PRINTED: 11/14/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B, WING		11/02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 155 SS=D	An unannounced Medicare/Medicaid standard survey was conducted 10/31/17 through 11/2/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 116 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents 1 through 21) and 4 closed record reviews (Residents 22 through 25). 483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO		F 158	our credible allegation of compliance. Preparation and execution of this plan of correction do not constitute admission or agreement by the provider of the conclusion se forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of	/or ne t
	to participate in experi- formulate an advance c)(8) Nothing in this participate as the right the provision of medical services deemed medical inappropriate. (g)(12) The facility must requirements specified subpart I (Advance Direction of the content of the c	to participate in or refuse mental research, and to directive. Iragraph should be of the resident to receive al treatment or medical cally unnecessary or st comply with the in 42 CFR part 489, ectives). Include provisions to the information to all adult the right to accept or refuse		F 155 Right to Refuse; Formu Advance Directives Criteria 1: Resident #2 DDNR order was corrected with initiation of new DDNR order resident's wishes on October 2017. On October 31, 2017, S Services audited all resident's charts verifying DDNR orders; additional errors were found. Criteria 2: Advance Directives/DDNR orders for admissions, readmissions, and residents with changes in condition will be reviewed we	per 31, ocial no

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 stifficient 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 racility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

Event ID: 5VVM11

Facility ID: VA0414

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING_			11	/02/2017	
NAME OF PROVIDER OR S CARRINGTON PLACE (X4) ID	AT RURAL	RETREAT ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368 ID PROVIDER'S PLAN OF CORRECTIO			(X5)	
PREFIX (EAC		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		SHOULD BE	_	COMPLETION DATE	
facility's por and application of all the entities to the legally respreduirement (iv) If an actime of adminformation has execut may give a individual's with State I (v) The faci provide this or she is ab Follow-up put the information appropriate 483.24 (a)(3) Person including Commergency medical per physician or directives. This REQUI by: Based on streview the facomplete a	cludes a walicies to imable State es are perm furnish this sonsible for a state or articular and a state or a	ritten description of the plement advance directives	F 18	by social services director designee for accuracy and corrections will be made resident/RP's wishes. Criteria 3: DON or design provide education to social services and nursing staff November 30, 2017 and consumer of accuracy and completion of Advance Doubletion of Advance Doubletion of Advance Doubletion of Advance Directives/DDNR workly for admissions, readmissions, and resident changes in condition to enaccuracy. Criteria 4: Results of audit presented to ED or design weekly by DON/social services are director. ED or designee were present results to facility Committee monthly for fur intervention or recommental necessary. Criteria 5: December 16, 2	d per lee will ial f by during reafter irectives Social audit of a orders ats with asure es will be ee vices vill QA orther idation			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368		
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	Section 1 and 2 of the form had not been con The record review review heen admitted to the financial property of the finan	Residents DDNR order impleted. ealed that Resident #2 had acility 01/04/2017. but were not limited to, gestive heart failure, and status) of the Residents tatus MDS (minimum data an ARD (assessment 05/2017 included a BIMS intal status) summary score 15 points. uded a DDNR order form interment of Health dated and 2 of this form had been DNR read in part, "I further r 2]: PABLE of making an included 2 above, check A, ee boxes below had also included a physicians 04/17/2017 indicating the	F	155			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER STON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
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F 164 SS=D	On 10/31/2017 at appunit manager was ask The administrative stamissing information or meeting with the surve approximately 2:45 p.r. On 11/01/2017 at appuadministrative staff vera 100% audit had been regarding DDNR's and identified. No further information provided to the survey conference. 483.10(h)(1)(3)(i); 483 PRIVACY/CONFIDEN' 483.10 (h)(I) Personal privacy medical treatment, writt communications, personal and the form for each resident has confidential personal and medical provided at	roximately 10:50 a.m. the ed about the DDNR. If were notified of the the DDNR during a sey team on 10/31/2017 at m. If were notified of the the DDNR during a sey team on 10/31/2017 at m. If we the DDNR during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2017 at m. If we the during a sey team on 10/31/2	F 16	F 164 Personal Privacy/Confidentiality of Record Criteria 1: On November 1, 2017, DØN provided education to nurses of Residents #19, #21, and #17 on regarding the proper utilization of the privacy screen option on the medication cart computers. Criteria 2: DON or designee will observe a sample of nurses weekly during medication pass to ensure privacy screen option on		
	§483.70			medication cart computer is being utilized properly.		

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	ROVIDER OR SUPPLIER	RETREAT		51	FREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368	*	
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F 164	(i) Medical records. (2) The facility must k information contained regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitte with 45 CFR 164.506; (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purpopurposes, research purposes, research purposes, research purposes, research purposes, research purposes as research purposes,	eep confidential all in the resident's records, or storage method of the release is- their resident permitted by applicable law; ment, or health care ed by and in compliance ctivities, reporting of abuse, idence, health oversight administrative proceedings, pses, organ donation rposes, or to coroners, meral directors, and to avert lth or safety as permitted with 45 CFR 164.512. is not met as evidenced , staff interview, facility clinical record review, the otect the private health of 25 Residents, Residents me facility staff failed to medical record. The d was left open and in the obsing the Residents	F	164	Criteria 3: DON or designee will provide education by November 30, 2017 to nursing staff regarding privacy of records to include utilization of the privacy screen. DON or designee will monitor/observe a sample weet o ensure utilization of privacy screen on computers. Criteria 4: Results of audits will presented to ED or designee weekly by DON or designee. ED designee will present results to facility QA committee monthly further intervention or recommendation as necessary. Criteria 5: December 16, 2017	r / kly be or	

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		495417	B. WING		0	11	/02/2017
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	had been admitted to Diagnoses included, it diabetes, heart failure cerebral ischemia. Section C (cognitive padmission MDS (miniwith an ARD (assess 10/17/2017 included amental status) summa possible 15 points. Seincluded the diagnosis On 11/01/2017 at app surveyors observed a wing. On top of this momental that the nurstheir medication pass. left open and the surve Resident #19's private The nursing staff was of this medication cart to observe numerous well as various staff. When LPN (licensed pto the medication cart she usually left the core #3 replied she did not.	the facility 10/11/2017. but were not limited to, hypothyroidism, and reatterns) of the Residents mum data set) assessment ment reference date) of a BIMS (brief interview for ary score of 13 out of a rection I (active diagnoses) a of diabetes. roximately 8:00 a.m. two medication cart on the east redication cart was a sing staff would use during This computer had been reversely were able to read health care information. The surveyors were able Residents in the hallway as reactical nurse) #3 returned the surveyor asked her if mputer open. To which LPN	F	164	DEFIGIENCY)		
	of a document titled "Ir Computer Usage Polic	e survey team with a copy nternet, E-Mail and y." This document read in computers, networksmay					

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	carried out on such sy limited toFailing to I controlled-access con electronic data system if you leave such communattended" No further information provided to the survey conference. 2. For Resident #21, the secure the Residents electronic health reconhallway unattended exprivate health information the provided to be private health information. The record review revelong has been admitted to Diagnoses included, but chronic obstructive pure depressive disorder, and section C (cognitive proposition of the provided amental status) summation possible 15 points. On 11/01/2017 at approximation of the survey or sobserved a wing. On top of this meaning computer that the nurse their medication pass. left open and the survey Resident #21's private.	the for inappropriate conduct systems, including, but not og off any secure, inputer or other form of in to which you are assigned, inputer or system It regarding this issue was at team prior to the exit The facility staff failed to medical record. The rid was left open and in the exposing the Residents tion. The realed that Resident #21 the facility 06/03/2017. The real was real timited to, limonary disease, dementia, and congestive heart failure. The reference date of BIMS (brief interview for rry score of 5 out of a reximately 8:10 a.m. two medication cart on the west	F	164			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	RETREAT	·	514 N	ET ADDRESS, CITY, STATE, ZIP CODE ORTH MAIN STREET AL RETREAT, VA 24368	23	
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F 164	of this medication can to observe numerous well as various staff. When LPN (licensed processes to the medication cart she usually left the computer left the computer left to the administrative standuring a meeting with 11/01/17 at approximation of a document titled "In Computer Usage Policipart "Use of Company be revoked at any time carried out on such sy limited toFailing to locontrolled-access computer left of a computer left of the survey limited to the survey unattended" No further information provided to the survey conference. 3. The facility failed to care information for Resident #17 was origion 5/20/17 with a readd Diagnoses included but heart failure, enterocol difficile, and hypokalen (minimum data set) was with an ARD of (assessed in the control of the survey was with an ARD of (assessed in the control of the survey conference).	t. The surveyors were able Residents in the hallway as practical nurse) #4 returned the surveyor asked her if imputer open. To which LPN go off by itself." If were notified of the above the survey team on stely 4:35 p.m. The survey team with a copy internet, E-Mail and cy." This document read in computers, networksmay be for inappropriate conduct stems, including, but not ag off any secure, inputer or other form of the to which you are assigned, butter or system Tregarding this issue was team prior to the exit protect the private health esident #17. Inally admitted to the facility mission date of 8/23/17. It not limited to: dysphagia,	F	164			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 164	had a cognitive score moderate cognitive im On 11/1/17 at 8:57 a.r. 2 was administering in After preparing the me medication cart and p. # 17's room. RN#2 did prior to entering the roinformation was not primedication cart was a that contained information was left unprotected. On 11/1/17 at 4:31 p.m. nursing), ADON (assis Adm (administrator), in MDS consultant, and in operations were made findings.	of 12 out of 15 indicating apairment. m., RN (registered nurse) # nedications to Resident #17. edication, RN # 2 locked the roceeded to enter Resident #1 not log off of the computer from and Resident #17's rotected. Also noted on the mempty medicine bottle ation for Resident #17 which which the DON (director of stant director of nursing), surse consultant, regional director of aware of the above	F	164			
F 167 SS=C	usage policy" which act the facility standard of any secure, controlled form of electronic data assigned, if you leave unattended" is inapprovided to the survey conference on 11/2/17 483.10(g)(10)(i)(11) RI RESULTS - READILY (g)(10) The resident has	regarding this issue was team prior to the exit at 5:15 p.m. GHT TO SURVEY ACCESSIBLE	F	67			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11	02/2017	
	ROVIDER OR SUPPLIER	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	EDED BY FULL PREFIX (EACH CORRECT INFORMATION) TAG CROSS-REFERENC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE	
	of the facility conducte surveyors and any pla respect to the facility; (g)(11) The facility mu (i) Post in a place read and family members a residents, the results of the facility. (ii) Have reports with results of the facility. (iii) Have reports with respecting the facility years, and any plan of respect to the facility, to review upon request (iii) Post notice of the areas of the facility that accessible to the public (iv) The facility shall not information about common this REQUIREMENT by: Based on observation facility staff failed to post the public of where to survey results in an areaccessible to all who eaccessible to all who eaccessible to all who eaccessible to all who eaccessible to locate the sign made to locate the sign m	ed by Federal or State an of correction in effect with and st dily accessible to residents, and legal representatives of of the most recent survey of respect to any surveys, aplaint investigations made during the 3 preceding f correction in effect with available for any individual at; and availability of such reports in at are prominent and c. ot make available identifying plainants or residents. is not met as evidenced and staff interview, the est signage that directed obtain the past 3 years of ea that was readily intered the facility to review. th consisted of 5 surveyors, 10/31/17 for an annual vey. Observations were	F	167	Criteria 1: On November 2, 2017 the survey results book was relocated to table in front lobby and signage stating "for any additional information regarding the past 3 years of surveys, pleas see the receptionist" were poste near the location of the survey results binder as well as in the front lobby window to ensure accessibility. Criteria 2: No other resident risk posed related to alleged deficien practice. Criteria 3: ED or designee will send notification to all residents/RPs to include the following: 1. most recent survey results, 2. Location of signage, and 3. Location of results as part of resident council. ED or designee will monitor monthly to ensure posting of results during administrative rounds. DON or designee will provide education to staff by November 30, 2017 regarding location of survey	se ed		

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F 167	could be found. These from 10/31/17 through On 11/2/17 at approxisurveyor notified the ano signage in the fron interested in reviewing where they were local signage that directed the past 3 years of surwanting to be reviewe notebook on a small to doors that had a coverstating "SURVEY RESA At approximately 1 pm the surveyor to come of the signage there we noted a laminated pag station that read in par located in the front lob surveyor went to the Esignage could be found.	e observations were made in 11/2/17. mately 12:30 pm, the administrator that there was it lobby that directed anyone go these survey results of ited. There was also no the public of where to obtain rivey results if they were d. There was a black able to the right of the front in page on the front of it SULTS". In the administrator asked to the nursing units and see ould be ok. The surveyor the at the West nurses' it " Survey Results are by". The administrator and itest nurses' station and no d. The administrator stated, letin board like the other	F	67	Criteria 4: ED will present results of monitoring monthly to facility QA committee for further intervention or recommendation as necessary. Criteria 5: December 16, 2017		
SS=D	483.10(a)(1) DIGNITY INDIVIDUALITY	cit conference on 11/2/17. AND RESPECT OF	F 2	41	F 241 Dignity and Respect of Individuality		
		nd in an environment that or enhancement of his or nizing each resident's y must protect and			Criteria 1: On November 2, 2017, LPN #1 was educated on importance of knocking and introducing one's self prior to entering resident's room by DON.		

PRINTED: 11/14/2017 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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by: Based on observation record review, the facility door or announce the room of 1 of 25 rest. The findings included: The facility staff failed announce themselves #12's room. The surveyor reviewed record on 10/31/17 and was admitted to the fact readmitted 6/16/17 with but not limited to urine infection, peripheral vatissue injury, atrial fibric cerebral infarction, dyshypertension, Vitamin deficiency, constipation and severe sepsis with Resident #12's significant as et (MDS) assess reference date (ARD) or resident with short term term memory problems cognitive skills for daily G Functional Status as require extensive assis mobility and assessed impairment on one side extremities. The surveyor and licensity as the surveyor and licensity as the same and the same as the same and the same as the same and the sam	is not met as evidenced n, staff interview and clinical slity staff failed to knock on themselves when entering sidents (Resident #12). to knock on the door or before entering Resident d Resident #12's clinical do 11/1/17. Resident #12 cility 3/10/17 and hodiagnoses that included retention, urinary tract ascular disease, deep llation, hyperlipidemia, aphagia, hemiplegia, Do deficiency, Vitamin B12 no, chronic pain, pneumonia, a septic shock. ant change in minimum septic shock. Section sessed the normal septic shock of 2 staff for bed the resident with an septic shock that involved both	F	241	Criteria 2: DON educated staff of November 2, 2017 on important of knocking and introducing self prior to entering resident's room. Criteria 3: DON or designee will provide education to staff regarding dignity and respect of residents by November 30, 2017 and during new hire orientation thereafter. Nursing admin or designee will monitor a sample of staff weekly to ensure accuracy. Criteria 4: This education and audit will be presented to ED weekly by DON or designee. Results of audits will be presented and reviewed by facility QA committee monthly for further intervention or recommendation as necessary. Criteria 5: December 16, 2017	ce n.	

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	PROVIDER OR SUPPLIER GTON PLACE AT RURAL I	RETREAT		514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 246 SS=D	when the surveyor asi resident's Foley cather Resident #12's room wannouncing herself ar side of the bed to chee The surveyor observe at 1:40 p.m. with licen providing the wound cassistant #3 assisting gathered the wound cassistant and alothe resident's room with announcing themselve provide wound care to The surveyor informed the above failure to knobefore entering in the above failure to knobefore entering	ked L.P.N. #1 to check the ter. L.P.N. #1 entered without knocking or and went directly to the left ck the Foley catheter. d wound care on 11/01/17 seed practical nurse #1 are and certified nursing in the care. L.P.N. #1 had are supplies from the ng with C.N.A. #1 entered thout knocking or as and proceeded to Resident #12. If the administrative staff of the day meeting on was provided prior to the 2/17. ABLE ACCOMMODATION INCES I Dignity. The resident has the respect and dignity, le and receive services in able accommodation of afterences except when to the health or safety of the	F 2	241	F 246 Reasonable Accommodation of Needs/Preferences Criteria 1: Care plan for Resident #6 was updated to reflect that resident does not utilize call bell, but instead yells out when something is needed. Criteria 2: During weekly checks of ambassador room assignments department managers or designees will monitor for proper location of call bells and will be	s,	
		and staff interview, facility			corrected if deemed necessary.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
_		495417	B. WNG			11	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	OULD BE COMPLÉTI			
F 246	staff failed to ensure of 2 of 25 residents in th # 6 and Resident # 10. Findings included: 1. Facility staff failed were accessible to Resident # 6 was orig on 2/16/15 with a reac Diagnoses included be diastolic congestive he chronic kidney diseas hypertension. The modata set) assessment with an ARD (assessment with a second to a second	call bells were accessible to e survey sample (Resident d). If to ensure that call bells esident #6. Inally admitted to the facility dmission date of 12/15/16. In the not limited to: chronic eart failure, hypothyroidism, estage 3, and est recent MDS (minimum was quarterly assessment ment reference date) of documented Resident #6's everely impaired with a sut of 15. Resident #6 was reviewed extensive assist of 2 extensive assist of 2 extensive assist of 2 extensive assist of 2 eility. A review of the current ent #6 had "call light within ion listed in problem areas emited to: risk of urinary tract inence, self-care deficit th ADL's (activities of daily alized weakness and have a history of cvalent), and at risk for pain onic disease processes,	F	246	Criteria 3: DON or designee will provide education to facility staf regarding proper location of call bells and resident respect and dignity by November 30, 2017. Department managers or designees will do weekly checks of ambassador room assignment to ensure accuracy. Criteria 4: Department manager or designees will present audit results to ED weekly. Results of audits will be presented and reviewed by facility QA committee monthly for further intervention or recommendation as necessary. Criteria 5: December 16, 2017	ts s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495417	B. WING			11.	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE I NORTH MAIN STREET IRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	-	(X5) COMPLETION DATE
	hanging down on the floor out of the reach of the reach. On 11/1/17 at 11:35 at room to talk with Reside patient care. The call be down the left side of the Resident # 6's reach. On 11/1/17 at 1:59 p.m. observed lying in bed of the reach. On 11/2/17 at 7:55 at roobserved by the surve bell was observed han the bed on the floor out the bed on the floor out on 11/2/17 at 12:18 p. (director of nursing), consultant nurconsultant, and regions were made aware of the No further information provided to the survey conference on 11/2/17 2. Facility staff failed were accessible to Resident and observed to the survey conference on 11/2/17	Her call bell was observed left side of the bed near the of the resident. m., Resident # 6 was asleep. Her call bell was with the left side of her bed one. m., surveyor went into dent #6 after she received bell was observed hanging he bed near the floor out of he., Resident # 6 was with her call bell hanging er bed near the floor out of he., Resident # 6 was yor lying in bed asleep. Call ging down the left side of it of her reach. m., the administrator, DON DON (assistant director of irse, regional MDS all director of operations he above findings. regarding this issue was team prior to the exit at 5:15 p.m. to ensure that call bells	F	246			

495417 B. WING		(X3) DATE SURVEY COMPLETED	
11/02/20		11/02/2017	
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL RETREAT STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME	EFIX (EACH DEFICIENCY M	(X5) COMPLETION DATE	
F 246 Continued From page 15 on 2/10/15 with a readmission date of 9/12/15. Diagnoses included but not limited to: major depressive disorder, multiple sclerosis, hyperlipidemia, and constipation. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/13/17. Facility staff documented Resident # 10's cognitive status was moderately impaired with a cognitive status was moderately impaired with a cognitive status was moderately impaired with a cognitive score of 11 out of 15. The clinical record for Resident # 10 was reviewed on 10/31/17 at 2:00 p.m. According to the most recent quarterly MDS assessment with an ARD of 10/31/17, the facility staff had documented that Resident # 10 required extensive assistance of 2 persons with bed mobility. A review of the current plan of care for Resident #10 listed "call light within reach" listed as an intervention listed in problem areas that included but not limited to: self-care deficit, risk for and/or complaints of pain related to multiple chronic disease processes including diagnosis of neuropathy, chronic pain, multiple sclerosis and muscle spasms, and history of frequent urinary tract infections. On 10/31/17 at 7:45 a.m., during the initial tour, Resident #10 was observed in bed attempting to dress herself. The call bell out of reach hanging down the right side of the bed. On 10/31/17 at 10:55 a.m., Resident # 10 was observed in bed with the call bell hanging down sobserved in bed with the call bell hanging down	on 2/10/15 with a readm Diagnoses included but depressive disorder, mu hyperlipidemia, and cons MDS (minimum data set assessment with an ARI date) of 10/13/17. Facili Resident # 10's cognitive impaired with a cognitive impaire		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/	02/2017
	PROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS 514 NORTH MAIN RURAL RETREA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)				(X5) COMPLETION DATE	
F 246	bell was not within reaction observed in bed with oright side of the bed owithin reach of the rescond of the reaction of the right side of the best of the	ach of the resident. m., Resident # 10 was call bell hanging down the nother floor. Call bell was not sident. m., Resident # 10 was the call bell hanging down and near the floor. The call ach of the resident. m., the administrator, DON aDON (assistant director of curse, regional MDS and director of operations the above findings. regarding this issue was a team prior to the exit at 5:15 p.m. EEPING & MAINTENANCE and maintenance services a sanitary, orderly, and is not met as evidenced , staff interview, facility clinical record review, the sure 2 of 25 residents' as clean and sanitary	F2	Criteri Reside Reside Were c Criteri: develo be utili night sl of amb departi designe	Housekeeping and enance Services ia 1: On November 2, 2017 ent #1 wheelchair and ent #14 wheelchair cushion cleaned by nursing staff. a 2: Nursing admin ped a cleaning schedule to ized by the nursing staff or hift. During weekly checks eassador room assignment ment managers or ees will monitor adaptive nent for cleanliness and will ected if deemed	o n is	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL F	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	1. The facility staff fai wheelchair was clean The surveyor reviewer record on 10/31/17 and admitted to the facility included but not limite pulmonary disease, urpain, depressive episoconstipation, hyperten mellitus, Vitamin D deheadaches, and anxie Resident #1's quarterly assessment with an assessment with a second and an assessment with a sast and a second an assessment with a sast and a second an assessment with a sast and a second an assessment with a sast an assessment with a second	led to ensure Resident #1's and sanitary. d Resident #1's clinical d 11/1/17. Resident #1 was 1/20/17 with diagnoses that d to chronic obstructive rinary tract infection, chronic odes, hyperlipidemia, sion, type 2 diabetes ficiency, seizures, periodic ty. y minimum data set (MDS) assessment reference date assed the resident with a for mental status) as 11 out stional Status assessed the us required a walker or a difference of the resident and ookes connected to a black ea had a whitish ners. The surveyor during the day on 10/31/17 e whitish material was	F	253	Criteria 3: DON or designee will provide education to facility staff regarding cleaning and sanitation of adaptive equipment to include cleaning schedule by November 30, 2017. Department managers or designees will do weekly checks of ambassador room assignments to ensure accuracy. Criteria 4: Department managers or designees will present audit results to ED weekly. Results of audits will be presented and reviewed by facility QA committee monthly for further intervention or recommendation as necessary. Criteria 5: December 16, 2017		
1	on 11/1/17 at 1:11 p.m.	The DON stated			· ·		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT	•	514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	resident care equipment might have to get back surveyor requested the resident equipment from the surveyor interview housekeeping other #The surveyor asked were prosible for the cleen equipment wheelchair Other #7 stated nursing cleaning equipment are responsible for resident The surveyor reviewer "Cleaning and Disinfer Surfaces" on 11/1/17. "Policy Statement Resincluding reusable iter equipment, will be clean according to current C disinfection and the Other and health administration.	ent and then stated "she ik with me on that." The ie facility policy on cleaning om the director of nursing. wed the director of 7 on 11/1/17 at 3:00 p.m. what department was raning of resident rs, Geri chairs, cushions. In was responsible for Ind housekeeping was Int rooms. If the facility policy titled ction of Environmental The policy read in part sident-care equipment, Ins and durable medical aned and disinfected IDC recommendations for SHA (occupational safety ion) Bloodborne Pathogens	F	253			
	which department was cleaning of resident carries the surveyor informed the above concern on No further information exit conference on 11/2. The facility staff fail #14's wheelchair cushing the surveyor reviewed record 10/31/17 and 15	tre equipment. I the administrative staff of 11/2/17 at 12:18 p.m. was provided prior to the 2/17.					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIO	N	(X3) DATE SURVEY COMPLETED	
		495417	B, WING			1.	1/02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS 514 NORTH MAIN RURAL RETRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	included but not limite quadriplegic cerebral psychosis, hyperlipide B deficiency, Vitamin I constipation, knee corosteoarthritis. Resident #14's quarter set) assessment with a date (ARD) of 11/2/17 a BIMS (brief interview out of 15. Section G F marked that Resident wheelchair for mobility Resident #14's current with the problem onset breakdown dated 1/24 approaches to care: P devices/equipment as The surveyor observed at 12:34 p.m. in the dir was sitting in a wheelch underneath him. On the wheelchair cushion, the material on the left side registered nurse #2 whhow often resident #14's conductive when Resident #14's conductive R.N. #1 stated "Not cleevidently." The surveyor interview on 11/1/17 at 1:11 p.m. housekeeping was respresident care equipment have to get back with measurement in the surveyor interview on the surveyor interview on 11/1/17 at 1:11 p.m. housekeeping was respresident care equipment have to get back with measurement.	d to epilepsy, spastic palsy, unspecified mia, anxiety, gout, Vitamin D deficiency, edema, atracture, and unspecified mly MDS (minimum data an assessment reference assessed the resident with of for mental status) of 13 functional Status was made an assessment reference assessed the resident with of for mental status of 13 functional Status was made and made and the following ressure relieving meeded. If Resident #14 on 10/31/17 thing room. The resident made and made	F	253			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11/	02/2017
	PROVIDER OR SUPPLIER STON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, S' 514 NORTH MAIN STREET RURAL RETREAT, VA	г		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO- DEFICIENCY)			(X5) COMPLETION DATE
F 253	equipment from the di The surveyor interview housekeeping other # The surveyor asked w responsible for the cle equipment-wheelchair Other #7 stated nursir cleaning equipment ar responsible for resider The surveyor reviewer "Cleaning and Disinfer Surfaces" on 11/1/17. "Policy Statement Res including reusable iten equipment, will be clea according to current C disinfection and the OS and health administrat Standard." The policy which department was cleaning of resident ca	intinued From page 20 suipment from the director of nursing. e surveyor interviewed the director of itsekeeping other #7 on 11/1/17 at 3:00 p.m. e surveyor asked what department was ponsible for the cleaning of resident intipment-wheelchairs, Geri chairs, cushions. It is resident into an interest of the search of the search of the search of the facility policy titled earling and Disinfection of Environmental faces" on 11/1/17. The policy read in part licy Statement Resident-care equipment, and interest ording to current CDC recommendations for infection and the OSHA (occupational safety health administration) Bloodborne Pathogens and drad." The policy was not specific as to concern the care equipment. surveyor informed the administrative staff of above concern on 11/2/17 at 12:18 p.m.		53			
	No further information of exit conference on 11/2 483.20(g)-(j) ASSESSI ACCURACY/COORDII	MENT	F 2	H 53	nent rdination/Cer tifled		
	must accurately reflect (h) Coordination	st conduct or coordinate		age of 65. On Resident #10 F	ident is over the November 2, 2017, RP was notified and for vaccine to be		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11.	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT	•	51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	participation of health (i) Certification (1) A registered nurse the assessment is cor (2) Each individual whassessment must sign that portion of the ass (j) Penalty for Falsification (1) Under Medicare arwho willfully and know (i) Certifies a material resident assessment is penalty of not more the assessment; or (ii) Causes another incand false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreement material and false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreement material and false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreement material and false statement in subject to a civil mone \$5,000 for each asses (2) Clinical disagreement material and false statement in the survey and clinical recipied to ensure an accresidents in the survey The findings included:	must sign and certify that impleted. To completes a portion of the in and certify the accuracy of essment. The accuracy of essment in a subject to a civil money an \$1,000 for each dividual to certify a material a resident assessment is y penalty or not more than sment. The accuracy of the accuracy of essment is y penalty or not more than sment. The accuracy of the accuracy of the accuracy of essment is y penalty or not more than sment. The accuracy of the accuracy of the accuracy of each accuracy of the accuracy of	F2	278	Criteria 2: MDS assessments with be reviewed by MDS coordinates for accuracy and will be correct if deemed necessary. Criteria 3: DON or designee with provide education to MDS coordinators and nursing staff regarding MDS accuracy and completion of assessments by November 30, 2017. MDS will do a review/audit of admissions, readmissions, and residents with changes in condition sample weekly to ensure accuracy. Criteria 4: MDS coordinator with review results of audits to ED weekly. ED will present results audits to facility QA committee monthly and reviewed for furth intervention or recommendation as necessary. Criteria 5: December 16, 2017	or red	× *
	The facility staff inaccu pneumococcal vaccine MDS for Resident # 10	as being up to date on the			ä		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUłLD		CONSTRUCTION		SURVEY PLETED
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368		702/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Resident # 10 was ori facility on 2/10/15 with 9/12/15. Diagnoses in dementia, multiple scl disorder, polyneuropa The most recent MDS quarterly assessment reference date) of 10/coded Resident # 10's of 15 indicating model 10 was also coded on (Brief Interview for Me of a possible 15. The clinical record was 2:00 p.m by the survey orders dated 10/7/17 have pneumovax 0.5 devery 5 years (unless received in the last 5 y face sheet it was noted received a pneumocod Section O of the quarte 10/13/17, specifically 0"is the pneumococcal The facility staff coded On 10/31/17 at 2:48 p. with the administrator a nursing) and made the Surveyor asked DON with the facility vaccina completely honest I had doing audits on the vac walked in and it got put	iginally admitted to the a readmission date of cluded but not limited to: erosis, major depressive thy, and hyperlipidemia. It (minimum data set) was a with an ARD (assessment 13/17. The facility staff is cognitive status as 11 out rate impairment. Resident # the MDS as having a BIMS ental Status) score of 11 out is reviewed on 10/31/17 at yor. The signed physician's had orders that stated "may be upon admission and otherwise indicated or rears)." Upon review of the did that Resident # 10 last becal vaccine on 10/12/12. In early MDS with an ARD of 200300A, the question reads vaccination up to date?" "yes." The survey team met and the DON (director of a maware of these findings. Who monitors and keeps up thions. DON stated "to be did a notebook on my desk becines and then you guys shed to the side." DON follow up on the situation.	F	278			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING_			11/	02/2017	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE	
	surveyor that the facili representative for Reconsent to administer On 11/2/17 at 3:42 p.t surveyor that the famili Resident # 10 had give facility would administ vaccine to Resident # No further information reported to the surveyon ference on 11/2/17483.10(c)(2)(i-ii,iv,v)(3) PARTICIPATE PLANN 483.10 (c)(2) The right to partiand implementation of plan of care, including (i) The right to particip including the right to its be included in the plan request meetings and revisions to the person (ii) The right to particip expected goals and out amount, frequency, an other factors related to plan of care.	ity was contacting the family sident # 10 to obtain the pneumonia vaccine. In. DON verbally reported to ity representative for the consent and that the fer the pneumococcal to. In regarding this issue was a team prior to the exit of at 5:15 p.m. In the plant of the exit of the exit of at 5:15 p.m. In the presentative for the exit of at 5:15 p.m. In the plant of the exit of at 5:15 p.m. In the plant of the development of this or her person-centered that not limited to: In the plant of the plant of the right to request of the right to request of the plant of the pla	F 2	F 280 Right to Partiplanning Care - Rev Criteria 1: On Nove Resident #13s care updated. Also on N 2017, non-pharmac special requiremen for all pain and anx medications to be o prior to administrat medication. Criteria 2: DON and admin added specia for non-pharmacolo interventions for pa medications to be o	icipate vise CP ember 2, 201 plan was lovember 2, cological it was added iety completed tion of I nursing al requireme ogical ain and anxie	nt		
		e care plan, including the ficant changes to the plan	1	prior to administrat medication.	IION OI			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			1	1/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		51	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET URAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	right to participate in hishall support the reside planning process must (i) Facilitate the inclusion resident representative (ii) Include an assessmost trengths and needs. (iii) Incorporate the resident representative (iii) Incorporate the resident preferences in 483.21 (b) Comprehensive Ca (2) A comprehensive Ca (3) Developed within 7 of the comprehensive assignification (ii) Prepared by an interincludes but is not limit (A) The attending physical (B) A registered nurse of resident. (C) A nurse aide with regresident.	inform the resident of the is or her treatment and ent in this right. The t ton of the resident and/or e. nent of the resident's ident's personal and developing goals of care. re Plans are plan must be- days after completion of sessment. rdisciplinary team, that ed to ician. with responsibility for the	F	280	Criteria 3: DON or designee will provide education to facility staregarding care plan updates and non-pharmacological interventions by November 30, 2017. DON or designee will conduct an audit weekly to ensure special requirements for non-pharmacological interventions are added to admissions, readmissions, and residents with changes in condition. Criteria 4: DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. Criteria 5: December 16, 2017	ff I		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495417	B. WING_		11/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
	An explanation must be medical record if the pand their resident representation practicable for the resident's care plan. (F) Other appropriate disciplines as determined as requested by the finite or as fi	esident's representative(s). De included in a resident's participation of the resident resentative is determined development of the staff or professionals in med by the resident's needs a resident. Seed by the interdisciplinary isment, including both the parterly review is not met as evidenced sew and clinical record failed to review and revise sive Care Plan) for 2 of 17 a sample (Residents #13) alled to review and revise sive Care Plan) for of care. Initted to the facility on ing diagnoses of, but not Disease, high blood Disease, heart failure, is. On the quarterly MDS of the na ARD (Assessment 10/17, the resident was	F 2	80	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED	
		495417	B. WING			11	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368	***************************************		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	assistance of 1 staff in personal hygiene and 1 staff member for ba The clinical record wa on 11/1 and 11/2/17. surveyor noted in the timed for 10/6/17 at 2: refuse medications an obtained" On 10/5/ nurses' note stated ". medications and care to note further docume Resident #13's clinical refusing care and medication Administration of October, 2017 and documentation made if the resident refusing to and/or having his bloomefusals were noted to times for the month that the surveyor. The DOCCP and stated," I know the surveyor. The DOCCP and stated, "I know this meds (medication exactly right, it is not on the exactly right, it is not on the exactly prior to the exactly p	nember for dressing and being totally dependent on thing. Its reviewed by the surveyor During this review, the nurses' notes dated and 55 am which stated "Did do to have blood sugar 17 at 9:25 pm anotherPatient refused" The surveyor continued entation throughout I record of the resident dications on different dications on different was noted that there was by the nursing staff as to be take his medications di sugar obtained. These be on different days and at was reviewed. The director of nursing (DON) we documented findings by N read over the resident's ow that he does refuse care in his care plan." Was provided to the cit conference on 11/2/17 at ailled to review and revise	F	280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495417	B. WING_		1.	1/02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	were appropriate for the Resident #19 was addressed to a trial fibrillat pressure, diabetes, the fractures, stroke, musicirrhosis. On the adm Set) with an ARD (Assof 10/17/17, the reside BIMS (Brief Interview 13 out of a possible so was also coded as recof 2 staff members for hygiene and being total member for bathing. The surveyor conducte #19's clinical record or noted that the resident "Tramadol HCL 50 mg mouth every 8 hours a The surveyor also revit During this review, the resident had been care stated the following unrisk for pain r/t (related Arthritis, Fracture right tibular (sic)". The followinterventions/approach "Call light within re" Medications as ord "Labs as ordered, redical doctor)" Document effective needed medications) a	ds in having interventions of pain that his resident. mitted to the facility on wing diagnoses of, but not ion, heart failure, high blood yroid disorder, other cle weakness and ission MDS (Minimum Data sessment Reference Date) and was coded as having a for Mental Status) score of core of 15. Resident #19 quiring extensive assistance dressing and personal failly dependent on 1 staff and a review of Resident and 11/2/17. The surveyor is had a physician order for (milligram) Take one by seneded for pain. (sic)". The surveyor noted that the explanned for pain which der Problem/Need: "I am at to)Rheumatoid femoral, Fractured left wing the ses were noted as follows: each dered by the physician report results to MD eness of any prns (as	F 2	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		70222017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	directed by facility "Encourage/escoractivities (sic)." The surveyor also not for Resident #19 undeficit": "Problem/Nee am in constant pain I activities I prefer to retherapy & getting well interventions/approact" "Place activity cabulletin board and in a "Staff to address r"Staff to introduce each contact "Provide one-on-owhen resident is unabactivities setting "If resident is relucted to the system of the set of the structure intellectual stimulation." Provide brief activity of the set of the	ain s as ordered t on admission, and as It me out of my for room Ited the following care planed er "Diversional activity ed Due to my 2 broken legs I do not wish to attend group ad & concentrate on I (sic)." The following thes were noted as follows: lendar in each room, on activity room resident by name at all times themselves to resident with Inne visits in quiet location alle to tolerate group Stant to attend activities with ses to identify reasons d activity program for Vities for resident" Innately 3 pm, the director of sked by the surveyor to read on for pain and activities for DN read over the care plan ted "These two don't ea, the resident says she her room and in another re planned for attending p activities."	F	280			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
			A BOILDIN	<u> </u>	
		495417	B. WING	E	11/02/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET	
CARRING	TON PLACE AT RURAL I	RETREAT			
				RURAL RETREAT, VA 24368	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
	surveyor prior to the et 5:15 pm. 483.21(b)(3)(i) SERVI PROFESSIONAL STA (b)(3) Comprehensive The services provided as outlined by the commust- (i) Meet professional statistical statistical record of the professional practice of the professional p	CES PROVIDED MEET ANDARDS Care Plans I or arranged by the facility, aprehensive care plan, Standards of quality. Is not met as evidenced Siled to follow standards of for Resident #23 for tion. The facility staff failed se prior to the medication Digoxin. Resident #23 was reviewed as was admitted to the facility is that included but not unspecified atrial sion, hyperlipidemia, fied dementia without es, adult failure to thrive, failure, chronic kidney a. Sion minimum data set than assessment of 8/20/17 assessed the prior interview for mental	F 28	F 281 Services Provided Meet Professional Standards	o o
	physician orders read '			accurately performing a nursing skin assessment/check. DON or	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	and September 2017 documentation showin Resident #23's apical of the digoxin. The director of nursing the standard of practic the drug digoxin. The the apical pulse was let that in school." The sistandards for administ DON stated the standards for administration of Digoral DON stated the standard administration of Digoral DON stated the standard in the director of nursing facility policy for administration of Digoral DON stated the standard in the director of nursing facility policy for administration of Digoral DON stated the standard in the director of nursing facility policy for administration of Digoral DON stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the standard in the digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the director of nursing facility policy for administration of Digoral DON Stated the standard in the digoral DON Stated the standard in the digoral DON Stated the standard in the digoral DON Stated the di	chic medication (eMAR) for August 2017 found that there was no not that staff had obtained pulse prior to administration (a) (DON) was asked what we was before administering DON stated hold the drug if we stan 60. "We learned curveyor asked for the facility wering medications. The eards of practice for the exin was the facility policy. If provided the surveyor the mistering medications on the policy read "If a dosage ropriate or excessive for a on has been identified as see consequences for the d of being associated with s, the person preparing or ication shall contact the mysician or the facility's cuss the concerns." If drug handbook, Wolters Drug Handbook, 38th of, digoxin is a cardiac chythmic medication which ut and decreases heart drug, take apical-radial cord and notify prescriber sudden increase or	F	281	designee will review/audit all net admissions, readmissions, and residents with changes in condition related to Digoxin to ensure accuracy and completion of special requirement or fixed parameter. All residents are at risk by the above mentioned alleged deficient practice. Skin assessment/check schedule was created and will be monitored weekly by DON or designee for completion and accuracy. Criteria 4: DON or designee will review results of audits with ED. ED or designee will present audit to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. Criteria 5: December 16, 2017	S	

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(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 495417 11/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET** CARRINGTON PLACE AT RURAL RETREAT **RURAL RETREAT, VA 24368** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 281 Continued From page 31 F 281 beats and, particularly, regularization of a previously irregular rhythm). Potter and Perry's, Fundamentals of Nursing, 6th edition (pg. 643) states, "Apical pulse less than 60 beats/min (bradycardia). Assess for the presence of factors that may alter heart rate (e.g., digoxin or other cardiac medications. It may be necessary to withhold prescribed medications until the physician can evaluate the need to adjust the dose." The surveyor informed the administrative staff on 11/2/17 at 12:18 p.m. of the concern with no apical pulses prior to the administration of Digoxin on Resident #23. No further information was provided by the facility prior to the exit on 11/2/17. Based on observation, resident interview, staff interview, facility, document review, and clinical record review, the facility staff failed to follow standards of professional practice for 2 of 25 residents in the survey sample, Resident # 6 and Resident #23. Findings included: Facility staff failed to identify and assess an open area to right lower buttock and assess pain and implement interventions for Resident # 6. Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism, chronic kidney disease stage 3, and hypertension. The most recent MDS (minimum data set) assessment was a quarterly

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/	02/2017	
	ROVIDER OR SUPPLIER	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	date) of 10/13/17. The Resident # 6's cognition impaired with a cognition on 10/31/17 at 9:30 a recent MDS with an Adocumented by the fathat Resident #6 was pressure ulcers. Sectidocumented that Resident #6 was pressure ulcers. Sectidocumented that Resident #6 was pressure ulcers. Sectidocumented that Residocumented presided and applications of the than to feet as sometimes of the survey her back. On 11/1/17 at 11:13 a. observed by the survey her back. On 11/1/17 at 11:15 a. nurse) #1 was preparing Resident #6's buttocks "she usually gets Greef and waiting on it to confict Richmond." I have an cream until it comes in MASD (moisture associbecause she is non-confict surveyor asked LPN # to turn herself? LPN # On 11/1/17 at 11:19 a.f CNA #1 (certified nursidadminister treatment to When CNA #1 touched thigh to assist her in turn herself? In the solution of the properties of the prope	ARD (assessment reference e facility staff documented ve status was severely tive score of 6 out of 15. Resident #6 was reviewed a.m. Upon review of the most RD of 10/13/17 it was cility staff in section M0150 at risk for developing on M1040 H. facility staff ident # 6 had moisture ge. In section M1200 facility sure reducing device for of ointments/medications kin and ulcer treatments. m., Resident # 6 was eyor lying in her bed flat on many facility in the from the pharmacy in order to use house barrier. "LPN #1 states she gets ciated skin damage) a lot impliant with turning. "I if Resident # 6 was able to stated "no."	F	281				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING		_	11/	02/2017
	NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL RETREAT			5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	wash Resident #6's be Resident # 6 flinched were touched by the too stated "it's hurting mash Resident #6's be the area instead of was Resident # 6 then stated Surveyor observed and Resident # 6 as follow buttock in the fold, one buttock, small open as both buttocks and 2 of There was redness not LPN #1 pressed an anshow that the area was applied Derma Septin Resident #6's buttock hurts" during the application of the procedure to asseprovide interventions, assisted Resident #6 and a pillow was place back. On 11/1/17 at 12:15 p. LPN # 1 regarding Resident LPN #1 stated "always complains of pust touch her she will know if it's her or if it's team asked the LPN # to do if a resident comstated that "you notify needs to be reassesses survey team asked LP	eft side. LPN #1 began to obttom with soap and water. as soon as her buttocks reatment nurse. Resident # by butt." LPN#1 continued to uttocks but started patting ashing in circular motion. Ited "she's hurting me." leas on the buttocks of ites: red area on right lower as open area right upper itea in the crease in between open areas on left buttock. Ited to bilateral buttocks. Ited to bilateral buttocks. Ited to bilateral buttock to be blanchable. LPN #1 then house barrier cream to be seed on the Derma Septin. Ites stop at any time during the seed on the right side of her in the survey interviewed sident #6's pain during the	F	281			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING	B. WING		11	/02/2017
	PROVIDER OR SUPPLIER GTON PLACE AT RURAL I	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 144 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 281	she complained of paidid not know that she surveyors were watch meeting with the LPN a lesson learned, whe pain, you stop and read on 11/2/17 at 10:30 at incontinence care of R was given by the reside informed surveyors the premedicated with Lor LPN #1 made surveyors on was now in the factor ordered. LPN #1 assess prior to initiating treatmed having pain. Refer left side with assistic CNA #3. When CNA #4 bottom to wash her bottom to wash the bottom to confer them to confer for them to confer the wash the area to the bottom and asked Resident #6 stated "row area on Resident #6's where it hurts?" Reside touched a different area buttocks and Resident and stated "yes." The sassess the resident and wished for them to confer them to co	in? LPN #1 stated that she could stop while the ing. The DON was in the #1 and told LPN #1 "this is n a resident complains of assess." Im. 3 surveyors observed tesident #6 after consent lent. LPN #1verbally at Resident #6 had been tab and topical Lidocaine. It is aware that the Greer's cility to be applied as assed resident's pain level ment and Resident #6 esident #6 was turned on to f2 persons, LPN #1 and 3 touched Resident #6's attom Resident #6 flinched the facility staff stopped to sked Resident #6 if she tinue treatment. Resident to attocks, Resident #6 ed "it hurts in that spot." eatment and assessed the ned an area on Resident "is this where it hurts?" "CNA #3 touched another bottom and asked "is this ent #6 stated "no." CNA #3 a on Resident #6's #6 immediately flinched	F	281			

PRINTED: 11/14/2017 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495417	B. WING			1/02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		SHOULD BE	(X5) COMPLETION DATE		
F 281	areas on Resident #6 yesterday. LPN#1 sta yesterday." LPN #1 ap Resident #6's bottom during application. LP she wanted her to sto "no." LPN #1 then sta lower buttock in the for not see it yesterday. L sanitized her hands an #1 attempted to touch blanched, but Resider complained of pain. Lift use house barrier creat the doctor that the are LPN # 1 placed Dermiright lower buttock in the treatment. On 11/2/17 team conducted an interest was observed by the streatment. On 11/2/17 team conducted an interest was asked about the abuttocks. CNA#1 did non Resident #6's right team asked CNA #1 if 1 stated "honestly I canot." Surveyor then as Resident #6's pain leving to the state of the she will think it's just from men CNA#1 what she would resident and they com stated that she would in the state of the she would resident and they com stated that she would in the state of the she would resident and they com stated that she would resident and they come she was a she would re	day? LPN #1 stated that the is bottom looked better than ted "they were more red oplied Greer's Goo to and Resident #6 flinched N #1 asked Resident #6 if p and Resident # 6 stated ted that the area to the right ld was new and that she did PN #1 changed gloves, and donned new gloves. LPN the area to see if the area on the area and notify a needs to be assessed. As Septin to the area on the he fold. # 6's right lower buttock surveyor on 11/1/17 during at 11:50 a.m., the survey erview with CNA #1 who the treatment nurse with at 11:19 a.m., CNA #1 areas on Resident #6's eport that she saw the area lower buttock. The survey the area was open. CNA # n't say if it was open or ked CNA # 1 stated "even before say you are hurting her." "I	F 2	81		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495417	B. WING	_		11/	02/2017
	ROVIDER OR SUPPLIER	RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 281	November 2017, Resi that stated "masd to b soap and water, pat devery incontinent epis." The facility provided the documentation of the storm of th	ent physician's orders for dent # 6 had current orders illateral buttocks, clean with ry, apply greers goo with ode until resolved." The surveyor with the assessments of the areas cks since treatment was ed 7/14/2017 at 4:22 p.m., ew order for treatment to thighs and sacrum, charrier cream bid (two times rief change due to severe kin damage." A note that if at 10:09 AM that was a restated "this nurse was fif regarding resident's rum worsening. Upon was observed to have ed areas that were noted to redness that was sesment. No s/s (signs or noted upon assessment. ss any pain during	F	281			
	injury and promote hea air-overlay to mattress and promote wound he to have adequate nutrit wound healing as well.				9		2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED				
		495417	B. WING	=======================================		11/	02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	E	(X5) COMPLETION DATE
F 281	episode until resolved for any acute changes of any acute changes. A note written on 7/31 "remains on skilled for person confused to tir appetite varies up with voiced complaints offer bladder and bowels by written on 8/10/2017 a skilled for nursing and confused to time and known skin warm and complaints offered poencouraged abd (abdono cough lungs clear vincontinent of bladder (continues) to heal." The surveyor reviewe assessments that was weekly skin assessment that was weekly skin assessment buttocks",8/19/17 und comments "tx current to buttocks acomments "tx current under comments "tx current under comm	n every incont. (incontinent) Null continue to monitor Null continue to me and place feeds self In lift sits in wheelchair no Null continent) of Null continent of Null	F 2	281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					VEY ED
		495417	B. WING_			11/02/2	:017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, Z 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		TO THE APPROPRIA		(X5) MPLETION DATE
	Per the facility "Press Policy", "Skin will be a developing pressure a more frequently if indistates "staff will perfor (with daily care)." "Nu inspect the skin if cha "Nurses will conduct sweekly to identify char Per the facility "Wound documentation it state information should be medical record 1. The type of woun 2. The date and time 3. The position in whylaced. 4. The name and titl performing wound care 5. Any change in the 6. All assessment dasize, drainage, etc.) of wound. 7. How the resident refureason(s) why. 10. The signature and recording the data." On 11/2/17 at 12:18 p. (assistant director of niconsultant nurse, regioner regional operations mathe above findings. The	ure Ulcer Risk Assessment assessed for the presence of alcers on a weekly basis or cated." The policy also rm routine skin inspections rses are to be notified to ages are identified." akin assessments at least ages." d Care Policy" under d "The following recorded in the resident's d care given. at the wound care was given. at the wound care was given. at (i.e., wound bed color, at (i.e., wound b	F2	281			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B WING		11/02/2017	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 281		regarding this issue was	F 28	F 309 Provide Care/Services fo		
presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m. 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.		F 30	Highest Well Being			
			requirement was added for all pain and anxiety medications to be completed prior to administration of medication. October 31, 2017, DON present survey team with copy of 72 ho	On ted		
	applies to all treatmen facility residents. Base assessment of a resid that residents receive accordance with profe practice, the comprehe care plan, and the resibut not limited to the form. The facility must ensure provided to residents we consistent with profess.	and care provided to the don't he comprehensive ent, the facility must ensure treatment and care in ssional standards of ensive person-centered idents' choices, including collowing: The that pain management is who require such services, sional standards of practice, rson-centered care plan,		interventions that were put in place for Resident #4. On November 1, 2017, physician for Resident #5 was notified regarding lab drawn on incorrect date, physician stated that lab obtained on October 24th was sufficient to discontinue order for the 21st. On November 1, 2017, clarification order received for Resident #12 NPO except for honey thick liquids per ST recommendations. On November 1, 2017 order obtained for	or	
1	(I) Dialysis. The facility residents who require services, consistent wi			Resident #6 to obtain and apply EMLA cream 30 minutes prior to wound treatment.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495417	B. WING				11/02/2017
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		11/02/2017
CARRING	TON PLACE AT RURAL	PETPEAT		5′	14 NORTH MAIN STREET		
CARRING	TON PEACE AT NORAL	RETREAT		R	URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	care plan, and the respreferences. This REQUIREMENT by: 3. For Resident #2, the provide any non-pharmal prior to administering to follow the bowel protection of the record review revibeen admitted to the finances included, be anxiety, hypertension, failure, and bipolar disceptional set) assessment with a reference date) of 09/0 (brief interview for mer of 15 out of a possible (bladder and bowel) we Resident was always occasionally incontiner	rehensive person-centered sidents' goals and is not met as evidenced the facility staff failed to macological interventions pain medication and failed otocol. realed that Resident #2 had facility 01/04/2017. return were not limited to, seizures, congestive heart order. return MDS (minimum data an ARD (assessment 05/2017 included a BIMS notal status) summary score 15 points. Section H as coded to indicate the continent of bladder and	F	309	Criteria 2: Nursing staff will monitor BM reports daily and follow bowel protocol accordito the standing orders. Physici orders will be reviewed as parmonthly review to ensure accuracy of current orders. Orders will be clarified and MI notified of any medication err Special requirement for non-pharmacological interventions were added on November 2, 2017 for pain an anxiety medications to be completed prior to administra of medication. Criteria 3: DON or designee with provide education to nursing so by November 30, 2017 in regato importance of CNA documentation of bowel	ian t of D ors. d tion ttaff	
	J (health conditions) w	as coded to indicate the	50		movements, nurse monitoring	of	
		pain medication but had nedication interventions.			BM reports, and process of		
	not received any non-n	nedication interventions.			utilizing bowel protocol from		
		omprehensive care plan)			physician standing orders. DOI	v or	
	included the problems				designee will provide educatio	n	
	constipation interventionstanding order for cons	ins included initiate stipation on the third day of		1	by November 30, 2017 to nurs	ing	
	no bowel movement ar				staff on the eight rights of		
		·			medication administration, ord	ler	
		nts current orders revealed			clarification, and physician		
	that Resident #2 was re grams every morning fo			notification. DON or designee	vill		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTIONS	NC	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11	/02/2017
CARRING	ROVIDER OR SUPPLIER			514 NORTH MAI	EAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Resident #2 was rece day up until 10/24/201 was changed to sennamouth once daily. A review of the Residerecords for October rewas coded as having again on 10/20/2017. The surveyor interview 10/31/2017 at approxil #2 verbalized to the stront move like they shout mot mot mot mot mot mot mot mot mot mo	and the surveyor with any the standing order protocol and the surveyor with any the standing order protocol and the survey team on nately 2:45 p.m. the stern to filed of the concerns as BM's the DON (director to the survey team that the going to the bathroom and	F	reside may redocur comp will the no lor repor order follow review be do be concerted to fact to be intervals as ne	tor BM reports to identify ents for whom intervention need to be initiated and ment follow-up has been eleted daily. DON or designed the verify that the resident neer being identified on the transport of the ADON/DON who forders, corrections to ecumented daily. Audits will inducted for 30 days. Fig. 4: DON or designee will be results of audits with ED. It designee will present audit tility QA committee monthly reviewed for further wention or recommendation of the commendation of t	ee is e	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUłLD	TIPLE CONSTRUCTION	(.	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP C 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATI	(X5) COMPLETION DATE	
	sounds. The DON als there had been a mali system. Resident #2 had been medications norco 5/3 as needed for pain an every 6 hours as need (electronic medication Resident #2 had recei October and the perco was unable to locate at the Resident had been non-pharmacological in administering the pain. The administrative tean non pharmacological in administering the pain meeting with the surve approximately 2:45 p.r. No further information these issues was proving prior to the exit conference of the record review reverse admitted to the factorial process included, but dementia with behavior Alzheimer's disease, dhypothyroidism.	o stated it appeared as if function in their computer function in their computer appeared to prescribed the pain and prescribed the pain administration record) and the norco 31 times in poet 7 times. The surveyor any information to indicate an offered any interventions prior to medications. In was asked about any interventions prior to medications during a sey team on 10/31/2017 at m. In regarding either one of ided to the survey team ence. In a facility failed to follow the col. In a facility failed to follow the col. In a facility o2/04/2016. In a facility o2/04/2016. In a facility of the Residents and data set) assessment assessment.	F	309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11/	02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		14 NORTH MAIN STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	memory and was sevi skills for daily decision (bladder and bowel) was resident was always bowel. A review of the Reside sheets for 09/30-10/3 Resident #4 had a BM have another BM until The facility had standi "Constipation: These corder given: If no bow 1. MOM (milk of magn QD (everyday) PRN (aconstipation-if no result suppository. 2. Biscadoly 10mg sup (per rectum) QD PRN results within 8-12 hours. If no results from #1 enema X1 not (notify) The DON (director of a surveyor with docume facility had provided the 10/24/2017. However, have a BM within 8-12 orders) the bowel prototocol during a meet on 10/31/2017 at apprentice.	d 1/1/3 to indicate the as with long and short term berely impaired in cognitive in making. Section H was coded to indicate the incontinent of bladder and bents BM (bowel movement) 1/2017 revealed that if on 10/20/2017 but did not in 10/26/2017. Ing orders regarding are the steps to follow in the ell movement in 3 days. It is included in the incontinent of bladder and in the incontinent in the incontinent in the incontinent in the incontinent in the indicate in the incontinent in the indicate in	F	309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	provided to the survey conference. 5. The facility staff fai practical well-being for Resident #5 was admit with the following diagranemia, high blood prodepression, end stage stenosis and low back MDS (Minimum Data Stage stenosis and low back MDS (Mi	led to provide the highest resident #5. itted to the facility on 2/1/17 moses of, but not limited to essure, anxiety disorder, erenal disease, spinal pain. On the quarterly Set) with an ARD ce Date) of 9/8/17, the shaving a BIMS (Brief tatus) score of 13 out of a Resident #5 was also ensive assistance of 1 staff and personal hygiene and staff member for bathing. Set a review of Resident 10/31/17 and 11/1/17. It eyor that on 9/19/17 the ler was noted "Mucinex quays, Lactulose 15 gram po" The surveyor reviewed edication Administration of September, 2017. The owing documentation on a (extended release) 600 the every 12 hours for 3	F	309			

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OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			/02/2017	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP (514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
i	director of nursing (Do documented findings. look and see how the the Lactulose was just Also during the clinical surveyor noted that Resurveyor noted for paid MAR, the staff documented 9/14/17 at 2:29 pm, 9/14/17 at 2:20 pm, 9/14/17 at 3:20 pm, 9/14	n, the surveyor notified the ON) of the above The DON stated "Let me Mucinex was ordered but to done wrong." If record review, the esident #5 was given by mouth three times a nominate spasms. On the ented that this medication ent on 9/12/17 at 4:20 am, 17/17 at 10:57 pm, 9/18/17 at 9:43 am. If the nurses' notes of the dove documented dates and enzaprine was given. There cological interventions used before the profit (as needed) at on these dates and times If the surveyor notified the cursing of the above. The assistant director of	F 3	DEFICIENCE 309	2Y)		
	At 4:35 pm, the adminion of the above documen surveyor. No further information	ntions." istrative team was notified ted findings by the					
	6. The facility staff fail	ed to follow the bowel					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT	1	5	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 309	regimen when Reside movements for 3 days Resident #13 was adr 1/19/17 with the follow limited to Alzheimer's pressure, Parkinson's dementia and diabete (Minimum Data Set) w Reference Date) of 10 coded as having a BIM Mental Status) score of 15. Resident #13 a assistance of 1 staff m personal hygiene and 1 staff member for bat The clinical record was on 11/1 and 11/2/17. surveyor noted that the movements document 10/15/17 and 10/17/17 On 11/1/17 at 4:35 pm was notified of the abothe surveyor. The surthe facility's standing of the following was note under the section of "G" Constipation: These is the order given: If no id 1. MOM 30 cc po (b PRN (as needed) for cwithin 8-12 hours do si 2. Bisacodyl 10 mg si	init #13 had no bowel inited to the facility on wing diagnoses of, but not Disease, high blood Disease, heart failure, is. On the quarterly MDS with an ARD (Assessment W10/17, the resident was WS (Brief Interview for of 3 out of a possible score also was coded as requiring member for dressing and being totally dependent on hing. Is reviewed by the surveyor During this review, the resident had no bowel are for 10/12 17 through we documented findings by veyor requested a copy of orders for bowel regimens. If the surveyor received a reders for Resident #13. The steps to follow in bowel movement in 3 days. It is not the steps to follow in constipation-If no results	F	309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B, WING		11	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT	•	STREET ADDRESS, CITY, STATE, ZIP C 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		702/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI. TAG	The state of the s	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	enema X1 not (sic) M No further information surveyor prior to the of 5:15 pm. 7. The facility staff fanon-pharmacological administration of a part #19. Resident #19 was add 10/11/17 with the follow limited to atrial fibrillar pressure, diabetes, the fractures, stroke, must Cirrhosis. On the adm Set) with an ARD (Assof 10/17/17, the reside BIMS (Brief Interview 13 out of a possible swas also coded as recof 2 staff members for hygiene and being tot member for bathing. The clinical record of performed by the survey MAR (Medication Adminonth of October, 2018 Resident #19 was gived (milligram) Take one beneeded for pain. On documented that this resident on 10/13/17 as	enema. #1 or #2 administer fleets ID." In was provided to the exit conference on 11/2/17 at illed to document interventions prior to the in medication for Resident mitted to the facility on ewing diagnoses of, but not ion, heart failure, high blood yroid disorder, other cle weakness and elission MDS (Minimum Data esessment Reference Date) ent was coded as having a for Mental Status) score of core of 15. Resident #19 quiring extensive assistance of dressing and personal ally dependent on 1 staff Resident #19 was eyor on 11/2/17. During for reviewed the resident's einistration Record) for the 7. The surveyor noted that en "Tramadol 50 mg y (sic) every 8 hours as	F	309			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	LTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED		
		495417	B. WING			11.	/02/2017		
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, (514 NORTH MAIN S RURAL RETREAT					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	10/27/17 at 12:12 am, 10/30/17 at 11:54 pm The surveyor reviewer Resident #19 on the at the "PRN" pain medic There was no docume non-pharmacological in prior to the administra. At approximately 2 pm was notified of the about the surveyor. No further information surveyor prior to the estimated to the estimated for Resident #1. The surveyor reviewed record on 10/31/17 and admitted to the facility included but not limited pulmonary disease, un pain, depressive episoconstipation, hypertens mellitus, Vitamin D def headaches, and anxiet Resident #1's quarterly assessment with an as (ARD) of 8/24/17 asses	am, 10/26/17 at 1:23 am, 10/27/17 at 10:27 pm, and 10/31/17 at 11:41 pm. If the nurses' notes for above dates and times that ation, Tramadol was given. Interventions being used tion of this pain medication. In the director of nursing ove documented findings by was provided to the exit conference on 11/2/17 at the director of nursing over the director of nursing over the exit conference on 11/2/17 at the director of nursing over the exit conference on 11/2/17 at the director of nursing over the exit conference on 11/2/17 at the exit conferenc	F	309					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD	TPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, C 514 NORTH MAIN ST RURAL RETREAT				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BI EFERENCED TO THE APPROPRIADES DEFICIENCY)		(X5) COMPLETION DATE	
	A physician order date "?(increase) Neurontir (one) po (by mouth) q ?Topamax to 100 mg at night x 1 wk (week) (twice a day) thereafted. The surveyor reviewed electronic medication and 11/1/17. There were the time dose of Topamax "Topamax 100 mg Tak 50 mg for total of 150 mg for total of 150 mg for total of 150 mg x 1 week. On the second entry rone by mouth at bedtir of 150 mg x 1 week. On the surveyor reviewed electronic medication and the second entry rone by mouth at bedtir of 150 mg x 1 week. On the surveyor reviewed electronic medication and the second entry rone by mouth at bedtir of 150 mg x 1 week. On the surveyor reviewed electronic medication and the surveyor reviewed electronic medication and the physician order for the end of the day mee p.m. Upon reviewing the regional minimum of stated the resident recomposition.	ed 9/7/17 at 3:00 p.m. read in to 400 mg (milligrams)? (every) 8 hrs (hours). in am (morning) & 150 mg (then 150 mg? po bid er." If the September 2017 administration records on the word of the september 2017 administration records on the night. The first entry read to 1 tablet at bedtime with mg x 1 week. Order Date: 08/17 Stop Date: 9/15/17" the difference of the night of the with 100 mg for a total order Date: 9/07/17 Start ate: 9/14/17. If the September 2017 mg was administered at through 9/15/17 for a total or 1 week as ordered. If the administrative staff of Topamax not followed in thing on 11/1/17 at 4:31 me September 2017 eMAR, data set registered nurse every was provided prior to the was provided prior to the	F	09		1.0		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	13 FOR MEDICARE &	MEDICAID SERVICES	- 2			IMB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SU COMPLE	
		495417	B. WING			11/02	2/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
CARRING	TON PLACE AT RURAL	RETREAT		514 NORTH MAIN STREET			
OARRING	TON'T EAGL AT ROIGE	NE INCAT		RURAL RETREAT, VA 243	68		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI' CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATI FICIENCY)		(X5) COMPLETION DATE
F 309	Amoxicillin as ordered to ensure the correct fluids was placed in R. The surveyor reviewe record on 10/31/17 arwas admitted to the fareadmitted 6/16/17 wibut not limited to urine infection, peripheral vitissue injury, atrial fibricerebral infarction, dynypertension, Vitamin	illed to administer Cipro and by the physician and failed order for consistency of desident #12's cooler. d Resident #12's clinical and 11/1/17. Resident #12 acility 3/10/17 and the diagnoses that included be retention, urinary tract ascular disease, deep illation, hyperlipidemia, sphagia, hemiplegia, D deficiency, Vitamin B12 in, chronic pain, pneumonia,	F	309			
	data set (MDS) assess reference date (ARD) resident with short term term memory problem cognitive skills for daily G Functional Status as require extensive assis mobility and assessed impairment on one sidextremities. (a). Resident #12 had 9/30/17 that read "1. S Amoxicillin suspension (every) 12 hours per P that delivers food, med for UTI (urinary tract in	e that involved both a physician order dated Stop Invanz. 2. Start 500 mgs (milligrams) q EG (tube in the stomach licines, or fluids) x 10 days fection)."					

administration record on 11/1/17. The order for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	495417	B. WING		1	1/02/2017		
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL R	ETREAT		STREET ADDRESS, CITY, STATE, 514 NORTH MAIN STREET RURAL RETREAT, VA 2436				
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
2017 eMAR with an ord start date of 10/1/17. To October 2017 eMAR. a.m. had a "star" in the 9:00 p.m. had a "N". R to the emergency room on 10/2/17 at 1238 a.m. received 18 doses of A 9:00 a.m. through 10/10 However, the physician 9 days as administered box from the director of pharmacy manifest for The stat box list was redirector of nursing. Am was in the stat box. Th #12 the order was for the was not in the stat box. for Amoxicillin was review manifest read "Amoxicilling/5 ml (milliliter) ***Se AJR***." The manifest stamp." The surveyor informed the above medication (A administered for 10 day the day meeting. The registered nurse stated enough of the medicatic September and October	Intered onto the September der date of 9/30/17 and a The surveyor reviewed the The entry on 1/1/17 at 9:00 box. The next entry at desident #12 had been sent in on 10/1/17 and returned in. Resident #12 then moxicillin from 10/2/17 at 0/17 at 9:00 p.m. In order was for 10 days-not in. In did the contents of the stat if nursing and the Amoxicillin 250 mg capsule in Endown and that in Endown and the Suspension and that in Endown and the Endown and the endown at the endow	F	309				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		495417	B. WING			1.	1/02/2017	
	ROVIDER OR SUPPLIER	L RETREAT		514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	(milligram) per peg days." The surveyor review electronic medicatic entry on the Septen "Ciprofloxacin 500 r (every) 12 hours for 10/09/17 Start Date 10/16/17." Resident #12 receiv on 9/9/17 at 9:00 p. p.m. for a total of fiff many. The surveyor inform the above medicatic 7days as ordered in The regional minimus stated Resident #12 of Cipro after review eMARs. No further informatic exit conference on 1 (c). The facility staff physician order for til #12's liquids was ac Resident #12's beds physician ordered.	rear "Cipro 500 mg q (every) 12 ° (hour) x 7 wed the September 2017 on administration records. An other 2017 eMARs read mg (milligrams) per peg q 7 days. Order Date: 10/09/17 Discontinue Date: red Cipro 500 mg beginning m. through 9/16/17 at 9:00 reen (15) doses- one dose too red the administrative staff of the end of the day meeting. Im data set registered nurse received an additional dose ring the September 2017 on was provided prior to the 1/2/17.	F	309				
İ	nectar thick liquids-n	othing by mouth) except for nouth care 4 times daily."						

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OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11/	02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COL 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	DE		
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F 309	cooler with melted ice (four) honey thickeners weetened tea honey. The surveyor checker 10/31/17 at 12:50 p.m ice and 3(three) hone (one) honey thickened. The surveyor interview #2 on 10/31/17 at 12: the honey thickened we cooler and stated he waccuracy. After check stated Resident #12 sliquids-not honey. The surveyor interview manager other #5 on #5 stated the coolers done by nursing staff. The surveyor informed the above concern du meeting on 11/1/17 at No further information exit conference on 11/1/17 and 10. The facility staff faprotocol for Resident included but not limite quadriplegic cerebral process.	over the bed table was a the cooler contained 4 d waters and one (1) consistency. If the cooler again on the cooler was filled with by thickened waters and 1 d tea. Wed licensed practical nurse 50 p.m. L.P.N. #2 agreed vater and tea were in the would check the order for king the order, L.P.N. #2 thould have nectar thick wed the district dietary 11/1/17 at 9:14 a.m. Other in the resident's rooms are not dietary staff. If the administrative staff of ring an end of the day 4:31 p.m. was provided prior to the 12/17. It died to follow the bowel 14. If Resident #14's clinical 1/1/17. Resident #14 was 1/10/17 with diagnoses that If to epilepsy, spastic	F3				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		CONSTRUCTION		E SURVEY PLETED
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	ROVIDER OR SUPPLIER TON PLACE AT RURA		ST 51	IREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368	1 11	/02/2017
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	constipation, kneed osteoarthritis. Resident #14's quaset) assessment widate (ARD) of 11/2/a BIMS (brief intervout of 15. Section Comarked that Reside wheelchair for mobi Bowel assessed the incontinent of bowe	contracture, and unspecified reterly MDS (minimum data th an assessment reference 17 assessed the resident with few for mental status) of 13 G. Functional Status was not #14 normally used a lity. Section H Bladder and the resident to always be lied. ent comprehensive care plan and of potential fluid volume constipation dated 1/24/17. For & document BM's (bowel with a 10/8/17 and 10/30/17. It have a bowel movement the 10/8/17. Resident #14 had an 10/2/17 and 10/9/17. It documented bowel with a 10/2/17 through 10/29/17. It documented bowel well movement in 3 days. It great the steps to follow in the well movement in 3 days. It great is great in 3	F 309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	enema X1 not (notify) The surveyor reviewe September 2017 and medication administrated outside documentation that the orders was implement been administered on did not have a bowel of through 10/8/17. The no documentation of \$10/6/17\$. The surveyor informed the above concern on No further information exit conference on 11/8 Based on observation, interview, facility documentation of \$10/6/17\$. Based on observation, interview, facility documentation of \$10/6/17\$. Resident with a facility documentation of \$10/6/17\$. The surveyor informed the above concern on \$1/6/15\$. Resident with a facility documentation of \$10/6/15\$. The findings included: 1. Facility staff failed interventions for pain received the staff failed interventions for pain received the staff failed diastolic congestive he chronic kidney disease	d Resident #14's October 2017 electronic tion records. There was no e first order of the standing ted. MOM should have 10/6/17 when the resident movement from 10/3/17 October 2017 eMAR had MOM administration on If the administrative staff of 11/2/17 at 12:18 p.m. was provided prior to the 2/17. resident interview, staff ment review, and clinical lity staff failed to ensure the peing for 10 of 25 residents Resident # 6, Resident # lent#4, Resident #5, at #19, Resident #1, sident # 14. It o assess pain and provide elief for Resident #6. hally admitted to the facility mission date of 12/15/16. It not limited to: chronic art failure, hypothyroidism,	F	309			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495417	B. WING _			11/02/2017	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)				(X5) COMPLETION DATE	
F 309	data set) assessment with an ARD (assess 10/13/17. Facility staft cognitive status was segonitive score of 6 of the clinical record for on 10/31/17 at 9:30 a recent MDS with an A staff documented in significant with the staff documented in significant with the staff documented in significant with the staff documented pressure and applications of oin than to feet as skin and applications of oin than to feet as skin and applications of oin than to feet as skin and applications of oin than to feet as skin and the staff documented pressure and applications of oin than to feet as skin and the staff documented pressure and applications of oin than to feet as skin and observed lying in her lead to provide treatment to LPN #1 tells surveyor goo but we are out of from the pharmacy in order to use house bain." LPN #1 states she associated skin dama non-compliant with tur #1 if Resident # 6 was #1 states "no." On 11/1/17 at 11:19 a. CNA #1 (certified nurs administer treatment to the CNA #1 touched thigh to assist her in the control of the staff of the control of th	was quarterly assessment ment reference date) of focumented Resident # 6's severely impaired with a severely impaired wit	F3	09			

STATEMENT OF DEFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495417	B. WING_		11/02/2017
NAME OF PROVIDE		RETREAT		STREET ADDRESS, CITY, STATE, 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	ZIP CODE
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Resid wash Resid were "it's h Resid area i Resid buttoo applie Reside hurts" The father provided assisted and a back. On 11/intervied during #6 "alvy you just don't k team a to do if stated needs	Resident #6's beent # 6 flinched touched by the urting my butt." lent #6's buttock instead of washi ent # 6 then start yor observed arent # 6 as followed; in the fold, on the context and 2 or was redness in the the area was down and that the area was down and the application of the context and 2 or was redness in the the area was down and the application of the applicati	eft side. LPN #1 began to bottom with soap and water. as soon as her buttocks LPN #1. Resident # 6 stated LPN #1 continued to wash as but started patting the ing in circular motion. It is but started patting me." It is a red area on right lower element of some area in the crease in between in the crease	F3	309	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PLAN OF CORRECTION A BUILDING S. WIMD CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391		
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL RETREAT (A4) ID PRETEX SUMMARY STATEMENT OF DEFICIENCIES (14) NORTH MAIN STREET RURAL RETREAT, VA. 24388 (A4) ID PRETEX (EACH DEFICIENCY MUST SE PRECEDED BY FULL 1760 MEGILANDRY OR LISC IDENTIFYING RECORDED BY FULL 1760 MEGILANDRY OR RECORDED BY FULL 1760 MEGILANDRY									
CARRINGTON PLACE AT RURAL RETREAT (A) ID SUMMARY SIA/TEMENT OF DEFICIENCIES (LEACH DEFICIENCY) TAG F 309 Continued From page 58 when she complained of pain? LPN #1 stated that she did not know that she could stop while the surveyors were watching. DON (director of nursing) was in the meeting with the LPN #1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess." On 11/2/17 at 10:30 a m., 3 surveyors observed incontinence care of Resident #6 father consent was given by the resident. LPN #1 verbally informed surveyors ware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed resident pain level prior to initiating treatment and Resident #6 fathed on her left side with assist of 2 persons treatment nurse and CNA #3. When CNA #3 touched Resident #6 fished again and stated "it hurts in that spot." The facility staff stopped treatment a sasses dith resident. CNA #3 touched and sasked "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched and asked "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched and asked "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched and asked "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6 stated "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6 stated "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6 stated "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6 stated "it hurts in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6 stated "it hurts in that spot." The facility staff stopped treatme			495417	B. WING			11/	02/2017	
CARRINGTON PLACE AT RURAL RETREAT (A4,10) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 58 when she complained of pain? LPN #1 stated that she did not know that she could stop while the surveyors were watching. DON (director of nursing) was in the meeting with the LPN #1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess." On 11/2/17 at 10:30 a.m., 3 surveyors observed incontinence care of Resident #6 flab been premedicated with Lortab and topical Lidocaine. LPN #1 made surveyors ware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed resident pain level prior to initiating treatment and Resident #6 denied having pain. Resident #6 was turned on her left side with assist of 2 persons treatment nurse and CNA #3. When CNA #3 touched Resident #6's bottom to wash her bottom treatment. Resident # 6 stated "try to." When CNA #3 continued to wash her bottom treatment and assessed the resident. CNA #3 touched an area on Resident #6's bottom and asked "is this where it hurts?" Resident #6's bottom and asked "is this where it hurts?" Resident #6's bottom and asked "is this where it hurts?" Resident #6's bottom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom and asked "is this where it hurts?" Resident #6's battom	NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
RURAL RETEAT, V. 24368 CALL DEPCEMBER CALL DEPCEMBER DEPCEMBER PREFIX REGULATORY OR I.SC IDENTIFYINS INFORMATION) PREFIX REGULATORY OR I.SC IDENTIFYINS INFORMATION) PREFIX REGULATORY OR I.SC IDENTIFYINS INFORMATION) PREFIX TAG CROSS-REFERENCE DO THE APPROPRIATE DEFICIENCY) F 309 Continued From page 58 When she complained of pain? LPN #1 stated that she did not know that she could stop while the surveyors were watching. DON (director of nursing) was in the meeting with the LPN #1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess." On 11/2/17 at 10:30 a.m., 3 surveyors observed incontinence care of Resident #6 after consent was given by the resident. LPN #1 readed with Lortab and topical Lidocaine. LPN #1 made surveyors ware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed resident #6 as ordered. LPN #3 touched Resident #6 stottom to wash her bottom Resident #6"s bottom to wash her bottom Resident #6"s bottom to wash her bottom Resident #6" if she wished for them to continue treatment. Resident #6 if she wished for them to continue treatment. Resident #6 stated "ty to." When CNA #3 continued to wash the area to the buttocks Resident #6 if she wished for them to continue treatment. Resident #6 if she wished for them to continue treatment and assessed the resident. Stated "ty to." When CNA #3 couched anstead "thuts." The facility staff stopped treatment and assessed the resident. A #3 touched an area on Resident #6"s bottom and asked "it hurts in that spot." The facility staff stopped treatment and assessed the resident. A #3 touched an area on Resident #6"s bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA #3 touched an area on Resident #6"s bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident #6"stated "no." CNA #3 touched another area on Resident #6"stated "no." CNA #3 touched another area on Resident #6"sta					, ا	514 NORTH MAIN STREET			
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 58 when she complained of pain? LPN #1 stated that she did not know that she could stop while the surveyors were watching. DON (director of nursing) was in the meeting with the LPN #1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess." On 11/2/17 at 10:30 a.m., 3 surveyors observed incontinence care of Resident #6 after consent was given by the resident. LPN #1 whise line premedicated with Lortab and topical Lidocaine. LPN #1 made surveyors aware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed resident #6 after consent her left side with assist of 2 persons treatment nurse and CNA #3. When CNA #3 touched Resident #6 flinched and stated "it hurts." The facility staff stopped to assess resident and asked Resident #6 stated "try to." When CNA #3 continued to wash the area to the buttocks Resident #6 stated "try to." When CNA #3 touched an area on Resident #6's bottom and asked "it hurts in that spot." The facility staff stopped treatment and assessed the resident. LPN #3 touched an stated "it hurts in that spot." The facility staff stopped treatment and assessed the resident. EAN #3 touched an area on Resident #6's bottom and asked "is this where it hurts?" Resident #6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident #6's bottom and asked "is this where it hurts?" Resident #6 stated "no." CNA#3 touched another area on Resident #6 stated "no." CNA#3 touched another area on Resident #6 stated "no." CNA#4 touched another area on Resident #6 stated "no." CNA#4 touched another area on Resident #6 stated "no." CNA#4 touched another area on Resident #6 stated "no." CNA#4 touched another area on Resident #6 stated "no." CNA#4 touched another area on Resident #6 stated "no." CNA#4 touched another area on Resident #6 stated "no." CNA#4 touched another area on Resident #6 stated "no." CNA#4 touched a	CARRING	TON PLACE AT RURAL	RETREAT		ı	RURAL RETREAT, VA 24368			
when she complained of pain? LPN #1 stated that she did not know that she could stop while the surveyors were watching. DON (director of nursing) was in the meeting with the LPN #1 and told LPN #1 "this is a lesson learned, when a resident complains of pain, you stop and reassess." On 11/2/17 at 10:30 a.m., 3 surveyors observed incontinence care of Resident #6 after consent was given by the resident. LPN #1 verbally informed surveyors that Resident #6 had been premedicated with Lortab and topical Lidocaine. LPN #1 made surveyors aware that the Greer's goo was now in the facility to be applied as ordered. LPN #1 assessed resident pain level prior to initiating treatment and Resident #6 denied having pain. Resident #6 was turned on her left side with assist of 2 persons treatment nurse and CNA #3. When CNA #3 touched Resident #6 flinched and stated "it hurfs." The facility staff stopped to assess resident and asked Resident #6 if she wished for them to continue treatment. Resident # 6 stated "try to." When CNA #3 continued to wash the area to the buttocks Resident # 6 flinched again and stated "it hurfs in that spot." The facility staff stopped treatment and assessed the resident. CNA #3 touched an area on Resident #6's bottom and asked "it hirs this where it hurts?" Resident #6 stated "no." CNA #3 touched an area on Resident #6's bottom and asked "its this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident #6's bottom and asked "its this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident #6's bottom and asked "its this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident #6's bottom and asked "its this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident #6's bottom and asked "its this where it hurts?" Resident #6 stated "no." CNA #3 touched another area on Resident #6's bottom and asked "its this where it hurts?" Resident #6's bottom and asked "its this where it hurts?" Resident #6's bottom a	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
Resident #6 stated "no." CNA # 3 touched a different area on Resident #6's buttocks and resident # 6 immediately flinched and stated "yes. The facility staff stopped to assess the resident and asked Resident #6 if she wished for them to		when she complained she did not know that surveyors were watch nursing) was in the m told LPN #1 "this is a resident complains of reassess." On 11/2/17 at 10:30 a incontinence care of F was given by the resident formed surveyors the premedicated with Lot LPN #1 made surveyors owas now in the faordered. LPN #1 asses prior to initiating treated having pain. Resident #6 shottom of Resident #6 flinched a facility staff stopped to Resident #6 flinched a facility staff stopped to the tolerate with the series on the tolerate when the series in that spot." It treatment and assesses touched an area on Resident #6 shottom and asked "is this where it "no." CNA #3 touched #6's bottom and asked "condifferent area on Resident #6 stated "no different area on Resident #6 immediate The facility staff stopped to the facility staff stopped to the series on Resident #6 immediate The facility staff stopped to the facility staff stopped to the series on Resident #6 immediate The facility staff stopped to the surveyor the series on Resident #6 immediate The facility staff stopped to the surveyor the su	I of pain? LPN #1 stated that she could stop while the sing. DON (director of eeting with the LPN #1 and lesson learned, when a pain, you stop and I.m., 3 surveyors observed Resident #6 after consent dent. LPN #1 verbally at Resident #6 had been reab and topical Lidocaine. For aware that the Greer's cility to be applied as seed resident pain level ment and Resident #6 esident #6 esident #6 esident #6 was turned on the of 2 persons treatment then CNA #3 touched to wash her bottom and stated "it hurts." The eassess resident and asked the facility staff stopped and the resident. CNA #3 esident #6's bottom and thurts?" Resident #6 stated another area on Resident d'is this where it hurts?" I c. "CNA # 3 touched a lent #6's buttocks and alent #	F	309				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495417	B, WING_			11/	02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
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	LPN #1 was asked by Resident #6's buttock yesterday? LPN #1 st Resident #6's bottom yesterday. LPN #1 at yesterday. LPN #1 at Resident #6's bottom during application. LP she wanted her to sto "no." LPN #1 then sta lower buttock in the fonot see it yesterday. Lesanitized her hands at #1 attempted to touch blanched, but resident pain. LPN #1 stated the barrier cream on the at that the area needs to placed Derma Septing lower buttock in the formation of the pain. LPN #1 stated the barrier cream on the attempted to be placed Derma Septing lower buttock in the formation of the pain. LPN #1 stated the barrier cream on the attempted to touch blanched, but resident pain. LPN #1 stated the barrier cream on the attempted to placed Derma Septing lower buttock in the formation of the pain of the properties of the pain of the properties of t	surveyors how the area to so looked in comparison to ated that the areas on looked better than ated "they were more red pplied Greer's Goo to and Resident #6 flinched N #1 asked Resident #6 if p and Resident #6 stated ted that the area to the right old was new and that she did LPN #1 changed gloves, and donned new gloves. LPN the area to see if the area to flinched and complained of that she will use house area and notify the doctor to be assessed. LPN #1 to the area on the right lid. # 6's right lower buttock of the area on the right lid. # 6's right lower buttock of LPN #1 who graph with CNA #1 was asked assident #6's buttocks. CNA# aw the area on Resident k. Survey team asked CNA en. CNA # 1 stated	F3	09			

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY MPLETED
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	F PROVIDER OR SUPPLIER NGTON PLACE AT RURAL	RETREAT		STREET ADDRESS, CITY, STATE, ZIP (514 NORTH MAIN STREET RURAL RETREAT, VA 24368	CODE	
(X4) II PREFI TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 36	she would report it to that "normally LPN # asked CNA # 1 "that" yesterday is it?" CNA On 11/2/17 at 12:18 p (assistant director of consultant nurse, reg regional operations in the above findings. That surveyors speak because of the cognit and her frequent com On 11/2/17 at 12:25 p went in and spoke wit asked Resident # 6 if treatment to her butto Resident # 6 stated "yasked Resident # 6 stated "yasked Resident # 6 stated "yestated to Resident # 6 having pain while they would you have prefewhile you were hurting # 6 stated "rather they asked Resident # 6 "wasked Resident # 6 "wasked Resident # 6 "wasked Resident # 6 stated "yes administrator were mathe conversation held No further information	the nurse. CNA #1 stated 1 stops." Surveyor then s not what happened a # 1 stated "no." D.m., the DON, ADON nursing), administrator, ional mds consultant, nanager was made aware of the facility staff requested with Resident #6 again tive status of the resident uplaints of pain. D.m., 2 surveyors and RN# 1 th Resident # 6. Surveyor she remembered receiving teks on 11/1/17 and tees." The surveyor then she remembered receiving teks on 11/2/17 and tes." The surveyor then "I noticed that you were to were treating your bottom, med for the staff to stop g or keep going?" Resident to keep going." Surveyor then when you complained of the staff to stop gor keep going." Surveyor then when you complained of the dead and gave you a break did that make it better?" D.m., the DON, ADON, and de aware of the details of	F	309		

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OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		495417	B. WING			11/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	for nectar thickened like Resident #17 was origon 5/20/17 with a reach Diagnoses included be heart failure, enteroord difficile, and hypokale (minimum data set) which an ARD of (asses 10/13/17. It was documented a cognitive score moderate cognitive immoderate cognitive immoderate cognitive immoderate regular water in a cup, locked stated "now she is on can have regular water water in a cup, locked stated "now she is on can have regular water #2 proceeded into Residential water. The clinical record for on 11/2/17 at 8:03 a.m. physician's order Residented Liquids. Upon review with an ARD of 10/13/K0510 Nutritional Apple documented a check realtered diet-required coliquids (e.g., pureed for review of Resident #1 "diet and/or liquid considerated and process and the side of the s	o follow physician's orders quids for Resident #17. ginally admitted to the facility finission date of 8/23/17. ut not limited to: dysphagia, litis due to clostridium mia. The most recent MDS as a quarterly assessment is ment reference date) of mented that Resident # 17 of 12 out of 15 indicating pairment. In., RN # 2 was it in to Resident #17. After fon RN #2 poured regular the medication cart. RN # 2 thickened liquids, but she r when I am with her." RN sident #17's room and ons followed by the regular Resident #17 was reviewed. According to the current dent #17 is to have nectar few of the most recent MDS 17 in section K specifically toaches, the facility staff mark under C. mechanically shange in texture of food or ood, thickened liquids). A 7's current plan of care had istency per MD orders as problem area potential for	F 36)9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495417	B, WING			11	/02/2017
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL RE	ETREAT		51	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
the DON (director of nu stated above. On 11/2/17 at 10:05 a.m the survey team that wh readmitted to the facility. The DON stated "she is should not have gotten. No further information reprovided to the survey to conference on 11/2/17 at 483.24(a)(2) ADL CARE DEPENDENT RESIDEN. (a)(2) A resident who is activities of daily living reservices to maintain good personal and oral hygier. This REQUIREMENT is by: 5. The facility staff failed received sufficient baths personal hygiene. Resident #3 was admitted.	n., the DON reported to men Resident #17 was a the free water stopped. To on thickened liquids and ther meds with water." The parding this issue was earn prior to the exit at 5:15 p.m. The PROVIDED FOR NTS Unable to carry out eccives the necessary and nutrition, grooming, and the. Is not met as evidenced at to ensure Resident #3 alshowers to provide good the dot the facility on include but are not limited the hypothyroidism, urinary and alzheimer's disease. The provide good the dot of the facility on include but are not limited the hypothyroidism, urinary and alzheimer's disease. The provide good the dot of the facility on include but are not limited the hypothyroidism, urinary and alzheimer's disease. The provide good the facility on include but are not limited the hypothyroidism, urinary and alzheimer's disease. The provided good the facility on include but are not limited the hypothyroidism, urinary and alzheimer's disease.		312	F 312 ADL Care Provided for Dependent Residents Criteria 1: Resident #10 stated that she would like to have a shower on November 1, 2017. DON confirmed that resident #10 did receive a shower the evening of November 1, 2017. Criteria 2: A facility wide ADL care audit was completed by ED for additional residents on November 1, 2017. DON developed new planutilizing shower aides, giving showers 6 days per week. Since November 13, 2017, daily shower audits are conducted by DON or designee to ensure showers offered and weekly notes		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A, BUILDI		E CONSTRUCTION		TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Review of Resident # care plan revealed un following: "Requires a related to generalized cognitive loss." Resident #3's activity revealed her bathing a she was not getting she was not getting shower was on 10/4/1 9/22/17, 9/23/17 and 9 On 11/1/17, the admin and director of nurses #3's lack of baths/shower	3's current comprehensive der problem/need the ssistance is for ADL's weakness, debility and of daily living sheet record. The record revealed nowers or daily bed bath 10/4/17. On 9/20/17 the ad a shower and the next 7. She had a bed bath on 9/28/17. histrator, director of nurses were informed of Resident wers.	F	312	Criteria 3: DON or designee will in-service nursing staff by November 30, 2017 regarding ADL care including bathing/shower care and documentation. DON or designe will audit daily ADL care for a minimum of 5 times a week for days. Criteria 4: DON or designee will review results of audits with ED. ED or designee will present audit to facility QA committee monthl to be reviewed for further intervention or recommendation as necessary. Criteria 5: December 16, 2017	90 ts y	
	clinical record review, provide necessary AD care for 3 of 25 Reside Residents #4, #8, and The findings included. 1. For Resident #4, the assistance with showe The record review reveleen admitted to the fa Diagnoses included, by dementia with behaviore.	e facility failed to provide rs/bathing. ealed that Resident #4 had acility 02/04/2016. ut were not limited to,					

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OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11/02/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BI S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	hypothyroidism. Section C (cognitive proparterly MDS (minim with an ARD (assessmed)05/2017 was coded Resident had problem memory and was severally decision (functional status) was hygiene and bathing the required extensive asseperform these tasks. A review of the Reside 09/30-10/31/2017 reverance and 10/19/2017. The Identity and well-groomed at the treatment of the survey revamped the bath teatment of the survey revamped the bath teatment of the survey revamped to the survey conference. 2. For Resident #8, the the Resident with assist showers/bathing.	ratterns) of the Residents aum data set) assessment ment reference date) of d 1/1/3 to indicate the is with long and short term erely impaired in cognitive in making. Section G is coded 3/2 for personal io indicate the Resident isistance of one person to sents bath sheets for ealed that Resident #4 had for on 10/04, 10/10, 10/14, Resident appeared clean the time of the survey. If was notified on mately 2:45 p.m. that the idea and that she had just im, hired a new person, ow have staff available to week. It is a regarding this issue was team prior to the exit is a facility failed to provide stance with	F	12			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
	dementia, hyperter osteoporosis, anxieneoplasm. Section C (cognitivannual MDS (miniman ARD (assessmento)/18/2017 include mental status) sumpossible 15 points. was coded 3/2 for pathing to indicate extensive assistant hygiene and was to for bathing. A review of the faciliconcern with the Reshowers/baths. For the month of 09 documented that the showers-09/05, 09/month of October 2 documented that the showers 10/09, 10/10/10/10/10/10/10/10/10/10/10/10/10/1	d, but were not limited to, asion, constipation, age related ety disorder, and malignant et patterns) of the Residents num data set) assessment with ent reference date) of da BIMS (brief interview for mary score of 4 out of a Section G (functional status) personal hygiene and 4/2 for the Resident required se of one person for personal stally dependent on one person dity concern log revealed a sesident regarding et Resident had received 4 11, 09/19, and 09/26. For the 10, 10/19, 10/20, and 10/25. Poproximately 12:35 p.m. the innon-staff person #1. Non end she did not bathe this fe Resident had gone 9 days	F	312			

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULT A, BUILDI		NSTRUCTION		SURVEY PLETED
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person, and the available to give No further inforprovided to the conference. 3. The facility seek in addition Resident # 6 we on 2/16/15 with Diagnoses includiastolic congent chronic kidney hypertension. In data set) assess with an ARD (a 10/13/17. Facilic cognitive status cognitive score. The clinical received and facility staff door Go120 that Reseivith bathing with persons to physical companion of the roster revealed documented the on 10/4/17, received a show	ped the bath team, at they would now he showers 6 days a mation regarding the survey team prior to taff failed to provide not bed baths to Reas originally admitted a readmission date uded but not limited stive heart failure, he disease stage 3, and he most recent MD sment was quarterly staff documented to was severely impart of 6 out of 15. Ord for Resident #6 19:30 a.m., Upon revolutions with an ARD of 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ave staff week. is issue was o the exit 2 showers per esident #6. ed to the facility of 12/15/16. to: chronic ypothyroidism, d S (minimum y assessment ee date) of I Resident #6's ired with a was reviewed iew of the 0/13/17, the G specifically otal assistance r more th, skin check if had ed a shower 0/15/17, further	F3	312			

	to i dittillebiorite or						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
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	ROVIDER OR SUPPLIER	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	On 10/31/17 at 2:48 p.m., the facility staff was made aware of the above findings.		F	312			
	The survey team spol nursing) regarding this showers weekly. DON of the issue and that did the showers for the could not work. The faperson to administer a facility would be administed weekly once the new. On 11/1/17 at 11:09 and nursing) made survey locate any other docu	ke with the DON (director of s resident not receiving 2 N stated that she was aware one of the aides that usually e residents got injured and acility has hired a new showers and that they nistering showers 6 days					
		regarding this issue was ey team prior to the exit 7 at 5:15 p.m.					
		ed to administer 2 showers bed baths for Resident #10.					
	facility on 2/10/15 with 9/12/15. Diagnoses in dementia, multiple scl disorder, polyneuropa The most recent MDS quarterly assessment reference date) of 10/coded Resident # 10's of 15 indicating model	ginally admitted to the a readmission date of cluded but not limited to: erosis, major depressive thy, and hyperlipidemia. (minimum data set) was a with an ARD (assessment 13/17. The facility staff cognitive status as 11 out rate impairment.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11.	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		5.	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	10/31/17 was reviewed section G0120 the fact Resident #10 required bathing with the support physically. Upon review of the fact check roster" it was do #10 received a shower beside bath day it was bath was given, on 10 was documented that complete bed bath, on it was documented that complete bed bath, on it was documented that Resident, 10/25/17 beside documented that Resident, 10/25/17 beside documented that Resident #10 allower. On 11/1/17 at 9:45 a.m assist Resident #10 "I think to shower day" Resident #10 going to take me a shower day" Resident #10 "Resident #10 "We will gothen" On 11/1/17 at 11:32 a.m with the DON (director resident not receiving 2)	ecent MDS with an ARD of d specifically section G. In cility staff documented that it total assistance with ort of one person to assist cility" hygiene, bath, skin ocumented that Resident on 10/4/17, on 10/19/17 documented that a partial /19/17 beside bath day it the resident received a 10/20/17 beside bath day at Resident #10 received a de bath day facility dent #10 received a partial bath day facility dent #10 received a metal bath day facility dent #10 received a metal bath day facility dent #10 received a stated "I thought I was swer." LPN #1 stated to oday is your make up #10 then stated "I'd really	F	312			
1		ually did the showers for d and could not work. The person to administer					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`-'	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/	/02/2017	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 114 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 312	Continued From pages showers and that they administering showers new hire comes on both of the comes of t	r facility would be so 6 days weekly once the pard. In surveyor observed elchair in activity room. essed in the same clothing essed in at 9:45 a.m. sked Resident# 10 if she ar? Resident # 10 stated In Resident # 10 was in her wheelchair. Resident in the same clothing that is a.m. Surveyor asked and received a shower? Inc., the facility staff spoke		312	DEFICIENCY)			
	consultant nurse, region regional director of opaware of Resident # 1 not receiving one. On 11/2/17 at 9:50 a.m.	sistant director of nursing, onal MDS consultant, and erations and made them 0 requesting a shower and n. DON verbally informed			a			
	shower on the evening No further information	dent # 10 had received a g of 11/1/17. regarding this issue was ry team prior to the exit						

NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL RETREAT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE	(X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL RETREAT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE	(X5) COMPLETION
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 312 Continued From page 70 conference on 11/2/17 at 5:15 p.m. F 314 SS=D (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review facility staff failed to identify and treat open area to skin for 1 of 25 residents in the survey sample, Resident # 6. The findings included: Resident # 6 was originally admitted to the facility on 2/16/15 with a readmission date of 12/15/16. Diagnoses included but not limited to: chronic diastolic congestive heart failure, hypothyroidism,	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
	27	495417	B. WING			11/	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368				
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	chronic kidney disease hypertension. The modata set) assessment with an ARD (assessing 10/13/17. Facility state cognitive status was a cognitive status was a cognitive score of 6 or The clinical record for on 10/31/17 at 9:30 a recent MDS with an Astaff documented in significant was at risk for device Section M1040 H., the that Resident # 6 had damage. In section M documented pressure and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet as skin and applications of oit than to feet a	se stage 3, and set recent MDS (minimum it was quarterly assessment ment reference date) of if documented Resident # 6's severely impaired with a set of 15. Resident #6 was reviewed .m. Upon review of the most uRD of 10/13/17, the facility ection M0150 that Resident eloping pressure ulcers. e facility staff documented moisture associated skin 1200 facility staff e reducing device for bed intments/medications other and ulcer treatments. .m., Resident # 6 was bed flat on her back. .m., LPN (licensed practical ing to provide treatment to s. LPN #1 tells the surveyor er's goo but we are out of it me from the pharmacy in a order to use house barrier a." LPN #1 stated she gets ciated skin damage) a lot compliant with turning." #1 if Resident # 6 was able 1 stated "no." m., LPN #1 assisted by assistant) #1 (certified an to administer treatment	F	314	Criteria 4: DON or designee will review results of audits with ED. ED or designee will present audit to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. Criteria 5: December 16, 2017	ts y		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495417	B_WING			11	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		70212011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	her in turning Resider CNA#1 along with LF her left side. LPN #1 #6's bottom with soap flinched as soon as h the LPN #1. Resident butt." LPN #1 continu buttocks but started p washing in circular me stated "she's hurting is areas on the buttocks red area on right lower open area right upper the crease in between areas on left buttock. bilateral buttocks. LPI left buttock to show th LPN #1 then applied I cream to Resident #6 stated "that hurts" dur Derma Septin. The facility staff did not the procedure to asse provide interventions. assisted Resident #6 and a pillow was place back. On 11/1/17 at 12:15 p interviewed LPN #1 re during the treatment. I #6 "always complains you just touch her she don't know if it's her or team asked the LPN # to do if a resident com	on her right thigh to assist that #6 stated "ooh my butt." N #1 turned Resident # 6 on began to wash Resident to and water. Resident # 6 er buttocks were touched by at #6 stated "it's hurting my ed to wash Resident #6's natting the area instead of otion. Resident # 6 then me." The surveyor observed to f Resident # 6 as follows: er buttock in the fold, one to buttock, small open area in the both buttocks and 2 open. There was redness noted to N #1 pressed an area on the last the area was blanchable. Derma Septin house barrier is buttocks. Resident #6 ing the application of the stop at any time during ss Resident # 6 for pain or LPN #1 and CNA # 1 with turning to her left side ed on the right side of her	F	314				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WIN	3		11	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRE T <i>A</i>	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 314	needs to be reassess Survey team asked LI to assess the resident she complained of pa did not know that she surveyors were watch nursing) was in the me told LPN #1 "this is a resident complains of reassess." On 11/2/17 at 10:30 a incontinence care of F was given by the resid informed surveyors the pre medicated with Lo LPN #1 made surveyor goo was now in the far ordered. LPN #1 asse level prior to initiating denied having pain. Re her left side with assis nurse and CNA # 3. W Resident #6 flinched a facility staff stopped to Resident #6 flinched a facility staff stopped to Resident #6 flinched to buttocks Resident # CNA # 3 continued to buttocks Resident #6 "it hurts in that spot." T treatment and assesse touched an area on Re asked "is this where it "no." CNA # 3 touched #6's bottom and asked Resident #6 stated "no different area on Resident different area on Resident	ed for their pain meds." PN #1 why she did not stop t during the treatment when in? LPN # 1 stated that she could stop while the ing. The DON (director of eeting with the LPN # 1 and lesson learned, when a pain, you stop and .m., 3 surveyors observed Resident #6 after consent lent. LPN #1 verbally at Resident #6 had been rtab and topical Lidocaine. ars aware that the Greer's cility to be applied as ssed Resident # 6's pain treatment and Resident #6 esident #6 was turned on t of 2 persons' treatment //hen CNA # 3 touched to wash her bottom and stated "ith urts." The assess and asked the dinched again and stated the facility staff stopped at the resident. CNA # 3 esident #6's bottom and hurts?" Resident #6 stated another area on Resident d "is this where it hurts?" o." CNA # 3 touched a		- 31				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET IRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
	The facility staff stopp and asked the resider continue treatment. Re LPN # 1 was asked by Resident #6's buttock; yesterday? LPN #1 st. Resident #6's bottom yesterday. LPN #1 appeared wanted her to stop "no." LPN #1 then staff lower buttock in the form to see it yesterday. Lanitized her hands ar # 1 attempted to touch blanched, but Resident complained of pain. Let use house barrier creat the doctor that the are LPN # 1 placed Dermaright lower buttock in the The area to Resident # was noted by surveyor treatment. On 11/2/17 team conducted an interest was the CNA assisting care on 11/1/17 at 11:1 asked about the areas CNA# 1 reported that seed conducted "honestly I can't the stated "honestly I can't the stated "honestly I can't	ed to assess the resident at if she wished for them to esident #6 stated "yes." a surveyors how the area to so looked in comparison to ated that the areas on looked better than ated "they were more red oplied Greer's Goo to and Resident #6 flinched N #1 asked Resident #6 if or and Resident #6 stated ated that the area to the right lid was new and that she did PN #1 changed gloves, and donned new gloves. LPN at the area to see if the area at #6 flinched and PN #1 stated that she will am on the area and notify a needs to be assessed. A septin to the area on the fine fold. #6's right lower buttock from 11/1/17 during at 11:50 a.m., the survey erview with CNA #1 who the LPN #1 with wound 19 a.m., CNA # 1 was on Resident #6's buttocks. She saw the area on er buttock. Survey team ea was open. CNA #1 say if it was open or not."	F	314			
	Policy", "Skin will be as	re Ulcer Risk Assessment ssessed for the presence of cers on a weekly basis or					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	' '	E SURVEY MPLETED
		495417	495417 B. WING		1.	1/02/2017
	ROVIDER OR SUPPLIER	AL RETREAT		STREET ADDRESS, CITY, STATE, ZIP 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 314	more frequently if states "staff will pe (with daily care)." 'inspect the skin if o "Nurses will condu weekly to identify of Per the facility "Wo following information resident's medical 1. The type of words. The position in placed. 4. The name and performing wound 5. Any change in 6. All assessment size, drainage, etc. wound. 7. How the reside 8. Any problems resident related to 9. If the resident reason(s) why. 10. The signature recording the data. On 11/2/17 at 12:18 (assistant director of consultant nurse, regional operations the above findings, team aware at this were also the facility weekly to identify the state of the stat	indicated." The policy also erform routine skin inspections 'Nurses are to be notified to changes are identified." It is skin assessments at least changes." Dund Care Policy", "The point should be recorded in the record. Dund care given. It is the wound care was given. It is the wound care was given. It is the resident was the resident's condition. It is the resident's condition. It is the resident's condition. It is the resident was the resident's condition. It is the resident was the resident and the	F	314		
		rvey team prior to the exit				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/	02/2017	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
CARRING	TON PLACE AT RURAL I	RETREAT	514 NORT		514 NORTH MAIN STREET			
CARRING	TON PLACE AT NOTAL	XETREAT		ı	RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
					F 315 No Catheter, Prevent UTI,			
F 314	F 1,000		F:	314	Restore Bladder			
	conference on 11/2/17							
	<u> </u>	CATHETER, PREVENT UTI,	F:	315	Criteria 1: DON provided			
SS=E	RESTORE BLADDER	•			education to LPN #1 and CNA #1	0		
	(e) Incontinence.				on November 1, 2017 regarding			
	(1) The facility must e	nsure that resident who is			proper personal care. Clarification	n		
		nd bowel on admission	1		order obtained on November 1,			
		assistance to maintain or her clinical condition is			2017 for Resident #10 to have a	า		
		continence is not possible			18 French with 5 mL balloon fole	ey		
	to maintain.				catheter due to leakage.			
	(0)[urinary incontingness based						
	· ·	urinary incontinence, based prehensive assessment, the			Criteria 2: Residents with curren	t		
	facility must ensure the				catheters were reviewed by			
					nursing admin on November 1,			
		ers the facility without an			2017 to ensure proper anchor			
	_	not catheterized unless the lition demonstrates that			devices were in place.			
	odificionzation was no	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Criteria 3: DON or designee will			
	(ii) A resident who enter				provide education for nursing			
	ū	subsequently receives one all of the catheter as soon			staff by November 30, 2017			
		resident's clinical condition			regarding anchoring of tubing			
	•	neterization is necessary			related to catheter, processing of	f		
l l	and				physician orders, and personal	1		
	(iii) A resident who is in	acontinent of bladder			care. Audit of residents with			
	, ,	eatment and services to			catheters will be conducted	1		
	prevent urinary tract in	fections and to restore			weekly to include admissions,			
	continence to the exter	nt possible.			readmissions, and residents with	.		
	(3) For a resident with	fecal incontinence, based			a change in condition requiring a			
		rehensive assessment, the			foley catheter by DON or			
	facility must ensure that	at a resident who is	i		designee to ensure proper order	s		
	incontinent of bowel re	ceives appropriate to restore as much normal			and anchoring devices are in			
	reaument and services	to restore as much normal			place.			
			F		1 1/2.2.2.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	- (X3	(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11/02/2017	
	PROVIDER OR SUPPLIER GTON PLACE AT RURAL	RETREAT	'	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	bowel function as post This REQUIREMENT by: Based on observation interview, facility documents, the facility staresidents received aptreatment in regards to (Residents #19, #10, The findings included 1. Resident #19 was 10/11/17 with the following included 1. Resident #19 was 10/11/17 with the following included 1. Resident #19 was 10/11/17 with the following with an ARD (Assolution of the fractures, stroke, must Cirrhosis. On the adm Set) with an ARD (Assolution of the facture of 10/17/17, the reside BIMS (Brief Interview 13 out of a possible sowas also coded as recof 2 staff members for hygiene and being totomember for bathing. On 11/2/17 at 8:30 ampractical nurse (LPN) froom. The surveyor as size of the Foley cathed LPN #1 looked at the factor of the surveyor conducted #19's clinical record of MAR (Medication Adm October, 2017, the following the surveyor conducted #19's clinical record of MAR (Medication Adm October, 2017, the following the surveyor conducted #19's clinical record of MAR (Medication Adm October, 2017, the following the surveyor conducted #19's clinical record of MAR (Medication Adm October, 2017, the following the surveyor conducted #19's clinical record of MAR (Medication Adm October, 2017, the following the surveyor with the following the surveyor with the facility of the surveyor with the facility of the facility	is not met as evidenced in, resident interview, staff iment and clinical record if failed to ensure 4 of 25 propriate care and o Foley catheter care #20 and #12). admitted to the facility on wing diagnoses of, but not ion, heart failure, high blood yroid disorder, other cle weakness and ission MDS (Minimum Data sessment Reference Date) ent was coded as having a for Mental Status) score of core of 15. Resident #19 quiring extensive assistance dressing and personal ally dependent on 1 staff if, the surveyor and licensed #1 went into Resident #19's sked LPN #1 to look at the eter that the resident had. catheter and stated "It is an	F	review results ED or designe to facility QA to be reviewe intervention of as necessary.	N or designee will sof audits with ED. we will present audits committee monthly and for further or recommendation cember 16, 2017		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING	r -		11/	/02/2017
	ROVIDER OR SUPPLIER	RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	leaf bag every 30 day documented as 10/18 documented as 11/10 The surveyor reviewe orders and monthly plan order for the Foley the surveyor. At approximately 2 pn notified the director of documented findings. reviewed the resident orders and stated "I carrent forward for the surveyor prior to the estable state of the surveyor prior to the estable state of the following for the state of the following for the surveyor prior to the estable state of the following for the state of the following for the state of the following for the following following for the following following for the following for the following for the following for the following following for the following for the following following for the following following for the following following for the following follow	s." The order date was //17 and the start date was //17 on the MAR. d all the supplemental hysician order sheets and catheter was not found by n on 11/2/17, the surveyor finursing of the above The director of nursing is MAR and supplemental an't find any orders for the was provided to the exit conference on 11/2/17 at the facility staff failed to atheter care, and ensure eley was inserted into the facility admitted to the a readmission date of cluded but not limited to: erosis, major depressive thy, and hyperlipidemia. (minimum data set) was a with an ARD (assessment 13/17. The facility staff cognitive status as 11 out	F	318			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRU	JCTION	(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		514 NORTH	DRESS, CITY, STATE, ZIP CODE HMAIN STREET ETREAT, VA 24368	11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & PROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	10 had an indwelling current physician's on was signed by the phyorders that stated "chweeks with 16F (Fren catheter collection bay "May remove foley caballoon if removed or securing device prese every shift" "foley BSI bedside or on w/c and cath cover in place for On 11/1/17 at 9:25 a.r. Resident #10 tugging Catheter tubing was n was positioned upwanflow back into the black of the position of t	catheter. Upon review of the ders for Resident # 10 that ysician on 10/7/17 had ange foley catheter every 3 ch) 10 cc balloon. Change g with every foley change." theter with 16F 10 cc leaking." "ensure foley catheter care 0 bag is placed properly at 1 not touching floor" "foley dignity". In., the surveyor observed on foley catheter tubing. ot secured and catheter d which would have urine leder. In., LPN (licensed practical certified nursing assistant) # # 10 and apply treatment # 10 stated "I thought I was ower." LPN #1 stated to oday is your make up # 10 then stated "I'd really hed" LPN # 1 then told get you cleaned up until have #18 French foley Ib inserted into the bladder ed upward. No leg strap equested that CNA # 2 get of Catheter. LPN #1 placed of Resident #10 and eter to the leg strap. After eg strap, the foley catheter	F	815			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495417	B. WING			11/02/2017
	ROVIDER OR SUPPLIER	RETREAT	•	STREET ADDRESS, CITY, STATE, Z 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED)		(X5) COMPLETION DATE
F 315	would flow back into to the resident was turn with the assistance of Resident #10 was not movement at the time nurse started cleaning after the bowel mover turned and CNA # 2 w washing vaginal area wash cloth. CNA # 2 t with the assistance of the stool from Resider perineal area. CNA # 3 up incontinent brief on in putting on her shirt, Resident #10 out of be stand up lift and place cover was noted to be bag. During the proceed change the water in be buttocks with the bowe vaginal area. They face perform catheter care Per the facility policy for according to the DON the facility standard of under care of the perinanal area last to avoid tract with fecal matter. Per the facility policy of which according to the standard of practice, 3 maintaining unobstruct urinary drainage bag in lower than the bladder	ed toward her right side the LPN #1 and CNA # 2. ed to have had a bowel of care. Initially treatment g Resident #10's buttocks nent. Resident #10 was vashed vaginal area. While stool was noted on the urned Resident #10 again the LPN #1 and cleaned nt #10's buttocks and 2 and LPN #1 applied a pull a Resident # 10 assisted her pants, and shoes, and got ed with the mechanical d in the wheelchair. Privacy in place on foley catheter dure the facility staff did not et ween washing the el movement and the sility staff also did not during the procedure. or giving a bed bath which (director of nursing) is also practice, it is documented neum to "always wash the contaminating the urinary	F	315		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11.	02/2017
	ROVIDER OR SUPPLIER	RETREAT	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	back into the urinary to catheters, it is documented that Resident #20 documented assessment with a cagnitive score The clinical record for on 11/2/17 at 9:35 a.m. recent quarterly MDS vaspecifically section H. documented that Residenter. A review of the catheter. A review of the catheter. A review of the catheter is documented that Residenter is documented that Residenter. A review of the catheter. A review of the catheter. A review of the catheter. A review of the catheter is documented that Residented and catheter. A review of the catheter.	pladder." Under changing ented under 2. "ensure that secured with a leg strap to overment at the insertion ubing should be strapped to igh.)" m., the DON and ade aware of the above regarding this issue was ey team prior to the exit of at 5:15 p.m. led to ensure that Resident ize catheter and bulb ler. Initially admitted to the facility idmission date of 5/27/16. Let not limited to: isscular dysfunction of the infection, major depressive it and set) was a quarterly an ARD (assessment 23/17. The facility staff had inted as cognitively intact of 15 out of 15. Resident #20 was reviewed and Upon review of the most with an ARD of 10/23/17 in H0100 facility staff dent #20 had an indwelling the current physician's esident #20 had orders for	F	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495417	B. WING_			11/	02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
	On 11/2/17 at 9:50 a.r Resident # 20 per req Resident # 20 per req Resident # 20 gave co her catheter. Resident had an 18 Fr catheter into the bladder. A legit was soiled and loose Per the facility policy which according to the standard of practice," is documented under remains secured with friction and movement Catheter tubing should resident's inner thigh.) On 11/2/17 4:28 p.m., (assistant director of nonsultant nurse, regional operations mathe above findings. No further information presented to the survey conference on 11/2/17 4. The facility staff fail #12's indwelling Foley The surveyor reviewed record on 10/31/17 and was admitted to the far readmitted 6/16/17 with but not limited to urine infection, peripheral vatissue injury, atrial fibricerebral infarction, dys	m. surveyor spoke with uest of the resident. Insent for surveyor to look at it # 20 was noted to have with a 5 cc balloon inserted strap was in place however e on Resident # 20's leg. In "Urinary Catheter Care" E DON is also the facility Under changing catheters it 2. "ensure that the catheter a leg strap to reduce that the insertion site. (Note: the be strapped to the at the DON, ADON ursing), administrator, onal MDS consultant, and anager were made aware of regarding this issue was by team prior to the exit at 5:15 p.m. ed to anchor Resident catheter. Resident #12's clinical that 11/1/17. Resident #12 cility 3/10/17 and the diagnoses that included retention, urinary tract scular disease, deep llation, hyperlipidemia,	F	315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B. WING_			11/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		E	(X5) COMPLETION DATE
F 315	and severe sepsis with Resident #12's signific data set (MDS) assess reference date (ARD) resident with short tenterm memory problem cognitive skills for dail G Functional Status a require extensive assis mobility and assessed impairment on one sidextremities. A telephone order date "Foley cath (catheter) centimeters) chg (chair The surveyor and the practical nurse #1 obscatheter 10/31/17 at 10 Foley catheter bag waside of the bed. L.P.N size and anchorage. Thowever, the Foley catheter strap may have be the strap may have be The surveyor requested catheter care from the 11/02/17 at 9:00 a.m. at 9:13 a.m. The policy titled "Catheter catheter remains secureduce friction and more date (ARD) assess the side of the tenter remains secureduce friction and more date (ARD) assess the side of the tenter remains secureduce friction and more date (ARD) assess the side of the side of the surveyor requested catheter remains secureduce friction and more date (ARD) assess the side of the side of the surveyor requested catheter remains secured to the resident of the surveyor requested catheter remains secured to the resident of the surveyor requested catheter remains secured to the resident of the surveyor requested catheter remains secured to the resident of the surveyor requested catheter remains secured to the resident of the surveyor requested to the surveyor	can, chronic pain, pneumonia, in septic shock. Cant change in minimum sment with an assessment of 10/24/17 assessed the momemory problems, long is, and severely impaired y decision making. Section issessed Resident #12 to stance of 2 staff for bed if the resident with an ite that involved both set and the that involved both involved Bo	F3	15			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED =	
		495417	B, WING _		11	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFILE (PROPROPROPROPROPROPROPROPROPROPROPROPROP	BE	(X5) COMPLETION DATE
	to the resident's inner The surveyor informe the above issue with a Foley catheter tubing 12:18 p.m. No further information exit conference on 11.483.25(b)(2)(f)(g)(5)(f) FOR SPECIAL NEED (b)(2) Foot care. To exproper treatment and and good foot health, (i) Provide foot care a with professional stanto prevent complication medical condition(s) a (ii) If necessary, assist appointments with a quarranging for transport appointments (f) Colostomy, ureterous the facility must ensure require colostomy, ure services, receive such professional standards comprehensive persor the resident's goals and (g)(5) A resident who is receives the appropriato prevent complication.	d the administrative staff of regards to Resident #12's not anchored on 11/2/17 at was provided prior to the /2/17. (i)(i)(j) TREATMENT/CARE S Insure that residents receive care to maintain mobility the facility must: Ind treatment, in accordance dards of practice, including insignment from the resident's indicated person, and station to and from such stormy, or ileostomy care, re that residents who terostomy, or ileostomy care consistent with sof practice, the in-centered care plan, and add preferences. Is fed by enteral means the treatment and services tions of enteral feeding	F 3.	F 328 Treatment/Care for Spe Needs Criteria 1: On November 1, 20 filters were cleaned and sanit for Residents #1 and #12.	17, zed 17, ed ded taff ng gen s. ll D. dits hly	
	including but not limite	d to aspiration pneumonia,		Criteria 5: December 16, 2017		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/02/2017	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL F	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
	administered consiste standards of practice aphysician orders, the operson-centered care goals and preferences (i) Respiratory care, in and tracheal suctionin that a resident who ne including tracheostom suctioning, is provided professional standards comprehensive person residents' goals and put this subpart. (j) Prostheses. The faresident who has a proand assistance, consistendards of practice, person-centered care pand preferences, to we prosthetic device. This REQUIREMENT by: Based on observation document review, and facility staff failed to enwas maintained in a clefor 2 of 25 residents (R#12). The findings included:	hydration, metabolic sal-pharyngeal ulcers. Parenteral fluids must be nt with professional and in accordance with comprehensive plan, and the resident's s. Including tracheostomy care g. The facility must ensure reds respiratory care, y care and tracheal such care, consistent with a of practice, the n-centered care plan, the references, and 483.65 of cility must ensure that a pathesis is provided care stent with professional the comprehensive plan, the residents' goals car and be able to use the is not met as evidenced I, staff interview, facility clinical record review, the issure oxygen equipment ean and sanitary condition desident #1 and Resident	F 32	28			
	 The facility staff faile 	ed to ensure the oxygen					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI		DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING_			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	The surveyor reviewer record on 10/31/17 ar admitted to the facility included but not limited pulmonary disease, upain, depressive epistic constipation, hyperter mellitus, Vitamin D de headaches, and anxietassessment with an ar (ARD) of 8/24/17 asses BIMS (brief interview of 15. Section O Speciand Programs was marked 2/3/17 read "CO pulmonary disease). A Change O2 tubing ever order." The October 2017 phy liters of O2 (oxygen) are surveyor and registed the surveyor and registed the surveyor and registed the surveyor and the surveyor the filter and the tubing filter from the back of the and said "Clean on one The filter had an accummaterial on one side."	anitary for Resident #1. and Resident #1's clinical and 11/1/17. Resident #1 was a 1/20/17 with diagnoses that ad to chronic obstructive rinary tract infection, chronic odes, hyperlipidemia, asion, type 2 diabetes afficiency, seizures, periodic aty. By minimum data set (MDS) assessment reference date assed the resident with a for mental status) as 11 out cial Treatments, Procedures arked for oxygen use. Comprehensive care plan DPD (chronic obstructive Approaches: O2 per order, ary week. O2 sats per	F3	328			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B WING			11/02/2017	
	ROVIDER OR SUPPLIER	L RETREAT		STREET ADDRESS, CITY, S 514 NORTH MAIN STREE RURAL RETREAT, VA	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE	SPLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	The surveyor reque 11/1/17 at 1:00 p.m. The policy titled "Do Therapy) Prevention Check filters once we continuous use. Dis between uses for di The surveyor inform the above concerned meeting on 11/1/17 No further information exit conference on 12. The facility staff f #12's oxygen filter we failed to document we changed. The surveyor review record on 10/31/17 awas admitted to the readmitted 6/16/17 when the time that the readmitted form th	y changed out every Tuesday. yed on the tubing. sted the facility policy on from the director of nursing. partmental (Respiratory n of Infection" read in part "9. yeekly while they are in scard filters or sterilize them fferent residents." led the administrative staff of during an end of the day lat 4:31 p.m. on was provided prior to the 1/2/17. failed to ensure Resident ly as clean and sanitary and ly when the oxygen tubing was led Resident #12's clinical land 11/1/17. Resident #12 facility 3/10/17 and ly with diagnoses that included line retention, urinary tract ly vascular disease, deep lo crillation, hyperlipidemia, ly sphagia, hemiplegia, lin D deficiency, Vitamin B12 lion, chronic pain, pneumonia,	F	328			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED			
		495417	B. WING			11	/02/2017
	PROVIDER OR SUPPLIER	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 328	term memory problem cognitive skills for dai O-Special Treatments programs was marked Resident #12's currer dated 10/30/17 read "COPD and am risk of other respiratory com as needed change tul Resident #12's Octob read in part "O2 at 2L nasal cannula as need (chronic obstructive p The surveyor and lice observed Resident #1 10:05 a.m. The oxyge bedside read that the liters of oxygen via na asked how often tubin cleaned. L.P.N. #2 str	ns, and severely impaired ly decision making. Section s, Procedures, and d for oxygen therapy. It comprehensive care plan It have a dx (diagnosis) of shortness of breath and plications. Approaches: O2 bing weekly. er 2017 physician orders //Min (liters per minute) via ded at bedtime for COPD ulmonary disease)." nsed practical nurse #2 2 in bed on 10/31/17 at	F	328			
	filter contained a lot of no date on the tubing. was Monday. It should cleaned. The surveyor reviewed electronic medication a (eMARs). There was weekly. The two entriewers 1. O2 @ 2lpm (linasal cannula) to mai	administration records no entry for tubing change es pertaining to oxygen iters per minute) via n/c					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A, BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495417	B, WING	<u></u>	11/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	14
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	11/1/17 at 1:00 p.m. fr The policy titled "Depa Therapy) Prevention of Check filters once were continuous use. Disca between uses for diffe The surveyor informed the above concern dure meeting on 11/1/17 at No further information exit conference on 11/ 483.45(d)(e)(1)-(2) DE FROM UNNECESSAF 483.45(d) Unnecessar Each resident's drug runnecessary drugs. A drug when used— (1) In excessive dose of therapy); or (2) For excessive dura (3) Without adequate in (4) Without adequate in (5) In the presence of a which indicate the dose discontinued; or	ed the facility policy on from the director of nursing. Fartmental (Respiratory of Infection" read in part "9. Belly while they are in fart filters or sterilize them from the administrative staff of fring an end of the day 4:31 p.m. Was provided prior to the 12/17. RUG REGIMEN IS FREE RY DRUGS BY DRUGS BY Drugs-General. Begimen must be free from from unnecessary drug is any discounting or monitoring; or monitoring; or modications for its use; or adverse consequences a should be reduced or aft the reasons stated in	F 32	F 329 Drug Regimen is Free Fro	7, nt ty
ľ				regarding care plan updates and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/02/2017	
	ROVIDER OR SUPPLIER	RETREAT	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÐ PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	483.45(e) Psychotrop Based on a compreheresident, the facility modified the facility standard to the facility standard to the facility standard the facility standard facili	ic Drugs. ensive assessment of a ust ensure that ve not used psychotropic ese drugs unless the ary to treat a specific d and documented in the e psychotropic drugs receive ns, and behavioral clinically contraindicated, in e these drugs; is not met as evidenced ew and clinical record if failed to provide interventions prior to the in to 1 of 25 residents to provide interventions prior to the in to Resident #5. tted to the facility on 2/1/17 inoses of, but not limited to essure, anxiety disorder, renal disease, spinal pain. On the quarterly set) with an ARD ise Date) of 9/8/17, the	F	329	interventions by November 30, 2017. DON or designee will conduct an audit weekly to ensure special requirements for non-pharmacological interventions are added to admissions, readmissions, and residents with changes in condition. Criteria 4: DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary Criteria 5: December 16, 2017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A, BUILDI		(X3) DATE SURVEY COMPLETED			
		495417	B. WNG			1	1/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE I NORTH MAIN STREET IRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 332	coded as requiring exmember for dressing total dependence of "During the review of (Medication Administ #5, the surveyor note "Ativan 1 mg (milligra for anxiety by mouth" the Ativan on the folio documented on the M 10/3/17 at 9:54 am, 1 at 12:45 pm and 10/2 The surveyor reviewer Resident #5 for the altimes that the Ativan non-pharmacological as being used before "prn" (as needed) Ativitimes by the staff. On 11/1/17 at 9:20 an assistant director of nod documented findings. nursing stated "You and document any interverse At 4:35 pm, the admir of the above document surveyor. No further information surveyor prior to the expression of the above prior to the expression of	Resident #5 was also stensive assistance of 1 staff and personal hygiene and 1 staff member for bathing. The October, 2017, the MAR ration Record) of Resident d that the resident was given m) every 8 hours as needed. The resident was given owing dates and times, as MAR, "10/1/17 at 5:45 pm, 0/7/17 at 5:35 pm, 10/18/17 0/17 at 11:42 am. Indicate the nurses' notes of cove documented dates and was given. There were no interventions documented the administration of the van dose on these dates and m, the surveyor notified the ursing of the above. The assistant director of re right. They didn't intions." Instrative team was notified inted findings by the was provided to the exit conference on 11/2/17. EMEDICATION ERROR	F3	329			
SS=D	. 5 . 7 . 6 . W.						

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495417	B. WING		11.	/02/2017
(EACH DEFICIENC)	RETREAT ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
that its- (1) Medication error ragreater; This REQUIREMENT by: Based on staff interviereview, clinical record medication pass and pfailed to ensure a medication error medication errors affect #17. The findings included. 1. For Resident #16, the administer the Resident the physician and admitters into both eyes whicalled for two drops. The record review reveload been admitted to the Diagnoses included, but insomnia, diabetes, conchronic kidney disease. There was no complete set) assessment on this Resident was alert and On 11/01/2017 at approsurveyor observed LPN #3 prepare and administrations. View of the set of the propagation of the propaga	tes are not 5 percent or is not met as evidenced ew, facility document review, and during a your observation, the facility ication error rate of less is errors in 35 opportunities rate of 8.5%. These yeted Residents #16 and the facility staff failed to yout observation, the facility ication error rate of less is errors in 35 opportunities rate of 8.5%. These yeted Residents #16 and the facility staff failed to yout one drop of thera when the physician order alled that Resident #16 he facility 10/20/2017. It were not limited to, youngestive heart failure, and your observation, the yout observation, the facility and your observation, the facility staff failed to he facility staff failed to	F 332	F 332 Free of Medication Error Rates of 5% of More Criteria 1: Expired Vancomycin was properly disposed of on November 1, 2017 by nursing admin and Voltaren was obtained from pharmacy on November 2, 2017. Vancomycin was obtained from pharmacy on evening of November 1, 2017 to be administered. Criteria 2: Nursing admin looked through medications located in medication rooms to ensure medication rooms to ensure medication pass reviews for nurses two time monthly. Criteria 3: Pharmacy consultant to conduct medication pass reviews for nursing staff regarding administration rights. Pharmacy consultant will conduct monthly medication cart/pass audits.	ds n s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				DATE SURVEY COMPLETED
		495417	B. WING				11/02/2017
	ROVIDER OR SUPPLIER	RETREAT		514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 332	voltaren cream and si pharmacy. After prepimedications LPN #3 and administered the medications after adminedications LPN #3 p. Residents eye drops. the surveyor to place in each of the Resider room the surveyor corshe had placed one deyes. A review of the Resider that the Resident short of the thera tears in each ad been omitted was four times daily. LPN #3 approached that approximately 11:00 contacted the pharma and had been told the current order for the voltare had only received one physician ordered call meeting with the surve approximately 4:35 p. The facility policy/proceed medications read in padministered in according the survey administered in according the survey administered in according the survey administered in according to the survey and the survey administered in according to the survey and the survey	Inot have the Residents he would need to notify the aring the Residents entered the Residents room Residents by mouth inistering these proceeded to administer the LPN #3 was observed by one drop of the thera tears into eyes. After leaving the infirmed with LPN #3 that proprior in each of the Residents ents clinical record revealed and have received two drops and eye. The voltaren that is ordered to be administered to be administered entered and stated she had cry regarding the voltaren entered ent	F	332	Criteria 4: DON or designee or review results of audits to ED weekly. ED or designee will present results of audits to for QA committee monthly to be reviewed for further interver or recommendation as necess. Criteria 5: December 16, 201	ncility e ntion sary.	

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET LURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	conference. 2. Facility staff attemp Vancomycin to Resident #17 was origon 5/20/17 with a reach Diagnoses included by heart failure, enterocodifficile, and hypokaler (minimum data set) was with an ARD of (asses 10/13/17. It is docume a cognitive score of 12 moderate cognitive im On 11/1/17 at 8:57 a.m. was administering mere Resident # 17 has a consideration from the resident # 18 has a consideration from the resident # 10/31/17. The RN # 2 showed stated "it's enough formus." Surveyor noted a Vancomycin was written 10/31/17. The RN # 2 preponent and took to administer to Reside RN # 2 out of the room medication and advise administer the medicate because of the discarded the that she would have to the pharmacy. On 11/1/17 at 4:28 p.m. nursing), ADON (assist)	ginally admitted to the facility dission date of 8/23/17. Let not limited to: dysphagia, litis due to clostridium mia. The most recent MDS as a quarterly assessment asment reference date) of anted that Resident # 17 has 2 out of 15 indicating pairment. In. RN (registered nurse) # 2 dications to Resident #17. Lurrent order for Vancomycin alligrams in 2.5 milliliters) by IRN # 2 retrieved the frigerator in the medication surveyor the bottle and the dose, she gets 2.5 a sticker on the bottle of the medication in the room and #17. Surveyor called the medication in the room and #17. Surveyor called the force administering any down the resident after 10/31/17 sticker on the medication and stated order the medication from	F	332				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495417	B. WING_		<u> </u>	11/	02/2017
	ROVIDER OR SUPPLIER	RETREAT		514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	119	(X5) COMPLETION DATE
F 334 SS=D	MDS consultant, and operations were made findings. No further information provided to the survey conference on 11/2/17 483.80(d)(1)(2) INFLU PNEUMOCOCCAL IM (d) Influenza and pneumonic (1) Influenza. The faciliand procedures to ensigned in the each resident or the receives education receives education receives education receives education receives education october annually, unless the immunization October annually, unless the immunized during this (iii) The resident or the has the opportunity to (iv) The resident's medicumentation that incomposition (A) That the resident or the following:	regional director of a aware of the above regarding this issue was a team prior to the exit of at 5:15 p.m. JENZA AND IMUNIZATIONS JENZA AND IMUNIZ	F3	332	F 334 Influenza and Pneumococcal Immunizations Criteria 1: Resident is over the age of 65. On November 2, 2017. Resident #10 RP was notified an gave consent for vaccine to be administered. Criteria 2: MDS assessments will be reviewed by MDS coordinato for accuracy and will be corrected if deemed necessary. Criteria 3: DON or designee will provide education to MDS coordinators and nursing staff regarding MDS accuracy and completion of assessments by November 30, 2017. MDS or designee will do a review/audit of admissions, readmissions, and residents with changes in condition sample weekly to	l or ed	
	immunization; and				ensure accuracy.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		DATE SURVEY COMPLETED
		495417	B_ WING				11/02/2017
	ROVIDER OR SUPPLIER	RETREAT	,	514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	immunization or did n immunization due to r refusal. (2) Pneumococcal dis develop policies and policies and policies and policies and policies and policies and potential immunization; (ii) Each resident is of immunization; (iii) Each resident is of immunization, unless medically contraindically contraindically already been immunization of the has the opportunity to (iv) The resident or the has the opportunity to (iv) The resident's medically contraindication that incomposite immunization; and (B) That the resident expreumococcal immunitation or refut this REQUIREMENT by: Based on staff interview.	either received the influenza of receive the influenza medical contraindications or ease. The facility must procedures to ensure that-pneumococcal esident or the resident's es education regarding the side effects of the effects of	F	334	Criteria 4: MDS coordinator we review results of audits to ED weekly. ED will present results audits to facility QA committed monthly and reviewed for furtintervention or recommendations as necessary. Criteria 5: December 16, 2017	of e her	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		E SURVEY PLETED
		495417	B, WING			11	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET RURAL RETREAT, VA 24368	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 334	failed to ensure that p status was up to date survey sample, Resid Findings included: Facility staff failed to e vaccine for Resident # 10 was ori facility on 2/10/15 with 9/12/15. Diagnoses in dementia, multiple sol disorder, polyneuropa The most recent MDS quarterly assessment reference date) of 10/coded Resident # 10's of 15 indicating moder The clinical record was 2:00 p.m. The signed 10/7/17 had orders the pneumovax 0.5 cc upo years (unless otherwisthe last 5 years)." Upo it was noted that Resid pneumococcal vaccine the physician's order, I pneumococcal vaccine as of 10/13/17. Further record did not reveal a to prevent Resident # pneumococcal vaccine. On 10/31/17 at 2:48 p. with the administrator a nursing) and made the	ensure that the pneumonia # 10 was up to date. ginally admitted to the a readmission date of cluded but not limited to: erosis, major depressive thy, and hyperlipidemia. (minimum data set) was a with an ARD (assessment 13/17. The facility staff is cognitive status as 11 out rate impairment. Is reviewed on 10/31/17 at physician's orders dated at stated "may have on admission and every 5 are indicated or received in on review of the face sheet dent # 10 last received a eron 10/12/12. According to Resident #10's ation status was out of date in review of the clinical ny documented indications 10 from receiving a	F	334			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
		495417	B. WING			11/	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	completely honest I had doing audits on the valual walked in and it got pustated that she would. On 11/2/17 at 8:55 a.m. surveyor that the facilit representative for Resconsent to administer. On 11/7/17 at 3:42 p.m. surveyor that the familit Resident # 10 had give facility would administ vaccine to Resident # No further information reported to the survey conference on 11/2/17 483.60(i)(1)-(3) FOOD STORE/PREPARE/SE (i)(1) - Procure food from considered satisfactory authorities. (i) This may include foo from local producers, sand local laws or reguluit. This provision does facilities from using progardens, subject to consider growing and food-(iii) This provision does facilities from gand food-(iii) This provision does facilities fro	ations. DON stated "to be ad a notebook on my desk accines and then you guys ushed to the side." DON follow up on the situation. In., DON reported to ty was contacting the family sident # 10 to obtain the pneumonia vaccine. In., DON verbally reported to by representative for en consent and that the er the pneumococcal 10. In regarding this issue was team prior to the exit at 5:15 p.m. PROCURE, ERVE - SANITARY In sources approved or by federal, state or local according to the state at to applicable State at the prohibit or prevent aduce grown in facility inpliance with applicable	F	334	F 371 Food Procure, Store/Prepare/Serve - Sanitary Criteria 1: On October 31, 2017, dietary manager discarded all opened and undated food items and hairnets firmly in place. Criteria 2: All residents are at risk by the above mentioned alleged deficient practice. Procedure on proper food storage to include proper labeling and dating will be reviewed by dietary staff.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY OMPLETED
		495417	B. WING				11/02/2017
	PROVIDER OR SUPPLIER	L RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET JRAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	accordance with proservice safety. (i)(3) Have a policy foods brought to resvisitors to ensure sahandling, and consumates and a seed on observation document review, the and date opened ite tray line temperature nets firmly secured thair. The findings include The surveyor toured beginning at 7:46 a. surveyor observed a dated 10/27/17 and dated 10/26/17 in the #3 was asked what discarding food and should discard after reach in refrigerator sour cream dated 10 sour cream should be The surveyor and ot refrigerator. A 5lb caspread was dated 10 pimento cheese was and a 5lb carton of cand dated 10/1/17.	re, distribute and serve food in ofessional standards for food regarding use and storage of sidents by family and other afe and sanitary storage, amption. IT is not met as evidenced ion, staff interview, and facility he facility staff failed to label ems of food, failed to record es and failed to ensure hair loose strands of employee's	F	371	Criteria 3: Dietary manager or designee provided education of staff regarding labeling, storage procedures, tray line temps, as proper fit of hairnets on November 2, 2017. Manager of designee will audit the refrigerators, freezers, and tendogs daily to ensure all food iterare in proper date range and to line temps all complete and accurate with follow up no less than 5 days per week for 8 week. Criteria 4: Dietary manager will review results of audits to ED weekly. ED will present results audits to facility QA committee monthly and reviewed for furthintervention or recommendations necessary. Criteria 5: December 16, 2017	to ge and or mp ms ray seks.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A BUILD		CONSTRUCTION	C. C. C.	E SURVEY PLETED
		495417	B. WING			11	/02/2017
	ROVIDER OR SUPPLIER			51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	shredded iceberg lettu opened. The surveyo shredded lettuce was "wilted". In the walk-in freezer, opened bag of rolls wi The surveyor was joind other #1 for the remain the dry storage area, a observed open to the anywhere on the bag of dietary manager stated and the bag secured with the dry storage area, and the bag secured with the cook. The surveyor and the count that the bag secured to the tray line temperature for the dialogated that the cook. The surveyor informed director of nursing of the an end of the day meet.	the surveyor observed an thout a date. The date of the dietary manager of the kitchen tour. In a box of thickener was air and without a date or box when opened. The date of the box should be labeled when opened. The ditchen, the surveyor wees wearing hairnets do other #4). The hair was be hair net. Each of the ingling from underneath the manager other #1 stated the se a different kind of the increase on recorded oner meal on 10/20/17 and	F	371			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		NSTRUCTION		E SURVEY IPLETED
		495417	B. WING _			11	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL	AL RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Procedures-Continue	± 101 d "Food and Supply Storage d" was reviewed 11/1/17. t "Discard leftovers not	F3	71			
F 425 SS=D	utilized within 48 hourness with conference on 11. 483.45(a)(b)(1) PHARACCURATE PROCED (a) Procedures. A fact pharmaceutical service that assure the accuradispensing, and admit biologicals) to meet the (b) Service Consultative mploy or obtain the sepharmacist who— (1) Provides consultative pharmacy this REQUIREMENT by: Based on observation interview, facility docurecord review, the facility sician ordered medical services on the service of the services of	was provided prior to the /2/17. MACEUTICAL SVC - DURES, RPH illity must provide es (including procedures ate acquiring, receiving, nistering of all drugs and e needs of each resident. on. The facility must bervices of a licensed ion on all aspects of the services in the facility; is not met as evidenced a, Resident interview, staff ment review, and clinical	F4	25	F 425 Pharmaceutical SVC-Accurate Procedures, RPH Criteria 1: RP and physicians we notified for all missed doses. Tylenol had been given to resident #16 on October 31, 20 when Norco was unavailable at was documented. Medications were all obtained prior to exit of November 2, 2017. Criteria 2: A medication availability audit was complete by nursing admin for other residents and no additional issue were noted on November 2, 2017. Criteria 3: DON or designee will educate clinical staff regarding	n17 nd on d	
		ne facility failed to ensure and the narcotic norco iinistration.			medication administration and management by November 30, 2017. DON or designee will aud medication availability daily at least 5 times a week for a minimum of 90 days.	it	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		1 ' '	SURVEY PLETED
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	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY 514 NORTH MAIN STR RURAL RETREAT, V	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 425	The record review reviad been admitted to Diagnoses included, linsomnia, diabetes, chronic kidney disease. There was no compleset) assessment on the Resident was alert and On 11/01/2017 at appropriate and admir morning medications. Residents medications. Residents medication surveyor that they did voltaren cream and slipharmacy. Upon enter Resident #16 verbaliz received her narcotic morning but had been A review of the Resident #16 had 1. Norco 5/325 take 1 daily for pain. 2. Voltaren gel apply the daily. A review of the Reside that on 10/31/2017 at and on 11/01/2017 at staff had documented was not available for a contacted the pharmace.	vealed that Resident #16 the facility 10/20/2017. but were not limited to, ongestive heart failure, and se. Ited MDS (minimum data his Resident. However, the id orientated. In (licensed practical nurse) hister Resident #16's When preparing the s LPN #3 verbalized to the not have the Residents he would need to notify the ring the Residents room ed that she had not pain medication that given tylenol instead. In the properties of the service of the ser	F	review rest weekly. ED present res QA commit reviewed fo or recomme	DON or designee will ults of audits to ED or designee will sults of audits to facilitiee monthly to be or further intervention endation as necessary December 16, 2017	1	

PRINTED: 11/14/2017 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED. A BUILDING B. WING 495417 11/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET** CARRINGTON PLACE AT RURAL RETREAT **RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 425 Continued From page 103 F 425 current order for the voltaren... On 11/01/2017 at approximately 2:40 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that no voltaren had ever been sent to the facility for this Resident and that an order for the Residents voltaren came over the fax machine for the first time today. On 11/01/2017 at approximately 2:50 p.m. the surveyor asked LPN #3 where she had obtained the voltaren previously for Resident #16. LPN #3 verbalized to the surveyor that there was some in the bottom of the medication cart and she guessed they just assumed it belonged to Resident #16. On 11/02/2017 at approximately 8:00 a.m. the surveyor spoke with Resident #16 regarding the voltaren. Resident #16 verbalized to the surveyor that the facility had put some medication on her lower back and shoulders. On 11/01/2017 at approximately 1:35 p.m. the DON (director of nursing) was asked if they had a backup pharmacy. The DON verbalized that there was a local pharmacy they could use. The facility policy/procedure titled "Administering Medications" read in part "... Medications must be administered in accordance with the orders..." The administrative staff were made aware of the issues regarding the Residents narcotic pain medication norco and voltaren during a meeting with the survey team on 11/01/2017 at approximately 4:35 p.m.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
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	ROVIDER OR SUPPLIER	RETREAT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET RURAL RETREAT, VA 24368	1.52	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	provided to the survey conference. 2. The facility staff fai #9 had an antibiotic, I administration. Resident #9 was adm with the diagnoses of, blood pressure, neuro Infection, Alzheimer's disorder and depressi (Minimum Data Set) w Reference Date) of 10 as having a BIMS (Bri Status) score of 15 ou Resident #9 was also assistance of 1 staff m personal hygiene and member for bathing. The surveyor conduct #9's clinical record on review, the surveyor added for 9/28/17 for the girling month of Administratiopharmacy notified st tonight". This medicat administrated on 9/29/was to be administrated On 11/2/17 at approximof nursing was notified findings. The director know why we didn't ha	regarding this issue was a team prior to the exit willed to ensure that Resident invanz, available for itted to the facility on 3/7/17 but not limited to high igenic bladder, Urinary Tract Disease, dementia, anxiety on. On the quarterly MDS with an ARD (Assessment inval)/23/17 coded the resident interview for Mental into a possible score of 15. coded requiring extensive itember for dressing and total dependence of 1 staff items are review of Resident 11/1/17. During this order a physician order ine following: "Invanz 850 iscularly once daily for 5 istso reviewed the resident's inistration Record) for the in Details which stated "	F	425		A	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		DATE SURVEY COMPLETED
		495417	B, WING			11/02/2017
	ROVIDER OR SUPPLIER	RETREAT	51	REET ADDRESS, CITY, STATE, ZIP CODE 4 NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	medication and I wou send all the doses sin No further information surveyor prior to the 6 5:15 pm. 3. The facility staff fail Ativan 0.5 mg give on anxiety) available for at 9:00 pm. Resident #3 was adm 5/30/16. Her diagnose to high blood pressure tract infection, anxiety Resident #3's minimu assessment, with an at (ARD) of 10/5/17 asse and could be understo have as cognitive stat assessment revealed assistance with daily at The physician order san order for: "Ativan 0 (0.25mg) by mouth even Resident #3's electron administration record The eMAR also containing take one half tab (night at bedtime."	Id think the pharmacy would ace it was just for 5 days." In was provided to the exit conference on 11/2/17 at a led to have the medication he half tab 0.25 mg (for administration on 10/11/17 Itted to the facility on easinclude but are not limited ex, hypothyroidism, urinary and Alzheimer's disease. In data set (MDS) assessment reference date eased her to understand and. She was assessed to us of 4 out of 15. Her in section G, she needed activities of living. The et dated 7/1/17 contained activities of living. The et dated 7/1/17 contained activities of living. The incomplete the order: "Ativan 0.5 one of the order: "Ativan	F 425			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED
OMB NO. 0938-0391

PRINTED: 11/14/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 495417 B. WING 11/02/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET **CARRINGTON PLACE AT RURAL RETREAT RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 425 Continued From page 106 F 425 On the administration record the following note was written: 10:28 pm, 10/11/17 (scheduled: 9:00pm, 10/11/17; Ativan 0.5 mg tablet) Ativan 0.5 mg take one half tab (0.25mg tablet) ...scheduled for 10/11/2017 9:00 pm unavailable. MD and pharmacy aware via telephone conversation due to requires code for Cubex." On 11/1/17 at 1:15 pm, the directors of nurses was asked to look at the administration record note for the Ativan that was not available on 10/11/17. After she looked she said, that looks right to me. However, the medication was unavailable for administration on 10/11/17 at 9:00pm, and there was no documentation made by the nurse placing the medication on hold until it was available. During the end of the day meeting on 11/1/17, the administrator and the director of nurses were informed of the medication not being available. No further information was provided by the facility related to the Ativan being unavailable for F 441 Infection Control, Prevent administration. Spread, Linens F 441 F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS SS=D Criteria 1: On November 2, 2017, (a) Infection prevention and control program. LPN #1 was educated by DON regarding hand hygiene and The facility must establish an infection prevention proper infection control practices. and control program (IPCP) that must include, at a minimum, the following elements: On November 1, 2017, LPN #5 was educated by DON regarding (1) A system for preventing, identifying, reporting, infection control during investigating, and controlling infections and

communicable diseases for all residents, staff,

medication pass.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		495417	B, WING			11/	02/2017
	ROVIDER OR SUPPLIER	RETREAT			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	conducted according accepted national statismplementation is Phase (2) Written standards, for the program, which limited to: (i) A system of surveill possible communicable communicable disease facility; (ii) When and to whom communicable disease reported; (iii) Standard and transto be followed to prevent to be followed to prevent including but the communicable disease restrictive possibility circumstances.	and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards (facility assessment ase 2); policies, and procedures in must include, but are not ance designed to identify le diseases or infections dito other persons in the in possible incidents of e or infections should be smission-based precautions ent spread of infections; lation should be used for a not limited to: tion of the isolation, fectious agent or organism the isolation should be the le for the resident under the under which the facility es with a communicable in lesions from direct or their food, if direct	F	441	by the above mentioned alleged deficient practice. Brief education was provided to staff on November 2, 2017 regarding infection control practices and hand hygiene. Criteria 3: DON or designee will provide comprehensive infection control education will be provide to facility staff by November 30, 2017 to include tracking of infections and hand washing. Pharmacy consultant will conduct monthly medication cart/pass audits. Criteria 4: DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facility QA committee monthly to be reviewed for further intervention or recommendation as necessary. Criteria 5: December 16, 2017	on ed et	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING _		11/02/2017	
	ROVIDER OR SUPPLIER TON PLACE AT RURAL F	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 441	Continued From page	108	F 44	41		
	(vi) The hand hygiene by staff involved in dir	procedures to be followed ect resident contact.				
	(4) A system for record under the facility's IPC actions taken by the fa					
	(e) Linens. Personnel process, and transpor spread of infection.	must handle, store, t linens so as to prevent the				
	(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:					
	document review and facility staff failed to fo	residents (Resident #12,				
	The findings included:					
	when going from dirty	ed to perform hand hygiene to a clean area and failed the scissors were used to m Resident #12's calf.				
	record on 10/31/17 and was admitted to the factors	h diagnoses that included retention, urinary tract scular disease, deep		9		
	cerebral infarction, dys hypertension, Vitamin	phagia, hemiplegia, D deficiency, Vitamin B12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED	
		495417	B. WING_		1	1/02/2017	
	PROVIDER OR SUPPLIER	AL RETREAT		STREET ADDRESS, CITY, STATE, ZIP (514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	deficiency, constipand severe sepsis Resident #12's sign data set (MDS) ass reference date (AR resident with short term memory problems cognitive skills for G Functional Status require extensive a mobility and assess impairment on one extremities. The surveyor observation of the surveyor observative and in the surveyor observative and the resident's room announcing the wound treatment cart and the resident's room announcing themse provide wound care. L.P.N. #1 placed a table. The over the prior to the placeme area of treatment w #1 applied gloves. solution on a 4 x 4 a L.P.N. #1 removed of new gloves. The hygiene. L.P.N. #1 dressing. L.P.N. #1 washed her hands. gloves, checked the catheter and remove	ation, chronic pain, pneumonia, with septic shock. Inificant change in minimum sessment with an assessment D) of 10/24/17 assessed the term memory problems, long ems, and severely impaired daily decision making. Section assessed Resident #12 to ssistance of 2 staff for bed sed the resident with an side that involved both Inved wound care on 11/01/17 rensed practical nurse #1 do care and certified nursing ing in the care. L.P.N. #1 had do care supplies from the along with C.N.A. #1 entered without knocking or elves and proceeded to	F				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	heel with Betadine sw removed and hands w pulled her scissors from applied and L.P.N. #1 Resident #12's left can returned to the clean liscissors was observed used. L.P.N. #1 removed a new pair of gloves. Observe L.P.N. #1 per #1 proceeded to clear Dakin's solution and the hand hygiene was observed and kerlix to the lecarried soiled dressing on the treatment cart liplaced the uncleaned. The surveyor requested dressing changes from 11/1/17. The surveyor interview nursing on 11/2/17 at 8 interview, the ADON with scissors be cleaned. They were used and after procedure had been recare nurse previously, asked when should on stated after glove removed. The surveyor interview 9:30 a.m. about the word 11/1/17. L.P.N. #1 states.	eaned Resident #12's left rabs three times. Gloves were washed. L.P.N. #1 on her pocket. Gloves cut the bandage from lf. The scissors were carrier. No cleaning of the d before or after they were wed her gloves and applied The surveyor did not form hand hygiene. L.P.N. on the area on the calf with onen removed gloves. No served. L.P.N. #1 donned a d applied xeroform gauze, 4 off calf wound. L.P.N. #1 gs to the trash can located ocated in the hall and scissors in the cart. and the facility policy on on the director of nursing on wed the assistant director of left as asked when should The ADON stated before ter. The ADON stated the leviewed with the wound The ADON was also le wash hands. The ADON loval. left L.P.N. #1 on 11/2/17 at loval care observation on left she thought she had	F	141			
	washed her hands after	er she had removed her					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING		11	/02/2017	
	ROVIDER OR SUPPLIER	RETREAT	514	REET ADDRESS, CITY, STATE, ZIP CODE I NORTH MAIN STREET IRAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 441	scissors but she didn' The surveyor reviewe "Dressing, Dry/Clean' read in part "Steps in clean gloves. Loosen dressing. 7. Pull glov into plastic or biohaza hands thoroughly. 13 The surveyor informed the above concern du care observation in th 11/2/17 at 12:18 p.m. No further information exit conference on 11/2. For Resident #18, t perform any hand hyg hands to wipe her nos administering insulin. The record review rev had been admitted to Diagnoses included, b diabetes, bipolar disor hypothyroidism. Section C (cognitive popuraterly MDS (minimous) with an ARD (assessmon) 09/05/2017 included a mental status) summa possible 15 points. On 11/01/2017 at appre	d the facility policy titled on 11/2/17. The policy the Procedure 6. Put on tape and remove soiled we over dressing and discard and bag. 8. Wash and dry b. Put on clean gloves." d the administrative staff of ring Resident #12's wound e end of the day meeting on was provided prior to the /2/17. he facility staff failed to itene after using her bare with a tissue and before ealed that Resident #18 the facility 08/15/2015. but were not limited to, ider, hypertension, and atterns) of the Residents um data set) assessment itent reference date) of BIMS (brief interview for rry score of 15 out of a	F 441				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A, BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495417	B. WING		11/02/2017	
NAME OF PROVIDER OR SUPPLIER CARRINGTON PLACE AT RURAL RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
tissue to wipe her nose. LPN #5 was observed by the surveyors to throw the tissue she had used to wipe her nose in the trash bin on the medication cart. Without performing any hand hygiene LPN #5 began preparing Resident #18's insulin for administration. After preparing the insulin LPN #5 applied a pair of gloves and entered the Residents room and administered the Residents insulin into the Residents abdomen. After administering the insulin LPN #5 removed her gloves and washed her hands. After exiting the Residents room, the surveyor asked LPN #5 about wiping her nose and the lack of any hand hygiene. LPN #5 verbalized to the surveyors that she didn't realize she had wiped her nose. The facility policy titled "Administering Medications" read in part " Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable" Per the CDC (centers for disease control) website accessed 11/03/2017. https://www.cdc.gov/handhygiene/download/hand _hygiene_core.pdf "Healthcare workers should wash hands with soap and water when hands are visibly dirty, contaminated or soiled and use an alcohol-based handrub when hands are not visibly soiled to reduce bacterial counts. Hand hygiene is indicated before: patient contact, donning gloves" On 11/02/2017 at approximately 7:55 a.m. the surveyor interviewed the designated infection	F 44'			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	completed any hand hands and before prepinsulin the ADON replination to the administrative tear infection control issue Resident #18 during a team on 11/01/2017 and No further information provided to the survey conference. 3. Facility staff failed the guidelines for clostridination #17. Resident #17 was origon 5/20/17 with a react Diagnoses included by the heart failure, enterocodifficite, and hypokaler (minimum data set) was with an ARD of (assess 10/13/17. It is docume a cognitive score of 12 moderate cognitive im On 11/1/17 at 8:57 a.m. 2 was administering matter preparing the mether hands and donned Resident #17's room a medications to Resident.	assistant director of I if LPN #5 should have hygiene after wiping her aring and administering ied Yes, she should have am were made aware of the regarding LPN #5 and meeting with the survey t approximately 4:35 p.m. regarding this issue was t team prior to the exit of follow infection control um difficile for Resident dinally admitted to the facility lmission date of 8/23/17. ut not limited to: dysphagia, litis due to clostridium mia. The most recent MDS as a quarterly assessment sment reference date) of nted that Resident # 17 has cout of 15 indicating pairment. n., RN (registered nurse) # edications to Resident #17 dication RN # 2 sanitized gloves and entered	F	441			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING		11/02/20	017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) MPLETION DATE
F 502 SS=E	isolation cart that was 17's room and there we the cart. On 11/1/17 at 9:30 a.r. RN#2. Surveyor asked wear an isolation gow 17's room? RN # 2 start Resident #17 has on a (clostridium difficile) we washes their hands be Resident #17 they did RN# 2stated "She (Reactivities and everythin On 11/1/17 at 2:48 p.m. nursing) and administrative above findings. Per the Clostridium difficile (i.e., residents with dia difficile (i.e., residents symptomatic) will be percautions. Healthcar wear gloves and gown of a resident with C. di No further information presented to the surve conference on 11/2/17 483.50(a)(1) ADMINIS	m., surveyor checked the placed outside Resident # were no isolation gowns in m., surveyor spoke with and RN# 2 why she did not in when entering Resident # ated that she was told that a brief and that the c difference and after contact with in the need to gown and glove. It is ident #17) comes out to ing." In., DON (director of rator were made aware of it is ficile facility policy which it is facility standard of precautions it states under arrhea associated with C. who are colonized and laced on Contact re workers and visitors will so when entering the room fficile infection." Tegarding this issue was y team prior to the exit at 5:15 p.m. TRATION	F 44	F 502 Administration Criteria 1: Resident #2 order obtained on November 1, 2017 for BMP to be obtained on next		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED			
		495417	B, WING		11/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL SUMMARY ST.	RETREAT ATEMENT OF DEFICIENCIES	10	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368 PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 502	services to meet the refacility is responsible of the services. This REQUIREMENT by: Based on staff intervices, the facility state ordered lab tests for 4 #2, #4, #23, and #11. The findings included. 1. For Resident #2, the obtain a BMP (basic or the facility state) and the facility state ordered lab tests for 4 #2, #4, #23, and #11. The findings included. 1. For Resident #2, the obtain a BMP (basic or the facility of the f	needs of its residents. The for the quality and timeliness is not met as evidenced ew and clinical record ff failed to obtain physician of 25 Residents, Residents e facility staff failed to netabolic panel) lab test. ealed that Resident #2 had facility 01/04/2017. but were not limited to, gestive heart failure, and tatus) of the Residents status MDS (minimum data an ARD (assessment 05/2017 included a BIMS natal status) summary score 15 points. luded a physicians 07/14/2017 for a BMP to inical record the surveyor results for this BMP.	F 50	Criteria 2: Labs to be drawn on November 1, 2017 were review and audited by nursing admin to ensure completion, documentation, and results obtained from lab. Criteria 3: DON or designee will educate licensed clinical staff regarding obtaining ordered lab and reporting results to provide by November 30, 2017. DON or designee will utilize a daily lab book audit tool to include results status and reporting compliance for a minimum of 90 days. Criteria 4: DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facil QA committee monthly to be reviewed for further intervention or recommendation as necessar. Criteria 5: December 16, 2017	red o os er t e

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/02/2017	
	ROVIDER OR SUPPLIER	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
F 502	On 11/01/2017 at app DON (director of nurs team that they had not team that they had not team on 11/01/2017 at	roximately 1:20 p.m. the ing) verbalized to the survey of obtained the BMP. If were notified of the meeting with the survey of approximately 4:35 p.m. regarding the missing BMP urvey team prior to the exit e facility failed to obtain the pratory tests CBC (complete comprehensive metabolic poid stimulating hormone). ealed that Resident #4 had acility 02/04/2016. But were not limited to, oral disturbances, liabetes, hypertension, and atterns) of the Residents are data set) assessment ment reference date) of 1/1/3 to indicate the swith long and short term arely impaired in cognitive making. ecord included a proder dated 07/03/2017 for it to be obtained.	F	502			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495417	B. WING_	_		11	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		5	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 502	the missing lab tests of approximately 9:55 a. During a meeting with 11/02/2017 at approxiverbalized to the survey unable to find any resident was provided to exit conference. 3. The facility staff failevel and a Vitamin Barrell The clinical record of 11/2/17. Resident #23/8/14/17 with diagnose limited to hypokalemia fibrillation, pleural effur hypertension, unspecibehavioral disturbance anemia, acute kidney disease, and dysphag Resident #23's admiss (MDS) assessment with reference date (ARD) resident with a BIMS (status) as 09 out of 15. The clinical record condated 9/21/17 that real Vitamin D & B12 level Vitamin D & B12 level Vitamin D & B12 level	nursing) was asked about on 11/01/2017 at m. the administrative team on mately 4:35 p.m. the DON ey team that the lab was ults for these lab tests. regarding the missing lab the survey team prior to the led to obtain a Vitamin D led level for Resident #23. Resident #23 was reviewed was admitted to the facility is that included but not a unspecified atrial sion, hyperlipidemia, fied dementia without es, adult failure to thrive, failure, chronic kidney is. sion minimum data set the an assessment of 8/20/17 assessed the brief interview for mental trained a telephone order d "1. D/C (discontinue) ordered for 9/20/17. 2. on 9/26/17."	F	502			
1		tamin B12 level completed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B, WING_	· · · · · · · · · · · · · · · · · · ·		11/	02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CO 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE
	on 9/26/17. The surveyor informer there were no results the Vitamin B12 level clinical record on 11/2 The director of nursing 11/2/17 at 10:30 a.m. the Vitamin B12 level been obtained. The surveyor informer the above concern du 12:18 p.m. No further information exit conference on 11/4. For Resident #11 the obtain physician order (Thyroid Stimulating Hesident #11 was adm 3/3/16 and readmitted diagnoses include but blood pressure, urinar depression, chronic part of the provided on the most in (MDS) with an assessing 8/09/17, the facility state understand and usually a 12 for his cognitive so on 7/27/17, a review of record revealed that the	d the director of nursing that for the Vitamin D level and ordered for 9/26/17 in the 1/17 at 10:00 a.m. g informed the surveyor that the Vitamin D level and ordered for 9/26/17 had not d the administrative staff of ring a meeting on 11/2/17 at was provided prior to the 1/2/17. The facility staff failed to red laboratory test, TSH formone). Initted to the facility on on 6/2/17. Resident #11's are not limited to: elevated by retention, thyroid disorder, ain, and anemia. In the scinical record recent minimum data set ment reference date of ff assessed the resident to by to be understood and as tatus. If Resident #11's clinical record rest, TSH on 9/5/17 to be	F	502			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495417	B, WING			11	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL SUMMARY ST.	RETREAT ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368 ID PROVIDER'S PLAN OF CORRE			(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 504 SS=D	and hard chart for the completion. However, in the record. On 11/1 of nurses was asked to After looking she state have one for that date. On 11/1/17 at approximeeting with the adminurses, the missing late. Prior to exit no further to the surveyor related obtained. 483.50(a)(2)(i) LAB S'ORDERED BY PHYS (a) Laboratory Services (2) The facility must- (i) Provide or obtain late ordered by a physiciar practitioner or clinical accordance with State	11's electronic clinical record results of the lab tests the results were not found /17 at 1:15 pm, the directors to assist in locating the labs. ed to the surveyor, "didn't e (9/7/17) I can't fix that". imately 5:25 pm, during a inistrator and the director of b results were discussed. Information was provided to the lab that was not were discussed. VCS ONLY WHEN ICIAN Es boratory services only when a; physician assistant; nurse		502	F 504 Lab SVCS Only When Ordered by Physician Criteria 1: Physician notification were completed on both residents #5 and #23. Criteria 2: Labs to be drawn on November 1, 2017 were review and audited by nursing admin to ensure completion, documentation, and results obtained from lab. Criteria 3: DON or designee will	red o	
	by: Based on staff interview review, the facility staff order prior to obtaining	is not met as evidenced ew and clinical record f failed to obtain a physician g a laboratory test for 2 of vey sample (Resident #5			educate licensed clinical staff regarding obtaining ordered lab and reporting results to provide by November 30, 2017. DON or designee will utilize a daily lab book audit tool to include resul status and reporting compliance for a minimum of 90 days.	er	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495417	B. WING		1	1/02/2017
CARRING	FROVIDER OR SUPPLIER STON PLACE AT RURAL I		- 10	STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	1. The facility staff order prior to obtaining Resident #5. Resident #5 was admixing the following diaganemia, high blood prodepression, end stage stenosis and low back MDS (Minimum Data & (Assessment Referencesident was coded as Interview for Mental Stages for the following at the following was noted by the surveyor conducter #5's clinical record on was noted by the surveyor a K+ level drawn on 9/that on a laboratory resident on a laboratory resident of the director of nursing above documented find 11/1/17 at 9:10 am. The and check the logs and At 4:35 pm, the adminisof the above document surveyor. The DON prophysician order dated following: "D/C K+ order following: "D/C K+ order the surveyor of the director of dated following: "D/C K+ order following: "D/C K	failed to obtain a physician g a laboratory test for litted to the facility on 2/1/17 noses of, but not limited to essure, anxiety disorder, renal disease, spinal pain. On the quarterly Set) with an ARD ce Date) of 9/8/17, the having a BIMS (Brief latus) score of 13 out of a Resident #5 was also ensive assistance of 1 staff and personal hygiene and staff member for bathing. Let a review of Resident 10/31/17 and 11/1/17. It eyor that on 9/19/17 the "K+ (Potassium) lab in 2 ould not find the results for 21/17. Instead it was noted sult of a K+ level dated as 1/17. (DON) was notified of the dings by the surveyor on the DON stated "Let me go it call the lab." Strative team was notified ed findings by the ovided a copy of a for 11/1/17 which stated the er to be drawn on 10/21 curveyor was also provided	F	Criteria 4: DON or des review results of audit weekly. ED or designed present results of audit QA committee monthly reviewed for further in or recommendation as Criteria 5: December 1	s to ED e will ts to facility y to be tervention necessary.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11.	/02/2017
	ROVIDER OR SUPPLIER	RETREAT	•	514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	11/1/17 at 10:03 am w (name of doctor) drawn on 10/21 was d (medical doctor) K+ di sufficient. Order to do draw K 10/24 received No further information surveyor prior to the e 2. The facility staff ob blood count) and a BN on 8/22/17 prior to obt The clinical record of F 11/2/17. Resident #23 8/14/17 with diagnoses limited to hypokalemia fibrillation, pleural effus hypertension, unspecif behavioral disturbance anemia, acute kidney f disease, and dysphagi Resident #23's admiss (MDS) assessment wit reference date (ARD) or resident with a BIMS (It status) as 09 out of 15. The laboratory section contained the results o 8/22/17. The surveyor was unab order for the BMP and	which stated "spoke with Dr. ") reported that K level to be lawn on 10/24. Per MD rawn on 10/24 was a (discontinue)10/21 lab and d. (sic)" was provided to the exit conference on 11/2/17. Italianed a CBC (complete MP (basic metabolic panel) aining the physician order. Resident #23 was reviewed a was admitted to the facility is that included but not a unspecified atrial sion, hyperlipidemia, fied dementia without is, adult failure to thrive, failure, chronic kidney a. Join minimum data set than assessment of 8/20/17 assessed the prief interview for mental in the set of the se	F	504			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495417	B. WING			11/02/2017	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
	could not be located in 11/2/17 at 10:00 a.m. The director of nursing 11/2/17 at 10:30 a.m. obtained on 8/22/17 worder. The surveyor informed the above concern du 12:18 p.m. No further information exit conference on 11/483.50(a)(2)(iv) LAB FLAB NAME/ADDRESS (a) Laboratory Services (2) The facility musticity File in the resident reports that are dated address of the testing This REQUIREMENT by: Based on staff interview, and clinical registed to ensure physic results were in the clin residents (Resident #1) The findings included:	in the clinical record on g informed the surveyor that the CBC and BMP was done without a physician of the administrative staff of ring a meeting on 11/2/17 at was provided prior to the 2/17. REPORTS IN RECORD - S s g clinical record laboratory and contain the name and laboratory. is not met as evidenced ew, facility document ford review, the facility staff fian ordered laboratory ical record for 1 of 25 d).		F 507 Lab Reports in Reconame/Address Criteria 1: Results were of from laboratory on Nove 2017 for Resident #14 and reviewed by physician with new orders obtained. Criteria 2: Labs to be drawn November 1, 2017 were on by nursing admin to ensure completion, documentating results obtained from lab. Criteria 3: DON or designed educate licensed clinical some regarding obtaining order and reporting results to pure by November 30, 2017. Documentation designee will utilize a daily book audit tool to include status and reporting compfor a minimum of 90 days.	obtained ember 1, ed was eith no wn on reviewed re on, and taff eed labs rovider ON or y lab result oliance		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION		ATE SURVEY DMPLETED
		495417	B. WING				11/02/2017
	ROVIDER OR SUPPLIER	RETREAT		514	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET RAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	record 10/31/17 and admitted to the facility included but not limited quadriplegic cerebral psychosis, hyperlipide B deficiency, Vitamin constipation, knee consteoarthritis. Resident #14's quarted set) assessment with date (ARD) of 11/2/17 a BIMS (brief interview out of 15. An order dated 1/13/17 panel), CMP (compreted TSH (thyroid stimulating level next Tuesday-? HTN (hypertension), so The surveyor reviewee the results of the orded were there except the "Laboratory Report" of "Ordered: PHENO Pelaboratory report had registered nurse #4 w 1-19-17." The surveyor reviewee laboratory section and results of the phenobal the end of the day mental the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the day mental the surveyor informed the end of the surveyor infor	ed Resident #14's clinical 11/1/17. Resident #14 was y 1/10/17 with diagnoses that ed to epilepsy, spastic palsy, unspecified emia, anxiety, gout, Vitamin D deficiency, edema, ntracture, and unspecified erly MDS (minimum data an assessment reference assessed the resident with w for mental status) of 13 7 read "FLP (fasting lipid hensive metabolic panel), ng hormone), phenobarbital (Increased) cholesterol, seizures." d the laboratory section for ared laboratory tests. All phenobarbital level. The ated 1/18/17 1145 read ending: PHENO." The been initialed and dated by ith the notation "Received d each page of the l was unable to locate the	F	507	Criteria 4: DON or designee we review results of audits to ED weekly. ED or designee will present results of audits to fact QA committee monthly to be reviewed for further intervent or recommendation as necess. Criteria 5: December 16, 2017	cility ion ary.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(MOSS 400	TE SURVEY MPLETED
		495417	B. WING			1	1/02/2017
	ROVIDER OR SUPPLIER	RETREAT		514 1	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET PLAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	JLD BE	(X5) COMPLETION DATE
F 514 SS=D	1/18/17. The DON we were located. The DOI the lab for the results. (medical doctor) had it stated she would inform was within normal limit. The facility policy titled Documentation" was in part "1. All observated administered, services documented in the result to ofference on 11/483.70(i)(1)(5) RES RECORDS-COMPLETE. (i) Medical records. (1) In accordance with standards and practice maintain medical recordare- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically organics.)	arbital level obtained on as asked where the results DN stated the staff called When asked if the MD open notified, the DON on the MD. "The lab result its-a 15 I believe." Id "Charting and reviewed. The policy read open resident's clinical records." was provided prior to the 1/2/17. TE/ACCURATE/ACCESSIB If accepted professional es, the facility must reds on each resident that Inted; If and anized I must contain- In to identify the resident;			F 514 Res Records - Complete/Accurate/Accessible Criteria 1: Facility staff was unable to provide any additional information for alleged deficient practice. Criteria 2: Nursing staff educate on implementation and documentation of bowel protocol. Nursing admin or designee monitoring BM report daily since November 2, 2017 to ensure completion and effectiveness of interventions.	t ed	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		LE CONSTRUCTION		DATE SURVEY COMPLETED
		495417	B. WING				44/02/2047
NAME OF P	ROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE		11/02/2017
					514 NORTH MAIN STREET		
CARRING	TON PLACE AT RURAL F	RETREAT		1	RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) Criteria 3: DON or designee of the control of the contro	LD BE PRIATE	(X5) COMPLETION DATE
F 514	Continued From page	125	F	51	provide education by Novem		
	' '	ve plan of care and services			regarding documentation to		
	provided;				ensure an accurate clinical re		
	(iv) The results of any	preadmission screening			DON or designee will provide		
	and resident review ev	-			education to nursing staff by		1
	determinations conduc	cted by the State;			November 30, 2017 in regard	to	
	(v) Physician's, nurse'	s and other licensed			importance of CNA		
	professional's progres				documentation of bowel		
					movements, nurse monitorir	g of	
		ogy and other diagnostic			BM reports, and process of		
	services reports as rec	quired under §483.50. is not met as evidenced			utilizing bowel protocol from		
	by:	is not met as evidenced			physician standing orders. Do	N or	
	•	ı, staff interview, facility			designee will provide educat	on	
		clinical record review, the			by November 30, 2017 to nu		
	facility staff failed to en accurate clinical record				staff on the eight rights of		
	******	nt #13, and Resident #6).			medication administration, o	rder	
		,			clarification, and physician		
	The findings included:				notification. DON or designed	will	
	1. The facility staff faile	ed to document the			monitor BM reports to identi	fy	
	administration of MOM				residents for whom intervent	ions	
1	Resident #14 on the O				may need to be initiated and		
	medication administrat	ion records (eMARs)			document follow-up has bee	1	1
	The surveyor reviewed	Resident #14's clínical			completed daily. DON or des		
	-	1/1/17. Resident #14 was			will then verify that the resid	_	į
		1/10/17 with diagnoses that			no longer being identified on		
	included but not limited						
	quadriplegic cerebral p	nia, anxiety, gout, Vitamin			report. Supervisor will review		
	B deficiency, Vitamin D				order entry on new orders		
		tracture, and unspecified			followed by the ADON/DON		
1	osteoarthritis.				review of orders, corrections		
	D14-4444	In MDC (maining up -1-4-			be documented daily. Audits	will	
	Resident #14's quarter	ly MDS (minimum data			be conducted for 30 days.		8

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		SURVEY PLETED
		495417	B, WING			110	/02/2017
	ROVIDER OR SUPPLIER	RETREAT		5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	set) assessment with date (ARD) of 11/2/17 a BIMS (brief interview out of 15. A review of the Octobe movements) Details R 11/1/7. The detailed r movement documente 10/3/17 through 10/8/no documentation of a 10/29/17 -a total of 4 of The surveyor reviewed There was no docume interventions had been and 10/8/17 or from 10 on the October 2017 of The director of nursing no evidence interventiin Resident #14's 6 days movement in October the "No BM Report." Treviewed. Next to Reswas written that it was MOM given on 10/29/17 medication MOM was 2017 eMAR. When as charted on the eMAR, "pleaded the 5th."	an assessment reference assessed the resident with v for mental status) of 13 er 2017 BM (bowel oster was completed eport did not have a bowel of for Resident #14 from 17 for a total of 6 days and 18 BM from 10/26/17 through days. If the October 2017 eMAR. Intation that any 10 offered between 10/3/17 0/26/17 through 10/29/17 MAR. If was informed there was ons had been done for and 4 days without a bowel 2017. The DON provided the "No BM Report" was ident #14's name, MOM given at 0600 10/7/17 and 7. However, the not charted on the October ked if the MOM should be the DON stated she	F	514	Criteria 4: DON or designee will review results of audits to ED weekly. ED or designee will present results of audits to facilit QA committee monthly to be reviewed for further intervention or recommendation as necessar. Criteria 5: December 16, 2017	n	
	read in part "20. As re medication, the individed medication will record in record: a. The date ar	wed 11/2/17. The policy quired or indicated for a			·		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		495417	B, WING			11,	/02/2017
	ROVIDER OR SUPPLIER TON PLACE AT RURAL I	RETREAT		514	REET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET URAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	exit conference on 11.2. The facility staff fai and accurate clinical representation of the control of the cont	was provided prior to the /2/17. led to maintain a complete ecord for Resident #13. mitted to the facility on ving diagnoses of, but not Disease, high blood Disease, heart failure, s. On the quarterly MDS vith an ARD (Assessment v/10/17, the resident was MS (Brief Interview for of 3 out of a possible score lso was coded as requiring member for dressing and being totally dependent on hing. Is reviewed by the surveyor The MAR (Medication) for the month of October, ed by the surveyor. On the 6:45 am, the staff or presents the staff noted to behaviors during that viewed the nurses' notes imentation of behaviors time. Under 10/6/17 at noted the staff documented the resident did not exhibit shift. The surveyor noted tation in the nurses' notes nich stated "has been	F	514			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A BUILDING			(X3) DATE SURVEY COMPLETED		
		495417	B, WING		1	1/02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP CO 514 NORTH MAIN STREET RURAL RETREAT, VA 24368		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	2:30 pm in the conferce The surveyor showed documentation on the notes for the above dodirector of nursing state staff did not accurately nurses' notes or on the No further information surveyor prior to the estate prior to the estate prior medication for Resident # 6 was originally staff failed to pain medication for Resident # 6 was originally staff failed by diastolic congestive heronic kidney disease hypertension. The modata set) assessment with an ARD (assessment with an ARD (assessment with an ARD (assessment)/13/17. Facility staff cognitive status was secognitive score of 6 outliness of the clinical record for on 10/31/17 at 9:30 a.recent MDS with an ARd documented by the fact that Resident #6 was a pressure ulcers. Sectic documented that Resident staff documented pressured and applications of	on 11/2/17 at approximately ence room by the surveyor. The director of nursing the MAR and in the nurses' ates and times. The ted "In these examples, the y document either in the e MAR for these dates". was provided to the exit conference on 11/2/17 at a paper appropriately document esident # 6. In ally admitted to the facility emission date of 12/15/16. In and limited to: chronic eart failure, hypothyroidism, as stage 3, and est recent MDS (minimum was quarterly assessment ent reference date) of documented Resident # 6's everely impaired with a let of 15. Resident #6 was reviewed extended the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of the most RD of 10/13/17 it was still the stage of 1	F	514		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3	(X3) DATE SURVEY COMPLETED			
		495417	B, WING			11/0	02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE, ZIP COD 514 NORTH MAIN STREET RURAL RETREAT, VA 24368	Æ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE		(X5) COMPLETION DATE
	On 11/1/17 at 11:13 a observed lying in her On 11/1/17 at 11:15 a nurse) #1 was prepar Resident #6's buttock "she usually gets Gre and waiting on it to consider the construction of the	.m. Resident # 6 was bed flat on her back. .m. LPN (licensed practical ing to provide treatment to s. LPN #1 tells surveyor er's goo but we are out of it ime from the pharmacy in norder to use house barrier n." LPN #1 stated she gets ociated skin damage) a lot compliant with turning. #1 if Resident # 6 was able to stated "no." .m. treatment nurse certified nursing assistant) eatment to Resident # 6's # 1 touched Resident # 6 on to ther in turning Resident # 6 CNA #1 along with LPN #1	F	514			

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495417	B. WING			1/02/2017
	ROVIDER OR SUPPLIER	RETREAT		STREET ADDRESS, CITY, STATE 514 NORTH MAIN STREET RURAL RETREAT, VA 2436	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 514	hurts" during the apple Facility staff did not stage provide interventions. assisted Resident #6 and a pillow was place back. On 11/1/17 at 11:25 at EMAR (electronic merecord) to assess if Repremedicated prior to documentation was not resident #6 had been to her buttocks. Surve asked if Resident #6 pain. LPN #4 stated "I Surveyor told LPN# the documentation of pair on 11/1/17. LPN#4 stated I gave it to her around she would show surve medication. Upon revino documentation that administered to Reside to see documentation on the controlled substance is count listed at 11. Upo mg in the lock narcotic count was 10 tablets. Controlled substance is controlled substance stages and assessment and tablets.	top at any time during the Resident # 6 for pain or LPN #1 and CNA # 1 with turning to her left side ed on the right side of her .m. surveyor reviewed the dication administration esident # 6 had been care to her buttocks. No oted to support that a premedicated prior to care eyor spoke with LPN # 4 and could have something." Into the did not see any a medications being given atted "I know I gave it to her, 10:00." LPN# 4 stated that eyor where she gave the ew of the EMAR there was to pain medication had been ent #6. Surveyor requested of the med administration trance log. Surveyor did substance log for to 5-325 mg give one by as needed for pain had the on counting the Lortab 5-325 of drawer for Resident #6 the LPN# 4 signed the sign out log at that time in I tab was administered to a.m.	F	514		

NAME OF PROMDER OR SUPPLIER CARRINGTON PLACE AT RURAL RETREAT DAY 10 PRETTY 1M3 F 514 Continued From page 131 reviewed and it is documented that Resident #6 received Lords h 52.5 fing at 11.47 a.m. Per the facility policy for administering medication which according to the DON is also the facility standard of practice, it is documented as number 2.0. *As required or indicated for medication, the individual administering the medication was administered, 1. Any results achieved and when those results were observed, and 3. The signature and title of the person administering, consultant nurse, regional MDS consultant, and regional operations manager were made aware of the above findings. No further information regarding the above findings was presented to the survey team prior to the exit conference on 11/2/17 at 5:15 p.m.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		E SURVEY PLETED
CARRINGTON PLACE AT RURAL RETREAT SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGARD REFLICATORY OR LSC IDENTIFYING INFORMATION) F514 Continued From page 131 reviewed and it is documented that Resident #6 received Lortab 5-325 mg at 11:47 a.m. Per the facility policy for administering medication which according to the DON is also the facility standard of practice, it is documented as number 20. "As required or indicated for medication, the individual administering the medication will record in resident's medical record: a. The date and time the medication was administered; b. The lossage; c. The route of administration; d. The injection site (if applicable) e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. On 11//1/17 at 2:48 p.m. DON (director of nursing), consultant nurse, regional MDS consultant, and regional operations manager were made aware of the above findings. No further information regarding the above findings was presented to the survey team prior			495417	B, WING			11	/02/2017
PREFIX TAG (EACH DEFICIENT MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 131 reviewed and it is documented that Resident #6 received Lortab 5-325 mg at 11:47 a.m. Per the facility policy for administering medication which according to the DON is also the facility standard of practice, it is documented as number 20. "As required or indicated for medication, the individual administering the medication, the individual administering the medication will record in resident's medical record: a. The date and time the medication was administered. b. The dosage; c. The route of administration; d. The injection site (if applicable) e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. On 11/1/17 at 2:48 p.m. DON (director of nursing), consultant nurse, regional MDS consultant, and regional operations manager were made aware of the above findings. No further information regarding the above findings was presented to the survey team prior			RETREAT		5	14 NORTH MAIN STREET		
reviewed and it is documented that Resident #6 received Lortab 5-325 mg at 11:47 a.m. Per the facility policy for administering medication which according to the DON is also the facility standard of practice, it is documented as number 20. "As required or indicated for medication, the individual administering the medication will record in resident's medical record: a. The date and time the medication was administered. b. The dosage; c. The route of administration; d. The injection site (if applicable) e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. On 11/1/17 at 2:48 p.m. DON (director of nursing), Administrator, ADON (assistant director of nursing), consultant nurse, regional MDS consultant, and regional operations manager were made aware of the above findings. No further information regarding the above findings was presented to the survey team prior	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
		reviewed and it is door received Lortab 5-325 Per the facility policy of which according to the standard of practice, it 20. "As required or incindividual administering in resident's medical ma. The date and time administered. b. The dosage; c. The route of administered. b. The injection site e. Any complaints or drug was administered. f. Any results achieve were observed; and g. The signature and administering the drug. On 11/1/17 at 2:48 p.m. nursing), Administrator of nursing), consultant consultant, and regions were made aware of the No further information findings was presented.	umented that Resident #6 mg at 11:47 a.m. for administering medication a DON is also the facility t is documented as number dicated for medication, the ig the medication will record ecord: the medication was inistration; (if applicable) r symptoms for which the d; ved and when those results If title of the person . in. DON (director of r, ADON (assistant director nurse, regional MDS al operations manager the above at to the survey team prior	F	514			