff member for bathing.		8.				
	Resident #386 on 2/27 the resident if he had r baseline care plan whe	ed a resident interview v 7/18. The surveyor aske eceived a copy of the en he was admitted to the e resident stated, "I don	ed ne				

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

JEOY11

If continuation sheet Page 19 of 75



NAME OF PROVIDER OR SUPPLIER	495349	B. WING		I C	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIED	STRE	I		03/01/2018		
OF THO VIDEN ON SUFFLIER		ET ADDRESS, CITY, STAT	FE, ZIP CODE			
CARRINGTON PLACE AT WYTHEVIL	LE - BIRDMONT 9	90 HOLSTON RD				
	N N	/YTHEVILLE, VA 2	4382			
PREFIX (EACH DEFICIENCY MUST BE PR	ENT OF DEFICIENCIES RECEDED BY FULL REGULATO ING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETIC	- NC	
F 655 Continued From page 19		F 655				
	remember getting anything on this when I was					
The surveyor conducted a cof Resident #386's chart. The baseline care plan dated for baseline care plan was compage of the care plan there from the resident or representad received copies of the bathat this care plan had been by the facility staff. The surveyor notified the abstindings to the director of nuapproximately 1:30 pm. The stated that she would find on been given to the resident of the above documented findings. The director of nual talked with staff and they did information on the baseline resident or representative. Started that yet." At 4 pm, the director of nurse surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility's possible of the surveyor with the facility of the surveyor with	The surveyor noted a r 2/23/18. The appleted but on the last were no signatures entative stating they baseline care plan or a reviewed with them above documented ursing on 2/28/18 at e director of nursing ut if this care plan had or representative. Imministrative team of angs on 2/28/18 at rsing stated, "I have do not go over the care plan with the They said they haven't ing provided the					
Care Plan". Under the section Explanation and Compliance policy stated the following: "4. A written summar	on of "Policy e Guidelines, the					
plan shall be provided to the representative in a language resident/representative summary shall include, at a refollowing: a. The initial goals of b. A summary of the						

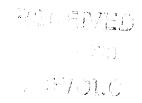
Printed: 03/16/2018 FORM APPROVED

OLIVICIO	OT ON MEDICANE & I	T TENERALD SERVICES				OMB	NO. 0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S	
		495349		B. WING		0.3	C 5/ 01/2018
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADDA	RESS, CITY, STATE.	710,0005		70172010
	STON PLACE AT WYT	UEVILLE DIDDMONT			, ZIP CODE		
OAINING.	TONT LACE AT WITH	HEVILLE - BIRDWIONI	i	LSTON RD VILLE, VA 24:	382		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		BE 071-11	1 045
PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	655 Continued From page 20			F 655			
	medications and dieta	ary instructions.					
	t contract the contract to the	ces and treatments to b	e .				
		facility and personnel a					
	on behalf of the facilit			!			
	No further information	was provided to the					
		exit conference on 3/1/1	8.	į			
	3. The facility staff fail	led to provide copies of	the				!
		Resident #26 when the					
		to the facility on 1/8/18					
	Resident #26 was adr	nitted to the facility on	į				
		ng diagnoses of, but no	ot .				
		Izheimer's disease, hig				•	
	blood pressure, anxie						
		Resident #26 was code	ed as	İ			1
	having a BIMS (Brief I	nterview for Mental Sta	itus)	i			
i	score of 7 out of 15 or		į				
	(Minimum Data Set).	The resident was also	:				
	coded as requiring ext	tensive assistance of 1	staff				
	member for personal h	nygiene and bathing.		ļ			
	The surveyor conducte						
į		sident being confused	and	:			
		stions on 2/28/18. The		į			
		presentative for the res					i
		tting a copy of the base					
		sident was admitted to					
i	facility on 1/8/18. The	representative stated,	"I				
		g any copies of paper o		İ			
		ed. I know I had to sig	n a				
	lot of papers when he	was admitted."	ļ				
	The surveyor conducte	ed a clinical record revi	ew				
	on Resident #26's clini	ical record. The survey	or				
	could not find documer	ntation of the facility sta					<u> </u>
ļ	explaining or provided	the resident or					1
ĺ	representative a copy of	of the baseline care pla	n i	İ			
	when the resident was	admitted to the facility	on				

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

JEOY11

If continuation sheet Page 21 of 75



	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/	C 01/2018
	ROVIDER OR SUPPLIER			ESS, CITY, STATE,	ZIP CODE		
CARRING	STON PLACE AT WYTH	HEVILLE - BIRDMONT		∟STON RD VILLE, VA 243	882		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 655	Continued From page 1/8/18.	e 21		F 655			
	The surveyor notified the above documented findings to the director of nursing on 2/28/18 at approximately 1:30 pm. The director of nursing stated that she would find out if this care plan had been given to the resident or representative. The surveyor notified the administrative team of the above documented findings on 2/28/18 at 1:40 pm. The director of nursing stated, "I have talked with staff and they did not go over the information on the baseline care plan with the resident or representative. They said they haven't started that yet." At 4 pm, the director of nursing provided the surveyor with the facility's policy titled "Baseline Care Plan". Under the section of "Policy Explanation and Compliance Guidelines, the policy stated the following: "4. A written summary of the baseline care plan shall be provided to the resident or representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following:						
	b. A summary medications and dietar	es and treatments to be acility and personnel ac					
	No further information surveyor prior to the ex		8.				
	4. The facility staff faile baseline care plan to the representative when R	ne resident or	the				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/	C /01/2018	
	OVIDER OR SUPPLIER			RESS, CITY, STATE,	ZIP CODE			
CARRING	STON PLACE AT WYTH	HEVILLE - BIRDMONT		ILSTON RD EVILLE, VA 243	382			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 655	Continued From page	e 22		F 655				
	readmitted to the facil	lity on 2/24/18.					j	
	2/24/18 with the follow limited to anemia, cor fibrillation, high blood vascular disease and pulmonary disease. Tadmission MDS (Minimat the time of the surv to person, place and textensive assistance obathing. The surveyor reviewed Resident #378 on 2/28 surveyor could not find facility staff explaining representative a copy	chronic obstructive The resident did not have mum Data Set) comple ey. The resident was a ime and did require of 1 staff member for d the clinical record of	not trial ve an ted alert					
		the above documented						
!		of nursing on 2/28/18 on The director of nursi		i i				
	stated that she would:	find out if this care plan	had				!	
!	been given to the resid	dent or representative.						
	The surveyor notified the administrative team of the above documented findings on 2/28/18 at 1:40 pm. The director of nursing stated, "I have talked with staff and they did not go over the information on the baseline care plan with the resident or representative. They said they haven't started that yet."							
	At 4 pm, the director of surveyor with the facilit Care Plan". Under the Explanation and Comp	ty's policy titled "Baselin section of "Policy	ne					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03	C / 01/2018	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE	, ZIP CODE			
CARRING	STON PLACE AT WYT	HEVILLE - BIRDMONT		LSTON RD	,			
				VILLE, VA 24	382			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ODDECTION	(VE)	
PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 655	Continued From pag	e 23		F 655			l .	
	policy stated the follo			, 655				
		summary of the baseline	care					
	plan shall be provided	d to the resident or						
	representative in a lai		i				i	
		ntative can understand.	The	i .				
	summary shall include	e, at a minimum, the					i	
	following:		i					
		goals of the resident.	!	ļ			i	
	medications and dieta	y of the resident's						
	c Any service	es and treatments to be	.	i			į .	
	c.Any services and treatments to be administrated by the facility and personnel acting							
	on behalf of the facility	y"	g	İ				
	•	•					ĺ	
	No further information		: i					
	surveyor prior to the e	exit conference on 3/1/1	8.	!				
	F. For Decident #007	al de las companyons		ļ				
	o. For Resident #38/	the facility staff failed to Resident representative					!	
	a written summary of	rtesident representative the baseline care plan.	with	ĺ				
	a willow ballinary or i	ine baseline care plan.						
	Resident #387 was ac	imitted to the facility on						
	02/16/18. Diagnoses i	ncluded but not limited	to					
	hypertension, gastroes	sophageal reflux diseas	se,	ļ				
ĺ	diabetes mellitus, hype	erlipidemia, osteoporosi	is,	1				
	anxiety, depression ar	nd schizophrenia.					i	
ĺ	The most recent MDC	(mainting on the first of the state of the s		Ì				
		(minimum data set) wit reference date) of 02/28		i				
:	coded the Resident as		3/18	İ				
	cognitive status. This i	s an admission MDS	!					
İ		o an admission MDG.						
	The Resident's baseling	ne care plan was review	ed i	!				
	on 02/27/18. The secti	on of the care plan entit	tled	į				
	"written summary" was	s blank. The care plan w	/as	i				
	dated as having been	completed on 02/16/18	and	į				
	dated as having been	reviewed with the Resid	lent				1	
	on 02/19/18.						i l	
İ	Surveyor spake with th	0 Donidont 00/07/4	!	!				
	ourveyor spoke with th	ne Resident on 02/27/18	at					

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STATE,	ZIP CODE	<u> </u>	_
CARRING	STON PLACE AT WYTH	HEVILLE - BIRDMONT		STON RD /ILLE, VA 243	382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 655	Continued From page	e 24		F 655			ᅦ
	approximately 0900. Resident stated that she had not received a written summary of her baseline care plan.						
	baseline care plan on 1705. DON could not whether or not the wriprovided to the Reside surveyor with a policy Plan" which read in paplan will: a. Be develor Resident's admission. of the baseline care plansident and represent	he DON regarding the 02/28/18 at approxima provide information as tten summary had bee ent. The DON provided entitled "Baseline Care art "1. The baseline cafe pped within 48 hours of " and 4. A written summan shall be provided to tative in a language that at ive can understand"	to n the e a mary the				
	the Resident/representative can understand". The concern of a written summary of the baseline care plan not being provided was discussed the administrative team during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit.		eline the 01/18				
	provide a written summal plan to the Resident and	mitted to the facility on	re l				
	diabetes mellitus, anxidisorder, attention defi- The most recent MDS an ARD (assessment recoded the Resident as	ety, schizoaffective cit hyperactivity disorde (minimum data set) wit reference date) of 02/2	er. :h 2/18				

ASSENTATION OF THE PROPERTY OF

ANAL OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT INAL ID SUMMARY STATEMENT OF DEPICIENCIES PREFIX (EACH DEPICIENCY MUST BE PRECORDED BY FULL REPOLATORY TAG OF THE CONTROL OF THE PROVIDER'S PLAN OF CONNECTION (EACH DEPICIENCY MUST BE PRECORDED BY FULL REPOLATORY TAG F 655 Continued From page 25 The Resident's baseline care plan was reviewed on 02/27/18. The section of the care plan was dated as having been completed on 02/13/18 and dated as having been reviewed with the Resident on 02/13/18. Surveyor spoke with the BoN regarding the baseline care plan on 02/28/18 at approximately 0925. Resident stated that she had not received a written summary of her baseline care plan on 02/28/18 at approximately 1705. DON could not provide information as to whether or not the written summary had been provided to the Resident. The DON provided the surveyor with a policy entitled "Baseline Care Plan" which read in part "1. The baseline care plan and a Beeveloped within 48 hours of a Resident's admission." and 4. A written summary of the baseline care plan not being provided was discussed the administrative team during a meeting on 03/01/18 at approximately (635. No further information was provided pnor to exit. 7. For Resident's 172, facility staff failed to initiate a baseline care plan, including the resident's goals for care, and share it with the resident. Resident #172 was admitted to the facility from home on 2/15/18. The admission Minimum Data Set assessment with assessment reference date 2/26/18 indicated the resident for the provident on the side of the provident of the resident for the provident of the provident of the facility from home on 2/15/18. The admission Minimum Data Set assessment with assessment reference date 2/26/18 indicated the resident for the provident of the provident of the provident of the provident of the provident of the provident of the provident of the provident of the provident of the provident of the provident of the provident of the provident of the provident		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE §	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS CITY, STATE ZIP CODE SOURCESTON RD WYTHEVILLE, VA 24382 PROMDERS PLAN OF COMESTION BY WYTHEVILLE, VA 24382 PROMDERS PLAN OF COMESTION BY (EACH DEPROEMEN' MUST DE PRÉCIDED BY PULL REQUAL/YORY PRÉEIX 7AG CRECI DEPROEMEN' MORT DE PRÉCIDED BY PULL REQUAL/YORY PRÉEIX TAG TAG CROSS-REFERÊNCED TO THE APPROPHIATE DEFICIENCY) F 655 Continued From page 25 The Resident's baseline care plan was reviewed on 02/27/18. The section of the care plan entitled "written summary" was blank. The care plan was dated as having been completed no 02/13/18 and dated as having been completed no 02/13/18 and dated as having been completed no 02/13/18 and not received a written summary of her baseline care plan on 02/28/18 at approximately 1705. DON could not provide information as to whether or not the written summary had been provided to the Resident. The DON provided the surveyor with a policy entitled "Baseline Care Plan" which read in part "I. The baseline care Plan" which read in all the provided to the Resident and representative in a language that the Resident sadmission," and 4. A written summary of the baseline care plan not being provided was discussed the administrative team during a meeting on 03/0/18 at approximately 1635. No further information was provided prior to exit. 7. For Resident #172, facility staff failed to initiate a baseline care plan, including the resident's goals for care, and share it with the resident's goals for care, and share it with the resident's son asseminent with assessment with assessment reference date 2/26/18 indicated the residents for the passing and the resident son the provided prior to exit. 1. For Resident #172 was admitted to the facility from home on 2/15/18. The admission Minimum Data Set assessment with assessment reference date 2/26/18 indicated the residents.		495349 B. WING		0.3	C 8/01/2018				
PREFIX TAG (EACH EDRICION Y MUST BE PRECEDED BY FULL REQUESTORY TAG CROSS-REFERENCED TO THE APPROPHIATE CROSS-REFERENCED THE APPROPHIATE CROSS-REFERENCED THE APP			HEVILLE - BIRDMONT	990 HO	LSTON RD				
The Resident's baseline care plan was reviewed on 02/27/18. The section of the care plan entitled "written summary" was blank. The care plan was dated as having been completed on 02/13/18 and dated as having been reviewed with the Resident on 02/16/18. Surveyor spoke with the Resident on 02/27/18 at approximately 0925. Resident stated that she had not received a written summary of her baseline care plan. Surveyor spoke with the DON regarding the baseline care plan on 02/28/18 at approximately 1705. DON could not provide information as to whether or not the written summary had been provided to the Resident. The DON provided the surveyor with a policy entitled "Baseline Care Plan" which read in part "1. The baseline cafe plan will: a. Be developed within 48 hours of a Resident's admission." and 4. A written summary of the baseline care plan shall be provided to the Resident and representative in a language that the Resident provided was discussed the administrative team during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit. 7. For Resident #172, facility staff failed to initiate a baseline care plan, including the resident's goals for care, and share it with the resident. Resident #172 was admitted to the facility from home on 2/15/18. The admission Minimum Data Set assessment with assessment reference date 2/26/18 indicated the resident scored 15/15 on	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION	
the brief interview for mental status and was		The Resident's baseli on 02/27/18. The seci "written summary" wa dated as having been dated as having been on 02/16/18. Surveyor spoke with tapproximately 0925. Finot received a written care plan. Surveyor spoke with tapproximately 0925. Finot received a written care plan. Surveyor spoke with the baseline care plan on 1705. DON could not whether or not the write provided to the Resides surveyor with a policy Plan" which read in paplan will: a. Be develor Resident's admission. of the baseline care plan will: a. Be develor Resident and represente Resident/represente Resident/represente Resident and represente Resident and represente Resident and represente Resident and represente Resident and represente Resident and represente Resident and represente Resident and represente Resident and represente Resident #172 was adhome on 2/15/18. The Set assessment with a 2/26/18 indicated the resident #172 was adhome on 2/15/18. The Set assessment with a 2/26/18 indicated the residente Reside	tion of the care plan entits blank. The care plan entits blank. The care plan is blank. The care plan is completed on 02/13/18 reviewed with the Resident on 02/27/18 Resident stated that she summary of her baseline the DON regarding the 02/28/18 at approximal provide information as atten summary had been entitled "Baseline Care art "1. The baseline care	titled was B and ident B at e had ne tely to the e a nary the at elline he i1/18 exit. tiate	F 655				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	ETED
	495349			B. WING		02	C / 01/2018
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	7ID CODE		101/2018
		HEVILLE - BIRDMONT		LSTON RD	ZIP CODE		
		TEVICEE - BINDINGIN		VILLE, VA 243	182		
040.45	01000000		***************************************	VILLE, VA 240	, o z		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 655	Continued From page	e 26		F 655			
	without symptoms of delusions, psychosis, or behavior affecting self or others. The resident was listed as the responsible party. The resident's diagnoses included hypertension, renal						
	diabetes mellitus.	ophagi reflux disease, a	and				
	During an brief interview during the entrance tour on 2/26/18, the resident reported concerns with discharge planning, diabetes care, and therapy services. On 2/27/18, the surveyor conducted a more extensive interview with the resident. The resident reported agreeing to a family request that she enter the facility for a month to gain strength after a fall at home that resulted in an Emergency Department visit without an admission. The resident reported that, while therapy staff have discussed discharge goals, there seems to be little effort to assist with increasing walking strength. Therapy consists mainly of riding a stationary bicycle. An aid assisted with walking in the hall once at the resident's specific request. The resident was also concerned that the insulin and antianxiety medication orders had been changed without						
	The nurse said that the about short-term place admitted for long term that the resident's grar the staff pictures on a the resident being disc	the resident's concern. It resident was mistaked thement. The resident was care. The nurse reported son had shown some cell phone that preclude that ged to the home. To dult Protective Service	n ed e of ed				
	On 02/27/18 11:46 AM	, the care plan in the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBE			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495349		B. WING _		C 03/01/2018	
	ROVIDER OR SUPPLIER	HEVILLE - BIRDMONT	990 HO	RESS, CITY, ST LSTON RD VILLE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 660	baseline care plan was incomplete and unsig documented that the term care. Sections a functional goals, psycoplans, barriers to resident or caregiver a signatures of interdisc contributing to the bassummary of baseline final page stated that baseline care plan have resident on 2/19/18. Vno summary of the cacoordinator reported twant a summary. On 2/28/18, the surve with the incomplete pladdress the resident are plan and failure to proplan to the resident are Discharge Planning Pt CFR(s): 483.21(c)(1)(i) §483.21(c)(1) Discharge facility must developed the proposed for the facility must developed the plant of the resident are planting processes the resident are planting	cord was dated 2006. The solocated and was need. The baseline care resident was to remain addressing therapy, shosocial needs, dischardent's discharge goals, educational needs, ciplinary team members seline care plan, and wo care plan were blank. The incomplete, unsigned been shared with the Vhen asked why there are plan, the MDS hat the resident did not a yor reported the conce an of care and failure to stated goals in the care vide summaries of the and a representative. Trocess (a)-(ix) The partners and effective discharge care, and the discharge care, and the discharge care, and the discharge care, and the discharge care and stated in the discharge planning istent with the discharge planning the stated of each and result in the	e plan long arge s written The ed was t rns o re care	F 660	F 660 Discharge Planning Process 1. For Resident #172, discharge planning was initiated and the resident discharged from the facility on 03/20/12. Residents currently residing i center have had their care plan review before 04/04/18 for goals and discharged from the facility on 03/20/12. Residents currently residing it center have had their care plan review before 04/04/18 for goals and discharged.	t was 8. in the ved on or	

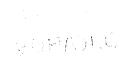
Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

		T		-T		OMB NO. 0938	<u>8-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/(1	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBI	ER:	A. BUILDIN	G	COMPLETED	
				1		C	
		495349		B. WING _		03/01/2018	
NAME OF PE	NAME OF PROVIDER OR SUPPLIER STREE				ATE, ZIP CODE		
CARRING	STON PLACE AT WYTH	HEVILLE - BIRDMONT		LSTON RD			
				EVILLE, VA	24382		
07.0.45	0.1444400.40		<u> </u>		24302		
(X4) ID PRÉFIX		TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE		ID	PROVIDER'S PLAN OF CORRECT		.5) ETION
TAG		ENTIFYING INFORMATION)	GOLATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	-D DL	TE
	· 				DEFICIENCY)	TIGALE	
F 660	Continued From page	e 28	····	F 660	3. In-servicing has been provi	1-11	
		evaluation of residents	to	1 000	3. In-servicing has been provi Administrator/Designee on or before	ded by the	
	identify changes that	require modification of	tho		04/04/2018 to the IDT regarding initi	stion of	
		lischarge plan must be	uie :		discharge planning upon admission,	initiation of	
		to reflect these change			a baseline care plan and presentation	n of the	
		sciplinary team, as defi			baseline care plan to the resident or	on the	
	hv 8483 21(h)(2)(ii) ir	the ongoing process (neu		responsible party. A review will be o	conducted	
	developing the discha				by the Administrator/Designee for (5) five	
		er/support person availa	ability		residents per week for (3) three mon	ths to	
	and the resident's or o		ability		ensure that discharge planning has I	peen	
		d capability to perform	i		initiated upon admission/readmission	n, a ,	
		of the identification of	į		baseline care plan has been initiated with		
	discharge needs.	appropriate goals and it has been presented to					
:	(v) Involve the residen	nt and resident	i		the resident or responsible party.	i	i i
!	representative in the o		i		4. Results of the reviews will be	e	
:	discharge plan and inf			İ	discussed by the Administrator/Design	nee at the	
!	resident representative	e of the final plan		!	QAPI Committee meeting monthly for months. The IDT will recommend re	r (3) three	
:	(vi) Address the reside		!		the plan as indicated necessary to su	visions to	
	treatment preferences			i	substantial compliance.	ıstam	ľ
;		esident has been aske	d	!	5. 04/04/18		l
	about their interest in r	receiving information			· · · · ·	į	l
	regarding returning to		1				ŀ
İ	(A) If the resident indic						- 1
	returning to the commi	unity, the facility must		i		:	
i	document any referrals	s to local contact agend	cies	!			
	or other appropriate er	ntities made for this		İ		i	
-	purpose.			1			j
	(B) Facilities must upd	ate a resident's		ļ		i	- 1
!	comprehensive care pl	lan and discharge plan	, as	!			
	appropriate, in respons	se to information receiv	ed	;]
!	from referrals to local of	contact agencies or oth	er [!]	!			
	appropriate entities.			ļ			
i	(C) If discharge to the	community is determine	ed	!		!	- 1
	to not be feasible, the f	facility must document	who	İ			
	made the determination					İ	
	(viii) For residents who	are transferred to anot	ther	!		i	
	SNF or who are discharged to a HHA, IRF, or				- 1		
	LTCH, assist residents		: 				
i	representatives in selecting a post-acute care			į			
	provider by using data	that includes, but is not	t !	i		!	
: 	limited to SNF, HHA, IF	RF, or LTCH standardiz	ed				

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

.

If continuation sheet Page 29 of 75

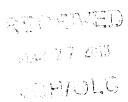


Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA		1.	LE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	R:	A. BUILDING	i	COMPL	COMPLETED	
495349			B. WING		03	C / 01/2018		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CARRING	TON PLACE AT WYTH	HEVILLE - BIRDMONT	990 HO	LSTON RD				
			WYTHE	VILLE, VA	24382			
(X4) ID	SIIMMARYS	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN C	AE CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETION	
F 660	Continued From page	e 29		F 660				
	patient assessment d	ata, data on quality						
	·	on resource use to the						
	extent the data is ava	ilable. The facility must						
		acute care standardized	i					
	patient assessment d	ata, data on quality						
		on resource use is relev						
		resident's goals of care	and					
	treatment preferences							
		ete on a timely basis b						
		ds, and include in the c						
		of the resident's disch plan. The results of the	•					
	•	scussed with the reside						
		tive. All relevant resider						
	information must be in							
		litate its implementation	n and					
		delays in the resident's						
	discharge or transfer.						1	
	This Requirement is	not met as evidenced b	y:					
		ew and clinical record r	eview					
	the facility staff failed							
	planning for 1 of 27 R							
	-	staff failed to initiate a						
		cluding the resident's g	oals					
	for care, and share it	with the resident.						
	Resident #172 was ac	dmitted to the facility fro	um.					
		e admission Minimum I						
		assessment reference		l				
		resident scored 15/15						
		mental status and was	,					
		delusions, psychosis, o	r				 	
		for others. The resider						
		onsible party. The resid						
	diagnoses included hy							
		ophagi reflux disease, a	ınd					
	diabetes mellitus.						i	
		ew during the entrance						
	on 2/26/18, the reside	nt reported concerns w	ith					

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

Y11 If continuation sheet Page 30 of 75



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PE	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	ZIP CODE		
CARRING	STON PLACE AT WY	THEVILLE - BIRDMONT		LSTON RD VILLE, VA 243	382		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUI TAG OR LSC IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 660	Continued From pa	age 30		F 660			
	i	, diabetes care, and thera	yge			:	
		18, the surveyor conducte					
	!	erview with the resident.					
	resident reported as	greeing to a family reque	st			i	
	that she enter the fa	acility for a month to gain	İ	į			
	strength after a fall	at home that resulted in a	an !			•	
	Emergency Departr	ment visit without an		i			
		sident reported that, while					
		discussed discharge goal	s,	ļ			
		ittle effort to assist with				:	
		strength. Therapy consis	its				
		tationary bicycle. An aiding in the hall once at the		1			
	!	equest. The resident wa	e aleo				
		insulin and antianxiety	s also			i I	
		nad been changed withou	t				
	prior discussion.		ï				
	·		:	: :			
		veyor spoke with the		İ			
	resident's nurse abo	out the resident's concerr	۱,				
		the resident was mistake					
		acement. The resident w					
	. —	rm care. The nurse repor	1				
	_	randson had shown som		;			
		a cell phone that preclud		!			
		lischarged to the home. if Adult Protective Service					
		l about the danger to the	35				
	resident.	about the danger to the		!			
	Toolaan.			İ			
	On 02/27/18 11:46	AM, the care plan in the					
		ecord was dated 2006. T	he	!			
	baseline care plan v	was located and was					
		igned. The baseline care				!	
		e resident was to remain	long				
		s addressing therapy,					
		ychosocial needs, discha	rge				
		sident's discharge goals,					
	_	r educational needs,					
	signatures of interdi	sciplinary team members				:	

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495349		B. WING	1		C 01/2018	
	ROVIDER OR SUPPLIER STON PLACE AT WY	THEVILLE - BIRDMONT		ESS, CITY, STA STON RD VILLE, VA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES JST BE PRECEDED BY FULL RE- IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 660	summary of baselin final page stated that baseline care plan have resident on 2/19/18. The summary of the coordinator reported want a summary. The facility policy tit process indicated the begin on admission discharge goals worker plan. 02/27/18 11:46 AM some discussion of social worker said the member's phone whome. Also, the resident would be available in plan at day 15 of the facility without a plan on 03/01/18 02:18 If director of nursing a Requested a dischate vidence that planning resident. The Director of a notice card indication would be held on Market in the control of the summarket in the director of a notice card indication.	aseline care plan, and we care plan were blank. The the incomplete, unsign and been shared with the when asked why there care plan, the MDS dethat the resident did not been shared planning we and that the resident's all did be included in the aselich preclude return to community. There were pictures on a faich preclude return to the dent to go home. Those in therapy. There was not be resident being held at the	The ed ed ed ed ed ed ed ed ed ed ed ed ed	F 660				
	Quality of Care CFR(s): 483.25			F 684	F 684 Quality of Care		04/04/18	
	-	care undamental principle that ent and care provided to	t					

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

JEOY11

If continuation sheet Page 32 of 75



Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE		
CARRING	TON PLACE AT WYT	HEVILLE - BIRDMONT	990 HO	LSTON RD			
				VILLE, VA	24382		
(X4) ID	STIMMARYS	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION)N (X5)	
PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RECENTIFYING INFORMATION)	GULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETIC	NC
F 684	Continued From pag	e 32		F 684	1. For resident #387, the resp	onsible	
	facility residents. Bas	ed on the comprehensi	ve		party and the physician were notified		
	assessment of a resid	dent, the facility must er	nsure		were no adverse effects to the reside		
	that residents receive	treatment and care in			associated with the medication varia		ı
	accordance with profe	essional standards of	İ		Resident #72, the responsible party		
	practice, the compreh	nensive person-centered	d '		physician were notified. There were adverse effects to the resident associated associate		
	care plan, and the res				the medication variance.	aated with	
		not met as evidenced b			2. For current residents residing	ng in the	
		ew and clinical record re	1		facility a review has been completed		
		ow physician's orders fo	or 2		DON/Designee for the previous (30)		
	of 27 Residents, #387	7 and 172.			of physician's order sets and telepho	ne orders	
	The finding included:		:		as compared with the Medication Administration Record to identify furt		
	The imaing moduce.						
	1. For Resident #387	the facility staff failed to	n		discrepancies. The responsible part physician will be notified as indicated		
	administer the medica	-	aza per the necessary.				
	physician's orders	·			3. In-servicing has been provide	ded to the	i
!					licensed nurses by the DON/Designe	e	- 1
İ		sician's Desk Reference	e,		regarding following physicians orders		
		on used to help reduce			administering medications as ordere		ı
	triglycerides.		i		physician and discontinuing medicati		
;	D 11		l I		ordered by the physician. A quality r be completed by the DON/Designee		
İ		dmitted to the facility on			residents/week for (3) months to ens	ure that	
		included but not limited			physician's orders are followed to inc		
1		esophageal reflux diseas perlipidemia, osteoporos			administering medications per physic	ian's order	
	anxiety, depression a	•	015,		and discontinuing medications when	ordered by	1
	andioty, dopicosion a	na somzopinema.			the physician.		
	The most recent MDS	(minimum data set) wi	th		4. The results of the reviews w		ļ
		reference date) of 02/2		i	discussed by the Administrator/Design QAPI Committee meeting monthly for		
İ		s 8 of 15 in section C,		į	months. The IDT will recommend re-		
:	cognitive status. This	is an admission MDS.			the plan as indicated necessary to su		
	Resident #387's clinic	al record was reviewed	on.		substantial compliance. 5. 04/04/18		
	02/27/18. It contained				J. 07/07/10		
		th of February which rea	ad in				
		cap by mouth q (every)					
		(electronic medication	,	:			
		for February 2018 was	i i				
		ed an entry, which read					
!		cam by mouth q day ord		!		i	

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

JEOY11

1987.11.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03	C / 01/2018	
	ROVIDER OR SUPPLIER	HEVILLE - BIRDMONT	990 HOL	ESS, CITY, STATE, STON RD VILLE, VA 24:				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	date: 02/191/8". This as having been admir this time frame. The surveyor spoke we nursing) on 02/28/18 is having not been adminot offer an explanation of the ensigned, not been signed, not been signed, not offer an explanation of the concern of not followed or the concern of	date: 02/16/18 discont entry had not been signistered at any time durbith the DON (director or egarding the medication instered. The DON coon as to why the eMAR could she confirm that the administered. Illowing the physician's with the administrative gron 03/01/18 at	ned ing if on uld had he	F 684				
	Alzheimer's disease, of disturbance, anemia, a disorders, and urinary annual minimum data assessment reference scored 3/15 on the brid status and was assess delirium, psychosis, or others, During clinical record raphysician telephone discontinue Seroquel varrived and to start Ris	s including hypertension dementia with behavior anxiety delusional tract infection. On the set assessment with date 1/25/18, the resident interview for mental sed as without signs of behaviors affecting serview, the surveyor not order dated 12/18/17 to when Risperdal Constant perdal Constant interview administration	lent If or ted D					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/01		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CARRING	TON PLACE AT WYT	HEVILLE - BIRDMONT		_STON RD VILLE, VA	24382			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 689	1/6/18. Seroquel 25 r continued until 2/19/1 was stopped on 12/1 written and signed by communication form nurse's comments "s (discontinued) 12/18/arrived. Risperdal Color 19, 2018). The administrator amoutified of the concert on 2/28/19. Free of Accident Haz CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensure \$483.25(d)(1) The reas free of accident has \$483.25(d)(2)Each resupervision and assist accidents. This Requirement is Based on observation document review and facility staff failed to experiment of the supervision and assist accidents.	e of Risperdal Consta of milligrams two times per 18 after an order "serod 8/17 please verify that" of the physician. A nursing dated 219/19 stated underoquel had not been do 18 when Risperdal Coronsta dod 21918 (Februard director of nursing wern during a summary mean during a summary	r day quel was ng der ccd ssta sary re ceting es ains nd	F 684	F 689 Free of Accident Hazards/Super Devices 1. For Resident #104, the oxygwas removed during the survey. The no adverse effects to the resident. 2. Environmental rounds/obserwere conducted by the Administrator/to ensure that there were no other ox tanks/e-cylinders in resident rooms the not secured in a cart/stand. 3. In-servicing has been provid Administrator/Designee to current emergarding ensuring that when oxygen cylinders are in use that these are util transported and secured in a cart/stant Environmental rounds/observations we conducted by the Administrator/Designive times/week for (3) three months to that oxygen tanks/e-cylinders are not unsecured in resident rooms and to experience.	gen tank re were rvations /Designee ygen nat were led by the aployees tanks/e- lized, nd. vill be gnee (5) o ensure left ensure	04/04/18	
	•	d to ensure an oxygen to t/stand in Resident #104			that if these are in use, that they are sappropriately in a cart/stand.	secured		
	The clinical record of reviewed 2/27/18 thro	Resident #104 was ough 3/1/18. Resident #	‡104					

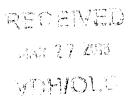
Printed: 03/16/2018 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/G			PLE CONSTRUCTION	(X3) DATE SU COMPLE	
495349 B. WNG		03/0	C 01/2018			
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT WYT	HEVILLE - BIRDMONT		ESS, CITY, STA STON RD VILLE, VA		J.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
PREFIX (EACH DEFICIENCY MUS	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
but not limited to high aspiration pneumonit protein malnutrition wigastrointestinal hemodeficiency anemia, di infarction, hemiplegia affecting right domina dysphagia, status possecondary to stroke, hypertension, demendisturbances, sacral phyperlipidemia, consturinary tract infection. Resident #104's 5 daset (MDS) assessmente reference date (ARD) resident with no issue issues with long-termindependence with so situations. During the initial tour p.m., the surveyor obsoxygen cylinder in Re Resident #104 was cuthe oxygen concentra. The surveyor informed #2 of the above concedid not know why the removed the oxygen to the surveyor informed and the director of nur	racility 1/30/18 and with diagnoses that inclusivith diagnoses that inclusivith diagnoses that inclusivith albumin of 1.4, prhage, atrial fibrillation diastolic heart failure, ceres following cerebral infairant side, muscle wasting at PEG tube placement fracture of femur, tia without behavioral pressure ulcer, cipation, dry mouth, and on the with an assessment of 2/6/18 assessed the es with short-term memory, and modified ome difficulty in new on 2/26/18 beginning at served a free-standing sident #104's room. Jurrently receiving oxygetor. In dicensed practical nurse of 1/20/20/20/20/20/20/20/20/20/20/20/20/20/	dere I, iron Tebral Tection II, Idata In ory, In original torem	F 689	4. The results of the rounds/ot will be discussed by the Administrate Designee at the QAPI Committee me monthly for (3) three months. The ID recommend revisions to the plan as in necessary to sustain substantial com 5. 04/04/18	or/ eeting OT will indicated	

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

JEOY11

If continuation sheet Page 36 of 75



OF DEFICIENCIES F CORRECTION					(X3) DATE SURVEY COMPLETED	
	495349		B. WING		C 03/01/2	
OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TON PLACE AT WYT	HEVILLE - BIRDMONT			24382		
(EACH DEFICIENCY MUS	ST BE PRECEDED BY FULL RE	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	D BE	(X5) COMPLETION DATE
Continued From pag	je 36		F 689			
"Fire Safety and Prev policy read in part "O cylinders in racks wit carts, or approved sta cylinders free-standir cylinders in any resid No further information exit conference on 3/	vention" on 2/28/18. The exygen Safety f. Store on the chains, sturdy portable ands. Never leave oxygeng. Do not store oxygen lent room or living area. In was provided prior to 1/18.	e xygen e gen				
CFR(s): 483.25(e)(1) §483.25(e) Incontinet §483.25(e)(1) The far- resident who is contin- admission receives s- maintain continence of condition is or become not possible to maintal §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who entindwelling catheter is resident's clinical con catheterization was n (ii) A resident who entindwelling catheter or is assessed for removas possible unless the demonstrates that cat and (iii) A resident who is receives appropriate of	nce. cility must ensure that ment of bladder and bow ervices and assistance unless his or her clinical res such that continence ain. esident with urinary on the resident's assment, the facility must eres the facility without a not catheterized unless dition demonstrates that ecessary; ters the facility with an esubsequently receives val of the catheter as so a resident's clinical condition to the condition of the catheter as so a resident's clinical condition to the catheter as so a resident as a resident as a resident as a resident as a resident as a resident as a resident as a re	to I I I I I I I I I I I I I I I I I I I	F 690	1. For Resident #115, the phy notified regarding diagnosis for the F catheter. Resident #115 was reasse regarding appropriateness for a bow bladder training program. For Resid the Foley catheter was anchored upoidentification during the survey proce Resident #32 and Resident #33, the catheter was anchored upon identification during the survey process. 2. Rounds/Observations have conducted by the DON/Designee for residents residing in the facility with porders for catheters to ensure that care anchored appropriately. A review been completed by the DON/Designe current residents residing in the facility physician's orders for catheters to enthere is an appropriate diagnosis and assessment for bowel and bladder residents.	sician was foley essed eel and ent #115, on ess. For Foley cation been current physician's atheters w has ee for ity with nsure that d that the etraining	04/04/18
•		•				
	Continued From page The surveyor reviewed "Fire Safety and Previously inders in racks wit carts, or approved stroylinders in any resident who is continued from page (SA83.25(e)(1)) The faresident who is continued from page (SA83.25(e)(1)) The faresident who is continued from the surveyor reviewed (SA83.25(e)(1)) The faresident who is continued from the surveyor from the	OVIDER OR SUPPLIER TON PLACE AT WYTHEVILLE - BIRDMONT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REOR LSC IDENTIFYING INFORMATION) Continued From page 36 The surveyor reviewed the facility policy title "Fire Safety and Prevention" on 2/28/18. The policy read in part "Oxygen Safety f. Store or cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygerylinders free-standing. Do not store oxyger cylinders in any resident room or living area. No further information was provided prior to exit conference on 3/1/18. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bow admission receives services and assistance maintain continence unless his or her clinical condition is or becomes such that continence not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without a indwelling catheter is not catheterized unless resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives is assessed for removal of the catheter as so as possible unless the resident's clinical condemonstrates that catheterization is necessary (iii) A resident who is incontinent of bladder receives appropriate treatment and services	OMIDER OR SUPPLIER TON PLACE AT WYTHEVILLE - BIRDMONT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 The surveyor reviewed the facility policy titled "Fire Safety and Prevention" on 2/28/18. The policy read in part "Oxygen Safety f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders in any resident room or living area." No further information was provided prior to the exit conference on 3/1/18. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	OVIDER OR SUPPLIER TON PLACE AT WYTHEVILLE - BIRDMONT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 The surveyor reviewed the facility policy titled "Fire Safety and Prevention" on 2/28/18. The policy read in part "Oxygen Safety f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders in any resident room or living area." No further information was provided prior to the exit conference on 3/1/18. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore	DOUDER OR SUPPLIER TON PLACE AT WYTHEVILLE - BIRDMONT SUMMARY STATEMENT OF DEPICIENCES BYTHEVILLE, VA 24382 (EACH DEPICIENCY MUST BE DEPECEDED BY PULL REQUATORY OR LSC IDENTIFYING INFORMATION) (EACH DEPICIENCY MUST BE DEPECEDED BY PULL REQUATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 36 The surveyor reviewed the facility policy titled "Fire Safety and Prevention" on 2/28/18. The policy read in part "Oxygen Safety f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders in any resident room or living area." No further information was provided prior to the exit conference on 3/1/18. Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e) (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. \$483.25(e)(2)For a resident with urinary incontinence, based on the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as a possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as a possible unless the resident's clinical condition demonstrates that catheterizat	OVIDER OR SUPPLIER TON PLACE AT WYTHEVILLE - BIRDMONT SUMMARY STATEMENT OF DEPICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) CONTINUED FROM PLACE AT WYTHEVILLE - BIRDMONT SUMMARY STATEMENT OF DEPICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) COntinued From page 36 The surveyor reviewed the facility policy titled "Fire Safety and Prevention" on 2/28/18. The policy read in part "Oxygen Safety f. Store oxygen cylinders in racks with chains, sturdy portable carts, or approved stands. Never leave oxygen cylinders free-standing. Do not store oxygen cylinders free-standing. Do not store oxygen cylinders in resident so intent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical and admission receives services and assistance to maintain continence unless his or her clinical condition demonstrates that continence is not possible to maintain. S483.25(e)(2)For a resident with urinary incontinence, based on the resident's most process. For Resident #32 and Resident #33. the Foley catheter was anchored upon identification during the survey process. For Resident #20 and Resident #31. The Foley catheter was anchored upon identification during the survey process. 2. Rounds/Observations have been conducted by the DON/Designee for current residents residing in the facility with physician's orders for catheters to ensure that there is an appropriately. A review has been completed by the DON/Designee for current residents residing in the facility with physician's orders for catheters to ensure that there is an appropriately and that the assessment for bowel and bladder retraining has been completed and followed up on appropriately. A resident who is incontinent of bladder receives appropriately read mental and services to resure that there is an appropriately and that the assessment for bowel and bladder retraining has been completed and followed u

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	CLIA		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
	OVIDER OR SUPPLIER	HEVILLE - BIRDMONT		ESS, CITY, STA STON RD VILLE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RED DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	
F 690	§483.25(e)(3) For a incontinence, based comprehensive assert ensure that a resider receives appropriate restore as much normal possible. This Requirement is Based on observation interview, facility docrecord review, the faindwelling Foley cathassessment for times obtain a diagnosis for catheter for 3 of 27 m. Resident #32 and Resident #32 and Resident #115's induted in the findings included to implement a bowe program when the resigned candidate." The clinical record of reviewed 2/27/18 throws admitted 11/10/17 but not limited to acu carpal tunnel syndrom hypertension, iron depolyosteoarthritis, chobesity, major depreconstipation.	resident with fecal on the resident's essment, the facility must the work incontinent of the treatment and services mal bowel function as a not met as evidenced by the services and the treatment review and clinic cility staff failed to anchorate, failed to implement doubled to implement doubled to the indwelling Foley esidents (Resident #115 esident #33). It is no obtain a diagnosis for welling Foley catheter, failed to a control of the indwelling Foley catheter and failed the service of the ser	powel to py: aff al or an t an o b, iiled ailed be a #115 uded mia, orbid	F 690	3. In-servicing has been prov Administrator/Designee to current noregarding an appropriate diagnosis catheter use and completing the boy bladder training assessment and approlification follow up if indicated. A review will accompleted by the DON/Designee for residents/week for (3) months to entesidents with physician's orders for have appropriate diagnosis, bowl are training assessments have been contained appropriately. 4. The results of the review we discussed by the Administrator/Designee (3) the QAPI Committee meeting monthmonths. The IDT will recommend rethe plan as indicated necessary to substantial compliance. 5. 04/04/18	ursing staff for wel and propriate pe r (5) five sure that r catheters ad bladder mpleted d catheters will be gnee at ally for (3) evisions to	
	assessment with an	ay minimum data set (Mi assessment reference d essed the resident with a	ate				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/0	C 01/2018
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE	, ZIP CODE		
CARRING	TON PLACE AT WY	THEVILLE - BIRDMONT		STON RD VILLE, VA 24	382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690	BIMS of 15. Section marked for an indiversity continence was marked a catheter. (a). The surveyor widiagnosis for the incidinical record and sinurse #1 on 2/27/18 diagnosis. L.P.N. # (b). The surveyor interveyor asked if the anchored with a piece #115 stated she did asked licensed prace Foley catheter for an a.m. LPN #1 chece stated the Foley was completed 11/3/17. Based on the legence Resident #115 was a individual training. The surveyor interview (MDS) registered nurregarding diagnosis stated Resident #11 bleeding with surger device. MDS RN stated diagnoses for the Foreviewed the initial abladder dated 11/3/1 would be a candidate.	n H Bladder and Bowel welling catheter and urinar riked as 9-not rated, resideras unable to locate a dwelling Foley catheter in poke with licensed pract at 10:05 a.m. regarding 1 stated she would find caterviewed Resident #115 During the interview, the e Foley catheter was see of tape or Velcro. Rein't think it was. The survitical nurse #1 to check the chorage on 2/27/18 at 1 ked the Foley catheter as unanchored. Viewed Resident #115's well and Bladder Training The assessment total wild at the top of the page, a good candidate for The legend for good candidate.	y lent the ical the out. on on sident reyor ne 0:16 nd "as 3. didate a.m. ginal na yor dent reyor dent reyor dent reyor ne	F 690			
1			.5 101				

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STATE	ZIP CODE		
CARRING	TON PLACE AT WYTH	HEVILLE - BIRDMONT		STON RD /ILLE, VA 24:	382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 690	Continued From page	e 39		F 690			
		ining program after the		T.			
	assessment and reco completed. MDS RN not implemented. The surveyor informe	mmendation had been stated the assessment d the administrative stands the end of the day me	t was				
!	on 2/28/18 at 1:32 p.r policy on catheters.	n. and requested the fa	cility				
	"Catheter Care Policy read in part "Policy Ex Guidelines: Female:	d the facility policy title " on 2/28/18. The polic xplanation and Complia 15. Secure catheter tu t movement on the uref	cy ince bing				
1	exit conference on 3/1	he facility failed to ancl					
	had been readmitted to Diagnoses included, b						
	Section C (cognitive p quarterly MDS (minim with an ARD (assess 12/04/17 was coded 1 Resident had problem memory and was seve skills for daily decision (bladder and bowel) w Resident has an indwe	patterns) of the Resider um data set) assessment reference date) of /1/3 to indicate the as with long and short to erely impaired in cognition making. Section H vas coded to indicate the elling catheter (foley).	erm ive				
	On 02/26/18 during in	itial tour of the facility, t	ine .				

REDEIMED SERVOIX

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/0	C 01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
CARRING	TON PLACE AT WYTH	HEVILLE - BIRDMONT		STON RD VILLE, VA	24382			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 690	Continued From page	e 40		F 690				
		at Resident #32 had a	foley					
	surveyor and CNA (co	•	nt) #2 en					
		rehensive care plan inc ential for infection relate g catheter.						
	The facility policy/procedure titled "Catheter Care Policy" included "Secure catheter tubing to the thigh to prevent movement on the urethra or excessive tension"							
	The administrative tea Resident #32's foley of during a meeting with 03/01/18 at approxim	catheter was not ancho the survey team on	red ·					
	provided to the surve conference. 3. For Resident #33	n regarding this issue we to team prior to the exit the facility staff failed to Foley catheter to prevet the urinary meatus.						
	admitted on 9/18/17. included, but were no atrial fibrillation, hype dementia without beh	it limited to: encephalop rtension, muscle weakr aviors, gout and anxiet	pathy,					
	assessment located in	imum Data Set (MDS) n the clinical record wa DS with an Assessmen						

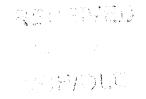
Printed: 03/16/2018 FORM APPROVED

		T OERVICES				OMB	<u>NO. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBI		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	
		495349		B. WING		03/	C / 01/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE	ZIP CODE		
CARRING	GTON PLACE AT WYTH	HEVILLE - BIRDMONT		LSTON RD	5522		
				VILLE, VA 24:	201		
() () (5)			L	VILLE, VA 24.	362		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 690	Continued From page	e 41		F 690			
	Reference Date (ARD staff coded that Resid Summary Score of 3. that Resident #33 requ	o) of 12/27/17. The fact ent #33 had a Cognitive The facility staff also coursed extensive (3/3) to a Activities of Daily Living. Bladder and Bowel, the talk Resident #3 had an effect. at 1 p.m. the surveyor 3's clinical record. Reviously conduced signed physician orders included, but	re coded total ng ne	F 690			
	FOLEY AND ANCHOR On February 27, 2018 asked a Licensed Prace	R Q (every) SHIFT." (side	c)				
	accompany the survey The surveyor and LPN #33's room and the sur Resident #33's Foley c back Resident #33's legs. T Resident #33 had an in that contained clear amnoted that Resident #33 anchored. The surveyor that Resident #33's Foll LPN stated the Foley wanchored.	or to Resident #33's ro walked down to Resident export requested to see atheter. The LPN pulled linens and exposed the surveyor noted that adwelling Foley cathetember urine. The survey 3's Foley catheter was propointed out to the LP ey was not anchored.	ent e ed or not				
	On February 27, 2018 a notified the Administrato Nursing (DON) and Ass (ADON) that Resident # not anchored. The surv facility Policy and Proce care.	or (Adm), Director of distant Director of Nursi distant Director of Nursi distance of Sales of Sales distance of Sales of Sales of Sales distance of Sales o	ng as				

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

JEOY11

If continuation sheet Page 42 of 75



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		l	C 1/ 2018
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARRING	TON PLACE AT WYTH	HEVILLE - BIRDMONT		LSTON RD VILLE, VA	24382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
	On February 28, 2018 reviewed the facility F'Catheter care Policy' conference room. The in part "15. Secure to prevent movement tension." (sic) No additional informa exiting the facility as to catheter was not anched. Resident's Care Super CFR(s): 483.30(a)(1)(s) §483.30 Physician Sean Aphysician must persecommendation that a facility. Each reside care of a physician. Assistant, nurse pract specialist must provide immediate care and resident to the facility must ensure supervised by a physician is unavailable. This Requirement is Based on staff interviet the facility staff failed supervised the Resideresidents in the surversect.	at 10:20 a.m., the sure Policy and Procedure tite that had been left in the policy and procedure catheter tubing to the ton the urethra or excestion was provided prior owhy Resident #33's Fored. Bervised by a Physician (2) Processionally approve in writing an individual be admitted an individual be admitted an individual be admitted an individual be admitted an individual physician itioner, or clinical nurse le orders for the residenceds. Supervision. Brute that- Bedical care of each residenced be excepted and clinical record in the physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole. The physician supervises ents when their attendire ole.	eled, ne read chigh ssive to coley ng a ted to the ent's dent the ng py: eview	F 710	F 710 Resident's Care Supervised by Physician 1. For Resident #378, the phy reviewed the resident's medical record Resident #378 has been seen by the physician. 2. For residents currently residentify, a review has been completed DON/Designee to ensure that each thas been seen by the physician and resident has their care supervised by physician. 3. In-servicing has been provied the DON/Designee to the physicians physician's extenders and licensed regarding ensuring that each resident their care supervised by a physician they are seen in a timely fashion by physician. A review will be complete DON/Designee for (5) five residents/ (3) months including new admissions to ensure that the resident has been physician and the resident's care is supervised by a physician.	ding in the doby that each y a ded by that has and that the doby t	04/04/18
	The findings included	:					

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 " "	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495349		B. WING			C / 2018
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	NTE, ZIP CODE		
CARRINGTON PLACE AT WYTH	HEVILLE - BIRDMONT		STON RD	24382		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
2/24/18 with the follow limited to anemia, confibrillation, high blood vascular disease and pulmonary disease. admission MDS (Minitat the time of the survival to person, place and extensive assistance bathing. The surveyor reviewer Resident #378 on 2/2 review, the surveyor into been seen by the the facility, nor was the note found in the clinical stated, "I cannot find seen by the physician been readmitted to the call and talk to medic have a dictation note resident." At 2 pm, the director surveyor and stated, progress note from the dated for 2/27/18 but the resident since he facility on 2/24/18. The clinical record was dathe NP also."	eadmitted to the facility wing diagnoses of, but ronary artery disease, a pressure, peripheral chronic obstructive. The resident did not had mum Data Set) completely. The resident was time and did require of 1 staff member for ed the clinical record of 18/18 and 3/1/18. During the director of nursing the director of nursing record of the resident awhere the resident had be facility on 2/24/18. Leal records and see if the from the physician on the physician on the physician on the physician on the physician has not say was readmitted back to the last progress note on the director 2/21/18 and it was tested for 2/21/18 and it was t	not atrial ve an eted alert ig the had ion to ss #378. on nd been let me eey his leen a leen o the aras by	F 710	4. The results of the review wi discussed by the Administrator/Desig QAPI Committee meeting monthly for months. The IDT will recommend rethe plan as indicated necessary to susubstantial compliance. 5. 04/04/18	gnee at the or (3) visions to	

DEORNALD SERVICE

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495349		B. WING		1	C 1/ 2018
	OVIDER OR SUPPLIER	HEVILLE - BIRDMONT		ESS, CITY, STA STON RD VILLE, VA		<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES OF BE PRECEDED BY FULL REG DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	.D BE	(X5) COMPLETION DATE
	findings in the confer No further informatio surveyor prior to the Posted Nurse Staffin	ence room. n was provided to the exit conference on 3/1/1 g Information	18.	F 710	F 732 Posted Nurse Staffing Informa		04/04/18
	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.		orked		1. The daily nurse staffing information identified as incomplete was corrected the survey. 2. Daily nurse staffing information previous 30 days has been reviewed DON/Designee. 3. In-servicing has been provious and previous a	rmation for the wed by the rovided by the person who tion. by the DON/ (3) months to formation is vations will be resignee at the resignee at the revisions to	
	specified in paragrap daily basis at the beg (ii) Data must be pos (A) Clear and readab (B) In a prominent plaresidents and visitors §483.35(g)(3) Public staffing data. The fawritten request, make available to the public exceed the communi §483.35(g)(4) Facility	ost the nurse staffing dath (g)(1) of this section of inning of each shift. Ited as follows: alle format. Ited accereadily accessible to access to posted nurse cility must, upon oral or enurse staffing data or for review at a cost noty standard.	on a		substantial compliance. 5. 04/04/18	Jetairi	

Printed: 03/16/2018 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ()	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE	03/01/2016	
CARRING	GTON PLACE AT WYTH	HEVILLE - BIRDMONT		LSTON RI			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION	
F 732	page 10			F 73	2		
	posted daily nurse sta 18 months, or as requ whichever is greater. This Requirement is r Based on observation document review, the complete the daily sta posting/sheet. The findings included. The facility had not up sheet to include the cli 02/28/18 and had not summary sheet for 03/	offing data for a minimulatived by State law, and met as evidenced by staff interview, and farguilty staff failed to ffing summary dated the staffing summical staffing hours for posted the staffing 101/18.	y: cility mary	F /3.			
	the facility had not upd for 02/28/18 to include the second and third sl the staffing summary s DON (director of nursir The administrative staffin a meeting with the stapproximately 4:45 p.m. No further information r provided to the survey conference.	the clinical staff's hour nifts and had not posted heet for 03/01/18. The ng) was notified of same of were notified of the aburvey team on 03/01/18 n. Tegarding this issue was team prior to the exit	ary s for d e. pove 3 at				
SS=E	Pharmacy Srvcs/Proce CFR(s): 483.45(a)(b)(1) §483.45 Pharmacy Ser The facility must provide drugs and biologicals to them under an agreeme §483.70(g). The facility personnel to administer	vices e routine and emergend hits residents, or obtain ent described in may permit unlicensed	cy	F 755	F755 Pharmacy Srvcs/Procedure/Pharm Records	acist/ 04/04/18	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1'''	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	CONNECTION	IDENTIFICATION NOMBE	in.	A. BOILDING		C	
		495349		B. WING	- ,	03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE		
CARRING	TON PLACE AT WYTH	IEVILLE - BIRDMONT		STON RD			
		40.44	WYTHE	/ILLE, VA	24382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 755	Continued From page	e 46		F 755	1 Resident #26 no longer resi	des in the	
F 755	permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical service that assure the accura dispensing, and admin biologicals) to meet the §483.45(b) Service Comust employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provision the facility. §483.45(b)(2) Establist receipt and disposition sufficient detail to enareconciliation; and §483.45(b)(3) Determin order and that an addrugs is maintained at This Requirement is in Based on staff interviet the facility staff failed in the state of the state	er the general supervisions. A facility must provides (including procedurate acquiring, receiving nistering of all drugs are needs of each resident on sultation. The facility of the services of a licent of the services of a licent of pharmacy services of all controlled drugs ble an accurate the service of all controlled of periodically reconcil of the services of all controlled of the periodically reconcil of the services of the services of all controlled of the services of the services of the services of the services of all controlled of the services of the services of all controlled of the services of the services of all controlled of the services of the services of the services of the services of the services of all controlled of the services of the services of all controlled of the services of the s	ide es ind ent. y ssed es in ds of in are ed. by: eview were	F 755	1. Resident #26 no longer resifacility. For Resident #387, Ativan is for administration. The physician and were notified. There was no adverse the resident related to the medication on 02/16/18, 02/17/18 and 02/18/18. Resident #378, medications are availadministration. Atrovent HFA inhaled discontinued on 02/21/18. The phys responsible party were notified. The adverse effects to the resident relate medication variance on 02/17/18. For #381, medications are available for administration. Medrol Dose Pack at ER have been discontinued. Tizanid available for administration. The physthe responsible party have been notified were no adverse effects to the resident to the medication variance on 02/25/2. For current residents residing facility, a review has been completed DON/Designee of current physician's including physician's order sets and to orders for the previous (30) thirty day compared to medications available as ord the physician. 3. In-servicing has been provided to the medications are available as ord the physician. 3. In-servicing has been provided the physician. 3. In-servicing has been provided the physician. 4. In-servicing has been provided the physician. 5. In-servicing has been provided the physician. 6. In-servicing has been provided the physician. 7. In-servicing has been provided the physician. 8. In-servicing has been provided the physician. 9. In-servicing has been provided the physician. 10. In-servicing has been provided the physician. 11. In-servicing has been provided the physician. 12. In-servicing has been provided the physician and administering medications as ordered physician. 13. In-servicing has been provided the physician and administering medication administration observations will be completed by the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physician and the physi	available d the RP e effect to n variance For lable for was ician and re were no d to the or Resident and Ranexa ine HCL is esician and fied. There ent related 18. ag in the l by the s orders delephone es and o ensure ered by ded to the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the ee d by the	
	For Resident #387 the facility staff failed to ensure the medication Ativan was available for administration.				are followed including ensuring that medications are available and admin the physician's order in order to minimedication variances.	istered per	
Š	According to the Phys Ativan is a medication	ician's Desk Reference used to treat anxiety.)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/01/2	
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	ATE, ZIP CODE	<u> </u>	
CARRING	STON PLACE AT WYT	THEVILLE - BIRDMONT		STON RD /ILLE, VA	24382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)	GULATORY	IÐ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	Resident #387 was a 02/16/18. Diagnoses hypertension, gastro diabetes mellitus, hy anxiety, depression. The most recent MD an ARD (assessmen coded the Resident cognitive status. This Resident #387's eM administration record to contained an entry 0.5 mg tablet by more 02/1/6/18 start date: 02/19/18" This entry 02/16-02/18/18 for the section of the eMAR dates which read in (Scheduled: 5:00PM Tablet) Ativan 0.5mg dascheduled for 02 administered-other" (scheduled: 5:00 PM tablet) Ativan 0.5mg dascheduled for 02 administered-other. Admini	admitted to the facility or sincluded but not limited be sophageal reflux disear perlipidemia, osteoporor and schizophrenia. IS (minimum data set) what reference date) of 02/2 as 8 of 15 in section C, as is an admission MDS. AR (electronic medication do was reviewed on 02/2 which read in part "Ativuth twice a day order data 02/16/18 discontinue do had been signed with "the 5 pm dose. The commontained entries for the part "11:40PM, 2/17/18 and "5:03 PM, 2/18/18 and "5:03 PM, 2/1	to se, sis, sis, sis, sis, sis, sis, sis,	F 755	4. The results of the medication administration observations will be disposed by the Administrator/Designee at the Committee meeting monthly for (3) m. The IDT will recommend revisions to as indicated necessary to sustain subcompliance. 5. 04/04/18	QAPI nonths. the plan	

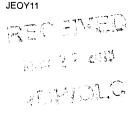
Printed: 03/16/2018 FORM APPROVED

NAME OF PROV		495349			······································	COMPLI	(X3) DATE SURVEY COMPLETED	
		450045		B. WING		033	C 01/2018	
	MDED OD GLIDDLIED		STREET ADDRE	SS, CITY, STATE	710 0005		01/2018	
CARRINGT		HEVILLE - BIRDMONT			E, ZIP CODE			
	ON PLACE AT WITH	TEALET - BIKDIAION I	990 HOLS	ILLE, VA 24	1382			
~~.	CUMMARY	FATEMENT OF DEFICIENCIES						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From page	e 48		F 755				
fi n	The concern of the medication not being available for administration was discussed during a meeting with the administrative staff during a meeting on 03/01/18 at approximately 1635. No further information was provided prior to exit.							
#	 The facility staff fail #378 had medications administration. 	led to ensure that Reside available for	ent					
2 li fi v p a a to	Resident #378 was readmitted to the facility on 2/24/18 with the following diagnoses of, but not limited to anemia, coronary artery disease, atrial fibrillation, high blood pressure, peripheral vascular disease and chronic obstructive pulmonary disease. The resident did not have an admission MDS (Minimum Data Set) completed at the time of the survey. The resident was alert to person, place and time and did require extensive assistance of 1 staff member for bathing.							
R s (I) T "!" m a m a m	Resident #378 on 2/28 surveyor also reviewed Medication Administration Medication Administration of the MAR for the month N" in the box for 2/17/nedications and times deministered: "Hydralazine 25 anouth every 8 hours" of dministered at 6 am a "Creon DR 24,000 aree times daily" which to 6 am. "Atrovent HFA Inhamed	d the resident's MAR ation Record) at that time th of February 2018 had a /18 for each of the following the medication was to be mg (milligram) 3 tablets which was to be	e by					

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

JEOY11

If continuation sheet Page 49 of 75



Printed: 03/16/2018 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		495349	B. WING		0.3	C 3/01/2018	
	OVIDER OR SUPPLIER		RESS, CITY, STATE,	ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
CARRING	TON PLACE AT WYTH		LSTON RD				
(X4) ID	SUBMAMADV CT		VILLE, VA 243				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FOR PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 755	Continued From page	e 4 9	F 755				
	On the "History" shee February, the docume the above documente "Medication is not ava	entation stated for each of dimedications was					
	surveyor, "I reviewed to was readmitted the aftenurses should had had the pharmacy and if no pharmacy. I was not he	DN) of the above The DON stated to the the chart and the resident ternoon on 2/16/18. The difference this from bot, should use the backup					
	The surveyor notified to the above documented pm in the conference r	he administrative team of d findings on 3/1/18 at 4:44 doom.					
	3. The facility star Resident #381 had me administration.	ff failed to ensure that dications available for					
	weakness. The reside completed MDS (Minin being admitted to the factoring to the nursir time of admission, the oriented to person, placalso required extensive member for bathing.	ing diagnoses of, but high blood pressure, eart failure and generalized int did not have a num Data Set) due to acility on 2/23/18. Ing documentation at the resident was alert and the assistance of 1 staff					
:	The surveyor conducte #381's clinical record ir	d a review of Resident cluding the MAR					

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

RECEIVED.

If continuation sheet Page 50 of 75

JEOY11

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495349		B. WING		(o:	C 3/01/2018	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	ZIP CODE			
CARRING	STON PLACE AT WYT	HEVILLE - BIRDMONT		LSTON RD				
			WYTH	EVILLE, VA 24:	382			
(X4) ID		TATEMENT OF DEFICIENCIES	· · · · · · · · · · · · · · · · · · ·	ID	PROVIDER'S PLAN OF (CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	PREFIX	(EACH CORRECTIVE ACTI	ON SHOULD BE	COMPLETION	
1710	ON EGO IDI	ENTIL TING INFORMATION)		TAG	CROSS-REFERENCED TO THE DEFICIENCY		DATE	
F 755	Continued From page	e 50		E 755		.,		
		ation Record) for the m	onth	F 755				
	of February, 2018. Th	he following medication	ionini s	ļ				
	were noted not to "ava	ailable from pharmacy"	for					
	the following dates an	nd times the medication	S					
	were to be administra	ted:		i				
		2 pm and 5 pm Medrol		:			!	
	Dose Pak 4 mg (millig							
	' 2/25/18 at 9 am Rane	exa ER (extended relea	se)	İ				
	500 mg po	idina 1101 A	'					
	2/25/18 at 2 pm Tizan	idine HCL 4 mg po.	İ					
	The surveyor notified the director of nursing							
	(DON) at 2 pm on 3/1/							
		The DON stated, "I do	n't	İ				
	understand why this w	asn't here from the	į.	I				
į	pharmacy. This is def	finitely an area for		!				
	improvement."						j	
	The surveyer petition t	Non-coloniaistasti (İ			i	
	the shove documented	the administrative team d findings at 4:44 pm or	or i	i				
	3/1/18.	a infairigs at 4.44 pint of	!	!				
į								
	No further information	was provided to the					1	
	surveyor prior to the ex	xit conference on 3/1/18	3.	ļ				
i	4 TI 6 W			!			1	
i.	4. The facility staff fails	ed to ensure that Resid	lent					
	#20 flau medications a	vailable for administrat	ion.				1	
	Resident #26 was adm	nitted to the facility on		!				
İ	1/8/18 with the followin	nd diagnoses of but not						
	limited to dementia, Alz	zheimer's disease, high	İ					
	blood pressure, anxiety	y disorder, and major	I	ĺ				
	depressive disorder. Resident #26 was coded as		1					
	having a BIMS (Brief In	nterview for Mental Stat	us)	İ				
	score of 7 out of 15 on	the admission MDS		İ			1	
	(Minimum Data Set). T	ne resident was also		!				
	coded as requiring extermember for personal hy	ensive assistance of 1 s	staff					
	member for personal n	ygiene and bathing.		ļ			į l	
i	The surveyor noted a te	elephone order that was		ĺ			į l	
	.,						<u> </u>	

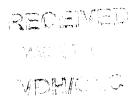
Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		I .	C I /2018
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	SS, CITY, STA	TE, ZIP CODE	!	
		HEVILLE - BIRDMONT		STON RD	24382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE	
F 755	Continued From pag	e 51		F 755			
	written by the Hospica am. The order read i (milligram/milliliter) via sublingual twice daily	e nurse on 2/28/18 at 9 n part "Ativan 2 mg/r al 0.25 ml by mouth or for agitation" On the ministration Record) for surveyor noted in the box, which medication was not	nl :				
	The surveyor notified the unit manager of the above documented findings at 11:30 am. The unit manager stated, "I just received this medication this morning and signed for it." The surveyor asked the unit manager which pharmacy she received this medication from. The unit manager stated, "It was from (name of pharmacy)." The surveyor asked the unit manager if the named pharmacy was used as the backup pharmacy to obtain this medication. The unit manager stated, "Yes."						
		the administrative tean ed findings on 3/1/18 at					
	No further information surveyor prior to the	n was provided to the exit conference on 3/1/	18.				
	Drug Regimen Revie CFR(s): 483.45(c)(1)	w, Report Irregular, Act (2)(4)(5)	On	F 756	F756 Drug Regimen Review, Report Act On	Irregular,	04/04/18
	§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.				Resident #53 has had a dru review completed. A review has been completed. DON/Designee for the previous 30 d current residents residing in the facility and the second reviews had been used that drug regimen reviews had been used that drug regimen reviews had been used to be a second reviews had been used to be second reviews had been used to be second reviews had been used to be second reviews had been used to be second reviews had been used to be second reviews had been used to be second reviews had been completed.	ed by the ays for ity to	
	§483.45(c)(2) This re of the resident's medi	view must include a revical chart.	view		ensure that drug regimen reviews ha completed in a timely fashion.	ive been	:
	§483.45(c)(4) The ph	armacist must report ar	ту				

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

JEOY11

If continuation sheet Page 52 of 75



Printed: 03/16/2018 FORM APPROVED

						OMR V	<u>10. 0938-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMBE	CLIA ER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		1				COMPLE	
		495349		B. WING		03/0	C 01/2018
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
CARRING	TON PLACE AT WYTH	HEVILLE - BIRDMONT		LSTON RD			
				VILLE, VA	24382		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES					
PREFIX	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL RE	GULATORY	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI		(X5) COMPLETION
TAG	OR LSC IDE	ENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
					DEFICIENCY)		
F 756				F 756	3. In-servicing has been provide	led by the	
	irregularities to the att	tending physician and t	he		Administrator/Designee to pharmacy	•	
	facility's medical direc	tor and director of nurs	ing,		representatives regarding the require	İ	
	and these reports mus				drug regimen reviews. A quality reviews	∍w will be	
	(i) irregularities includ	de, but are not limited to	ο,		completed by the DON/Designee for	(5) five	!
	any drug that meets the	ne criteria set forth in			residents/week for (3) three months to that drug regimen reviews have been	o ensure	
Ī	drug.	section for an unnecess	sary		completed in a timely fashion.		
	•	oted by the pharmacist	i		 The results of the quality rev 	iews will	
	during this review mus	st be documented on a	. !		be discussed by the Administrator/De	signee at	İ
	during this review must be documented on a separate, written report that is sent to the				the QAPI Committee meeting monthly	v for (3)	
İ	attending physician and the facility's medical				three months. The IDT will recomme	nd	
i	director and director of	f nursing and lists, at a		ļ	revisions to the plan as indicated necessustain substantial compliance.	essary to	
!	minimum, the resident	's name, the relevant d	rug		5. 04/04/18		ļ
į	and the irregularity the	pharmacist identified.		İ	3 17 17 17 17 17 17 17 17 17 17 17 17 17		
	(iii) The attending phys	sician must document i	n the				İ
	resident's medical reco	ord that the identified		i		İ	
	action has been re	eviewed and what, if ar	ıy,			İ	
	he no change in the me	to address it. If there is	s to	i		ļ	
	nhysician should door	edication, the attending ment his or her rational]			ĺ	
	the resident's medical	record	e in	!			
ĺ	and residents medical	record.	ĺ				
	§483.45(c)(5) The facil	ity must develop and				l	1
ļ	maintain policies and p	rocedures for the mont	thly	į			
	drug regimen review th	at include, but are not					1
	limited to, time frames i	for the different steps in	n				
ļ 1	the process and steps t	the pharmacist must ta	ke	j		i	
,	when he or she identifie	es an irregularity that		!		i	
	requires urgent action t	to protect the resident.		į		1	
	Inis Requirement is no	ot met as evidenced by	:	į			
	Based on staff interview	v and clinical record		:			
	regimen review for one	failed to complete a dr of 27 Residents, Resid	ug	i i			
	#53.	or 27 residents, Residents	ient				
7	The findings included:						
ļ	Resident #53 did not L-	nuo e dui i	. !	!			ļ
'	completed for the month	ave a drug regimen revi	iew	İ			
	mond to the month	n or September 2017.	į	į		l i	
			!	i		i	I

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C			
		495349		B. WING		03/01/2018		
	OVIDER OR SUPPLIER TON PLACE AT WYT	HEVILLE - BIRDMONT		SS, CITY, STA STON RD /ILLE, VA				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REI ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 756	The clinical record re #53 had been admitted Diagnoses included, congestive heart failunchronic kidney disease. Section C (cognitive quarterly MDS (minimovith an ARD (assess 01/10/18 included a Emental status) summ possible 15 points. The clinical record direview for Septembe. On 03/01/18 at 8:35 averbalized to the sum were unable to find a September.	view revealed that Resigned to the facility 12/05/1 but were not limited to, are, diabetes, dementia, sec. patterns) of the Resider num data set) assessment reference date) of BIMS (brief interview for ary score of 15 out of and not include a pharmace.	and ants eent cy	F 756				
	pharmacy review in a team on 03/01/18 at No further informatio	a meeting with the surve approximately 4:45 p.m n regarding this issue w ry team prior to the exit	ey .					
	Free from Unnec Psy CFR(s): 483.45(c)(3)	/chotropic Meds/PRN U (e)(1)-(5)	se	F 758	F758 Free from Unnec Psychotropic PRN Use	Meds/ 04	4/04/18	
	that affects brain acti processes and behave	opic Drugs. chotropic drug is any dru vities associated with m vior. These drugs includ drugs in the following	nental		1. For Resident #387 the PRN has been discontinued.	N Ativan		

JEOY11

If continuation sheet Page 54 of 75



_	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495349		B. WING		C 03/01/2018		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE			
		HEVILLE - BIRDMONT	990 HO	LSTON RD				
OAMMIN O	10101 27102711 11111			VILLE, VA	24382			
		TATELLE OF DEFINITION			· · · · · · · · · · · · · · · · · · ·			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 758	Continued From pag	e 54		F 758	2. Residents currently residing	in the		
	(iv) Hypnotic				facility with physician's orders for psy			
!	(··/ ·· /				medication s have the potential to be			
	Based on a comprehe	ensive assessment of a	1		A review has been completed by the			
	resident, the facility m	nust ensure that			Designee to ensure that psychotropic			
	•				medications are appropriately ordere	eu and that		
	§483.45(e)(1) Reside	nts who have not used			necessary PRN psychotropics have time frames ordered as well.	appropriate		
		re not given these drug			3. In-servicing has been provide	ded by the		
		is necessary to treat a			DON/Designee to physicians, physic	-		
		diagnosed and docume	ented		extenders and licensed nurses regar			
	in the clinical record;				making sure psychotropic medication			
	\$492.45(a)(2) Posido	nto who use psychotre	nio		ordered when necessary and that as needed			
		nts who use psychotro I dose reductions, and	pic		psychotropic medications are ordered for limited time frames up to, but not to exceed (14) fourteen days. A quality review will be			
	behavioral intervention							
		effort to discontinue th	nese		completed by the DON/Designee for			
	drugs;				residents/week with physician's orde			
	J-1,		:		psychotropic medications to ensure			
	§483.45(e)(3) Reside	nts do not receive			psychotropic medications ordered ar			
		ursuant to a PRN order			necessary and that as needed psych			
		n is necessary to treat		medications are ordered for a limited time				
	,	ondition that is docume	nted		frame only up to, but not to exceed (fourteen days.	14)		
	in the clinical record;	and			4. The results of the reviews v	vill be		
	0.400 45/ \//\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		.		discussed by the Administrator/Design			
		rders for psychotropic of			QAPI Committee meeting monthly for			
		s. Except as provided i attending physician or			months. The IDT will recommend re			
	prescribing practition		!		the plan as indicated necessary to si	ustain		
		RN order to be extende	ed		substantial compliance. 5. 04/04/18			
		or she should documen			; U4/U4/T0			
		ent's medical record and						
	indicate the duration	for the PRN order.			:			
	§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be							
	renewed unless the attending physician or							
	prescribing practitioner evaluates the resident for							
	the appropriateness							
	·	not met as evidenced I	-					
		ew and clinical record i						
	the facility staff failed	to ensure 1 of 27 Resi	dents					

		(X1) PROVIDER/SUPPLIER/O IDENTIFICATION NUMBE	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		495349		B. WING_		C 03/01/2018			
	ROVIDER OR SUPPLIER		STREET ADDR	DDRESS, CITY, STATE, ZIP CODE					
CARRIN	GTON PLACE AT WYT	HEVILLE - BIRDMONT		LSTON RE VILLE, VA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REG DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION			
F 758	Continued From pag	je 55		F 758					
	were free of unneces	ssary medications #387.							
	The findings included	d :	!						
	For Resident #387 the facility staff failed to discontinue the prn medication Ativan after 14 days.					į			
	Resident #387 was admitted to the facility on 02/16/18. Diagnoses included but not limited to hypertension, gastroesophageal reflux disease, diabetes mellitus, hyperlipidemia, osteoporosis, anxiety, depression and schizophrenia.								
	The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/28/18 coded the Resident as 8 of 15 in section C, cognitive status. This is an admission MDS.								
	Resident #387's clinical record was reviewed on 02/27/18. It contained a physician's order summary for the month of February which read in part "Ativan 0.5 mg tablet by mouth two times a day prn (as needed) anxiety". This entry had an order date of 02/16/18, but did not have a discontinue date listed.								
	The concern of the prodiscontinue date was administrative team do at approximately 1635	discussed with the uring a meeting on 03/0 ⁻	1/8						
	No further information	was provided prior to ex	×it.						
	Residents are Free of CFR(s): 483.45(f)(2)	Significant Med Errors		F 760	F 760 Residents are Free of Significan Errors	ot Med 04/04/18			
	medication errors.	re that its- ts are free of any signific not met as evidenced by	į.		For Resident #33, the physici responsible party have been notified. were no adverse effects to the resident associated with the medication variance.	There t			

Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	495349		B. WING		03/01/		
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT WYT	HEVILLE - BIRDMONT		ESS, CITY, STA STON RD VILLE, VA				
PREFIX (EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
it was determined the ensure that 1 of 27 F survey was free of S. The Findings Included Resident #33 was a admitted on 9/18/17 included, but were natrial fibrillation, hypodementia without be. The most current Mi assessment located Significant Change M. Reference Date (AR staff coded that Res. Summary Score of 3 that Resident #33 renursing care (4/2) w. (ADL's). In Section staff coded that Res. an anticoagulant. On February 27, 201 reviewed Resident # of the clinical record orders. Signed phys. were not limited to: "daily." (sic) The order. Continued review of the February 2018 M. Records (MAR's). The not document the adding on 2/25/18. On February 27, 201	riew and clinical record r at the facility staff failed Residents in the sample significant Medication En	was pathy, ness, y. s a t tility e coded total ng ty s of r iew ian t th ced d d did hadin	F 760	2. For current residents residir facility, a review has been completed DON/Designee for the previous (30) of physician's order sets and telephonas compared with the Medication Adrecord (MAR) to identify further discribrer responsible party and physicians notified as indicated necessary. 3. In-servicing has been providicensed nurses by the DON/Designe following physician orders and admin medications as ordered by the physic quality review will be completed by the Designee for (5) five residents/week months to ensure that physician's order followed to include administering medications as order to minimize variances. 4. The results of the review will discussed by the Administrator/Desig QAPI Committee meeting monthly formonths. The IDT Committee will recrevisions to the plan as indicated necrevisions.	by the thirty days ne orders ministration repancies. It will be ded to the regarding istering sian. A re DON/ for (3) three dications medication I be since at the regarding interest of the desired in the left of the desired in the left of the le		

RECEIVED MANDA O

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
CARRING	TON PLACE AT WYT	HEVILLE - BIRDMONT		LSTON RD VILLE, VA 24	4382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REG DENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 760	Continued From pag	ge 57		F 760			
	that Resident #33 ha	nd physician orders for					
		ry day. The surveyor no	tified				
	_	w of the February 2018				, ,	
	MAR's failed to docu	ment the administration	of				
	the Coumadin 4 mg	on 2/25/18. The surveyo	or			İ	
	reviewed Resident #	33's clinical record with	the				
		or pointed out the specifi					
	order for the Couma	din 4 mg every day. The		i		! !	
	-	ed the February 2018 M					
		surveyor specifically po	inted				
		in 4 mg had not been		ĺ			
		inistered on 2/25/18. Th					
		o the medication cart loc				į	
		station and obtained th					
	_	lication blister pack. The					
		nedication blister pack ba was sitting at the nurses		i		!	
	· ·	tated that the card had b					
		the facility and that the	Jeen				
		s correctly reflected the	;				
	•	4 mg tablets missing fr	om :				
		r pack. The surveyor loc		1			
		ng blister pack. The surv					
		e Coumadin had been		ĵ			
	administered on 2/25	5/18 and the ADON shoo	ok	ļ			
	her head side to side	e, indicating "No." The					
	surveyor notified the	ADON that the facility no	ot	ļ			
	administering the phy	ysician ordered Coumad	lin				
	was considered a sig	inificant medication erro	r.			i	
	On February 27, 201	8 at 4:30 p.m., the surve	avor				
		ator (Adm), Director of	-yoi				
		ADON that Resident #33	Was				
		every day. The surveyo					
	_	rative Team (AT) that the	1	1			
		s failed to document the		: : !			
	•	Coumadin on 2/25/18. T				:	
		AT that the ADON and					
		ed the Coumadin blister	pack	į			
		curately reflected the		1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			1'''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495349		B. WING		C 03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
CARRING	TON PLACE AT WYTI	HEVILLE - BIRDMONT		STON RD VILLE, VA	24382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 760	Continued From pag	e 58		F 760			
	as given on the Februs urveyor notified the Medication error had #33 had not received Coumadin No additional informa survey team prior to e Resident #33 had a s	been identified, as Res the physician ordered tion was provided to the exiting the facility as to v ignificant medication er an ordered Coumadin n	ident e why ror	F 770	F 770 Laboratory Services	04/04/18	
33-0	§483.50(a) Laborator §483.50(a)(1) The facilaboratory services to residents. The facility and timeliness of the (i) If the facility provid services, the services requirements for labor of this chapter. This Requirement is Based on staff intervier review, the facility star ordered lab test for two Residents #42 and #7. The findings included 1. For Resident #42, the physician ordered lab. The record review review had been admitted to Diagnosis included, b	y Services. cility must provide or ob meet the needs of its is responsible for the query services. es its own laboratory must meet the applical ratories specified in paranot met as evidenced between and clinical record ff failed to obtain physical of 27 Residents, 72. The facility failed to obtain oratory test. realed that Resident #4, the facility 05/13/16, ut were not limited to, ux disease, benign pro-	uality ble t 493 y: cian		1. For Resident #42, the urinal culture and sensitivity have been colliphysician and responsible party have notified for Resident #72. The physician responsible party were notified. 2. For residents currently resid facility a review has been completed DON/Designee for the previous (30) of comparing physicians order sets and orders to lab results to ensure that lab been obtained per physician's order, physician and responsible party have notified. 3. In-servicing has been provid DON/Designee regarding obtaining la ordered by the physician, following up physician's orders on lab results, and the results are present on the medical quality review will be competed by the Designee for (5) five residents/week for three months to ensure that labs are and followed up on per the physician's and results are present on the medical	ected. The been sian and ing in the by the days telephone os have The been led by the lib tests as o per the ensuring I record. A e DON/ for (3) obtained s order,	

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

Printed: 03/16/2018 FORM APPROVED 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 C	
		495349		B. WING	11. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	03/01/2018	
	OVIDER OR SUPPLIER TON PLACE AT WYTH	HEVILLE - BIRDMONT		STON RD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 770	pulmonary disease, a Section C (cognitive property MDS (minim with an ARD (assess 01/05/18 included a Emental status) summar possible 15 points. The clinical record incetelephone order dated (urinary tract infection sensitivity)." The surveyor was unathis lab test in the clinical record incetelephone order dated (urinary tract infection sensitivity)." The surveyor was unathis lab test in the clinical record practic missing lab test. On 02/27/18 at 11:09 LPN (licensed practic missing lab test. On 02/28/18 at 10:47 unit manager (LPN #2 record. After reviewin calling the contracting the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test. RN (region of the surveyor that the lethis lab test.	patterns) of the Resider aum data set) assessment reference date) of the Resider ary score of four out of a studed a physician's doz/23/18 to recheck "to C+S (culture and able to locate any resultical record. a.m., the surveyor asked and any the surveyor and a surveyor a surveyor and a surveyor and a surveyor a surveyor and a surveyor and a surveyor a surveyor and a surveyor an	ots ent UTI ts for ed the d to ng on	F 770	4. The results of the reviews w discussed by the Administrator/Desig QAPI Committee meeting monthly fo months. The IDT will recommend rethe plan as indicated necessary to susubstantial compliance. 5. 04/04/18	gnee at the or (3) three visions to	
		DON were notified of t /28/18 at 1:34 p.m. dur ey team.					
,	with a copy of nursing 02/28/18. "LE (late en has decreased agitati	ity provided the surveyor notes transcribed on try) for 2/24/18Resid on this afternoon. Clear ent to Lab. Awa	ent 1				

PECENTER.

u yyolg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STATE,	ZIP CODE		
CARRING	TON PLACE AT WY	HEVILLE - BIRDMONT	990 HO	LSTON RD			
			WYTHE	VILLE, VA 240	382		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	:	ID	PROVIDER'S PLAN OF CORRECT		
PREFIX TAG		ST BE PRECEDED BY FULL REC DENTIFYING INFORMATION)	SULATORY	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		
		. ,		i	DEFICIENCY)		
F 770	Continued From page	ge 60		F 770			
	results." and "This n	urse called lab fo	or				
	results on 2-25-18 UA C&S. Lab was sent to and UA was not done but culture is in			:			
	process and will be	complete tomorrow."	!			:	
	No further informatio	n regarding this issue wa	e !	i		į	
		ey team prior to the exit		!			
	conference.						
	2. For Resident #72, facility staff failed to						
	discontinue a medica	ation when the physician					
	ordered.		:				
	Resident #72 was ac	imitted to the facility on					
		es including hypertensio	n, :				
Ï		dementia with behavior		:			
	disturbance, anemia			İ			
		y tract infection. On the		İ			
		a set assessment with					
		ce date 1/25/18, the resid	lent				
		rief interview for mental					
į		ssed as without signs of or behaviors affecting se	lf or				
	others.	or benaviors uncoming se					
İ							
		v on 2/18/18 revealed a					
ļ		d 2/23/27 for "OBX3-ane					
		olood 3 times for anemia	· :				
	_	on form dated 2/27/17 ui Order written for occult b					
		pecimens obtained as of					
		no signs/sx of bleeding.					
į		continue)." The physiciar					
		me form on 2/28/27 "stoo					
		ocytic anemia". A physici	1				
		lease collect stool for Of		!			
		nia." The record containe					
		occult blood dated 3/3/1		ļ			
	· · · · · · · · · · · · · · · · · · ·	esults had a note to star		İ		ĺ	
		the resident on the list f					
	rounds Monday 3/6/1	7). An order dated 3/6/1	8	!			
						I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING			C 1/ 2018
	OVIDER OR SUPPLIER TON PLACE AT WYTI	HEVILLE - BIRDMONT	990 HO	RESS, CITY, STA LSTON RD EVILLE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 770	dated 3/16/18 "Need Previous results +(po There was a result fo dated 3/16/17 result p 3/3/17 test was date order and 5 days afte second result was da	e 61 If X1- anemia" and another results for OB please - sitive) ordered on 3/6". If a stool for occult blood positive. The first result d 9 days after the originer the second order. The sted 10 days after the orn the day of the second	d on al e iginal	F 770			
	notified of the concer on 3/1/18.	d director of nursing we n during a summary me	eeting				
	CFR(s): 483.60(i)(1)(§483.60(i) Food safe The facility must - §483.60(i)(1) - Procu approved or consider state or local authorit (i) This may include f from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accorde standards for food se This Requirement is Based on observation	ty requirements. re food from sources red satisfactory by feder ies. lood items obtained dire subject to applicable Sulations. les not prohibit or prevent ompliance with applicable d-handling practices. les not preclude resident is not procured by the fampliance with professional	ral, ectly tate of ts accility.	F 812	F 812 Food Procurement Store/Prepa Sanitary 1. The ham salad identified as 02/25/18 was removed and discarded 02/26/18. The opened box of raisins with no open date were removed and on 02/26/18. The deep pan of yeast rewere only partially covered with Sarar not dated were removed and discarded 02/26/18. The tray of pureed peached as expired on 02/24/18 were removed disposed of on 02/26/18. 2. Observations have been conthe kitchen by the Administrator/Desigensure that there are no other expired that food items are covered appropriat that food items have appropriate dates open dates.	expired on lon identified discarded rolls that a wrap and ed on sidentified d and iducted in gnee to litems, tely and	04/04/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING			C / 2018
-	OVIDER OR SUPPLIER	HEVILLE - BIRDMONT		ESS, CITY, STA STON RD VILLE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES OF BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	and failed to ensure to secured. The findings included the facility staff failed expired dates were reprigerators and failed food items was secured. The surveyor toured beginning at 6:14 p.m. the walk-in refrigerators alad with an expiration surveyor asked the eshould be removed a "Yes" and promptly restricted the refrigerator. The surveyor observed with a "use by date" opened by the dietary stated the raisins proof the surveyor observed date. The evening contact and were thrown. The surveyor observed dated 2/24/18. The expeaches should have the tray from the refricted.	items from the refrigeral the covering on food wards to ensure food items were do to ensure the covering ed to ensure the covering ed. Ithe kitchen 2/26/18 and with the evening cook or was a container of half on date of 2/25/18. The vening cook if the hame and the evening cook state amoved the container from the ed an opened box of rail of 9/28/18 but no date way staff. The evening cook bably should be dated. The evening cook is a deep pan full of year with saran wrap but half ook stated the rolls were an away. The evening cook stated the element of the dietary manager of the dietary mana	vith g on In m essalad ated om sins when ok ast d no es	F 812	Administrator/Designee to dietary er regarding disposing of expired food covering and dating food items apprincluding dating items when opened Observations of the kitchen will be country by the Administrator/Designee (5) five week for (3) three months to ensure items are not expired, covered approand dated appropriately, including the food item was opened. The results of the observation discussed at the QAPI Committee monthly for (3) three months. The II recommend revisions to the plan as necessary to sustain substantial contol. 04/04/18	mployees items, opriately conducted /e times/ that food opriately ne date the ions will be neeting DT will indicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		495349		B. WING		I .	 / 2018
	OVIDER OR SUPPLIER TON PLACE AT WYT	HEVILLE - BIRDMONT		ESS, CITY, STA STON RD VILLE, VA 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REC ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	on 2/27/18 at 12:50 pmanager. The policy Ready-to-Eat, Time/Safety Food, Date M "READY-TO-EAT, TII CONTROL FOR SAF held in a FOOD EST 24 hours shall be cledate or day by which on the premises, sold a temperature of 5° (c°F (Fahrenheit) or less The surveyor informed and the director of nuon 2/28/18 at 1:32 p. staff again on 3/1/18 No further information exit conference on 3/Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resident (ii) The facility may not resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical residential exceptional standard	ed the facility policy provount from the regional distitled "3-501.17 Temperature Control for arking" read in part ME/TEMPERATURE TETY FOOD prepared at ABLISHMENT for more arly marked to indicate in FOOD shall be consumed, or discarded when he degrees) C (centigrade) as for a maximum of 7 distance of the above conducted that it is a state of the interim administrative at 4:37 p.m. In was provided prior to in 1/18. In dentifiable Information 483.70(i)(1)-(5) Int-identifiable information that is on the public. In the public is an agent only in intract under which the indisclose the information that is on an agent only in intract under which the idisclose the information the facility itself is permitation the facility itself is permitation.	ind than the ned Id at (41 ays." ator cern ve the sis s agent tted	F 842	F 842 Resident Records – Identifiable Information 1. For Resident #378, the admassessment was completed for read facility on 02/24/18 and placed in the appropriate resident's medical record 2. For Residents that currently the facility, a review has been condute DON/Designee for the previous (to ensure that for newly admitted or residents an admission assessment completed and is present in the appreciation of the president's medical record.	nission mission to ed. y reside in cted by (30) days readmitted has been	04/04/18

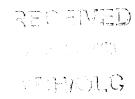
Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

		T SERVICES				OMB NO	<u>0. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i i	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		С	
NAME OF DE	ROVIDER OR SUPPLIER		OTDSST 188			03/01	1/2018
		UE\///		RESS, CITY, ST	ATE, ZIP CODE		
CARRING	STON PLACE AT WYTI	HEVILLE - BIRDMON!		EVILLE, VA	24202		
()(1)(5)	OLIVA AND A DECEMBER OF THE PROPERTY OF			-VILLE, VA	24302		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS OR LSC ID	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE i	(X5) COMPLETION DATE
F 842	Continued From page	e 64		F 842	3 In continue has been		
	(ii) Accurately docume	ented;			3. In-servicing has been pro DON/Designee to licensed nurses	vided by the	
	(iii) Readily accessible				completion of admission assessme	regarding	
	(iv) Systematically org	ganized			admission/readmission as well as r	nis upon	
					resident information in the appropri	ate	
į ·	§483.70(i)(2) The faci	lity must keep confiden	tial		resident's medical record. A review	v will he	
	all information contain	ed in the resident's rec	ords.		conducted by the DON/Designee for	or (5) newly	
!	regardless of the form	or storage method of t	he		admitted/readmitted residents/weel	k for (3)	
!	records, except when		i.		three months to ensure that admiss	e months to ensure that admission	
	(i) To the individual, or	r their resident	!	ļ	assessments have been completed in a timely		
i		permitted by applicable	· law;		fashion and are present in the appr	opriate	
	(ii) Required by Law;		ļ		resident's medical record. 4. The results of the reviews		
	(iii) For treatment, pay			İ	discussed by the Administrator/Des	will be	
	with 45 CFR 164.506;	ed by and in complianc	e	i	QAPI Committee meeting monthly f	or (3) three	
1		activities, reporting of al		i	months. The IDT committee will re-	commend	
	neglect or domestic vi	iolence, health oversigh	ouse,		revisions to the plan as indicated ne	cessary to	
	activities judicial and	administrative proceedi	ngo.		sustain substantial compliance.		j
i	law enforcement purpo	oses, organ donation	rigs,	1	5. 04/04/18	!	1
	purposes, research pu	rposes, or to coroners,	Ì	į			
	medical examiners, fur	neral directors, and to a	ivert	į		İ	
	a serious threat to hea	Ith or safety as permitte	ed			i	ľ
	by and in compliance v	with 45 CFR 164.512.		ĺ			
	§483.70(i)(3) The facili	ty must safeguard med	ical	!			
	record information aga	inst loss, destruction, o	r				1
ļ	unauthorized use.						
İ	§483.70(i)(4) Medical r	ecords must be retaine	d				
1	for-			İ			i
i	(i) The period of time re	equired by State law; or	. ;	:		!	
	(ii) Five years from the	date of discharge wher	ו			!	
1	there is no requirement	t in State law; or		İ		İ	
1.	(iii) For a minor, 3 years	s after a resident reach	es	i		j	
	legal age under State la	aw.	!				
	8492 70/i\/E\ The	1					[
	§483.70(i)(5) The medic	cai record must contain	-				[
	(i) Sufficient information (ii) A record of the resid	i to identify the resident	t;			İ	1
	(iii) The comprehensive	nent s assessments;		İ		Į.	
	(iii) The comprehensive provided;	: plan of care and service	ces			l l	
1.1	orovided,		į			Į	1

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

JEOY11

If continuation sheet Page 65 of 75



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETE		(X3) DATE SURVEY COMPLETED C	
	495349	B. WING		03/01/2018
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	
CARRINGTON PLACE AT WYT	HEVILLE - BIRDMONT 990	HOLSTON RD		
	WY	THEVILLE, VA 2	4382	
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
TAG OR LSC ID	ENTER FING IN CRIMATION)	IAG	DEFICIENCY)	1000
F 842 Continued From pag	e 65	F 842		
(iv) The results of any	preadmission screening			
and resident review e				
determinations condu	cted by the State;			
(v) Physician's, nurse	's, and other licensed			:
professional's progre	ss notes; and	i i		
(vi) Laboratory, radiol	ogy and other diagnostic			
services reports as re	quired under §483.50.			
	not met as evidenced by:			
The state of the s	ew and clinical record			
review, the facility sta				
	e clinical record for 1 of 27			
residents in the surve	y sample (Resident #378).			
The findings included	:			
Resident #378 was re	eadmitted to the facility on			į
	ving diagnoses of, but not			
	onary artery disease, atrial			
fibrillation, high blood	pressure, peripheral			
vascular disease and	chronic obstructive			
pulmonary disease.	The resident did not have an			
	mum Data Set) completed			
	ey. The resident was alert			i
to person, place and	•			
	of 1 staff member for			İ
bathing.		į		!
The surveyor reviewe	d the clinical record of			
	8/18 and 3/1/18. The			
	/18 that there was not an	ř .		
admission assessme	nt in the electronic or paper			ļ
clinical record for Res	ident #378 when he was			
readmitted back to the	e facility on 2/24/18.			1
. The surveyor notified	the director of nursing of the			
	ndings on 3/1/18 at 2 pm.			
	-			
	g returned to the surveyor at			
	We found the resident's			
admission assessmen	nt documented in another			

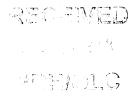
Printed: 03/16/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03/01/	
	OVIDER OR SUPPLIER	HEVILLE - BIRDMONT		RESS, CITY, STA	ATE, ZIP CODE		
			WYTHE	VILLE, VA	24382		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR TAG OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	Continued From page	ge 66	i	F 842			
	know it is this resider resident has not bee since he was origina The surveyor notified	h the same last name. In the same last name. In the same last name. In the same last name in the facility admitted to the facility admitted to the facility of the administrative teamed findings on 3/1/18 at	ity y." n of				
	No further informatio	n was provided to the exit conference on 3/1/1	8.				
	§483.75(g)(1) A faciliassessment and assat a minimum of: (i) The director of nuiting the director of n	ssessment and assuran ity must maintain a quali urance committee consi urance committee consi rsing services; ctor or his/her designee; er members of the facili who must be the , a board member or oth ship role; uality assessment and e must: terly and as needed to h respect to which qualit urance activities are not met as evidenced beiew and facility documer inned that the facility state the Quality Assurance ast quarterly.	ty sting ty's er ty y:	F 868	1. A Quality Assurance Perford Improvement Committee meeting was or before 04/04/18. 2. A Quality Assurance Perford Improvement (QAPI) Committee meeting held on or before 04/04/18. 3. In-servicing has been provide Administrator, DON and the Medical on or before 04/04/18 by the Regional of Clinical Operations regarding the CASSURANCE Process including Quality Assurance meetings and frequency of Meetings. The Regional Director of CO Operations (RDCO)/Designee will pain the monthly QAPI meetings for (3) the months to ensure that QAPI meetings being conducted appropriately. 4. Results of the observations of RDCO/Designee will be discussed by Administrator/Designee at the QAPI monthly. The IDT/RDCO/Designee werecommend revisions to the plan as in necessary to sustain substantial comp. 5. 04/04/18.	mance is held on mance ting was ded to the Director al Director Quality of Clinical rticipate hree s are by the / the meeting vill indicated	04/04/18
	On March 1, 2018 at	9:45 a.m., the surveyor	met				

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

JEOY11

If continuation sheet Page 67 of 75



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
	OVIDER OR SUPPLIER	HEVILLE - BIRDMONT	990 HO	RESS, CITY, ST. LSTON RD EVILLE, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 868	with the Administrator (DON), Regional Mini Nurse, Corporate Corn New Administrator. facility's Quality Assurequested to see the sheets of the people of meetings. The DON's Committee met monto The Adm produced the reviewed the manual had conducted QA me 12/27/17 and 1/29/18 the facility should have meeting in February 2. The surveyor pointed the facility had not have survey team prior to eather facility failed to hat for the facility.	r (Adm), Director of Nur mum Data Set (MDS) impliance nurse (CCN) at The surveyor discussed rance (QA) program an QA meeting signature who attended the QA stated that the QA only and at least quarterlie QA manual. The sur and noted that the facility and a QA committee that the thad a QA committee thad a QA committee thad a QA committee thad a QA committee thad a QA committee thad a QA committee thad a QA committee thad a QA committee thad a QA committee that the thad a QA committee	and If the If th	F 868			
	development and tran diseases and infection \$483.80(a) Infection program. The facility must estal and control program (a minimum, the follow	2)(4)(e)(f) Introl I	ntion e, at		F 880 Infection Prevention & Control 1. For Resident #381, Resident #386 Resident #378 the handheld nebulizer devic was stored in a plastic bag on 02/27/18 by tl DON/Designee. For Resident #378, the em 1000cc IV bag and tubing were removed an discarded by the DON on 02/27/18. For Resident #104, the nebulizer facemask was stored in a plastic bag by the DON/Designee 02/27/18. 2. Observations have been conducted the DON/Designee for current residents resi in the center to ensure that nebulizer equipn is stored in a plastic bag and that residents receiving Intravenous(IV) fluids do not have IV bag/tubing still hung in the room.	e e e e e e e e e e e e e e e e e e e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				1_			С
		495349		B. WING		03/01	1/2018
	ROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
CARRING	TON PLACE AT WYT	HEVILLE - BIRDMONT		STON RD			
			WYTHE	/ILLE, VA	24382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	and communicable d staff, volunteers, visit providing services un arrangement based u conducted according accepted national state §483.80(a)(2) Written procedures for the procedures for the probut are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor communicable disease reported; (iii) Standard and trant to be followed to prev (iv)When and how iscresident; including but (A) The type and durate depending upon the initial involved, and (B) A requirement that least restrictive possibility circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the (vi)The hand hygiene by staff involved in direct of the contact with residents contact will involved in direct of the contact will transmit the contact will involved in direct of the contact will be staff involved in direct of the contact with residents contact will involved in direct of the contact will be staff involved in direct or staff involved in direct	ng, and controlling infective as a contractual upon the facility assessing to §483.70(e) and followed and fol	ment wing and ude, tify ties the er the try le	F 880	3. In-servicing has been provicurrent employees by the DON/Desi regarding appropriately storing nebu equipment in a sanitary fashion in a bag and discarded IV tubing/bag afte Observations will be conducted by the Designee for (5) five residents/week months with orders for nebulizer and to ensure nebulizer equipment is sto sanitary fashion in a plastic bag and bags/tubing are discarded after use. 4. The results of the observation be discussed by the Administrator/Double QAPI Committee meeting month three months. The IDT will recommerevisions to the plan as indicated necessation substantial compliance. 5. 04/04/18	gnee lizer plastic er use. ne DON/ for (3) I IV fluids red in a the IV ons will esignee at ly for (3)	
				!			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		495349		B. WING		03	C /01/2018	
	OVIDER OR SUPPLIER	IEVILLE - BIRDMONT	990 HOL	ESS, CITY, STATE, STON RD VILLE, VA 243				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	transport linens so as infection. §483.80(f) Annual rev The facility will conduct IPCP and update their This Requirement is r Based on observation document review the restablished infection or residents in the survey 386, # 378 and #104). The findings included: 1. The facility staff held nebulizer device if #381. Resident #381 was ad 2/23/18 with the follow limited to heart attack, diabetes, congestive he weakness. The reside completed MDS (Minir being admitted to the file.)	e, store, process, and to prevent the spread of the prevent the spread of the program, as necessar not met as evidenced by staff interview and fact acility staff failed to follow the program of the program of the program of the program of the program of the program of the program of the program of the process of the program of the process of the program of the process of the program of the process of the program of the process of the program of the process of the program of the process of the program of the process of the program of the process of the process of the program of the process of the pro	ts ry. ry: cility low of 27 31, #	F 880				
!		ce and time. The resid	dent					
	of the nebulizer was ly the resident's bed and bag. The surveyor ma	ne director of nursing w	of estic					

Printed: 03/16/2018 FORM APPROVED 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	
		495349		B. WING		03/0	C 01/ 2018
l	VIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATE,	, ZIP CODE		
CARRING	TON PLACE AT WYT	THEVILLE - BIRDMONT		LSTON RD VILLE, VA 24:	382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGI DENTIFYING INFORMATION)	ULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	The surveyor request storage of nebulizer. The surveyor receive policy titled "Administ Small Volume (Hand from the director of normal with the result of the surveyor notified the above document of the above document of the above document of the above document of the above document of the above document of the above document of the above document of the above document of the above document of the above document of the above document of the admitted to chronic obstand oxygen dependent of the admitted of the admitted of the above document of the admitted of the above document of the admitted of the above document of the admitted of the admitted of the above document of the admitted of the above of the admitted	ated, "I'll take care of this sted a copy of the policy of equipment." and a copy of the facility's strating Medications through the policy stated in the policy stated in the policy stated in the policy stated in the administrative team and the district of the exit conference on 3/1/18 at 4 and the policy stated in the po	gh a am I, " ate of :44	F 880			
		nis equipment was not		!			

RECEWED HIMMES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495349		B. WING		C 03/01/2018	
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STATE,	ZIP CODE		-
CARRING	TON PLACE AT W	THEVILLE - BIRDMONT		LSTON RD VILLE, VA 24:	382		
(X4) ID PREFIX TAG	(EACH DEFICIENCY N	Y STATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL REG CIDENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 880	stored in a plastic to (DON) walked by the surveyor made this asked the DON to The Don stepped in surveyor pointed on the Don stepped in surveyor pointed on the policy titled "Admin Small Volume (Harfrom the director of When equipment plastic bag with the on it" The surveyor notification the above document plastic bag with the onit" The surveyor notification the above document surveyor prior to the surveyor prior to the 3. The facility sheld nebulizer devitable. The surveyor went 9:15 am on 2/27/18. The hand held moulying out in the roor plastic bag and A 1000cc empty bate a pole in the reside attached. At 9:30 am, the surveyor and the surveyor and the surveyor bate attached.	bag. The director of nursing the resident's room when the survey come into the resident's room and the survey come into the resident's room and the policy to the DON that the nut was lying out on the table in a plastic bag. The DOD care of this immediately." I wed a copy of the facility's distrating Medications through the policy state is completely dry, store in the resident's name and the exist completely dry, store in the resident's name and the exist conference on 3/1/18 at the policy state is a completely dry, store in the resident's name and the exist conference on 3/1/18 at the policy state is a completely dry, store in the resident's name and the exist conference on 3/1/18 at the policy state is a completely dry, store in the resident's name and the exist conference on 3/1/18 at the policy of the nebulizer was and observed the following the policy of the nebulizer was and was not stored in a go of IV fluids was hanging ont's room with the tubing store of the director of the policy of th	he reyor com. In the seyor com. In this seyor com. In the seyor com. In the seyor com. In the seyor co	F 880			
		ome to the resident's roon					

NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT SUMMANY SYSTEMATION OF PROFIDENCES OF PLACE AND AND STORE OF PROVIDER STATEMENT OF DEFICIENCY OR IS CURRENT OF MALE CONTROL OF PLACE AND AND STATEMENT OF DEFICIENCY OR IS CURRENT OF MALE CONTROL OF PLACE AND AND STATEMENT OF DEFICIENCY OR IS CURRENT OF MALE CONTROL OF PLACE AND AND STATEMENT OF DEFICIENCY OR IS CURRENT OF MALE CONTROL OF PLACE AND AND STATEMENT OF DEFICIENCY OR IS CURRENT OF MALE CONTROL OF PLACE AND AND STATEMENT OF DEFICIENCY OR IS CURRENT OF MALE CONTROL OF PROFIDENCE OR IS CURRENT OF THE APPROPRIATE OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
AND INTERPRETATION PLACE AT WYTHEVILLE - BIRDMONT PRETIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH CORRECTION SHOULD BE CROSS-REFERENCE) TO THE APPOPHIATE DEPICIENCY F 880 Continued From page 72 The DON came into the resident's room and the surveyor notified her of the observations as documented above. The DON began taking down the empty IV bag and placed in the resident's trash can. The DON stated, "I will take care of the rest and replace the nebulizer equipment." The surveyor received a copy of the facility's policy titled "Administrating Medications through a Small Volume (Handheld) Nebulizer' at 10:30 am from the director of nursing. The policy stated." "When equipment its completely dry, store in plastic bag with the resident's name and the date on it" The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm. No further information was provided to the surveyor prior to the exit conference on 3/1/18. 4. The facility staff failed to ensure the nebulizer facemask was contained in a plastic bag when not used by Resident #104. The clinical record of Resident #104 was reviewed 2/27/18 through 3/1/18. Resident #104 was admitted to the facility 1/30/18 and readmited 2/16/19 with diagnoses that included but not limited to high fever, likely due to aspiration pneumonitis, acute bronchitis, severe protein maintrition with albumin of 1.4.			495349		B. WING			3
Ox4 ID PREFIX (EACH OERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEGIC CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DA				990 HO	LSTON RD			
FREEN TAG OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 72 The DON came into the resident's room and the surveyor notified her of the observations as documented above. The DON began taking down the empty IV bag and placed in the resident's trash can. The DON stated, "I will take care of the rest and replace the nebulizer equipment." The surveyor received a copy of the facility's policy titled "Administrating Medications through a Small Volume (Handheld) Nebulizer" at 10:30 am from the director of nursing. The policy stated, "When equipment is completely dry, store in plastic bag with the resident's name and the date on it" The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm. No further information was provided to the surveyor prior to the exit conference on 3/1/18. 4. The facility staff failed to ensure the nebulizer facemask was contained in a plastic bag when not used by Resident #104. The clinical record of Resident #104 was reviewed 2/27/18 through 3/1/18. Resident #104 was admitted to the facility 1/30/18 and readmitted 2/16/18 with diagnoses that included but not limited to high fever, likely due to aspiration pneumonitis, acute bronchitis, severe protein malnutrition with albumin of 1.4.				WYTHE	VILLE, VA 243	382		
The DON came into the resident's room and the surveyor notified her of the observations as documented above. The DON began taking down the empty IV bag and placed in the resident's trash can. The DON stated, "I will take care of the rest and replace the nebulizer equipment." The surveyor received a copy of the facility's policy titled "Administrating Medications through a Small Volume (Handheld) Nebulizer" at 10:30 am from the director of nursing. The policy stated, "When equipment is completely dry, store in plastic bag with the resident's name and the date on it" The surveyor notified the administrative team of the above documented findings on 3/1/18 at 4:44 pm. No further information was provided to the surveyor prior to the exit conference on 3/1/18. 4. The facility staff failed to ensure the nebulizer facemask was contained in a plastic bag when not used by Resident #104. The clinical record of Resident #104 was reviewed 2/27/18 through 3/1/18. Resident #104 was reviewed 2/27/18 through 3/1/18. Resident #104 was admitted to the facility 1/30/18 and readmitted 2/16/18 with diagnoses that included but not limited to high fever, likely due to aspiration pneumonitis, acute bronchitis, severe protein malnutrition with albumin of 1.4.	PREFIX	(EACH DEFICIENCY MU	ST BE PRECEDED BY FULL RE	GULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMP	LETION
gastrointestinal hemorrhage, atrial fibrillation, iron deficiency anemia, diastolic heart failure, cerebral infarction, hemiplegia following cerebral infarction affecting right dominant side, muscle wasting, dysphagia, status post PEG tube placement secondary to stroke, fracture of femur, hypertension, dementia without behavioral	F 880	The DON came into surveyor notified her documented above. down the empty IV be resident's trash can care of the rest and equipment." The surveyor receive policy titled "Administ Small Volume (Hand from the director of many with the policy titled policy	the resident's room and rof the observations as The DON began taking bag and placed in the The DON stated, "I will replace the nebulizer ed a copy of the facility's strating Medications through the downward of the policy states in the strating of the policy states completely dry, store in the downward of the administrative teams and the downward of the administrative teams and the exit conference on 3/1/18 at the strating of the place of the exit conference on 3/1/18 at the place of the exit conference on 3/1/18 at the place of the exit conference on 3/1/18 at the place of the exit conference on 3/1/18 at the place of the exit conference on 3/1/18 at the place of the place	take ugh a 0 am ed, " n date n of 4:44 #104 ded ere eighting iron ebral ction	F 880			

C 03/01/2018 RECTION (X5) HOULD BE COMPLETION DATE
HOULD BE COMPLETION
HOULD BE COMPLETION
HOULD BE COMPLETION

Printed: 03/16/2018 FORM APPROVED 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	
495349			B. WING	B. WING		C 03/01/2018		
	ROVIDER OR SUPPLIER			RESS, CITY, STATE	, ZIP CODE			
CARRING	STON PLACE AT WYTI	HEVILLE - BIRDMONT		LSTON RD VILLE, VA 24	382			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880				F 880				
	No further information exit conference on 3/	n was provided prior to 1/18.	the					
							: 	
	!			}				
			!					
	 			!				
			4					
				I .				
				:				
							: 	
			!					
	· ·			İ				
			!	ļ				
				!				
			!					
			İ	i				
:								
			!					
				!				

RE-JEOMI JED

01/11/11/11/11/11	A Made of the Barrett								
	TOF ISOLATED DEFICIENCIES WHICH CAUSE VITH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER #	DATE SURVEY COMPLETE:						
FOR SNFs Al	NI) NFs	495349	03/01/2018						
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE	, ZIP CODE						
	TON PLACE AT WYTHEVILLE - BIRDMONT CENTER	990 HOLSTON RD WYTHEVILLE, VA. 24382							
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES								
F 582	F 582 Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)								
	§483.10(g)(17) The facility must (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A)								
	§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This Requirement is not met as evidenced by:								
Based on staff interview and facility document review the facility staff failed to provide two Residents with Advance Beneficiary Notice's prior to Medicare services ending, supplemental Resident #1 and supplemental Resident #2. The findings included: 1. For supplemental Resident's #1 the facility staff failed to provide the Resident with an Advance Beneficiary Notice prior to services ending. Supplemental Resident #1 was admitted to the facility on 10/19/17 and Medicare Part A services ended on 11/29/17. The DON (director of nursing) informed the surveyor on 02/28/28 at approximately 1555 that the facility had not provided the Resident and/or representative with an Advance Beneficiary Notice prior to Medicare services ending.									
							The concern of the Advance Beneficiary Notice not being provid discussed with the administrative team during a meeting on 03/0		rior to services ending was
							No further information was provided prior to exit		

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 are requisite to continued program participation.

The above isolated deficiencies pose no actual harm to the residents

If continuation sheet 1 of 2

CENTERS FO	OR MEDICARE & MEDICAID SERVICES		"A FURM				
NO HARM W	OF ISOLATED DEFICIENCIES WHICH CAUSE WITH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER #	DATE SURVEY COMPLETE:				
FOR SNFs Al		495349	03/01/2018				
	ROVIDER OR SUPPLIER FON PLACE AT WYTHEVILLE - BIRDMONT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 990 HOLSTON RD WYTHEVILLE, VA. 24382					
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES						
F 582							
	2. For supplemental Resident #2, the facility staff failed to prov services ending.	vide the Resident with an Advance B	seneficiary Notice prior to				
	Supplemental Resident #2 was admitted to the facility on 12/28/17 and Medicare Part A services ended on 02/16/18. The Advance Beneficiary Notice was signed by the Resident's representative on 02/21/18; 5 days after services had ended.						
	The concern of the Advance Beneficiary Notice not being providiscussed with the administrative team during a meeting on 03/		prior to services ending was				
	No further information was provided prior to exit.						
			RECEIVED				
			MARI Ex MA				
			VDH/OLC				
			Committee Commit				

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.

The above isolated deficiencies pose no actual harm to the residents

PRINTED: 03/16/2018 FORM APPROVED State of Virginia (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING _ 03/01/2018 495349 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 990 HOLSTON RD CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENT WYTHEVILLE, VA 24382 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 000 F 000 Initial Comments Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth An unannounced Medicare/Medicaid standard on the statement of deficiencies. This plan survey and biennial State Licensure Inspection of correction is prepared and/or executed was conducted 02/26/18 through 03/01/18. solely because required. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 137 certified bed facility was 121 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 3 closed record reviews. As this years survey was an Annual Licensure 04/04/18 F 001 F 001 Non Compliance and Recertification Survey, the attached Plan of Correction will cross reference to the The facility was out of compliance with the statement of deficiencies for the State following state licensure requirements: Licensure requirements. This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Homes Policies and Procedures Policies and Procedures 12 VAC 5-371-140- cross reference to F849 12 VAC 5-371-140- cross reference to F849 Residents Rights 12 VAC 5-371-150- cross reference to F550. Residents Rights 12 VAC 5-371-150- cross reference to F550, F565, and F582 F565, and F582 Quality Assurance

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

12 VAC 5-371-170- cross reference to F868

12 VAC 5-371-180- cross reference to F812 and

TITLE

12 VAC 5-371-170- cross reference to F868

12 VAC 5-371-180- cross reference to F812

(X6) DATE 03/26/2018

Executive Director

If continuation sheet 1 of 2

Quality Assurance

Infection Control

F880

Infection Control

and F880

PRINTED: 03/16/2018

FORM APPROVED State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING _ 03/01/2018 B. WING 495349 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 990 HOLSTON RD **CARRINGTON PLACE AT WYTHEVILLE - BIRDMONT CENT** WYTHEVILLE, VA 24382 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) Continued From Page 1 F 001 F 001 **Nurse Staffing** Nurse Staffing 12 VAC 5-371-210 (B)- cross reference to F732 12 VAC 5-371-210 (B)- cross reference to F732 **Nursing Services Nursing Services** 12 VAC 5-371-220- cross reference to F684, F760 12 VAC 5-371-220- cross reference to F684, and F758 F760 and F758 Physician Services Physician Services 12 VAC 5-371-240- cross reference to F635 and 12 VAC 5-371-240- cross reference to F635 and F710 F710 Resident Assessment and Care Planning Resident Assessment and Care Planning 12 VAC 5-371-250- cross reference to F641, 12 VAC 5-371-250- cross reference to F641, F655, F660 and F690 F655, F660 and F690 Pharmacy Services **Pharmacy Services** 12 VAC 5-371-300- cross reference to F755 12 VAC 5-371-300- cross reference to F755 and and F756 F756 Diagnostic Services Diagnostic Services 12 VAC 5-371-310- cross reference to F770 12 VAC 5-371-310- cross reference to F770 Administration Administration 12 VAC 5-371-360- cross reference to F360, 12 VAC 5-371-360- cross reference to F360, F689 F689 and F842 and F842 RECEIVED

VDHIOLG