DEPARTI CENTER	MENT OF HEALTH S FOR MEDICARE	AND HUMA/ ERVICES		_ <u>-</u> _		FORM OMB NO	: 03/16/2017 APPROVED : 0938-0391
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COM	E SURVEY MPLETED
		495299	B. WING			- 1	/09/2017
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABE ⁻	TH ADAM CRUMP H	EALTH AND REHAB) MOUNTAIN ROAD EN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F (000			•
F160 SS=D	standard survey wa 3/9/17. Complaints surveyCorrection with 42 CFR Part 4 requirements. The census in this 167 at the time of 1 consisted of 24 cc (Residents 1 throu closed record revie 483.10(f)(10)(v) CFUNDS UPON DE (v) Conveyance up death. Upon the discharg resident with a per facility, the facility resident's funds, a funds, to the residindividual or probaresident's estate, This REQUIREMED by:	pon discharge, eviction, or ge, eviction, or death of a resonal fund deposited with the must convey within 30 days the and a final accounting of those ent, or in the case of death, the ate jurisdiction administering the in accordance with State law.		160	The statements made on this plan of correction are not as admission to and do not constitute an agreement with the alleged deficiencies here. To remain in compliance with all federal and state regulations, the center has taken or is planning to take actions set forth in the following plan of corrections. The following plan of corrections the center's allegation of compliance. A alleged deficiencies cited here or are to be corrected the date or dates indicated.	th ein. th the n. ction All nave d by	
	review, and clinical determined that far funds upon death survey sample, Ro For Resident #25, funds within thirty	terview, facility document al record review, it was acility staff failed to convey for one of 29 residents in the esident #25. I facility staff failed to convey days after her death on k was written to her family on	,		RECEIVE MAR 3 0 201 VDH/OL	7	

LAB ORATORY DIRECTOR'S OR PROVIDER/SUPPLIED REPRESENT 7-20-17 12minisman Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 day's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

Facility ID: VAD083

(X6) DATE

DEPARTMENT OF HEALTH AND HU! J.SERVICES

PRINTED: 03/17/2017

		ININD HOL I SEIVICES		(FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		<u> </u>	OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495299	B. WING _		03/09/2017
NAME OF I	PRO VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
ELIZADE	THE ADAM COURD HE	EALTH AND DELLAD		3600 MOUNTAIN ROAD	
CLIZADE	TH ADAM CRUMP H	EACITI AND RETIAD		GLEN ALLEN, VA 23060	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
F 160	Continued From pa	ge 1	F 16	60 F160	
	The findings include:			1. A check was written to	the
	Resident #25 was a	idmitted to the facility on		responsible party on 3/8/	17.
		ses that included but were not			
tale of Philosophical Communication and published	limited to dementia		alau-ramanan lebeggi akal san malau-ra-	2. Any resident who has a	
		c pain, high blood pressure,		resident trust account has	
		rosis, major depressive		potential of being affecte	d.
		alized anxiety disorder. t recent MDS (minimum data		3. A resident trust review	Was
		facility assessment with an		conducted to verify that t	
	ARD (assessment reference date) of 12/28/16.			balances were closed with	
	O= 2/0/47 =t =====	imatah 10.00 a sa Daribah			
		imately 10:00 a.m., Resident unt fund was requested from		thirty days. The business	
	the DON (Director o			manager was re-educated	
		member) #2. The business		the policy regarding closic	ng
	office manager coul	d not be found in her office.		resident trust accounts.	4
	On 2/9/17 at 5:20 n	m at the and of day mastine		4. The Administrator will me	eet
		m. at the end of day meeting, lent account fund was		with the business office	
		cond time from the DON,		manager weekly to ensure t	that
	ASM #2 and ASM #			discharge resident trust	
		.		accounts are closed within	
		m., Resident #25's resident quested by OSM (other staff		thirty days. Results of the	
		siness office manager. OSM		weekly meeting will be	
		at information to (Name of		reviewed at the monthly Q	API
	Administrator). I jus	t closed her account		meeting for three months t	
		oversight because we		ensure compliance.	
	twice and then re-op	. All accounts were closed ened. I feel terrible about it. d apologized and told them I		5. Compliance Date: 4/7/1	7
		the mail." When asked the			

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after death."

appropriate time frame to convey funds, OSM #8 stated, "It is supposed to be within thirty days

Review of Resident #25's statement documented

Event ID: OL2511

Facility ID: VA0083

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DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BUILL	A. Building		С		
		495299	B. WING	B. WING		03/09/2017		
	NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			360	EET ADDRESS, CITY, STATE, ZIP CODE 0 MOUNTAIN ROAD EN ALLEN, VA 23060			
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	JX5) COMPLETION DATE	
F 160	Continued From pa	age 1	F	160				
	The findings include	le:	:	٠				
no mana, na angunangan aka dalah, n dalah	3/01/16 with diagn	admitted to the facility on oses that included but were not			A Secretaria de la companya del companya de la companya del companya de la compan	amena vigoralus, paralikarittamakkal	and the same of th	
	disturbance, chron age related osteop disorder and gener Resident #25's mo set) was a death in ARD (assessment On 3/8/17 at appro	a without behavioral ic pain, high blood pressure, porosis, major depressive ralized anxiety disorder. Is trecent MDS (minimum data a facility assessment with an reference date) of 12/28/16.						
		of Nursing), ASM ff member) #2. The business uld not be found in her office.						
	Resident #25's resident requested for the s	o.m. at the end of day meeting, ident account fund was second time from the DON, #1, the administrator.					:	
	account fund was member) #8, the b #8 stated, "I gave and Administrator). I juyesterday. It was a switched companion twice and then resulted the family a will send a check is appropriate time from the send and the send and the send and the send a check is appropriate time from the send and the send and the send a check is appropriate time from the send and the send a	a.m., Resident #25's resident requested by OSM (other staff usiness office manager. OSM that information to (Name of ust closed her account an oversight because we es. All accounts were closed opened. I feel terrible about it. and apologized and told them In the mail." When asked the ame to convey funds, OSM #8 sed to be within thirty days						
	Review of Resider	nt #25's statement documented	:					

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Event ID: OL2511

Facility ID: VA0083

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	MENT OF HEALTH	· · · · · · · · · · · · · · · · · · ·				APPROVED
CENTER	S FOR MEDICARE	& MEDIČAID SERVICES				0938-0391
STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CDNSTRUCTION NG	СОМ	E SURVEY PLETED
		495299	B. WING		1	0 9/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABE	TH ADAM CRUMP HE	EALTH AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 160	Continued From pa	ge 2 ent Balance \$78.00Status	F1	60		
	reason: Expired 12 by OSM #8 was atta statement and docu Account closed and	28/16." A document signed ached to the resident's umented the following: "3/8/17 I check (check number)				
:	party) (Name of RP	l; Contacted RP (Responsible '), to apologize for the delay eck will be mailed 3/9/17."			New Colonial Colonia	
		a.m., ASM #1, the ISM #2, the DON (Director of e aware of the above				
	Policies," documen a patient whose fur the Living Center in Funds expires or is Business Office will the account is refur	"Resident Trust Fund ts in part, the following: "When hads are held and managed by h (sic) the Resident Trust permanently discharged, the I ensure that the balance of haded, and a full accounting days if expiration or discharge				
	to the: patient or le probate jurisdiction estate OR other ag allowed by state re notification of fund	gal representative, individual or administering the patient's lency or entity, as required or gulation or case—specific disbursement"				
F 252 SS≕E	483.10(e)(2)(i)(1)(i) SAFE/CLEAN/COMENVIRONMENT	I(ii) MFORTABLE/HOMELIKE	F	252		: : :
	possessions, include as space permits, to	etain and use personal ding furnishings, and clothing, unless to do so would infringe nealth and safety of other				

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(i)(1) A safe, clean, comfortable, and homelike

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Facility ID: VA0083

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PRINTED: 03/16/2017



DEPARTMENT OF HEALTH AND HUP I SERVICES CENTERS FOR MEDICARE & MEDIC SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 03/09/2017	
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, 0 3600 MOUNTAIN R GLEN ALLEN, VA			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD ERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
	Continued From penvironment, allowher personal beloward in the personal beloward in the personal beloward in the personal layout of independence and the protection of the pro		F 2	F252 1. Resi 10 and Each s deep of 2. Each showe of bein 3. Hea employ on the cleanin not lim discha cleani refres weeks under cleani 4. Wee directo weeks		om d. nd fial ed s fine vo	
	safe manner. 3. The facility starshower rooms (A	ff failed to maintain two of three unit and B unit) in a safe, elike environment.		be rev Q A PI r to ens	iewed at the monthly neeting for three mon ure compliance.		
	1. A black substa	nce (approximately five inches					

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Event ID: OL2511

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PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 3/09/2017	
		<u> </u>		STREET ADDRESS, CITY, STAT		3/09/2017	
	NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION CACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 252	cove base and tile number B10A.	page 4 ed in the crevice between the tile e floor in the bathroom of room p.m., observation of the		252			
	bathroom in room A black substance long) was observed cove base and tile area was observed sink (while facing). On 3/7/17 at 4:20 conducted with C #4. CNA #4 state residents' bathroom housekeeping de CNAs clean. CN substance in the #4stated, "I can't what." CNA #4 what."	n number B10A was conducted. e (approximately five inches ed in the crevice between the tile e floor in the bathroom. The ed in the right corner under the					
	conducted with Chousekeeper). Codepartment conducted morning and swewipes over-bed to #4 stated during staff also makes are clean. OSM break, the house cleaning by dusticleaning over the area between the bathroom was cleaning. OSM #	o p.m., an interview was pSM (other staff member) #4 (a pSM #4 stated the housekeeping ucts a "walk through" every seps rooms, takes out trash, ables and mops if needed. OSM the "walk through" housekeeping sure toilets, mirrors and sinks #4 stated after the 10:00 a.m. keeping staff conducts detailed and, cleaning the windows and expressers. OSM #4 stated the expressers and floor tile in the eaned during the detailed the was shown the black bathroom of room B10A. OSM					

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PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/09/2017	
		495299	B. WING			
	NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	JX5J COMPLETION OATE
F 252	Continued From p	page 5	F 2	252		
	detailed cleaning if that area should stated, "some roo OSM #4 stated so needed to clean to couldn't tell this substance was. Nooked clean and On 3/8/17 at 5:00 member) #1 (the of the above finding The facility documents of the cound of th	a should be cleaned during the every day. OSM #4 was asked look the way it looked, OSM #4 ms you can scrape all day." ome elbow grease would be hat area. OSM #4 stated she urveyor what the black When asked if the bathroom homelike, OSM #4 stated, "No." p.m., ASM (administrative staff administrator) was made aware ngs. The property of the property				
		'dig' out debris. 3. Use Scraper	. *			
	No further inform	ation was presented prior to exit.				į
		ff failed to ensure that Resident as maintained in a clean and				:
	12/4/16 with diag not limited to, der	s admitted to the facility on noses that included, but were nentia, high blood pressure, a rolapse and heart failure.				
	set), an admissio (assessment refe Resident #11 as l	ost recent MDS (minimum data n assessment with an ARD rence date) of 12/10/16, coded naving a BIMS (brief interview of ore of seven out of a possible	:			

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DEPARTMENT OF HEALTH AND HU 1 SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495299	B. WING		03/09	/2017	
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZII 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	CODE	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE C HE APPROPRIATE	IX5) OMPLETION OATE	
F 252	cognitively severe	ating that Resident #11 is ely impaired.	F2	252			
		45 a.m. an observation was	!				
Same summer of about the latest territory and a		t #11 sitting on the edge of her		Section of the Mark (No. 1) - Production and the Company of the Co			
	time of her bathro and her roommat were made; The bathroom of dust on the heating part of the wall or into the bathroom A wheelchair coand propped aga dust across the to Along the top et the commode ext gray colored grimtagray colored grim	ushion was observed on the floor inst the wall, also with a layer of op. dge of the tile baseboard behind rending beneath the sink a dust/ e was observed. Immode a 0.5" gap was observed baseboard and a thick black observed in the gap. Ittached to the wall and grout was observed with areas of a					
	around the back - Behind the com observed on the - The floor was of in multiple areas The wall behind that had the shap - There was no tentrance point into between the living where the thresh space thick, blace - Handrails were	nmode an old toilet roll was floor and appeared to be wet. observed with dark colored grime					

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Facility ID: VA0083

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MAR 30 2017

DEPARTMENT OF HEALTH AND HUN 'SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

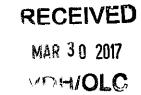
I` '		1 ' '		CON	E SURVEY APLETED
	495299			1	/09/2017
	AND REHAB		STREET ADDRESS, CITY, STATE, Z 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
DEFICIENCY MUST	BE PRECEDED BY FULL		X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE
e of the common handrails were erved with a pal- down the plate a ust on the portion	secured to the wall e substance that was and there was a thick	F2	252		
nd rails were ob ards and out of position the hand to side and the	the way. When in their I rails were easily move bolts in the left handrai	ed			
walking around hing her hands. served in the bacom was observas described at bserved to be in	her bathroom and at the There was no toilet throom. On inspection the to be in the same bove. The empty toilet	ne :			
d with OSM (other per on the hallow m was located. It cleaned the resease of that as, OSM #9 stated the "high/low ped the bathrooclean everything already cleaned room on this day. This writer ask any her into Resi	ter staff member) #9, the vay where Resident OSM #9 was asked he sident rooms. OSM #9 wo to three times per included the resident ed that it did. When formed, OSM #9 stated of dusting" and then sweems. OSM #9 further g." OSM #9 was asked Resident #11's room of the cosm	pt I if			
in the contract of the contrac	R SUPPLIER CRUMP HEALTH UMMARY STATEMENT IN DEFICIENCY MUST IN ATORY OR LSC IDEN d From page 7 le of the commode handrails were derived with a pale down the plate a lust on the portion the hand rails. Ind rails were obtained and out of position the hand re loose in the way of at 10:20 a.m. For at 10:20 a.m. For a walking around hing her hands. It is served in the base of a secribed at the commode. 7 16 2:40 p.m. a red with OSM (other asked if that the cleaned the result at she	R SUPPLIER CRUMP HEALTH AND REHAB UMMARY STATEMENT OF DEFICIENCIES IN DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) d From page 7 de of the commode. The wall plates e handrails were secured to the wall served with a pale substance that was down the plate and there was a thick lust on the portion of the plate that the hand rails. Ind rails were observed to have the ability wards and out of the way. When in their position the hand rails were easily move at to side and the bolts in the left handrait re loose in the wall. 7 at 10:20 a.m. Resident #11 was at walking around her bathroom and at the hing her hands. There was no toilet reserved in the bathroom. On inspection from was observed to be in the same as described above. The empty toilet observed to be in the same as described above. The empty toilet observed to be in the same position from was located. OSM #9 was asked here cleaned the resident rooms. OSM #9 at she cleaned two to three times per ten asked if that included the resident may come asked if that included the resident may os M #9 stated that it did. When that cleaning performed, OSM #9 stated that it did. When that cleaning performed, OSM #9 stated the bathrooms. OSM #9 stated the bathrooms. OSM #9 stated the bathrooms. OSM #9 was asked already cleaned Resident #11's room aroom on this day, OSM #9 stated that This writer asked OSM #9 to any her into Resident #11's bathroom.	A BUILDI 495299 B. WING R SUPPLIER CRUMP HEALTH AND REHAB UMMARY STATEMENT OF DEFICIENCIES ID DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) d From page 7 de of the commode. The wall plates enhandrails were secured to the wall erved with a pale substance that was down the plate and there was a thick flust on the portion of the plate that the hand rails. When in their position the hand rails were easily moved to side and the bolts in the left handrail reloose in the wall. 7 at 10:20 a.m. Resident #11 was a walking around her bathroom and at the hing her hands. There was no toilet reserved in the bathroom. On inspection from was observed to be in the same as described above. The empty toilet observed to be in the same necessary and the resident rooms. OSM #9 was asked how a cleaned the resident rooms. OSM #9 stated that it did. When that cleaning performed, OSM #9 stated did the "high/low dusting" and then swept ped the bathrooms. OSM #9 stated did the "high/low dusting" and then swept ped the bathrooms. OSM #9 was asked if allready cleaned Resident #11's room on this day, OSM #9 stated that This writer asked OSM #9 to any her into Resident #11's bathroom.	A BUILDING 495299 R SUPPLIER CRUMP HEALTH AND REHAB JUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAGS ID PROVIDER'S PLAN OF PERCEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) d From page 7 e of the commode. The wall plates e handrails were secured to the wall erved with a pale substance that was down the plate and there was a thick lust on the portion of the plate that the hand rails. Ind rails were observed to have the ability wards and out of the way. When in their position the hand rails were easily moved to side and the bolts in the left handrail re loose in the wall. 7 at 10:20 a.m. Resident #11 was a walking around her bathroom and at the hing her hands. There was no toilet isserved in the bathroom. On inspection from was observed to be in the same as described above. The empty toilet observed to be in the same position her commode. 7 16 2:40 p.m. an interview was add with OSM (other staff member) #9, the eper on the hallway where Resident may as located. OSM #9 was asked how a cleaned the resident rooms. OSM #9 at she cleaned two to three times per ten asked if that included the resident may be stated that it did. When hat cleaning performed, OSM #9 stated did the "high/low dusting" and then swept ped the bathrooms. OSM #9 further clean everything." OSM #9 was asked if already cleaned Resident #11's room room on this day, OSM #9 stated that This writer asked OSM #9 to	A BUILDING B

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

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		40,500				C		
		495299	B. WING		/09/2017			
	NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			3600	ET ADDRESS, CITY, STATE, ZIP CO MOUNTAIN ROAD N ALLEN, VA 23060	JDE		
			1	OLL,		RECTION	i WE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 252	Continued From	page 8	i F	252				
,		tive staff member) #2, the		-				
		ig, was asked to observe	1					
		athroom at this time. ASM #2		•				
		ner or not the bathroom was						
		stated that it was not clean. ASM						
***************************************		2, the director of maintenance,		w=da .=- w 1 x= x+. d-	and the second property and the second se	NO ASSESSMENT AND ASSESSMENT OF THE PROPERTY AND	- Management and a superior su	
	into the room at this time to address the hand							
		commode. When OSM #2 was						
	asked how much	n side to side "play" the handrails	1				İ	
		M #2 stated that they should not						
		thout side to side movement.						
	OSM #2 was obs	served moving the hand rails side	∌					
	to side and then	stated, "These rails have too						
	much side to side	e play, and the bolts are not					i	
	completely secur	re in the wall. I will get this fixed.	33					
		acility housekeeping protocol,						
		d by the administrator on 3/8/7 at	: :				:	
		led, in part, the following	:					
		"DRY steps: 1. Pull trash. Wipe	е				:	
		sary replace liner. 2. Fill					:	
		o, paper, etc., 3. Dust mop. Pick						
	up trash, use du:	st mop. WET Steps: 4. Sanitize					!	
		or, sink, fixtures and pipes. 5.					:	
		de, tank, bowl & base. Use brus	h:				İ	
		l. 6. Spot clean - Walls,					:	
		witches. 7. Damp mop. Start in	١					
		pehind commode, move trash						
	can, mop out the	e door.	:					
			:					
		0 p.m. an end of day meeting	į					
		SM #1, the administrator. ASM	:					
	#1 was made aw	vare of the above findings.	1				:	
		and the second s	:					
1		nation was provided prior to the	:					
	end of the surve	y process.						
							1	
	6 TI - 6 '99 '	off fails of the magnetic from of these	1				:	
1	 3. The facility sta 	aff failed to maintain two of three					1	

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Event ID: OL2511

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

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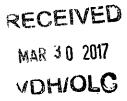
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
						C	
		495299	B. WING			3/09/2017	
	NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, Z 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE	
F 252	environment. Observation was	page 9 a safe, sanitary and homelike made of the B unit shower room p.m. There were three shower	F2	252			
	areas and one to area had a brush under a bench st to be a wheelcha the bench seat. I with red edges or crawling on it. The standing water of had three gloves style seat. In the observed on the floor drain, were and band aids or all wet, and it couwere used. The fof the way with a of the wall was observed where the course of the way are and three quarter was observed look bristles were tank shower room had	ifet area. The left front shower and a used glove on the floor yle seat. A wheel, that appeared ir wheel, was also located under There was something tan colored in it on the floor with an ant is to the floor. The back left shower on the floor under the bench is shower room, band aids were floor drain. To the right of the paper packages from band aids in the floor. The band aids were all not be determined if they floor drain was covered two thirds collection of hair. The lower foot overed in a pink/tan substance is seat area, a black substance here the floor meets the walls. Opproximately five inches in length the standing water all over the floor. The right back it standing water all over the flain was covered two thirds of					
	room on 3/8/17 a standing outside nurse's station. room, in the halfy was buckling app	vas made of the A unit shower at 8:10 a.m. This surveyor was the shower room, near the The outside wall of the shower way, was observed with paint that proximately one foot by three were made of cinderblock. Once					

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C 03/09/2017	
		495299	B. WING			
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, Z 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	IP CODE	
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 252	Continued From a key was obtained standard sitting c	page 10 ed to enter the shower room, a hair was observed in the shower	F:	252		
	room with what a over the seat. The	ppeared to be feces smeared all ere were three shower areas a. Standing water was observed				
	was observed wit smeared on the s collection of hair The back left sho black/green/brow the handles and	The back right shower room the what appeared to be feces shower curtain. There was a observed over the floor drain, wer room was observed with a management of the walls a inches in width all the way from a floor.				
	ASM #1) came to a.m. on 3/8/17. It concerns. The di staff member (Os administrator. Will this bathroom in stated, "No, Ma'a	r (administrative staff member - o the unit at approximately 8:45 He was shown the above rector of housekeeping, other SM) #1 was with the hen asked if he would shower in the condition it was in, OSM #1 am." OSM #1 informed this staff was cleaning the B unit o.				
	administrator on how the houseke that are in need of do room rounds of housekeeping of addressed. The sheets from the part of the sheets from the part of the sheets from the part of the	conducted with the 3/9/17 at 8:58 a.m. When asked reping staff is informed of things of cleaning, ASM #1 stated, "We revery day. We make a list for things that need to be next morning the room round previous day are reviewed and are corrected from the previous				
		or presented a policy on cleaning in 3/8/17 at 4:04 p.m. The policy,				·

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DEPARTMENT OF HEALTH AND HU(N SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	ŀ	TIPLE CONSTRUCTION DING		TE SURVEY MPLETEO
		495299	B. WING	i	03	C 8/ 09/2017
	PROVIOER OR SUPPLIE	R HEALTH AND REHAB		STREET AOORESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES ICY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREF TAG	25222 55555 125C T	ACTION SHOULO BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 252	from the door and room clockwise. cans. 3. Any are are very importar handle, cabinet h stubborn stains Place wet floor si doorway. Mop sh as possible. App baseboards. Use 'dig out' debris. Use a figures eig the room. Make behind commode of mop in corners no refuse is left in changed if you can the administrato findings on 3/8/1. On 3/9/17 at 8:30 conducted with A #1, director of mainted shower rooms with shower room still black/green/brows shower room whithe pink/tan substitutions.	ing" documented in part, "Step alls and/or Partitions: 1. Start d work your way around the Pay special attention near trash a that people touch every day at to wipe (light switches, door andles) 4. Use brush on Step 7, Damp Mop Floor: 1. gn in a visible location in the hould be wrung out as thoroughly ly pressure on edges and a foot on top of mop in corners to Use scraper to clean buildup. In the motion starting in the back of sure area under sinks and as are mopped. Use foot on top is to 'dig' out debris. Make sure in doorway. Water should be an't see the bottom of bucket." The was made aware of the above at 5:15 p.m. Dia.m., a tour of the facility was some some and OSM #2, the enance. The A unit and B unit dere inspected. The B unit contained the contained the stance on the bottom of the walls stance on the bottom of the walls.		252		
	black/green/brow shower room wh the pink/tan subs in the back left sl if the shower roo #2 stated, "Yes." The administrate 3/9/17 at 9:20 a.	n substance in the back left ere the wall meets the floor and				

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Event IO: OL2511

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DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

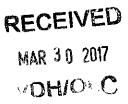
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
	495299	B. WING		03	C 3/09/2017
			STREET ADDRESS, CITY, STATE, Z 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE
Assurance)" docu the Care Keeper r Director of Nursing Worker, d. Dietary of nursing, f. Clinic	mented in part, "1. Members of ounding team may include: a. g, b. Activities Director, c. Social manager, e. Assistant director cal Nurses/Supervisors, g.	F2	252	nome in the consequence when also before in the color in a second in the color in t	
member of facility meeting. 2. Each approximately 8 – numbers) on a un members for appr will work together obtain information complete the Res member will provi their Resident Carone of the partner their partner will in the partner's resident monitoring frought and update as neobtain and completer member time during resident and room form. 7. The observation of the Care Keepe by each facility (i.e. survey)."	that may be attending morning member will select 10 residents (consecutive room it. 3. There will be at least two eximately 20 residents and they as a team. 4. Each partner will about their residents to ident Care Keeper Form. Each de their partner with a copy of re Keeper Form. IN the event is on the unit is not available, nonitor both their residents and lents. Each partner will maintain in an easily accessible area eded. 5. Each member will lete a Care Keeper rounding in 8 a.m. and 9 a.m. and at any that day. 6. Observations of its will be documented on the ervations will be discussed at and forwarded to QA (Quality in ittee. 8. Items may be added be Rounding list as determined each of the provided prior to exit.		272		
(b) Comprehensiv	ve Assessments				
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From p Assurance)" docu the Care Keeper r Director of Nursing Worker, d. Dietary of nursing, f. Clinic Rehab Director, h member of facility meeting. 2. Each r approximately 8 - numbers) on a un members for appr will work together obtain information complete the Res member will provi- their Resident Car one of the partner their partner will r the partner's reside the monitoring fro and update as ner obtain and comple form daily betwee another time durin resident and room form. 7. The obse morning meeting Assurance) comm to the Care Keepe by each facility (i.e. survey)." No further informat 483.20(b)(1) CON ASSESSMENTS	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 Assurance)" documented in part, "1. Members of the Care Keeper rounding team may include: a. Director of Nursing, b. Activities Director, c. Social Worker, d. Dietary manager, e. Assistant director of nursing, f. Clinical Nurses/Supervisors, g. Rehab Director, h. Administrator, i. Any other member of facility that may be attending morning meeting. 2. Each member will select approximately 8 - 10 residents (consecutive room numbers) on a unit. 3. There will be at least two members for approximately 20 residents and they will work together as a team. 4. Each partner will obtain information about their residents to complete the Resident Care Keeper Form. Each member will provide their partner with a copy of their Resident Care Keeper Form. IN the event one of the partners on the unit is not available, their partner will monitor both their residents and the partner's residents. Each partner will maintain the monitoring from in an easily accessible area and update as needed. 5. Each member will obtain and complete a Care Keeper rounding form daily between 8 a.m. and 9 a.m. and at another time during that day. 6. Observations of resident and rooms will be documented on the form. 7. The observations will be discussed at morning meeting and forwarded to QA (Quality Assurance) committee. 8. Items may be added to the Care Keeper Rounding list as determined by each facility (i.e. Deficiencies cited during survey)." No further information was provided prior to exit. 483.20(b)(1) COMPREHENSIVE	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 Assurance)" documented in part, "1. Members of the Care Keeper rounding team may include: a. Director of Nursing, b. Activities Director, c. Social Worker, d. Dietary manager, e. Assistant director of nursing, f. Clinical Nurses/Supervisors, g. Rehab Director, h. Administrator, i. 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No further information was provided prior to exit. 483.20(b)(1) COMPREHENSIVE F 272 ASSESSMENTS	ROVIDER OR SUPPLIER TH ADAM CRUMP HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY YILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 Assurance)* documented in part, "1. Members of the Care Keeper rounding team may include: a. Director of Nursing, b. Activities Director, c. Social Worker, d. Dietary manager, e. Assistant director of nursing, f. Clinical Nurses/Supervisors, g. Rehab Director, h. Administrator, l. Any other member of facility that may be attending morning meeting, 2. Each member will select approximately 20 residents and they will work together as a team. 4. Each partner will obtain information about their residents to complete the Resident Care Keeper Form. In the event one of the partners residents. Each partner will maintain the monitoring from in an easily accessible area and update as needed. 5. 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DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	OF DEFICIENCIES OF CORRECTION	(AT) THE TREE TO SET THE TENT OF THE TENT		COV	(3) DATE SURVEY COMPLETED C		
		495299	B. WING_			i	/09/2017
	PROVIDER OR SUPPLIER	EALTH AND REHAB		3600	ET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD N ALLEN, VA 23060	-	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 272	Continued From pa	_	F 2	72	F272		
		ssment Instrument. A facility			1. Resident #1 has expired.		
		orehensive assessment of a trengths, goals, life history and			Resident #9 and #10 CAA's		
		the resident assessment			were completed with the da	ite	÷
		pecified by CMS. The			and location of information	DN	
Australia de la companio del companio del companio de la companio del companio del companio de la companio del companio de la companio del c	assessment must i	nclude at least the following:			3/21/17.		
	(i) Identification a (ii) Customary rou (iii) Cognitive patte				Each resident's MDS has to potential of being affected.	the	
	(iv) Communicatio				3. Comprehensive assessme	ents	i
	(v) Vision.	avier nettorne			were reviewed for completi		:
	(vi) Mood and behalic(vii) Psychological v				with dates and locations.		
		inctioning and structural	:		Corrections were made as		
	problems.		į		necessary. The Interdisciplin	າລກາ	
	(ix) Continence.		:		•		
	(x) Disease diagno (xi) Dental and nut	osis and health conditions.	:		Team (IDT) was re-educated CAA completion.	ווט ג	
	(xii) Skin Condition				4. CAA worksheets will be		
	(xiii) Activity pu		:			م مانه .	
	(xiv) Medication				completed and reviewed by		
		ents and procedures.	:		Director of Nursing Services		:
	(xvi) Discharge				designee for completion wi	th	
		ation of summary information tional assessment performed			date and location of		:
	on the	donal assessment performed			information weekly for fou	r	
		as triggered by the completion			weeks then monthly for the		
	of the Minimum Da		:		months. Results will be		:
:	(xviii) Document	ation of participation in			reviewed at the monthly Q	ΔΡΙ	
		assessment process must	•				
	include direct	the same and a second s			meeting for three months	i.U	
		tion and communication with	:		ensure compliance.		
	licensed and	ell as communication with nsed direct care staff members			5. Compliance Date: 4/7/1	.7	
	on all shifts.		ŧ				

DEPARTMENT OF HEALTH AND HU(I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495299 B. WING			03/09/2017			
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIG 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
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	observation and as well as comm	page 14 process must include direct communication with the resident, unication with licensed and ect care staff members on all	F	272		e de l'annual des la company de la company d	
	by: Based on staff in and facility documentate the facility statement in the facility statement	MENT is not met as evidenced interview, clinical record review, ment review, it was determined aff failed to document date and ion on the CAA Summary for 3 of the survey sample; Residents #1,					
	and location of the clinical record the Resident #1's an	aff failed to document the date ne information obtained from the at was used to complete inual assessment with an ARD erence date) of 7/15/167/15/16					
	information from utilized to compl- triggered areas,	aff failed to document the date of the clinical record that was ete the assessment of the on Resident #9's annual MDS an ARD of 10/27/16.					
	and date of infor that was utilized the triggered are	aff failed to document the location mation from the clinical record to complete the assessment of eas, on Resident #10's significant sessment with an ARD of					
	The findings incl	lude:					
	6/14/13 with the	was admitted to the facility on diagnoses of but not limited to:					

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Event ID: OL2511

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DEPARTMENT OF HEALTH AND HU! I SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		1	T(PLE CONSTRUCT(ON (NG		(X3) DATE SURVEY COMPLETED	
		495299	B. W(NG		03/09/2017		
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, C(TY, STATE, Z(3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) (D PREF(X TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	(D PREF TAG		(ON SHOULD BE HE APPROPR(ATE	(X5) COMPLETION DATE	
	Continued From obstructive pulmo cardiomegaly, prodepression, diabordisorder, psychosomost recent MDS quarterly assessing Reference Date) coded as being in scoring a 12 of a Interview for Merican Compreher assessment with Section V, the Caras of: 01. De Loss/Dementia, Communication, Functional/Rehal Incontinence and 12. Nutritional St Maintenance, 15 Ulcer, 17. Psychowith the exception Services, next to "CAA WS (works column for "Loca documentation." for each of these	page 15 charry disease, glaucoma, essure ulcer, bladder disorder, etes, high cholesterol, delusional sis, and mood disorder. The 6 (Minimum Data Set) was a ment with an ARD (Assessment of 1/13/17. The resident was hildly cognitively impaired, possible 15 on the BIMS (Brief htal Status) exam. Inical record revealed the most ensive MDS, an annual an ARD of 7/15/16. Review of eare Area Assessment Summary the resident triggered for the lirium, 02. Cognitive 03. Visual Function, 04. 05. ADL folitation Potential, 06. Urinary 1 Indwelling Catheter, 11. Falls, eatus, 14. Dehydration/Fluid 1. Dental Care, 16. Pressure cotropic Drug Use, and 19. Pain 10. On of area 12. Nutritional each area was documented sheet) dated 8/31/16" under the eation and Date of CAA A review of the CAA worksheet eareas failed to identify any eurce of documentation used to	F:	PEFICIENC.	7)		
	#7 (Registered N stated that she d summary was no location informat	36 a.m., in an interview with RN lurse), the MDS nurse, she id not know why the CAA of completed with date and ion, and that the nurse who did t #1's assessment) was no					

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Event (D: OL2511

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DEPARTMENT OF HEALTH AND HU V SERVICES CENTERS FOR MEDICARE & MEDICAD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495299	B. WING		03	C 5/09/2017	
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
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F 272	Continued From plants there. No further informathe survey.	page 16 ation was provided by the end of	F 2	272 .			
. Priest Communicated And Del Del Distriction and a state		MDS documents at the top of the ginstructions:			Shown the all Phone & Phone Shi de alexandra and a security		
	1. Check column	A if the Care Area is triggered.	:				
	a new care plan, continuation of cu address the prob assessment of th the Care Plan col days of completing	ered Care Area, indicate whether care plan revision, or urrent care plan is necessary to lem(s) identified in your e care area. The Addressed in umn must be completed within 7 to the RAI (MDS and CAA(s)). if the triggered care area is care plan.					
	information column the CAA can be for should include info	Location and Date of CAA on where information related to ound. CAA documentation formation on the complicating any referrals for this resident for					
	Services) RAI (Reversion 3.0 User' "CHAPTER 4: CA (CAA) PROCESS Other Considerat CAAs. Use the "Documentation" (Section V of the CAA information documentation category)	(Center of Medicare/Medicaid esident Assessment Instrument) is Manual documented, ARE AREA ASSESSMENT is AND CARE PLANNING. 4.5 ions Regarding Use of the Location and Date of CAA column on the CAA Summary MDS 3.0) to note where the and decision making an be found in the resident's eate in the column "Care					

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		сом	(X3) DATE SURVEY COMPLETED C		
	495299	B. WING			09/2017		
			STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
Planning Decisionarea is addressed	n" whether the triggered care d in the care plan."	F2	272				
utilized to completriggered areas, of	ete the assessment of the on Resident #9's annual MDS			F v. 70 TO Telephonological annual an			
11/16/15 with dia not limited to atria obstructive pulme and major depresement MDS quarterly assessing reference date) occurred as being secoring a 03 of 1	gnoses that included but were al fibrillation, COPD (chronic charry disease), liver cirrhosis, ssive disorder. Resident #9's 6 (minimum data set) was a ment with an ARD (assessment of 1/12/17. Resident #9 was severely cognitively impaired 5 on the BIMS (Brief Interview						
recent compreher annual MDS ass (assessment reference Resident #9. Parence Assessment Surricare Area Assessment MDS triggered for the function, communutiving) Functional Incontinence and Nutritional Status psychotropic drugs The following was "Location and Data an	ensive MDS assessment was an essment with an ARD erence date) of 10/26/16 for rt A, "CAA (Care Area nmary) results" under Section V ssment Summary" of the annual S documented that Resident # 9 following CAA areas: "Cognitive inication, ADL (Activities of Daily al/Rehabilitation Potential, Urinand Indwelling Catheter, Falls, so, Pressure Ulcer, and g use and physical restraints." as documented under the late" column for CAA triggered	:					
	SUMMARY S (EACH DEFICIENT REGULATORY OF REGU	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Planning Decision" whether the triggered care area is addressed in the care plan." 2. The facility staff failed to document the date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #9's annual MDS assessment with an ARD of 10/27/16. Resident #9 was admitted to the facility on 11/16/15 with diagnoses that included but were not limited to atrial fibrillation, COPD (chronic obstructive pulmonary disease), liver cirrhosis, and major depressive disorder. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/12/17. Resident #9 was coded as being severely cognitively impaired scoring a 03 of 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the clinical record revealed the most recent comprehensive MDS assessment was an annual MDS assessment with an ARD (assessment reference date) of 10/26/16 for Resident #9. Part A, "CAA (Care Area Assessment Summary" of the annual assessment MDS documented that Resident #9 triggered for the following CAA areas: "Cognitive function, communication, ADL (Activities of Daily	A BUILD 495299 B. WING PROVIDER OR SUPPLIER ETH ADAM CRUMP HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Planning Decision" whether the triggered care area is addressed in the care plan." 2. The facility staff failed to document the date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #9's annual MDS assessment with an ARD of 10/27/16. 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A review of the clinical record revealed the most recent comprehensive MDS assessment was an annual MDS assessment with an ARD (assessment Summary) results" under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary) results under Section V "Care Area Assessment Summary of the annual assessment MDS documented that Resident #9 triggered for the following CAA areas: "Cognitive	A BUILDING 495299 B. WING STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Planning Decision" whether the triggered care area is addressed in the care plan." 2. The facility staff failed to document the date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #9's annual MDS assessment with an ARD of 10/27/16. Resident #9 was admitted to the facility on 11/16/15 with diagnoses that included but were not limited to atrial fibrillation, COPD (chronic obstructive pulmonary disease), liver cirrhosis, and major depressive disorder. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 1/12/17. Resident #9 was coded as being severely cognitively impaired scoring a 03 of 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the clinical record revealed the most recent comprehensive MDS assessment was an annual MDS assessment summary) of the annual assessment Summary) results" under Section V "Care Area Assessment Summary) of the annual assessment MDS documented that Resident # 9 triggered for the following CAA areas: "Cognitive function, communication, ADL (Activities of Daily Living) Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Pressure Ulcer, and psychotropic drug use and physical restraints." The following was documented under the "Location and Date" column for CAA triggered	A BUILDING COM 495299 B. WING 37 THADAM CRUMP HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCES (LEAN DEFICIENCY) STORES (LEAN DEFICIENCY) STORES PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCES (LEAN DEFICIENCY) STORES (LEAN DEFICIENCY) Continued From page 17 Planning Decision" whether the triggered care area is addressed in the care plan." 2. The facility staff failed to document the date of information from the clinical record that was utilized to complete the assessment of the triggered areas, on Resident #9's annual MDS assessment with an ARD of 10/27/16. Resident #9 was admitted to the facility on 11/16/15 with diagnoses that included but were not limited to atrial fibrillation, COPD (chronic obstructive pulmonary disease), liver cirrhosis, and major depressive disorder. Resident #9's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/12/17. 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Event 1D: OL2511

Facility ID: VA0083

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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 C		
		495299	B. WING		·	0.2	3/09/2017	
	PROVIDER OR SUPPLIE	<u>. L </u>	ļ	36 00	STREET ADORESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		1 00,00,2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 272	the triggered area	page 18 e date of information used for a, "Nutritional Status." 8 a.m., an interview was	F2	272				
	conducted with R	N (registered nurse) #4, an . When asked about the					Linkson - National	
	process for the loused to complete stated, "I review that areas triggered a information came the date of the interest CAA and then dearea." RN #4 state for the nutritional in section V. RN matter of educatifacility use the Roundstrument Manu completing Section On 3/8/17 at 5:20 member) #1, the DON (Director of the above concerts)	cation and date of information the MDS assessment, RN #4 the CAA to determine why the nd document where the from in the clinical record and formation. I sign and date the cide whether to care plan that sted that she did not see a date assessment that was identified #4 stated, "That would be a ng dietary." RN #4 stated that AI (Resident Assessment al) as a reference when on V of the MDS. 1 p.m., ASM (administrative staff administrator, and ASM #2, the Nursing) were made aware of the contraction of the MDS.						
	No further inform	ation was presented prior to exit.					:	
	and date of informathat was utilized the triggered area change MDS ass 1/20/17.	ff failed to document the location mation from the clinical record to complete the assessment of as, on Resident #10's significant sessment with an ARD of						
	6/22/16 with diag	s admitted to the facility on noses that included but were not tia with Lewy bodies [1], fracture						

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Event ID: OL2511

Facility ID: VA0083

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	TMENT OF HEALTH	AND HUI I SERVICES & MEDICALD SERVICES			(FORM): 03/16/2017 MAPPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		TE SURVEY MPLETED C
		495299	B. WING		·	03	3/09/2017
	PROVIDER OR SUPPLIER	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
				GLE		OTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ae 19		2 7 2			
1 212	•	ype two diabetes, high blood	! '	212			:
		r depressive disorder.	!				
		st recent MDS (minimum data	:				
		nt change assessment with an					1
		reference date) of 1/21/17.					
		coded as being cognitively	i		·		
		o make daily decisions, on the BIMS (Brief Interview					1
	for Mental Status)		:	;			
	A review of the clini	cal record revealed the most					
		ive MDS was a significant	!				
		it with an ARD (assessment	:				
		I/21/17 for Resident #10. Part					į
		Assessment Summary)					
		ion V "Care Area Assessment		ı			
		gnificant change MDS mented that Resident # 10					•
		lowing CAA areas: "Visual					
		vities of Daily Living)					
		tation Potential, Urinary					
		ndwelling Catheter, Mood					
		onal Status, Pressure Ulcer,	:				•
		rug use" The following was					:
		the "Location and Date"					:
		A triggered area "Mood State:" et) dated 2/16/17." The	•				:
		mented under the "Location					
	<u> </u>	or the CAA triggered area					:
		CAA WS dated 2/3/17."	; ,				ı
	Review of the CAA	worksheets failed to reveal	:				:
		on of information for the	:				
	triggered areas, "M Ulcer."	ood State" and "Pressure					
	conducted with RN	a.m., an interview was (registered nurse) #4, the When asked about the	:				

process for the location and date of information

Event ID: OL2511

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

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495299	B. WING		03	C 3/09/2017
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	IX5) COMPLETION OATE
F 272	stated, "I review the areas triggered a information came the date of the interest CAA and then de	the MDS assessment, RN #4 the CAA to determine why the nd document where the from in the clinical record and formation. I sign and date the cide whether to care plan that	F 2	272		
	location and date areas of "Mood S V of the MDS ass worksheets. RN be responsible fo section. When a completing the pre	ated that she did not see the of information for the care state" and "Pressure" in Section sessment on the CAA #4 stated that social work would be completing the mood state sked who was responsible for ressure ulcer section, RN #4 has responsible and it was an				
	member) #1, the DON (Director of the above concer	o p.m., ASM (administrative staff administrator, and ASM #2, the Nursing) were made aware of rns. ation was presented prior to exit.	:			:
F 275 SS=D	deposits of a probrain. These deposits in the can lead to proble behavior, and moobtained from Thattps://www.nia.nwy-body-dementi	sease associated with abnormal tein called alpha-synuclein in the osits, called Lewy bodies, affect brain whose changes, in turn, ems with thinking, movement, od." This information was be National Institutes of Health. Lih.gov/alzheimers/publication/le ia/basics-lewy-body-dementia. COMPREHENSIVE ASSESS AT 2 MONTHS	F:	275		
		uired. Subject to the timeframes 3.343(b) of this chapter, a facility	1			

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Event ID: OL2511

Facility ID: VA0083

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL* A. BUILDI		CONSTRUCTION		ATE SURVEY OMPLETED
		405000	D WING				C
		495299	B, WING			1 0	3/09/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FI IZABE	TH ADAM CRUMP H	EALTH AND REHAB			00 MOUNTAIN ROAD		
22.2, 122				GL	EN ALLEN, VA 23060		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 2 7 5	Continued From pa	age 21	F 2	75			
		mprehensive assessment of a	:		F275		
		nce with the timeframes					
		aphs (b)(2)(i) through (iii) of			 Resident #1 expired. 		
		meframes prescribed in	:		2. Each resident's MDS has	tho	
	§413.343(b) of this	chapter do not apply to CAHs.	A SECOND COMPANIES AND A SECOND COMPANIES AND ASSESSMENT ASSESSMEN				
	(iii) Not loss than o	nce every 12 months.			potential of being affected	•	:
		NT is not met as evidenced			3. A calendar for annual		
	by:		:		assessments due for the		:
		erview, facility document review			remainder of the year was		•
		review, it was determined that			implemented. Both MDS		:
		ed to complete an annual MDS) assessment in a timely	:		Coordinators were re-edu	rated	
		residents in the survey	:		to OBRA timing of assessn		
	sample; Resident #		1		to OBKA tilling of assessing	ients.	
	D - 1.1 1.11	I MDC			4. The Director of Nursing		
	- '	al MDS assessment with and nce date of 7/15/16 was not	•		Services or designee will r	eview	:
	completed until 8/3				the MDS calendar for time	liness	
	•		•		weekly for four weeks the	n	
					monthly for three months		:
	The findings includ	e:			results will be reviewed at		:
	Resident #1 was a	dmitted to the facility on			monthly QAPI meeting for	three	
		agnoses of but not limited to			months to ensure complia		•
		, hemiparesis, chronic	:				
		ary disease, glaucoma,	•		5. Compliance Date: 4/7/	17	
		ssure ulcer, bladder disorder, es, high cholesterol, delusional					:
		s, and mood disorder. The					
	most recent MDS (minimum data set) was a					
		ent with an ARD (assessment					:
	•	1/13/17. The resident was					
		ldly cognitively impaired, ossible 15 on the BIMS (Brief					:
		al Status) exam. Resident #1					
		iring total care for bathing,					
	extensive assistan	ce for hygiene, dressing, and					
	transfers; as indep	endent for eating; and was					·

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

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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	
		495299	B. WING		ı	C 03/09/2017	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	D. WING	STREET ADDRESS, CITY, STATE,		/09/2017	
	ETH ADAM CRUMP H			3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE	
F 275	Continued From page 22 coded as incontinent of bowel and bladder. A review of the annual comprehensive MDS with		F.	275			
	an ARD of 7/15/16	revealed that the Care Area) worksheet summary					
	documentation use completed and dat weeks after the AF of RN Assessment Assessment Compone on 3/8/17 at 10:36 #7 (Registered Nu at one time, the fact the MDS assessment assessment Compone on 3/8/17 at 10:36 #7 (Registered Nu at one time, the fact the MDS assessment Compone of the MDS assessment Compone of the MDS assessment Compone of the factor of the MDS assessment Compone of the factor of the MDS assessment Compone of t	ed to complete this MDS was sed 8/31/16; approximately 6 RD. Section Z0500 "Signature a Coordinator Verifying pletion" was dated 8/31/16. i a.m., during an interview RN rse) an MDS nurse stated that cility was behind on completing ents, but that she was not sure ent was approximately 6 weeks he nurse that completed it was cility.					
	the survey. According to the Commedicaid Services Resident Assessment is a commerce a resident that multiple basis (at least even (Significant Chang SCPA (Significant Assessment) has recent comprehencompleted"	tion was provided by the end of enters for Medicare and Long-Term Care Facility ent Instrument User's Manual 010, page 2-19: "The Annual omprehensive assessment for st be completed on an annual ry 366 days) unless a SCSA e in Status Assessment) or a Correction to Prior been completed since the most sive assessment was					
F 278 SS=D	483.20(g)-(j) ASSE	ESSMENT PRDINATION/CERTIFIED	F	278		:	
	(a) Accuracy of As	sessments. The assessment	1			!	

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Event ID: OL2511

Facility ID: VAO083

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		495299	B. WING			03	3/09/2017
	ROVIDER OR SUPPLIER	HEALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD LEN ALLEN, VA 23060	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION OATE
F 2 7 8	Continued From p	-	F2	2 7 8	F278		
	must accurately re	eflect the resident's status.		:	1. Resident #4 MDS was		:
	(h) Coordination		-		modified on 3/9/17. Resider		
	A registered nurse must conduct or coordinate each assessment with the appropriate		1		#16 was modified on 3/20/1		
o to an angle of the second se	participation of he	alth professionals.			2. Each resident's MDS has t	he	
	(i) Certification		:		potential of being affected.		·
	` '	urse must sign and certify that			The height and weight on		I ·
	the assessment is	completed.			MDS's were reviewed for		!
	(2) Each individua	I who completes a portion of the	:		proper coding and the use o	f	
		sign and certify the accuracy of			the dash. The IDT was re-		l
	that portion of the	assessment.			educated on the proper use	of	
					dashes on the MDS.		:
	 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or 				4. The Director of Nursing Services or designee will revenue the height and weight on the MDS weekly for four weeks then monthly for three monto ensure compliance. Resu	nths	
	and false stateme	er individual to certify a material nt in a resident assessment is noney penalty or not more than assessment.	:		will be reviewed at the mon QAPI meeting for three mor to ensure compliance.		
	(2) Clinical disagre material and false	eement does not constitute a			5. Compliance Datę: 4/7/17		
	Based on staff int and clinical record the facility staff fai MDS (minimum d	terview, facility document review I review, it was determined that iled to maintain an accurate ata set) assessment for two of e survey sample, Residents #4		-			

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		SURVEY			
AND PLAN D	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _	, variety ,		PLETED
		495299	B. WING	.		03/09/2017	
NAME OF I	PROVIDER DR SUPPLIER	455255	1 2. 17,110		REET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	09/2017
,	TH ADAM CRUMP H	EALTH AND REHAB		3 6 0	00 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED CORRECTION (CROSS-REFERENCED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	JX5) COMPLETION DATE
F 278	Continued From pa	age 24	F	278			
e e e e e e e e e e e e e e e e e e e	Resident #4's heig	failed to accurately code ht on an annual MDS n ARD (assessment reference		: :			
	2. The facility staff Resident #16's hei significant change	failed to accurately code ght and weight section on the MDS assessment with an ARD ence date) of 12/28/16.					
	The findings include	e:					
	Resident #4's heig	failed to accurately code ht on an annual MDS n ARD (assessment reference	: - - - :				
	1/16/15. Resident were not limited to weakness and con recent MDS, a sign assessment with a resident's cognitive making as modera the resident's heig Resident #4's annual reside	dmitted to the facility on #4's diagnoses included but high blood pressure, muscle stipation. Resident #4's most inficant change in status in ARD of 1/29/17, coded the eskills for daily decision tely impaired. Section K coded that as 60 inches. Section K of ual MDS assessment with an oded the resident's height as					The same of the sa
	conducted with RN #4 (both MDS coordiscrepancy in height assessments. RN was coding "99" or	a.m., an interview was I (registered nurse) #3 and RN rdinators) regarding the ghts on the above MDS #4 stated at one time, staff in the MDS if staff was unable to height. RN #4 stated	:				

DEPARTMENT OF HEALTH AND HUP I SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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OL: TI	10 1 OIL INIEDIONILLE	- WINDOWN OF CELLANDED				1110 110	. 0000 000 1	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	[X3] DATE SURVEY COMPLETED		
		405300	D WING	ı			C	
	PROVIDER OR SUPPLIER	495299 EALTH AND REHAB	B. WING 03/09/20 STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060					
(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 APPROPED DEFICIENCY)) BE	IX5) COMPLETION DATE	
F 2 7 8	staff was unable to When asked if the inaccurately coded matter of educating manager." RN #3 responsible for ent MDS assessments employed part time didn't have a RAI (instrument) manual the facility when coin her office but co coordinators if she the dietician probal supposed to code obtain a resident's On 3/8/17 at 5:00 pmember) #1 (the alof the above concerns the CMS (Centers)	ras supposed to be coded if obtain a resident's height. 12/29/16 MDS was , RN #4 stated, "It would be a gethe dietician or dietary stated the dietician was ering residents' heights on the and the dietician was only e. RN #3 stated the dietician resident assessment I (the manual referenced by impleting MDS assessments) uld speak to the MDS had questions. RN #3 stated only thought she was still "99" if staff was unable to height.	F	2278				
	Record height to the mathematical roun measurement is X. height upward to the measurement num down to the nearesheight of 62.5 inches	5 inches or greater, round ne nearest whole inch. If height ber is X.1 to X.4 inches, round st whole inch). For example, a less would be rounded to 63 to 62.4 inches would be						
		ocuments, "If a resident , for example because of						

extreme pain, immobility, or risk of pathological

DEPARTMENT OF HEALTH AND HU/ N SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	<u> </u>	СОМ	E SURVEY IPLETED C
		495299	B. WING			03/	09/2017
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		STREET ADDRESS, 3600 MOUNTAIN F GLEN ALLEN, V			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORRECTI DRRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 278	Continued From p	age 26	F 2	278			
		standard no-information code rationale on the resident's		į			
	No further informa	tion was presented prior to exit.					
	Resident #16's he significant change (assessment reference Date) of coded as severely make daily life detotal care for all as	ight and weight section on the ight and weight section on the MDS assessment with an ARD rence date) of 12/28/16. admitted to the facility on iagnoses of but not limited to age, pathological hip fracture, and epilepsy. The most recent ata Set) was a significant ent with an ARD (Assessment of 12/28/16. The resident was a cognitively impaired in ability to be cisions. The resident required reas of activities of daily living ant of bowel and bladder.					
	Section K "Swallo section K0200 He was coded as 99 Record most recemost recemost recemost recent admirresident was code pounds). Base whast 30 days; mea according to standa.m. after voiding etc.)] On 3/8/17 at 10:36	ove identified MDS revealed in wing / Nutritional Status," in ight and Weight, the resident inches [A. Height (in inches) nt height measure since the ssion/entry or reentry.] The ed as 999 pounds [B. Weight (in eight on most recent measure in sure weight consistently, dard facility practice (e.g., in before meal, with shoes off,					
		irse) the MDS nurse, she stated	d i				*

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

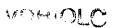
Event 10: OL2511

Facility ID: VA0083

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PRINTED: 03/16/2017 DEPARTMENT OF HEALTH AND HU! I SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAND SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 495299 B. WING 03/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES [X5] COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 27 F 278 that since this section is usually coded with numbers to reflect height and weight, that if there is no height and weight to code, then the section should be dashed (-) instead of using 99 or 999 to reflect that height and weight information was not available. She stated this was a coding error. No further information was provided by the end of the survey. According to CMS's RAI (Centers for Medicaid and Medicare Services Resident Assessment Instrument) Version 3.0 Manual: Steps for Assessment for K0200A, Height 1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches. 2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again. Coding Instructions for K0200A, Height Record height to the nearest whole inch. Use mathematical rounding (i.e., if height measurement is X.5 inches or greater, round height upward to the nearest whole inch. If height

rounded to 62 inches.

measurement number is X.1 to X.4 inches, round down to the nearest whole inch). For example, a height of 62.5 inches would be rounded to 63 inches and a height of 62.4 inches would be

Steps for Assessment for K0200B, Weight

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		& MEDIČA D SERVICES	()(0) 1 0 1	TID	LE CONSTRUCTION		O. 0938-0391 PATE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		LE CONSTRUCTION		OMPLETED
			A. BUILD			İ	С
		495299	B. WING			l o	3/09/2017
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
		TALTH AND DELLAD		;	3600 MOUNTAIN ROAD		
ELIZABE	TH ADAM CRUMP H	EALTH AND REHAB		1	GLEN ALLEN, VA 23060		
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PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR		COMPLETION DATE
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1	-						
F 278	Continued From pa	ge 28	F2	2 7 8	S		
	1. Base weight on t	he most recent measure in the			1		
	last 30 days.						
		consistently over time in					
:		cility policy and procedure, t current standards of practice					
	(shoes off, etc.).	t current standards of practice			7.33		
,		assessments, check the	: !				
		enter the weight taken within					
		of this assessment.					
		ed weight was taken more	!				
		to the ARD of this assessment is not available, weigh the					:
	resident again.	is not available, weight the	:				
		veight was taken more than					
		ceding month, record the					
	most recent weight						:
		for K0200B, Weight					-
		atical rounding (i.e., If weight is more, round weight upward to					:
		bound. If weight is X.1 to X.4	:				:
	lbs, round down to	the nearest whole pound). For					:
		of 152.5 lbs would be rounded	!				:
		eight of 152.4 lbs would be					:
	rounded to 152 lbs	annot be weighed, for example	•				:
		e pain, immobility, or risk of					
		res, use the standard					:
		e (-) and document rationale	:				:
	on the resident's m		_		:		
	483.2 0 (d);483.21(b		F :	279	€		
SS≍D	COMPREHENSIVE	E CARE PLANS	:				i :
	483.20		:				
		nust maintain all resident					•
	assessments comp	pleted within the previous 15	:				
		lent's active record and use the					
		ssments to develop, review	ŧ				
	and revise the resid	dent's comprehensive care					

PRINTED: 03/16/2017

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

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			E CONSTRUCTION		ATE SURVEY OMPLETED
		495299	B. WING				C 93/09/2017
	ROVIDER OR SUPPLIE	R HEALTH AND REHAB		3	TREET ADORESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEDEO BY FULL R LSC IOENTIFYING INFORMATION)	ID PREFI TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 279	Continued From plan.	page 29	F2	279			
	pran.		1		1. Resident #6's care plan	was	
					updated to include visual		
	483.21	or Orace Plane			function. Resident #7's ca	re	
elike a silandahan ing ing menjada a mel	(b) Comprehensi	ve Care Plans	: 		plan_was_updated to include	le	
	(1) The facility mu	ust develop and implement a	!		care needs related to her		
	comprehensive p	erson-centered care plan for			history of a mastectomy.		
		nsistent with the resident rights			Resident #11's care plan w	as	
		10(c)(2) and §483.10(c)(3), that			updated to include cogniti	on,	:
		able objectives and timeframes at's medical, nursing, and mental	:		visual function and		:
	and psychosocial	needs that are identified in the ssessment. The comprehensive	:		communication.		
		escribe the following -			2. Each resident's care plan	n has	
		hat are to be furnished to attain			the potential of being affe	cted.	
		esident's highest practicable	-		The comprehensive		
	pnysical, mental,	and psychosocial well-being as 483.24, §483.25 or §483.40; and	:		assessments were reviewe	d for	
					triggered CAA's selected fo	r	
	(ii) Any services t	hat would otherwise be required			care planning to ensure th	e	
		483.25 or §483.40 but are not			presence on the care plan.	The	
		he resident's exercise of rights occuding the right to refuse			IDT was re-educated to pro	oper	:
	treatment under		•		CAA completion and care p	· -	
			•		decision making to formul		
	rehabilitative serverowide as a resurrecommendation findings of the PA	ed services or specialized vices the nursing facility will lit of PASARR s. If a facility disagrees with the ASARR, it must indicate its esident's medical record.			the care plan.		
	(iv)In consultation resident's repres	n with the resident and the entative (s)-					· ;
	(A) The resident'	s goals for admission and					;

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

	OF OEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION		OATE SURVEY OMPLETEO C
		495299	B. WING				3/09/2017
,	PROVIOER OR SUPPLIER	HEALTH AND REHAB		3600	EET AOORESS, CITY, STATE, ZIP COO) MOUNTAIN ROAD EN ALLEN, VA 23060		
(X4) IO PREFIX TAG	(EACH OEFICIENC	TATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE API OEFICIENCY)	IOULO BE	(X5) COMPLETION OATE
F 279	future discharge. I	- -	F 2	2 7 9	4. The Director of Nursir services or designee will CAA's and care plans for	l review	
	local contact agent entities, for this put (C) Discharge plan plan, as appropriate requirements set if section. This REQUIREME by: Based on staff intreview, it was determined to the put of the put o	essessed and any referrals to cies and/or other appropriate arpose. In the comprehensive care te, in accordance with the forth in paragraph (c) of this ENT is not met as evidenced derview and clinical record ermined that the facility staff a comprehensive care plan for			inclusion of triggered CA care plan completion we four weeks then month three months. Results were reviewed at the month meeting for three mont ensure compliance. 5. Compliance Date: 4/1	AA's and eekly for ly for will be y QAPI ths to	
	three of 29 resider Resident #6, Resi 1. The facility staff comprehensive ca area of visual fund MDS (minimum da (assessment refer 2. The facility staff	nts in the survey sample, dent #7 and Resident #11. If failed to develop a are plan for the triggered care ction on Resident #6's annual ata set), with an ARD rence date) of 6/16/17. If failed to develop a care plan to needs related to Resident #7's					
	3. The facility star comprehensive ca areas on Residen (minimum data se	ff failed to develop a are plan for the triggered care t #11's admission MDS at the area of the triggered care t #11's admission MDS at the area of the trigger and the area of the trigger area of trigger area of the trigger area of trigger area of trigger area of trigger area.					

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

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED C
		495299	B. WING			3/09/2017
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 230		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TD THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 2 7 9	10/5/06 and readr that included but v	ns admitted to the facility on mitted on 5/1/12 with diagnoses were not limited to: high blood on's disease (1), dementia,	F:	279		
	The most recent rassessment, with of 2/2/17 coded the short term memor cognitively to make was coded as required activities of dail activities of the annual case of	minimum data set, a quarterly an assessment reference date he resident as having long and ry problems and as impaired the daily decisions. The resident uiring assistance from staff for ly living. The daily decisions are from staff for ly living. The daily decision are decision. The daily decision are decision assistance from staff for ly living. The daily decision are decision assistance from staff for ly living. The daily decision are decision assistance from staff for ly living.				
		nt #6's care plan initiated on vidence documentation related				:
	a.m. with RN (reg MDS coordinators process for develor RN #3 stated, "W make a decision to Resident #6's CA assessment. Who impaired vision, Resided if a care plant RN #4 stated, "Ye vision we should be reviewed Resider there had been a	conducted on 3/8/17 at 11:05 istered nurse) #3 and RN #4, s. When asked about the oping a care plan from the CAA, e sign and date the CAA. We to care plan it." RN #4 reviewed A from the 6/3/16 MDS en asked if the resident had RN #4 stated she did. When an should have been developed, es, because she had impaired that a care plan. RN #4 at #6's care plan. When asked if care plan developed for visual tated, "No." When asked what				

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			CON	(X3) DATE SURVEY COMPLETED		
		495299	B. WING				/09/2017	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		3600 MC	ADDRESS, CITY, STATE, ZIP CO DUNTAIN ROAD ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE	
F 279	assessments, RN	page 32 d for completing the MDS N #4 stated they used the RAI ment instrument).	F 2	279				
		p.m. ASM (administrative staff administrator was made aware		W. (1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		The state of the s		
	comprehensive a completion of both process, as well Comprehensive a upon admission, change in a resid	assessments are completed annually, and when a significant lent's status has occurred or a tion to a prior comprehensive						
	(1) Parkinson's d (PD) is a type of when nerve cells enough of a brain Sometimes it is g seem to run in fa the environment information was	ation was provided prior to exit. isease Parkinson's disease movement disorder. It happens in the brain don't produce n chemical called dopamine. genetic, but most cases do not milies. Exposure to chemicals in might play a role. This obtained from: us.gov/parkinsonsdisease.html						
	(2) Atrial fibrillation with the speed or fibrillation (AF) is arrhythmia. The electrical system	on - An arrhythmia is a problem rhythm of the heartbeat. Atrial the most common type of cause is a disorder in the heart's . This information was obtained llineplus.gov/atrialfibrillation.html						
	2. Resident #7 w	as admitted to the facility on					:	

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DEPARTMENT OF HEALTH AND HUN I SERVICES CENTERS FOR MEDICARE & MEDICADU SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`'	TIPLE CONSTRUCTION NG		MPLETED C	
		495299	B. WING		03	/09/2017	
	PROVIOER OR SUPPLIER	REALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP O 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	OOE		
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION OATE	
F 279	diagnoses that inc	page 33 dmitted on 11/29/16 with cluded but were not limited to: stroke, high blood pressure and	F 2	79 :			
	change assessme coded the resider on the BIMS (brie indicating the resimake daily decision requiring assistant daily living. Review of the nur documented, "A feextremities, and labreast has been resider."						
	11/29/16 docume	ical health status notes dated nted, "Skin Concern #1. Site: st. Description: surgical scar ."					
	revised on 11/16/	e plan initiated on 2/5/16 and 16 did not evidence garding Resident #7's history of tectomy.					
	a.m. with LPN (lic unit manager. Wh plan, LPN #1 stat asked why a resid stated, "It's to lay Resident #7 had mastectomy, LPN LPN #1 reviewed	conducted on 3/9/17 at 9:15 ensed practical nurse) #1, the nen asked who used the care ed, "MDS and nursing," When dent had a care plan, LPN #1 out their care." When asked if a care plan related to her I #1 stated, "She should have." the care plan and stated there for the mastectomy. When					

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIOER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB (X4) IO SUMMARY STATEMENT OF OEFICIENCIES IO PROVIOER'S PLAN OF CORRECTION (X5) (FACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.) B. WING STREET ADORESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060 (X5) (FACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)		OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION		TE SURVEY MPLETEO
ELIZABETH ADAM CRUMP HEALTH AND REHAB COLID SUMMARY STATEMENT OF OFFICIENCIES DISCHARLEN, VA 20060 PROVIDERS PLAN OF CORRECTION (EACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH OFFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH OFFICIENCY) COMPARISON C			495299	B. WING		03	C 5/09/2017
FREEN TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 279 Continued From page 34 asked if there was any special care provided to residents with mastectomies, LPN #1 stated, "You don't take a blood pressure on that arm." An interview was conducted on 3/9/17 at 9-45 a.m. with LPN #12, the nurse caring for Resident #7. When asked if there was any special care provided to residents with mastectomies, LPN #12 stated, "Don't do blood pressure checks on that arm." Check that they don't have edema (swelling)." When asked how this would be communicated, LPN #12 stated, "Sometimes they have a sign above their bed not to take them (blood pressure) on that arm." When asked if the resident had a sign over her bed, LPN #12 stated, "No, she doesn't. It should be care planned." On 3/9/17 at 11:12 a.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings. No further information was provided prior to exit. 3. Resident #11 was admitted to the facility on 12/4/16 with diagnoses that included, but were not limited to; dementia, high blood pressure, heart failure and a history of a rectal prolapse. Resident #11's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 12/10/16. Resident #11 was coded on the BIMS (brief interview of mental status) as having a score of seven out of a possible 15, indicating					3600 MOUNTAIN ROAD		
asked if there was any special care provided to residents with mastectomies, LPN #1 stated, "You don't take a blood pressure on that arm." An interview was conducted on 3/9/17 at 9:45 a.m. with LPN #12, the nurse caring for Resident #7. When asked if there was any special care provided to residents with mastectomies, LPN #12 stated, "Don't do blood pressure checks on that arm. Check that they don't have edema (swelling)." When asked how this would be communicated, LPN #12 stated, "Sometimes they have a sign above their bed not to take them (blood pressure) on that arm. When asked if the resident had a sign over her bed, LPN #12 stated, "No, she doesn't. It should be care planned." On 3/9/17 at 11:12 a.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings. No further information was provided prior to exit. 3. Resident #11 was admitted to the facility on 12/4/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, heart failure and a history of a rectal prolapse. Resident #11's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 12/10/16. Resident #11 was coded on the BIMS (brief interview of mental status) as having a score of seven out of a possible 15, indicating	PREFIX	(EACH OEFICIENG	CY MUST BE PRECEOEO BY FULL	PREF	X (EACH CORRECTIVE AC CROSS-REFERENCEO TO	TION SHOULO BE THE APPROPRIATE	(X5) COMPLETION DATE
a.m. with LPN #12, the nurse caring for Resident #7. When asked if there was any special care provided to residents with mastectomies, LPN #12 stated, "Don't do blood pressure checks on that arm. Check that they don't have edema (swelling)." When asked how this would be communicated, LPN #12 stated, "Sometimes they have a sign above their bed not to take them (blood pressure) on that arm." When asked if the resident had a sign over her bed, LPN #12 stated, "No, she doesn't. It should be care planned." On 3/9/17 at 11:12 a.m. ASM (administrative staff member) #2, the director of nursing was made aware of the findings. No further information was provided prior to exit. 3. Resident #11 was admitted to the facility on 12/4/16 with diagnoses that included, but were not limited to; dementia, high blood pressure, heart failure and a history of a rectal prolapse. Resident #11's most recent MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 12/10/16. Resident #11 was coded on the BIMS (brief interview of mental status) as having a score of seven out of a possible 15, indicating	F 279	asked if there was residents with ma don't take a blood	s any special care provided to stectomies, LPN #1 stated, "You pressure on that arm."		279		
set) assessment was an admission assessment with an ARD (assessment reference date) of 12/10/16. Resident #11 was coded on the BIMS (brief interview of mental status) as having a score of seven out of a possible 15, indicating		a.m. with LPN #12 #7. When asked i provided to reside #12 stated, "Don't that arm. Check ti (swelling)." When communicated, Li have a sign above (blood pressure) or resident had a sign "No, she doesn't. On 3/9/17 at 11:12 member) #2, the aware of the finding No further information. 3. Resident #11 v 12/4/16 with diagrant limited to; den	2, the nurse caring for Resident f there was any special care ents with mastectomies, LPN to do blood pressure checks on that they don't have edema asked how this would be PN #12 stated, "Sometimes they to their bed not to take them on that arm." When asked if the gn over her bed, LPN #12 stated, It should be care planned." 2 a.m. ASM (administrative staff director of nursing was made ngs. ation was provided prior to exit. was admitted to the facility on noses that included, but were nentia, high blood pressure,				
impaired. Further review of Resident #11's MDS with an		set) assessment with an ARD (ass 12/10/16. Reside (brief interview of score of seven outhat Resident #11 impaired.	was an admission assessment essment reference date) of ent #11 was coded on the BIMS mental status) as having a ut of a possible 15, indicating was severely cognitively				

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		(r	SOINITED:	02/46/2047
	MENT OF HEALTH	AND HUN SERVICES & MEDICALD SERVICES			(FORM	: 03/16/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		495299	B. WING _			l l	09/2017
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		i
ELIZABE	TH ADAM CRUMP H	EALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 279	Continued From pa	ige 35	F 27	79			
	•	, that the care areas "02.	!				
	Cognitive Loss/Den	nentia. 03. Visual Function.					:
	=	"were checked under the		:			1
	heading "B. Care P	lanning Decision" to be care	: I				·
	states "2 For each	truction provided in Section V n triggered Care Area, indicate				THE PARTY AND ADDRESS OF THE PARTY ADDRESS OF THE PARTY ADDRESS OF THE PARTY AND ADDRESS OF THE	· · · · · · · · · · · · · · · · · · ·
	whether a new care	e plan, care plan revision, or		;			:
		ent care plan is necessary to					
		m(s) identified in your		1			
		care area. Check column B if	:				
	the triggered care a plan."	area is addressed in the care					:
	pian.						
	A review of Resider	nt #11's comprehensive care					
		16 did not reveal a care plan to					
	address cognition,	vision or communication.					
	On 2/9/47 at 11:15	a.m. an interview was					
		(registered nurse) #3 and RN					
		dinators at the facility. RN #3	-				-
	was asked who wa	s responsible for developing					•
	and updating care	plans. RN #3 stated that the					-
	unit managers and	nursing did input updates on					
		vell as the MDS coordinators. ed that the MDS coordinators					
		plans from the CAAs. RN #4					
	was asked to desc	ribe the process of developing	•				1
	a care plan. RN#4	4 stated that the process would					
		AAs, understand why the areas					
	triagered, where th	e information was located in					

the clinical data and whether or not a care plan would be developed for the triggered area. RN #3 was asked to review Resident #11's MDS, specifically Section V. RN #3 was then asked to

demonstrate where cognition, vision and communication were care planned in Resident #11's care plan. RN #3 reviewed both Section V and Resident #11's care plan and was unable to

demonstrate that cognition, vision and

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CON	CON	(X3) DATE SURVEY COMPLETED C		
		495299	B. WING		· <u>·····</u>		/09/2017
	PROVIDER OR SUPPLIER T H ADAM CRUMP H	HEALTH AND REHAB		3600 M	FADDRESS, CITY, STATE, ZIP CO OUNTAIN ROAD ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 279	that she did not se RN #3 further state put them (cognitio there." RN #3 was	ere care planned. RN #3 stated be those areas care planned. ed, "It is possible we forgot to n, vision and communication) in as asked what she used as a	F2	279			
F 281 SS=D	developing care plused the RAI (resion of the RAI (resion of the above concrequested for the constraints) did not have a political record of the survey 483.21(b)(3)(i) SE PROFESSIONAL (b)(3) Comprehen The services provas outlined by the mustical record facility staff failed	RVICES PROVIDED MEET STANDARDS	F:	281			

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PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495299	B, WING			0	3/09/2017
	PRDVIDER OR SUPPLIEF	HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	Continued From p	age 37	F:	281	F281		
		iled to prevent staff from taking od pressure on her left			 Resident #7 blood pressur order was clarified to state the no blood pressure is to be ta 	nat	
	The findings include:				in the left arm related to her		
	12/18/15 and read diagnoses that inc	admitted to the facility on Imitted on 11/29/16 with luded but were not limited to: troke, high blood pressure and			mastectomy. 2. An audit of each resident with a mastectomy will be conducted to ensure orders		
	Review of the most recent MDS, a significant change assessment, with an ARD of 1/7/17 coded the resident as having scored 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of				state that no blood pressure to be taken in the arm on the side of the mastectomy. 3. Licensed staff will be reeducated on the standards of practice of caring for residen	f	
	daily living.				with a diagnosis of mastecto		
	documented, "A fe extremities, and la	view of the nurse's note dated 12/18/15 cumented, "A few small scars on buttock and remities, and large scar left chest where ast has been removed."			4. The Director of Nursing Services or designee will conduct audits on residents		
	11/29/16 documer	ical health status notes dated nted, "Skin Concern #1. Site: t. Description: surgical scar			who have had a mastectomy ensure that blood pressures a being completed according to standards of practice. Audits	are O	:
	revised on 11/16/1	e plan initiated on 2/5/16 and l6 did not evidence garding Resident #7's history of ectomy.	:		will be performed weekly for four weeks the monthly for three months. Results will be reviewed at the monthly QAF	e	
	11/1/16 to 2/15/17	od pressure summary log from documented that the resident ssure taken on her left arm on	'		meeting to ensure compliance 5. Compliance Date: 4/7/17	e.	:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 03/09/2017
	PROVIDER OR SUPPLIE	<u> </u>		STREET ADDRESS, CI 3600 MOUNTAIN RO GLEN ALLEN, VA	AD	00,00,2011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
F 281	Continued From p		F 2	281		
	a.m. with OSM (o resident's physicia	conducted on 3/9/17 at 9:12 ther staff member) #4, the an. When asked if it would be				
	Resident #7's left not advisable. Wh	aff to take blood pressures on arm, OSM #4 stated, "No, it is nen they do a mastectomy they biopsy. No they shouldn't do on the left (arm)."				
	a.m. with LPN (lic unit manager W special care provi mastectomies, LF blood pressure or the blood pressur	conducted on 3/9/17 at 9:15 ensed practical nurse) #1, the /hen asked if there was any ded to residents with PN #1 stated, "You don't take an that arm." LPN #1 reviewed se summary log documenting res had been taken on Resident				
	a.m. with LPN #1 #7. When asked a provided to reside #12 stated, "Don' that arm. Check t (swelling)." When communicated, L have a sign abov (blood pressure) resident had a sig "No she doesn't."	conducted on 3/9/17 at 9:45 2, the nurse caring for Resident if there was any special care ents with mastectomies, LPN t do blood pressure checks on hat they don't have edema asked how this would be PN #12 stated, "Sometimes they e their bed not to take them on that arm." When asked if the gn over her bed, LPN #12 stated, it should be care planned."				
	member) #2, the aware of the findi professional stan	2 a.m. ASM (administrative staff director of nursing was made ngs. When asked what dard the nurse's used, ASM #2 t." No further information was				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495299	B, WING		03	/09/2017
	PROVIDER OR SUPPLIER TH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 281	Continued From pa	it.	F2	281		
	Practice Edition 10 "PATIENT EDUCAT	cott Manual of Nursing documented on page 893, FION GUIDELINESTo		1 1		; !
	the removal of lym guidelines to preve blood and lymph flu pressure taken on a	RVICES BY QUALIFIED		282		
		ive Care Plans led or arranged by the facility, comprehensive care plan,				
	care. This REQUIREMENT by: Based on staff interview, and clinical determined that the the written plan of control of the state of the s	qualified persons in ach resident's written plan of NT is not met as evidenced erview, facility document record review, it was a facility staff failed to follow care for three of 29 residents in Residents #6 and 12				
		d to keep Resident #6's heel times as care planned and sician.	:			
	2.a. The facility state #12's written plan of administration.	ff failed to follow Resident of care for oxygen				
	b. The facility staff	failed to follow Resident #12's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				ATE SURVEY DMPLETED
		495299	B. WING			0	C 3/09/2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	' 	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
	~:. 4 D 414 OD 1140 11	EALTH AND DELIAD	1	360	00 MOUNTAIN ROAD		
ELIZABE	TH ADAM CRUMP H	EALTH AND REHAB		GL	LEN ALLEN, VA 23060		
(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 APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 40	F 2	282			
	written plan of care restriction.	e for the monitoring of fluid		;	F282		
	The findings include	le:			1. A) The physician's order	rfor	
	-				heel protectors for Reside		į
	1. Facility staff failed to keep Resident #6's heel protectors on at all times as care planned and				was clarified by the physic		
	ordered by the physician.			-	and the care plan has bee	n	
			:		updated. B) Resident #12	care	
	Resident #6 was admitted to the facility on 10/5/06 and readmitted on 5/1/12 with diagnoses				plan has been reviewed ar	nd is	
		rere not limited to: high blood			being followed for oxygen		į
		on's disease (1), dementia,			administration. C) Residen	t #12	:
	irregular heart bea	t and arthritis.	:		care plan has been review		:
	The most recent m	ninimum data set, a quarterly			and is being followed for t		:
		an assessment reference date			monitoring of fluid restrict	ions.	:
		e resident as having long and y problems and as impaired			2. A) A review of residents	with	
	cognitively to make	e daily decisions. The resident			heel protectors was condu	cted	
		uiring assistance from staff for			to ensure utilization as per	-	
	all activities of dail	y living.			physician order and is care	!	:
	Review of the phys	sician's orders dated 9/27/16			planned. B) A review of res	sident	:
	documented, "Pre-	valon boots (3) to bilateral feet	İ		oxygen concentrators was		
	at all times, remov every shift."	e for hygiene and skin checks			conducted to ensure the se	etting	į
	every stillt.		i !		is as per physician orders.	•	!
		ruary 2017 treatment			review of resident's who a	re on	
		ord documented, "Prevalon			fluid restrictions was condi	ucted	
		eet at all times, remove for checks every shift."	1		to ensure physician orders	were	:
	nygiene and skin c	Moone of only office.			being followed.		
	revised on 2/15/17 for Pressure ulcer mobility and toiletii (extremities). Inter	e plan initiated on 12/15/11 and documented, "Focus At risk due to: requires Assist with bedingedema to lower ext's ventions. Prevalon Boots on at r hygiene and bathing."	1				

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IOENTIFICATION NUMBER:		` '	ING		COMPLETEO		
		495299	B. WING		03	C / 09/201 7	
	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOR 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		03/09/2017	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFI TAG		OULO BE	(X5) COMPLETION OATE	
F 282	of Resident #6. Th	age 41 s made on 3/7/17 at 3:35 p.m. e resident was in bed. The rearing the heel boots.	F2	282 3. A) Licensed staff will be educated on following the of care for heel protector Licensed staff will be re-	e plan		
	of Resident #6. The dining room. She was crocs shoes. An observation was of Resident #6. The	s made on 3/8/17 at 8:55 a.m. e resident was sitting in the vas wearing a white pair of s made on 3/8/17 at 4:25 p.m. e resident was in the as wearing the white shoes.		educated on following the of care for oxygen administration. C) Licens staff will be re-educated following the plan of care the monitoring of fluid restrictions.	sed on		
	of Resident #6. Th	s made on 3/9/17 at 9:30 a.m. e resident was sitting up in a ed. She was wearing the white		4. A) Audits of heel proto B) oxygen therapy and C restrictions will be condo) fluid ucted		
	p.m. with ASM (ad the director of nurs #1, the assistant d informed of the ab asked if the reside on, ASM #2 stated	conducted on 3/8/17 at 4:25 ministrative staff member) #2, sing and RN (registered nurse) irector of nursing. ASM #2 ove observations. When nt was to have protective boots I, "(RN #1) is she to have ted, "Yes. She had a heel sore"		weekly for four weeks the monthly for three weeks Results of audits will be reviewed at the monthly meeting for three month sustain compliance. 5. Compliance Date: 4/7	s. , QAPI ns to		
	a.m. with LPN (lice unit manager. Whe care plans, LPN # care." When asker follow the care plan. An interview was of	conducted on 3/9/17 at 9:15 ensed practical nurse) #1, the en asked why residents had 1 stated, "It's to lay out their d if staff were expected to n, LPN #1 stated, "Yes." conducted on 3/9/17 at 9:38 rtified nursing assistant) #2, the					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495299	B. WING	B. WING		03/09/2017		
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			•	360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060			
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION OATE	
F 282	Continued From pa	age 43	F	282				
	with the speed or rifibrillation (AF) is the arrhythmia. The can electrical system.	- An arrhythmia is a problem hythm of the heartbeat. Atrial he most common type of use is a disorder in the heart's his information was obtained heplus.gov/atrialfibrillation.html						
	This information was https://search.nih.g %E2%9C%93&affiots&commit=Search	jov/search?utf8= liate=nih&query=prevalone+bo ch		•				
	2.a. The facility sta #12's written plan of administration.	ff failed to follow Resident of care for oxygen						
	2/2/16. Resident # were not limited to: chronic obstructive disease. Resident (minimum data set an ARD (assessme coded the resident impaired. Section	admitted to the facility on 12's diagnoses included but heart failure, diabetes and pulmonary (respiratory) #12's most recent MDS), an annual assessment with ent reference date) of 1/17/17, is cognition as severely G coded Resident #12 as with setup help only with motion.						
	a physician's order physician on 1/29/ for oxygen at two li	t #12's clinical record revealed summary signed by the 17 that documented an order ters per minute via nasal ess of breath as needed.						
	on 4/12/16 docume	mprehensive care plan initiated ented, "Alteration in Respiratory o) Dx (diagnosis) of COPD						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
							С
	. <u>-</u>	495299	B. WING			03/	09/2017
	PROVIDER OR SUPPLIER T H ADAM CRUMP H I	EALTH AND REHAB		30	TREET ADDRESS, CITY, STATE, ZIP CODE		
				G	SLEN ALLEN, VA 23060		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊΧ	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CROSS-REFERENCE)	D BE	(X5) COMPLETION OATE
E 292	Cartinued Frances	ano 11		202			
F 202	Continued From pa	-	۲,	282			
	(chronic obstructive disease)Intervent needed per Physici	tions: Administer oxygen as					
		.m., observation of Resident	1				
		I. The resident's oxygen				- Professor Marille State Assessment	:
		in the bed while the resident					
	•	r hands. When asked if she					
		all the time, Resident #12 out to put her oxygen back on					-
		al cannula back on her face.					
		gen concentrator flowmeter					
		tioned between the line for one	:				-
		the line for two liters. When	:				:
		djusts the flowmeter knob on trator, Resident #12 stated she	: : :				:
	On 3/7/17 at 3:35 r	o.m., Resident #12 was					
		the oxygen nasal cannula. The	1.				:
		concentrator flowmeter was					1
	•	n the line for one and a half					
	liters and the line for	or two liters.					
	0 = 0/0/47 = + 44:05	Booldont #12 was	!				
		a.m., Resident #12 was					:
		the oxygen nasal cannula. The concentrator flowmeter was	•				:
	, ,	the line for one and a half	1				
		or two liters. This observation	:				-
	was confirmed by a						:
	•						:
		a.m., an interview was					
		N (licensed practical nurse) #6	•				!
	` -	or Resident #12). LPN #6 was	:				
		where the ball in the oxygen	:		•		
		eter should be located if a					:
		sician's order for two liters;					

concentrator and stated the middle of the ball

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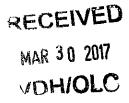
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		495299	B. WING		03	3/09/2017	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB	1	STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
	Resident #12 kne on and off but she the resident adjustated she check once a day to mathe prescribed rankesident #12's or stated, "To me it's to go up a little bi flowmeter knob s resting on the two flowmeter ball was wasn't completely asked how facility plans are followed cards to follow ar plans in the compound on 3/8/17 at 11:5 conducted with L facility staff ensure followed. LPN #1 was relayed to no change report, no plans and CNAs #12's care card (is A&O (alert and	wo liter line. LPN #6 stated we how to turn her concentrator to (LPN #6) had not ever seen at the flowmeter knob. LPN #6 as the resident's concentrator ke sure the flowmeter is set at the of two liters. When shown aygen concentrator, LPN #6 and the on that the middle of the ball was a liter line. LPN #6 stated the can't completely on two liters and ay off two liters. LPM #6 was a staff ensures residents' care d. LPN #6 stated the CNAs had and nurses could look at the care	F 2	282	NCY)		
		p.m., ASM (administrative staff administrator) was made aware cern.					
	documented, "1. flow and method	titled, "Oxygen Administration' Check physician's order for liter of administration6. Nasal of tubing to humidifier outlet and s ordered"	:				

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

Event ID: OL2511

Facility ID: VA0083

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DEPARTMENT OF HEALTH AND HUN I SERVICES CENTERS FOR MEDICARE & MEDIC. J SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION ING	COMPLETED		
		495299	B. WING		03	/09/2017	
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	ARAGA RECEDENACE TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From p	page 46	F:	282			
	documented, "No flowmeter, locate the flowmeter. No ball rises to the li	entrator operator's manual te: To properly read the the prescribed flowrate line on ext, turn the flow knob until the ne. Now, center the ball on the hinute) line prescribed"					
	No further inform	ation was presented prior to exit	•				
		ff failed to follow Resident #1 2 's re for the monitoring of fluid					
	order summary s 1/29/17 documer	ent #12's most recent physician's igned by the physician on nted, "1.5L (liters) fluid restriction d to HEART FAILURE"				:	
	on 4/12/16 docur Status r/t (related (chronic obstructi	entions: Diet and fluid restriction	У				
	MARs (medication documented, "1.5 related to HEART centimeters) from The MARs document for day shift, 360	anuary 2017 and February 2017 on administration records) 5L fluid restriction every shift FAILURE1260cc (cubic dietary 240cc from nursing" mented an allowance of 480cc for evening shift and 360cc	:				
	documented, "1.5 related to HEAR 240cc from nursi	esident #12's March 2017 MAR 5L fluid restriction every shift F FAILURE1260cc from dietan ng" The MAR failed to	; y				

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Event ID: OL2511

Facility ID: VA0083

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PRINTED: 03/16/2017 DEPARTMENT OF HEALTH AND HUI 1 SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING ____ B. WING 495299 03/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID COMPLETION (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 282 F 282 Continued From page 47 to evidence each shift monitored/communicated how much fluid was administered. On 3/8/17 at 11:28 a.m., an interview was conducted with LPN (licensed practical nurse) #6 regarding the facility process for the documentation and monitoring of fluid restriction. LPN #6 stated the dietary department gave residents with fluid restrictions a certain amount of fluids and then the nursing department was allowed to give residents a certain amount each shift. LPN #6 stated each nursing shift documented how much fluid was given to the residents on fluid restrictions. LPN #6 was asked to look at Resident #12's March 2017 MAR. This surveyor asked LPN #6 if the process was for each nursing shift to document how much fluid

was given to the resident each shift. LPN #6 stated she gives Resident #12 60cc of fluid in the mornings and the resident receives fluids on her lunch tray. LPN #6 stated Resident #12 is non-compliant with fluid restrictions when she goes out of the facility (note- review of the resident's progress notes revealed the resident was non-compliant with fluid restriction). LPN #6

documentation for each shift on Resident #12's March 2017 MAR. LPN #6 was asked how the resident's fluid intake/restriction was monitored each shift and how nursing staff communicated the resident's fluid intake each shift. LPN #6 stated, "Usually when we give report, we go through that." LPN #6 stated she didn't know if all nurses report the resident's fluid intake during shift change report and confirmed she didn't see documentation of Resident #12's fluid intake for each shift on the March 2017 MAR. LPN #6 was asked how facility staff ensures residents' care plans are followed. LPN #6 stated the CNAs had

confirmed she didn't see fluid intake

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI			(X3) DATE SURVEY COMPLETED		
			A. BOILL	vo	<u> </u>	l c	
		495299	B. WING	;		1	/ 0 9/ 201 7
NAME OF	PROVIDER OR SUPPLIER	<u> </u>			REET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABE	ETH ADAM CRUMP H	EALTH AND REHAB		}	00 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 48	F	282			•
,	•	nurses could look at the care	,				
		a.m., an interview was N #1 (unit manager) regarding		:			
	monitoring of fluid amount of fluid to be fluid restriction is do between how much trays and how much LPN #1 stated each amount of fluid give administration and supplements that a stated nurses docueach shift on the Meach nurse knows during the previous be given during the only thing I can say #1 stated she coul so. LPN #1 was a residents' care plan care plan information CNAs during shift at the care plans a (note-Resident #1)	for the documentation and restriction. LPN #1 stated the pe given to each resident on ifferent and is broken down ifferent and is broken down ifferent and is broken down ifferent and is broken down ifferent and is broken down if fluids are served on meal ch should be given by nurses. In nurse has to calculate the en during medication the nurse must include are administered. LPN #1 ument the amount of fluid given IAR. LPN #1 was asked how how much fluid has been given is shift and how much fluid can be shift. LPN #1 stated, "The y is they tell each other." LPN if and not confirm every nurse did asked how facility staff ensures in are followed. LPN #1 stated for is relayed to nurses and change report, nurses can look and CNAs have care cards 2's care card (no date) occ fluid restriction"					
	member) #1 (the a	o.m., ASM (administrative staff administrator) was made aware ern. A policy regarding fluid owing care plans was					
		a.m., ASM #1 stated the hausted all of their efforts to ed policies.					

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Event ID: OL2511

Facility ID: VA0083

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

		(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .	CONSTRUCTION	COMPLETED	
		495299	B. WING		03/09/2017	
	PROVIDER DR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB	360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTID (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 282	Continued From pa	ge 49	F 282	F309		
		ion was presented prior to exit.) PROVIDE CARE/SERVICES ELL BEING	F 309	 Resident #12 fluid restriction order has been revised on EMAR to include the amount 	the	
	applies to all care a residents. Each re facility must provide services to attain or practicable physical well-being, consiste comprehensive asservices. (k) Pain Managemet The facility must errovided to resident consistent with provided to resident consistent with provided to resident consistent with provided to residents who requised and the residents who requiservices, consistent of practice, the concare plan, and the preferences. This REQUIREME by: Based on staff intereview, it was determined to maintain a well-being for one cample, Resident #	andamental principle that and services provided to facility sident must receive and the extremental the necessary care and remaintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care. The sure that pain management is a ts who require such services, fessional standards of practice, a person-centered care plan, goals and preferences. The cility must ensure that a prehensive person-centered that with professional standards a prehensive person-centered residents' goals and The is not met as evidenced erview and clinical record remined that the facility staff resident's highest level of the for 29 residents in the survey		fluid per shift. 2. A review of residents on restrictions was conducted ensure the amount of fluid shift is on the EMAR. 3. Licensed staff will be reeducated on the appropria procedure to input fluid restriction as ordered by the physician on the EMAR. 4. Audits of residents who fluid restriction orders will conducted weekly for four weeks then monthly for the months. Results of the audit will be reviewed at the mo QAPI meeting for three moto sustain compliance. 5. Compliance Date: 4/7/17	to per te have be ree lits nthly	

	MENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES				FOR	D: 03/16/2017 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		495299	B. WING			0	3/09/2017
	PROVIDER OR SUPPLIER TH ADAM CRUMP H	EALTH AND REHAB		;	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	JX5) COMPLETION DATE
F 309	Continued From pa physician ordered f 2017.	age 50 fluid restriction during March	F3	309)) :		
	The findings includ	e:					
	2/2/16. Resident # were not limited to: chronic obstructive disease. Resident (minimum data set an ARD (assessme coded the resident impaired. Section	admitted to the facility on 12's diagnoses included but heart failure, diabetes and pulmonary (respiratory) #12's most recent MDS; an annual assessment with ent reference date) of 1/17/17, 's cognition as severely G coded Resident #12 as with setup help only with motion.					
	order summary sig	t #12's most recent physician's ned by the physician on ed, "1.5L (liters) fluid restriction to HEART FAILURE"					:
	on 4/12/16 docume Status r/t (related t (chronic obstructiv	tions: Diet and fluid restriction					:
	MARs (medication documented, "1.5L related to HEART centimeters) from The MARs docume for day shift, 360cc for night shift. Res documented, "1.5L	nuary 2017 and February 2017 administration records) fluid restriction every shift FAILURE1260cc (cubic dietary 240cc from nursing" ented an allowance of 480cc c for evening shift and 360cc sident #12's March 2017 MAR fluid restriction every shift FAILURE1260cc from dietary					

PRINTED: 03/16/2017

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

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
			/			С	
		495299	B. WING		03	3/09/2017	
	PROVIDER OR SUPPLIER ET H ADAM CRUMP H I	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	DE		
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F 309	document a fluid al to evidence each sl how much fluid was	" The MAR failed to lowance for each nursing shift hift monitored/communicated sheing administered.	F3	309			
	conducted with LPN regarding the facilit documentation and LPN #6 stated the cresidents with fluid of fluids and then the allowed to give resishift. LPN #6 state documented how mesidents on fluid reto look at Resident surveyor asked LPN each nursing shift to was given to the restated she gives Recentimeters) of fluid resident receives fluid restrictions when should restriction when should restriction. LF fluid intake documented the shift. LPN #6 state report, we go through didn't know if all nursintake during shift con the control of the co	a.m., an interview was N (licensed practical nurse) #6 y process for the monitoring of fluid restriction. dietary department gave restrictions a certain amount he nursing department was dents a certain amount each deach nursing shift nuch fluid was given to the estrictions. LPN #6 was asked #12's March 2017 MAR. This N #6 if the process was for a document how much fluid sident each shift. LPN #6 esident #12 60cc (cubic din the mornings and the uids on her lunch tray. LPN #6 in the mornings and the uids on her lunch tray. LPN #6 in the mornings and the uids on her lunch tray. LPN #6 in the mornings and the uids on her lunch tray. LPN #6 in the mornings and the uids on her lunch tray. LPN #6 in the mornings and the uids on her lunch tray. LPN #6 in the goes out of the facility resident's progress notes in was non-compliant with PN #6 confirmed she didn't see that in for each shift on the hand how nursing staff resident's fluid intake/restriction in shift and how nursing staff resident's fluid intake each d, "Usually when we give gh that." LPN #6 stated she reses report the resident's fluid change report and confirmed mentation of Resident #12's a shift on the March 2017					

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	SURVEY PLETED
		495299	B. WING			1	09/2017
•	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD ILEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	JX5) COMPLETION DATE
F 309	Continued From pa MAR. On 3/8/17 at 11:50	ge 52 a.m., an interview was	F:	309			
	conducted with LPN	I #1 (unit manager) regarding for the documentation and					-
	monitoring of fluid r amount of fluid to b fluid restriction is di between how much trays and how much LPN #1 stated each amount of fluid give administration and supplements that a stated nurses docu each shift on the Market each nurse knows in during the previous be given during the only thing I can say	estriction. LPN #1 stated the e given to each resident on fferent and is broken down fluids are served on meal n should be given by nurses. In nurse has to calculate the en during medication the nurse must include re administered. LPN #1 ment the amount of fluid given AR. LPN #1 was asked how now much fluid has been given shift and how much fluid can ir shift. LPN #1 stated, "The is they tell each other." LPN not confirm every nurse did					
	member) #1 (the ac	.m., ASM (administrative staff dministrator) was made aware rn. A policy regarding fluid ested.					
		a.m., ASM #1 stated the nausted all of their efforts to do policy.					:
	No further informati 483.25(b)(1) TREA PREVENT/HEAL P		F	314			
	(b) Skin Integrity -		:				:

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495299	B. WING	;			03/09/2017
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	Ē	
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F 314	Continued From	page 53	F;	314	4		
	(1) Pressure ulce	ers. Based on the			F314		
	•	assessment of a resident, the	:				
	facility must ensu	ıre that-	:		 Infection control practi 	ces	:
	: : (i) A resident res	nives care consistent with			are being followed for res	sident	
		eives care, consistent with dards of practice, to prevent			#3-wound-treatments.		
	pressure ulcers a	and does not develop pressure individual's clinical condition	:		2. Residents receiving wo	und	
		at they were unavoidable; and	:		care treatments have the	;	
					potential of being affecte	ed.	
	nécessary treatm	n pressure ulcers receives nent and services, consistent with ndards of practice, to promote			3. Licensed staff will be re educated on infection co	e-	:
	healing, prevent	infection and prevent new ulcers	i		_ :		:
	from developing.		:		techniques for wound ca		1
		IENT is not met as evidenced	!		The staff performing wou	und	
	by:	vation staff interview and clinical	:		care treatments will be		:
		vas determined the facility staff			observed randomly to er	ısure	
		wound care care, consistent with	i		proper infection control		
	professional star	ndards of practice, to prevent			techniques are being foll	lowed	
	healing and prev	and in a manner to promote ent infection of a pressure sore	:		during treatments.		:
		idents in the survey sample,			4. Observations of woun	d care	:
	Resident #3.		!		treatments will be condu	ucted	
	The wound nurse	e, LPN (licensed practical nurse)	!		weekly for four weeks th	nen	
		her scissors prior to using them	:		monthly for three month		
	during a dressing	g change for Resident #3.			Results of audits will be		!
			i		reviewed at the monthly	ιΩΛΡΙ	:
	The Paris Soul		:		• - •	•	:
	The findings incl	uae:	:		meeting for three montl sustain compliance.	15 10	
	with diagnoses the to: dementia, dec seizures, depres	admitted to the facility on 2/7/17 nat included but were not limited ep vein thrombosis (blood blot), sion, vitamin D deficiency, and al reflux disease.			5. Compliance Date: 4/7	/17	

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

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			1 ` '		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
		495299	B. WING	i		03/09/2017		
	PROVIOER OR SUPPLIEF	HEALTH AND REHAB		360	REET AOORESS, CITY, STATE, ZIP COO 00 MOUNTAIN ROAD LEN ALLEN, VA 23060			
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F 314	Continued From p	page 54	F	314				
· · · · · · · · · · · · · · · · · · ·	assessment, a sig with an assessme coded the residen make daily cogniti coded as being de	MDS (minimum data set) gnificant change assessment, ent reference date of 2/14/17, at as being severely impaired to live decisions. The resident was ependent or requiring extensive I of her activities of daily living.						
	documented, "Cle with wound cleans	ers dated, 1/31/17, eanse right lateral ankle wound ser, apply Santyl, cover with and dry dressing QD (every nift."						
	2/28/17, documer later ankle wound Pressure sore (1) (centimeters) by 1	wound doctor notes dated, nted Resident #3 had a right , that was a Stage IV (four) measuring 2.3 cm. I.9 cm. by 0.1 depth. It was aving 100% granulation tissue		٠				
	nurse) #3, the wo providing wound of gathered her supplied treatment cart. Lither pocket and cutape. She was no scissors. When a scissors, LPN #3 was asked when LPN #3 stated, "Edressing change." pocket she had re #3 reached into h	5 a.m., LPN (licensed practical und nurse was observed care to Resident #3. LPN #3 plies and placed them on the PN #3 pulled her scissors out of a piece of white adhesive tobserved cleaning the sked if she cleaned her stated, "No, I didn't." LPN #3 scissors should be cleaned. Before I cut anything for a "When asked what was in the emoved the scissors from, LPN er pocket and showed this and keys. LPN #3 proceeded to						

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PRINTED: 03/16/2017 DEPARTMENT OF HEALTH AND HUN **SERVICES** FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 495299 03/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ΙD {X51 (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 55 F 314 provide the dressing change to Resident #3 using the tape cut with the scissors she had not cleaned. On 3/8/17 at 11:20 a.m., during the wound care, RN (registered nurse) #1, the assistant director of nursing, came to assist LPN #3 with the dressing change. RN #1 was asked when a nurse should clean her scissors. RN #1 stated, "Before and after each use." LPN#3 completed the remainder of the dressing change using good technique. An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 3/8/17 at 2:08 p.m., regarding when staff should clean scissors being used for dressing changes. ASM #2 stated, "Before you cut anything." A policy was requested on dressing changes and cleaning of the scissors. ASM #2 was made aware of the concern. The administrator was made aware of the above findings on 3/8/17 at 5:15 p.m. On 3/9/17 at 10:45 a.m. ASM #2 informed this

patients sick.

dressing changes.

surveyor that the facility did not have a policy on

In one study, a researcher gathered scissors that nurses and physicians kept in their pockets, as well as communal scissors left on dressing carts and tables. Three-quarters of the scissors carried microorganisms, including Staphylococcus aureus, Groups A and B streptococcus, and

In a study conducted by the International Conference on Nosocomial and Healthcare related Infections in Atlanta Georgia, March 2000 showed that ordinary items can make your

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

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495299	B. WING		03	6/09/2017	
	PROVIDER OR SUPPLIER TH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZII 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 314	If health care worked alcohol after each use the risk of transmissitudy, contaminate	illi. The solution is quite simple. ers swab the scissors with use, they will virtually eliminate sion of microorganisms. In the d scissors were effectively	F	314·		,	
	alcohol. Reference: Embil JM, Dyck B, potential source of Presented at the 4t Conference on Nos	McLeod J, et al. Scissors as a nosocomial infection? h Decennial International socomial and ated Infections. Atlanta; March					
F 323 SS=D	(1) Unstageable Pr full-thickness skin a Full-thickness skin a Full-thickness skin extent of tissue darbe confirmed becareschar. If slough of 3 or Stage 4 pressing Stable eschar (i.e. erythema or fluctual limb should not be information was obwebsite: http://www.npuap.cc.clinical-resources/r	and tissue loss in which the mage within the ulcer cannot use it is obscured by slough or or eschar is removed, a Stage ure injury will be revealed. dry, adherent, intact without ance) on the heel or ischemic softened or removed. This stained from the following org/resources/educational-and-puap-pressure-injury-stages/1)-(3) FREE OF ACCIDENT	F	323			
	(d) Accidents. The facility must er	nsure that -				:	

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Event ID: OL2511

Facility ID: VA0083

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DEPARTMENT OF HEALTH AND HUI 'SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
			1 5012.2			(
		495299	B. WING			03/0	09/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADORESS, CITY, STATE, ZIP CODE			
ELIZABE	TH ADAM CRUMP HI	EALTH AND REHAB			600 MOUNTAIN ROAD			
			!		LEN ALLEN, VA 23060	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 323	Continued From pa	ge 57	F;	323	F323			
	(1) The resident en	vironment remains as free			1. Resident #11 bathroom was	S		
	from accident haza	rds as is possible; and			repaired by covering the tile			
	(2) Each resident re	eceives adequate supervision			floor with LVT such that there	is		
		ices to prevent accidents.			a smooth surface. The			
		•	!		handrails were secured.			
		e facility must attempt to use			2. Facility and a second			
		tives prior to installing a side or side rail is used, the facility	!		2. Each resident room	r		
	must ensure correct	t installation, use, and	:		bathroom has the potential of	ĺ		
		d rails, including but not limited			being affected.			
	to the following eler	ments.	i : !		3. Each resident room			
	(1) Assess the resid	dent for risk of entrapment			bathroom was reviewed by maintenance staff on 3/8. Ar			
	from bed rails prior			•	i			
	(O) Davieus the entire	and handita of had rails with			floor found to be noncomplia	nt		
		s and benefits of bed rails with dent representative and obtain			was repaired by placing LVT			
,	informed consent p	•	:		over the floor tile to ensure a			
	·				smooth surface throughout th	ne	:	
		bed's dimensions are resident's size and weight.	i		bathroom. Cove base was			
; :		NT is not met as evidenced	:		replaced as needed. Hand rail	is		
	by:				were secured as identified.		:	
		tion, staff interview and facility			Each maintenance staff will b	_		
		t was determined that the maintain a safe and hazard	!		assigned a unit which they wi			
		one of 92 resident bathrooms			be responsible for. A residen	t		
	and one of six med				room maintenance checklist		:	
		ind to adduces atom balta	:		was implemented which		!	
	-	led to address steel bolts, If inch diameter that protruded	:		identifies areas in the residen	t		
		s bathroom floor beside the			room and resident room		:	
	commode above th	e level of the tile floor and in	:		bathroom to observe. Each		:	
	the direct path of R between the comm	esident #11 when moving ode and the sink.			room will be reviewed month	ly.		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		PLE CONSTRUCTION G		C C
		495299	B. WING	}		<u> </u>	03/09/2017
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From p	page 58	F;	32	23		
	The findings inclu	· ·			4. In addition to the		
	rno mango mo					••	:
	Resident #11 was	admitted to the facility on			maintenance checklist, car		
	12/4/16 with diagr	noses that included, but were			keeper round sheets will b		
	not limited to, den	nentia, high blood pressure, a			submitted to the Administ	rator	
	history of rectal p	rolapse and heart failure.			daily for review and follow	ιup.	
	:	(14D0 / 12m m data			Results will be reviewed a	t the	
		ost recent MDS (minimum data	:		monthly QAPI meeting to		
		n assessment with an ARD rence date) of 12/10/16, coded			ensure compliance.		
		naving a BIMS (brief interview of			ensure compnance.		
		ore of seven out of a possible			5. Compliance Date: 4/7/	17	
		ating that Resident #11 is			5. compliance sater 1777		
		ely impaired. Resident #11 was	i				
		uiring supervision and	:				÷
	assistance of one	person for personal hygiene					:
	and extensive ass	sistance of two people for					:
	toileting.		!				
		45	1				
		45 a.m. an observation was					
		t #11 sitting on the edge of her An inspection was made at this	1				:
		oom, shared by Resident #11	:				
		e. On the tiled floor of the					i
		x areas, approximately 3 - 5" in					
	diameter, with mi	ssing tiles and a gray, concrete					1
		had been placed over these					
		spection revealed that in the					
		these areas there was a steel					:
		om the concrete substance; the					:
		httly above the level of the tile,					i
		t flush to the surface. This					
		her foot over the areas to					
		teel bolts were not flush. The baced around the front of the					
		of the areas were in the direct	•				
		commode and the sink causing	1				:
	,	ne who used the bathroom and	:				
	did not wear shoe						

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Event ID: OL2511

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING	i			C 03/09/2017
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		3 60	REET ADDRESS, CITY, STATE, ZIP COI 10 MOUNTAIN ROAD EN ALLEN, VA 23060	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From p	age 59	F	323			
	observed walking sink washing her wearing shoes an	a.m. Resident #11 was around her bathroom and at the hands. Resident #11 was d was performing personal care					
	member) #2, the of (other staff member) #2 (other staff member Resident #11's bath oos M #2 was asked sticking up above os M #2 stated the handrails were seen removed "a inspected the area "These are not sath of the floor." Os Mands over the both and os M #2 acknown sharp and that it would stand where	p.m. ASM (administrative staff director of nursing and OSM er) #2 were asked to inspect throom with this surveyor. ed about the bolts that were the tile surface on the floor. at they were from when the cured to the floor; they had long time ago." OSM #2 as of concern and stated, fe the way they are sticking out M #2 and this surveyor ran our old that was closest to the sink nowledged that the bolt was vas located where the resident moving between the commode 2 stated that he would fix the tely.					
	ASM #1, the adm aware of the above	p.m. a meeting was held with inistrator. ASM #1 was made re findings. A policy regarding fety of resident bathrooms was	:				
F 328 SS=D	end of the survey	(5)(h)(i)(j) TREATMENT/CARE	F	328			

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PRINTED: 03/16/2017 DEPARTMENT OF HEALTH AND HUN **SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _____ B. WING 495299 03/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 328 Continued From page 60 F 328 (b)(2) Foot care. To ensure that residents receive F328 proper treatment and care to maintain mobility and good foot health, the facility must: 1. Resident #12 is receiving oxygen per physician order. (i) Provide foot care and treatment, in accordance with professional standards of practice, including 2. A review of residents utilizing to prevent complications from the resident's oxygen concentrators was medical condition(s) and conducted to ensure the (ii) If necessary, assist the resident in making concentrator was set at appointments with a qualified person, and ordered liters. arranging for transportation to and from such appointments 3. License staff will be reeducated on the oxygen (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who therapy policy. require colostomy, ureterostomy, or ileostomy 4. A review of residents who services, receive such care consistent with professional standards of practice, the use oxygen concentrators will comprehensive person-centered care plan, and be conducted weekly for four the resident's goals and preferences. weeks then monthly times three. Results of audits will be (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services reviewed at the monthly QAPI to ... prevent complications of enteral feeding meeting for three months to including but not limited to aspiration pneumonia, sustain compliance. diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. 5. Compliance Date: 4/7/17 (h) Parenteral Fluids. Parenteral fluids must be

goals and preferences.

administered consistent with professional standards of practice and in accordance with

person-centered care plan, and the resident's

(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure

physician orders, the comprehensive

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PRDVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495299	B. W(NG		03	C /09/2017	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		STREET ADDRESS, C(TY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) (D PREF (X TAG	(EACH DEF(C(E)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	(D PREF TAG		CT(ON SHOULD BE O THE APPROPR(ATE	(X5(COMPLETION DATE	
F 328	Continued From	page 61	F3	328			
	including trached suctioning, is pro professional star comprehensive p	ho needs respiratory care, betomy care and tracheal by ovided such care, consistent with andards of practice, the person-centered care plan, the and preferences, and 483.65 of		·			
	resident who has and assistance, standards of praperson-centered and preferences prosthetic devices. This REQUIREM by: Based on obserinterview, facility record review, it staff failed to pro	The facility must ensure that a s a prosthesis is provided care consistent with professional ctice, the comprehensive care plan, the residents' goals, to wear and be able to use the e. MENT is not met as evidenced vation, resident interview, staff document review and clinical was determined that the facility ovide respiratory care services for ints in the survey sample,					
		failed to administer oxygen to r physician's order.				:	
	The findings incl	ude:					
	2/2/16. Residen were not limited chronic obstruction disease. Reside (minimum data san ARD (assess coded the reside impaired. Section	as admitted to the facility on the thickness of the thick					

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Facility (D: VA0083

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DEPARTMENT OF HEALTH AND HUI SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 03/09/2017	
•••	PROVIDER OR SUPPLIE			360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD .EN ALLEN, VA 23060	, 00	70072011
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.DBE	(X5) COMPLETION DATE
F 328	a physician's orde physician on 1/29 for oxygen at two	omotion. Int #12's clinical record revealed er summary signed by the /17 that documented an order liters per minute via nasal	F3	328			
	Resident #12's co on 4/12/16 docun Status r/t (related (chronic obstructi	ntions: Administer oxygen as					
	#12 was conducted tubing was sitting placed lotion on had wears her oxyger stated she was a and placed the national The ball in the ox was observed poand a half liters a asked if she ever	p.m., observation of Resident ed. The resident's oxygen on the bed while the resident her hands. When asked if she hall the time, Resident #12 bout to put her oxygen back on asal cannula back on her face. ygen concentrator flowmeter sitioned between the line for one and the line for two liters. When adjusts the flowmeter knob on entrator, Resident #12 stated she	The second secon				
	observed wearing ball in the oxyger	ip.m., Resident #12 was g the oxygen nasal cannula. The n concentrator flowmeter was en the line for one and a half for two liters.					
	observed wearing ball in the oxyger	5 a.m., Resident #12 was g the oxygen nasal cannula. The n concentrator flowmeter was en the line for one and a half					1

DEPARTMENT OF HEALTH AND HUM N SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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CENTER	49 LOV MEDICAKE	& MILDIO, AD BLICHOLD			CIVID INC	. 0000 0001	
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		495299	B. WING_		0 3	/09/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
EL IZADE	TU AD AM CDUMD U	FALTU AND DEUAD		3600 MOUNTAIN ROAD			
ELIZABE	ELIZABETH ADAM CRUMP HEALTH AND REHAB			GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION OF CORRECTIVE ACTION	ON SHOULD BE IE APPROPRIATE	IX5) COMPLETION DATE	
	<u> </u>		<u> </u>		,	<u> </u>	
F 328	: Continued From pa	age 63	F 3:	28			
1 020	•	-	1 0				
		or two liters. This observation	!			ļ	
	was confirmed by a	another surveyor.					
	On 3/8/17 at 11:28	a.m., an interview was					
		V (licensed practical nurse) #6	İ	; •			
		or Resident #12). LPN #6 was			. 		
	asked to describe	where the ball in the oxygen					
		eter should be located if a	:				
	resident has a physician's order for two liters;						
		nother resident's oxygen	i i			:	
		tated the middle of the ball					
		o liter line. LPN #6 stated	i				
		how to turn her concentrator	•				
		(LPN #6) had not ever seen	i	:		:	
		the flowmeter knob. LPN #6				į	
		the resident's concentrator	:				
		e sure the flowmeter is set at	!				
	•	of two liters. When shown				i	
		gen concentrator, LPN #6	1			-	
		on two liters but the ball needs		•			
		' LPN #6 adjusted the					
		that the middle of the ball was				İ	
		liter line. LPN #6 stated the	!				
		n't completely on two liters and					
		off two liters. LPM #6 was staff ensures residents' care					
		LPN #6 stated the CNAs had					
	J	nurses could look at the care	:			!	
	plans in the compu						
	•		:			:	
	On 3/8/17 at 11:50	a.m., an interview was	!				
		N #1. LPN #1 was asked how				i	
		s residents' care plans are	1			:	
		stated care plan information	:			:	
		ses and CNAs during shift				!	
		ses could look at the care	-				
		ad care cards (note- Resident				1	
	#12's care card (no	o date) documented, "Resident					

is A&O (alert and oriented)- 02 (oxygen) 2l/min

DEPARTMENT OF HEALTH AND HUI 'SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER: 495299		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	Ι' '	TIPLE CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		495299	B. WING		0:	C 3/09/2017	
NAME OF PROVIOER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB				STREET AOORESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) IO PREFIX TAG	(EACH OEFICIENC)	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	PREFI TAG		ON SHOULO BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 328	On 3/8/17 at 5:00 p	PRN (as needed)" o.m., ASM (administrative staff dministrator) was made aware	F	328			
	documented, "1. C flow and method of	tled, "Oxygen Administration' heck physician's order for liter f administration6. Nasal tubing to humidifier outlet and ordered"		:			
	documented, "Note flowmeter, locate the the flowmeter. Nex ball rises to the line	ntrator operator's manual e: To properly read the ne prescribed flowrate line on kt, turn the flow knob until the e. Now, center the ball on the nute) line prescribed"		· · ·			
	No further informat	ion was presented prior to exit.				:	
F.054	Potter, 6th edition, treated as a drug. such as atelectasis any drug, the dosa should be continued should routinely cheverify that the client oxygen concentrate medication administration."	amentals of Nursing, Perry and page 1122, Oxygen should be It has dangerous side effects, sor oxygen toxicity. As with ge or concentration of oxygen rusly monitored. The nurse eck the physician's orders to t is receiving the prescribed ion. The six rights of stration also pertain to oxygen		354			
	483.35(b)(1)-(3) W DAYS/WK, FULL-1	AIVER-RN 8 HRS 7 FIME DON	F	354			
		aived under paragraph (e) or he facility must use the				:	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		C 03/09/2017		
NAME OF	PROVIDER OR SUPPLIE		7	STREET ADDRESS, CITY, STATE, ZIP		109/2017	
ELIZABETH ADAM CRUMP HEALTH AND REHAB				3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
F 354	(2) Except when (f) of this section, registered nurse nursing on a full t	stered nurse for at least 8 s a day, 7 days a week. waived under paragraph (e) or the facility must designate a so serve as the director of	F3	F354 1. There is RN coverag week for 8 hours per c	day.		
	nurse only when occupancy of 60 This REQUIREM by: Based on staff in review, it was det failed to maintain for eight consecu	the facility has an average daily or fewer residents. ENT is not met as evidenced atterview and facility document the ermined that the facility staff RN (registered nurse) coverage tive hours each day. Tailed to utilize the services of a recutive hours on Saturday day 2/26/17.		Services (DNS) will condaily review to ensure appropriate RN coverage. 3. In-servicing appropriate to contact the DNS who calls in. The staffing coordinator will be into ensure an RN is school days a week for 8 hours.	mplete a e age. riate staff hen an RN -serviced neduled 7		
	assignment sheemember) #2 (the RN coverage on stated she or the may have been in #2 was asked to who was in the bound of time card for RN card documented building on 2/25/1 for 4.1 hours. As	to p.m., review of daily ts with ASM (administrative staff director of nursing) revealed no 2/25/17 and 2/26/17. ASM #2 assistant director of nursing in the building those days. ASM present time cards for any RN uilding on those days. 15 a.m., ASM #2 presented a #3 (MDS coordinator). The time of RN #3 was present in the 17 for 5.45 hours and on 2/26/17 ISM #2 stated the assistant of was present in the building on		4. An audit sheet will submitted at the QAP weekly for four week monthly for three moensure compliance. 5. Compliance Date: 4	PI meeting s then onths to		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		495299	B. WING)	03	/09/2017
	PROVIDER OR SUPPLIER	HEALTH AND REHAB				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE A	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 354	2/26/17 but neithe so she could not p	age 66 ASM #2) was in the building on r of them utilized the time clock provide evidence that either of building on those days.	F;	354		
F 371	conducted with CN #5 (the staffing co facility utilized a R CNA #5 stated the manager, a 3:00 p supervisor and an supervisor. When eight hours on the facility was curren and was looking for On 3/8/17 at 5:00 administrator) was concern and the fa 3/9/17 at 11:36 a.r staff had exhauste the requested political No further informat 483.60(i)(1)-(3) FO	ation was present prior to exit.		371		
SS=F	(i)(1) - Procure for considered satisfa authorities. (i) This may include from local produce and local laws or the constant of the constant includes the	does not prohibit or prevent				
	(ii) This provision	_				

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PRINTED: 03/16/2017 DEPARTMENT OF HEALTH AND HUN **SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 495299 B. WING 03/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD **ELIZABETH ADAM CRUMP HEALTH AND REHAB** GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 371 Continued From page 67 F 371 gardens, subject to compliance with applicable F371 safe growing and food-handling practices. 1. The metal pot was removed (iii) This provision does not preclude residents from the storage rack. The from consuming foods not procured by the facility. baking sheet pans and steam (i)(2) - Store, prepare, distribute and serve food in table pans were cleaned on accordance with professional standards for food 3/9/17. The food scale on the service safety. prep table was cleaned. The slicer was removed from the (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other kitchen. Refrigerated/freezer visitors to ensure safe and sanitary storage, items were wrapped and dated handling, and consumption. properly. The box on the stock This REQUIREMENT is not met as evidenced room floor was stored Based on observation, staff interview and facility correctly. Additional vegetables document review, it was determined that the were ordered. facility staff failed to, store and prepare food in a sanitary manner. 2. Each resident has the potential of being affected. The findings include: 3. Kitchen staff were in-serviced on the cleaning schedule policy On 3/7/17 at approximately 11:10 a.m., a tour of the kitchen was conducted with the dietary and the proper storage and manager, OSM #11 (Other Staff Member). The labeling of items that are to be following items were observed: stored in the refrigerator or - A large (multiple quarts sized) metal pot which freezer. The assistant manager had approximately 1/4 to 1/2 inch of water in the was in-serviced on how to order bottom, was observed on a storage rack of clean

items ready for use.

residue around the bottom side.

- A stack of 25 large size steam table pans were

observed on another storage rack of clean items ready for use. The lip of the pans had a greasy

food based on established par

checklist was implemented to

levels. A daily compliance

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER			\$1	REET ADDRESS, CITY, STATE, ZIP CODE		
-1.17 A D C	THE ADAM COUNTY HE	EALTH AND DEHAD		36	600 MOUNTAIN ROAD		1
ELIZABE	TH ADAM CRUMP HE	EALTH AND KERAB		G	LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 371	Continued From pa	age 68	. F.	371			I
	•	king sheets were observed			1 P		!
		line of these sheets had	:		ensure cleanliness through	iout	Ì
•		of dried black crusty residue			the kitchen.		
	around the lip of the	e pans.			4.Tray line audits will be		
,	- A food scale cove	red in dried food residue was			randomly conducted 8 tim	res	
	observed on a prep	table.	!		each week to ensure the r	nenu	
	- A meat slicer that was stored covered and ready for use was observed with dried residue in the		is being followed and appropriate portions are				:
							İ
	grooves of the supp		prepared. The items stored in				•
	9,		i		the refrigerator/freezer w		
		erator, an opened package of	:				
	*****	dated 3/1/17. The back was		eek and			
	not sealed, exposin	ng the cheese to the	to ensure proper storage and labeling. The audits will be				
	environment.		!		-		
	- Also in a storage i	refrigerator, a pan of cooked	!		completed by the Food Se		
		only loosely covered in plastic					
	wrap, exposing the	chicken to the environment.	:		Weekly follow ups will be		
	An upper and loss	er convection oven had dried			completed by the District		1 :
		both sections of the oven.	•		Regional Manager. Resul	ts of	!
	black residue all in	both bootions of the over.			the audits will be reviewe	d at	
		antry area, a box of 192 count			the monthly QAPI meetin	g for	
	•	observed stored directly on the)		three months to ensure		
	floor.				compliance.		1
		or, OSM #11, dietary manager, ems and stated that these e this way.			5. Compliance Date: 4/7/	17	
		a.m., policies addressing re requested from OSM #11.	:				

following:

The policies that were provided documented the

A policy on "Food Storage - Dry Goods" documented, "1. The Food Services Director or

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		495299	B. WING		03	C /09/2017	
NAME OF PROVIDER OR SUPPLIER EL ZABETH ADAM CRUMP HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 3 7 1	Continued From		F;	371 :			
	above the floor o	onsible to store all items 6 inches n shelves, racks, dollies, or other acilitate thorough cleaning."		:			
		Storage: Cold" documented,	and the same of the same of the same of	· · · · · · · · · · · · · · · · · · ·			
	A policy on "Equi Food Services Dequipment is rour accordance to maraining materials will ensure that a trained in the cleaned and san Food Services Dontact equipment Took Services Dontact e	vices Director / Cook(s) insures are stored properly in covered and dated, and arranged in a not cross contamination." pment" documented, "1. The irector will ensure that all tinely cleaned and maintained in anufacturer directions and a. 2. The Food Service Director and maintained in staff members are properly aning and maintenance of all the Food Services Director cood contact equipment is dized after every use. 4. The irector ensures that all non-food ant is clean." A page from the provided by the facility 305.11 Food StorageFood of from contamination by storing clean, dry location (2) Where it is splash, dust, or other and (3) At least 15 cm inches) above the floor."					
	No further inform the survey.	ation was provided by the end of	:				
	According to the	Federal Food Code:				:	
	protect the integr	ge Integrity. I shall be in good condition and lift of the contents so that the osed to ADULTERATION or					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB						
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F 3 7 1	Continued From potential contamir 3-305.11 Food Sto 1. (A) Except as	nants.	F3	371		
F 431 SS=D	contamination by 1. (1) In a clean, 2. (2) Where it is other contamination 3. (3) At least 15 4-601.11 Equipment Nonfood-Contact (A) Equipment utensils shall be of (B) The food- equipment and particulated grease accumulations. (C) Nonfood- shall be kept free food residue, and 483.45(b)(2)(3)(g) LABEL/STORE D The facility must proceed the standard particulated grease food residue, and 483.45(b)(2)(3)(g) LABEL/STORE D The facility must proceed greate	s not exposed to splash, dust, or on; and of cm (6 inches) above the floor. ent, Food-Contact Surfaces, Surfaces, and Utensils. It food-contact surfaces and Idean to sight and touch. Pfoontact surfaces of cooking and shall be kept free of deposits and other soil contact surfaces of equipment of an accumulation of dust, dirt, other debris. In Idea (Inches and Economics) and emergency cals to its residents, or obtain reement described in part. The facility may permit and the contact surfaces of equipment of an accumulation of dust, dirt, other debris. In Idea (Inches and Economics) and Economics and Economics (Inches and Economics) a		431		

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	MENT OF HEALTH	AND HUN SERVICES			<u> </u>	FOR	D: 03/16/2017 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		ATE SURVEY DMPLETED
		495299	B. WING			0	C 3/09/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABE	TH ADAM CRUMP HE	EALTH AND REHAB	· · · ·		500 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 7 1	F.	431			
	(1) 0	-1: The feeth			F431		į
		ation. The facility must e services of a licensed			1. Medication carts are be	ing	
	pharmacist who				locked when unattended.		
		stem of records of receipt and	·		2. Observation audits will	be	
		ntrolled drugs in sufficient accurate reconciliation; and			conducted on all licensed	staff	
	detail to enable an	accurate reconciliation, and			to ensure medication cart	s are	:
		drug records are in order and all controlled drugs is			locked according to policy	'.	:
		iodically reconciled.	i		Licensed staff will be re	-	
	() 1 1 1 1 1 1 1 1 1 1	and Districts	:		educated on the policy		
	(g) Labeling of Drug	gs and Biologicals. als used in the facility must be			regarding the locking of		:
		ice with currently accepted			medication carts when		
	professional princip appropriate access	les, and include the ory and cautionary			unattended.		
	· ·	e expiration date when	:		Audits of staff during		
	applicable.		:		medication administratio	n will	
	(h) Storage of Drug	s and Biologicals.			be conducted weekly for	four	:
		with State and Federal laws,			weeks then monthly for t	hree	- : :
		re all drugs and biologicals in			months. Results of the au	udits	:
		nts under proper temperature to only authorized personnel to			will be reviewed at the m	onthly	:
	have access to the				QAPI meeting for three n		:
			:		to sustain compliance.		
	permanently affixed controlled drugs list Comprehensive Dr	t provide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to			5. Compliance Date: 4/7/	/17	

by:

be readily detected.

abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can

This REQUIREMENT is not met as evidenced

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495299	B. WING		03	C /09/2017
	PROVIDER OR SUPPLIE	<u>, </u>	1	STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		70072017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 431	document review facility staff failed medications during	page 72 ration, staff interview, facility , and clinical record review, the to ensure safe supervision of ng the Medication Pour and Pass ne of three wings (Wing C).		131		
	Wing C, RN (Reg the medication ca room. The medical line of sight and a	ion pour and pass observation in jistered nurse) #5 failed to lock art prior to entering a resident's cation cart was out of RN #5's a resident was observed e feet away from the cart.				
	The findings inclu	de:				
	administration ob preparing Reside medication cart in and entered their Resident #17's rot to retrieve another residents' blood s #17's room and residents' blood s #17's room. The unlocked and out she was in Resid was observed in feet away from the medication admir #17's room and residents' room and resid	p.m., during the medication servation, RN #5 was observed in #17's medications at the in the hall. RN #5 locked the cart esident's room. While in from, RN #5 stated she needed or glucometer strip (used to test sugar). RN #5 exited Resident etrieved glucometer strips from fart. RN #5 failed to lock the rior to re-entering Resident medication cart remained of RN #5's line of sight while ent #17's room; another resident a wheelchair approximately five the medication cart. After instration, RN #5 exited Resident eturned to the medication cart. It was asked if the cart was ed. RN #5 pulled open a drawer cart (without having to unlock ed, "I'm sorry." RN #5 confirmed				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY MPLETED C
		495299	B. WING			03/	09/2017
	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(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 APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 431	Continued From pathe medication carront present.	age 73 t should be locked when she is	F	131			
		o.m., ASM (administrative staff dministrator) was made aware		:			
	The facility policy to Administration- Ge "During administration cart is lout of sight of the resident #17 was 2/7/17. Resident # were not limited to and major depress most recent MDS (admission assess)	itled, "Medication neral Guidelines" documented, tion of medications, the kept closed and locked when medication nurse or aide" admitted to the facility on 17's diagnoses included but high blood pressure, diabetes live disorder. Resident #17's (minimum data set), an ment with an ARD (assessment 2/14/17, coded the resident as		:			
		tion was presented prior to exit. (e)(f) INFECTION CONTROL, ND, LINENS	F.	441			
	(a) Infection preve	ntion and control program.	:				
		stablish an infection prevention m (IPCP) that must include, at flowing elements:					
	investigating, and communicable disc volunteers, visitors providing services	eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual d upon the facility assessment					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING			0:	C 3/09/2017
NAME OF	PROVIDER OR SUPPLIE	ER	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODI		
		LICALTH AND DELLAD	• 1	360	00 MOUNTAIN ROAD		
ELIZABE	TH ADAM CRUMP	HEALTH AND REHAB		GL	EN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE \PF DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
	1		<u> </u>	İ			
F 441	Continued From	page 74	F 4	41	a al mi i Cartina control		
		ding to §483.70(e) and following			1. A) The infection control		
		al standards (facility assessment			are complete and current.		:
	implementation is	s Phase 2);			Hand washing procedures		· · · · · · · · · · · · · · · · · · ·
	(2) Written stand	ards, policies, and procedures			being followed. C) Medica		!
		which must include, but are not			administration procedures		
	limited to:		:		being followed by licensed	l staff	
	(i) A system of su	rveillance designed to identify			for residents. D) Infection		
		nicable diseases or infections			control practices are being	3	
		spread to other persons in the			followed during wound		:
	facility;		•		treatments. Proper hand		-
	(ii) When and to	whom possible incidents of			hygiene is being done pric		
		isease or infections should be			resident #18 receiving the		
	reported;				medications. Resident #1	9 is	
	o	I			receiving their medication		
		I transmission-based precautions prevent spread of infections;			according to proper medi	cation	
	to be followed to	prevent spread of infections,	:		administration standards.		
		ow isolation should be used for a			Resident #3 is receiving th	neir	
	resident; includin	g but not limited to:			wound care according to	proper	
	(Δ) The type and	duration of the isolation,			infection control standard	ls.	
		the infectious agent or organism			2. A) A review of new anti	hiotic	
	involved, and				orders in the last 30 days		
		nt that the isolation should be the cossible for the resident under the			completed to ensure accu		:
	circumstances.	possible for the resident drider the			and proper documentation	="	
	GII GUITTO GUITTO G		1		made in the infection con		
		ances under which the facility			logs. B) Licensed staff wil		•
		ployees with a communicable ed skin lesions from direct			iogs. b) Licenseu stan wii	יי אכ	
		dents or their food, if direct	:		observed during medicat	ion	
		mit the disease; and			administration for proper	hand	
					washing procedure. C) Lic	ensed	•
		giene procedures to be followed			staff will be observed dur		
	by stair involved	in direct resident contact.			medication administratio	_	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY DMPLETED
		495299	B. WING			0:	C 3/09/2017
NAME DF	PROVIDER OR SUPPLIE	R		ST	REET ADDRESS, CITY, STATE, ZIP COD		
El IZARE	TH AD AM CRUMP	HEALTH AND REHAB			00 M DUNTAIN RDAD		
ELIZADE	TITADAM CROWN	TEACHT AND REITAB		Gl	LEN ALLEN, VA 23060	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PRDVIDER'S PLAN OF CORRE (EACH CDRRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEF;CIENCY)	IDULD BE	(X5) COMPLETION DATE
F 441		ecording incidents identified	F4	141	proper procedures are be followed. D) Observation		
	actions taken by	<u>.</u>			reviews of staff performin wound care treatments w ———conducted-to-ensure-prop	vill be	
		onnel must handle, store, sport linens so as to prevent the n.		:	infection control technique being followed.		
	annual review of program, as necestaris REQUIREM by: Based on observed document review was determined from the complete infection by incomplete information by incomplete information of five residents, and failed to main during a dressing	The facility will conduct an its IPCP and update their essary. ENT is not met as evidenced ration, staff interview, facility and clinical record review, it acility staff failed to maintain a n control program as evidenced ection control tracking logs for and January 2017; and the aintain infection control medication administration for two Resident #18 and Resident #19; atain infection control practices chnage for one of 29 residents aple, Resident #3.			3. A) Licensed staff will be educated on proper infection control techniques during wound care. B) Licensed swill be re-educated on proper medication administration Licensed staff will be reeducated on proper medication procedure administration procedure Licensed will be re-educated proper infection control technique during wound	tion staff oper during n. C) ication es. D) ated on care.	
	infection control I documented evid organism found in December 2016. 2. RN (Registere hand hygiene pricto Resident #18.	ff failed to maintain a complete og as evidenced by no ence regarding the result of the name that the cultures obtained during and January 2017. If nurse) #5 failed to perform or to administering medications Practical nurse) #6	:		4. A) Audits of the Infecticontrol logs, B) reviews of washing procedure during medication administration procedures and D) wound treatments will be conducted weekly for four weeks the monthly for three weeks	of hand on, C) on d care ucted een	

administered a pill to Resident #19 after touching

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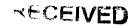
		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l • •		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING	;		o l	C 3/09/2017	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		3	STREET ADDRESS, CITY, STATE, ZIP COD 8600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE	
F 441	the pill with her b	-	F	441	reviewed at the monthly meeting for three month sustain compliance.	is to		
	previous survey is and revealed the - On the Decembeurine cultures do There was no do the result of the control of the control of the January cultures and three as being taken. The control of the January cultures and three as being taken.	infection control logs from the n March 2016 was completed following: ter 2016 log there were nine cumented as being completed. cumented evidence regarding organism found in the cultures. 2017 log there were 13 urine e wound cultures documented frere was no documented in gregarding the result of the		Transport Special Control	5. Compliance Date: 4/7;	17		
	p.m. with RN (reg director of nursin infection control infections were to stated, "To make to the organism." of the cultures we on the infection of looked at them be asked if the resultance.	conducted on 3/8/17 at 2:15 gistered nurse) #1, the assistant g who is responsible for the program. When asked why tacked and trended, RN #1 sure the antibiotic is susceptible. "When asked where the results are for the items identified above control logs, RN #1 stated, "I ut I didn't document it." When its should be documented, RN w I should be putting the c&s sittivity) results on the logs. It's my						
	On 3/8/17 at 5:00	p.m. ASM (administrative staff						

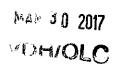
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	PROVIDER OR SUPPLIER ETH ADAM CRUMP H			STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		70072011
(X4) 1D PREF1X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	of the findings. Review of the facil	age 77 dministrator was made aware ity's policy titled, "Infection be" initiated in February 2017	F	441		
	Control Committee control program ar activities. The score Establishing baselinates. B. Review or Review of resident whether an infection (centers for disease Review and analystinclude: Infections Clusters of infection Nosocomial infections baseline" There regarding docume	e (ICC) directs the infection of maintains minutes of all one of surveillance includes: A. ine nosocomial (1) infection of microbiological reports. C. infections to determine on is nosocomial using the CDC of control) guidelines. D. is of surveillance data to due to unusual pathogens. On rate exceeds the was no specific documentation on the infection control of had a column titled, TURED."				
	(1) Nosocomial , contracted becaus exists in a certain This information whttp://www.healthlid-nosocomial-infer 2. RN (Registered	ne.com/health/hospital-acquire				
	2/17/17. Resident were not limited to	admitted to the facility on ##18's diagnoses included but tractured right arm, high blood etes. Resident #18's				

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

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC	TIPLE CONSTRUCTION		ATE SURVEY DMPLETED
		495299	B. WING		o	3/09/2017
	PROVIDER OR SUPPLIER	IEALTH AND REHAB		STREET ADDRESS, CITY, STATE, Z 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	with an ARD (asse 2/24/17 was in pro	age 78 ninimum data set) assessment essment reference date) of egress; however, section C was ded the resident as being	F	141		
	administration obs administering med After administratio returned to the me Resident #18's me medications to Re hand hygiene (han While administerin RN #5 was observ	p.m., during the medication ervation, RN #5 was observed lications to another resident. In to that resident, RN #5 edication cart, prepared edications and administered the sident #18 without performing and washing or hand sanitizer). In the medication cup to the resident to swallow the residen				
	conducted with RN should be done in administration to e stated hand sanitiz didn't transfer "sor next. At this time perform hand hygi medication to Res	p.m., an interview was N #5. RN #5 was asked what between medication each resident and why. RN #5 zer should be used so she mething" from one person to the RN #5 confirmed she did not ene prior to administering ident #18 and was then hand sanitizer on her hands.				
		p.m., ASM (administrative staff administrator) was made aware ern.				
	"2. Handwashing a person administer	titled, "Medication eneral Guidelines" documented, and Hand Sanitization: The ing medications adheres to e, which includes washing				

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

Event ID: OL2511

Facility ID: VA0083

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MAR 30 2017
VOH/OLC

PRINTED: 03/16/2017 DEPARTMENT OF HEALTH AND HUM 1 SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICみり SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 495299 B. WING 03/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 441 Continued From page 79 F 441 hands thoroughly before beginning a medication pass prior to handling any medication after coming into direct contact with a resident, before and after administration of ophthalmic, topical, vaginal, rectal, and parenteral preparations, and before and after administration of medicationsvia enteral tubes... b. Hand sanitization is done with an approved sanitizer between handwashings, when returning to the medication cart or preparation area (assuming hands have not touched a resident or potentially contaminated surface). at regular intervals during the medication pass such as after each room, again assuming handwashing is not indicated..." No further information was presented prior to exit. 3. LPN (Licensed practical nurse) #6 administered a pill to Resident #19 after touching the pill with her bare hand.

intact.

Resident #19 was admitted to the facility on 10/29/10. Resident #19's diagnoses included but were not limited to: diabetes, high blood pressure and incontinence. Resident #19's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/26/16, coded the resident as being cognitively

On 3/8/17 at 8:07 a.m., during the medication administration observation, LPN #6 was observed

administering medications to Resident #19.
Resident #19 placed the medication cup of pills to

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			1	C / 09/201 7
NAME OF	PROVIDER OR SUPPLIEF		12		REET ADDRESS, CITY, STATE, ZIP CODE	_	/09/2017
		` HEALTH AND REHAB		360	0 MOUNTAIN ROAD EN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	the resident's gow LPN #6 picked the placed the pill into	oill dropped out of the cup onto on covering the resident's chest. e pill up with her bare hand, the medication cup and	F	141			
	On 3/8/17 at 8:19 conducted with LF observation. LPN been picked up with the conducted wi	a.m., an interview was PN #6 regarding the above #6 stated the pill should have the a glove because the resident contaminated by what was on and.					
	staff member) #2 presented an in-se by LPN #6. The in passing medication Do Not touch any	3 a.m., ASM (administrative (the director of nursing) ervice dated 3/8/17 and signed n-service documented, "When ons ensure to follow protocols. meds (medications) with bare nother pill if one is dropped."					
		p.m., ASM #1 (the s made aware of the above					:
		titled, "Medication eneral Guidelines" failed to urse should do if a pill is		·			
	No further informa	ation was presented prior to exit.					
		f failed to maintain infection during a dressing change for					
	Resident #3 was	admitted to the facility on 2/7/17	:				

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

Event ID: OL2511

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DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDIC, 4D SERVICES

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		495299	B. WING			0	3/09/2017	
	PROVIDER OR SUPPLIER	EALTH AND REHAB		360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD .EN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION OATE	
F 441	: : Continued From pa	age 81	F.	141				
	to: dementia, deep	It included but were not limited vein thrombosis (blood blot), on, vitamin D deficiency, and reflux disease.						
	assessment, a signification with an assessment coded the resident make daily cognitive coded as being deassistance with all On 3/8/17 at 10:55 nurse) #3, the wouproviding wound or gathered her supptreatment cart. LP her pocket and cuttape. She was not scissors. When as scissors, LPN #3 was asked when s LPN #3 stated, "Bedressing change." pocket where the standard change and the scissors after each use."	milicant change assessment, intreference date of 2/14/17, it as being severely impaired to be decisions. The resident was pendent or requiring extensive of her activities of daily living. In a.m. LPN (licensed practical and nurse, was observed are to Resident #3. LPN #3 lies and placed them on the PN #3 pulled her scissors out of a piece of white adhesive observed cleaning the sked if she cleaned her estated, "No, I didn't." LPN #3 icissors should be cleaned. The effore I cut anything for a when asked what was in her escissors were removed from, into her pocket and showed this d keys. During the wound care, rese) #1, the assistant director of assist LPN #3 with the dressing as asked when a nurse should. RN #1 stated, "Before and conducted with administrative						
	staff member (ASI on 3/8/17 at 2:08 p should clean sciss	M) #2, the director of nursing, o.m. When asked when staff cors being used for dressing stated, "Before you cut					. :	

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Event ID: OL2511

Facility ID: VA0083

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DEPARTMENT OF HEALTH AND HU/ N SERVICES CENTERS FOR MEDICARE & MEDIC. 10 SERVICES

• ,	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	X3) DATE SURVEY COMPLETED	
			7. 50.20	10] (c	
		495299	B. WING			03/	09/2017	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
FLIZARE	TH ADAM CRUMP HI	FAITH AND REHAR		_	600 MOUNTAIN ROAD			
				G	GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
					:		!	
F 441	Continued From pa	-	F₄	141	· ·		•	
		was requested on dressing ing of the scissors. ASM #2 f the concern.						
	The administrator v	vas made aware of the above	: :		•			
Townstee China and the Control of Control	findings on 3/8/17 a		; (
			:					
		a.m. ASM #2 informed this cility did not have a policy on					:	
	dressing changes.	clifty did flot flave a policy of						
	4. 200g							
		ed by the International	:					
		socomial and Healthcare n Atlanta Georgia, March 2000	:		•			
		ry items can make your	:				:	
	patients sick.	.,					:	
		earcher gathered scissors that						
		ans kept in their pockets, as						
		scissors left on dressing carts quarters of the scissors carried	;		•		·	
		cluding Staphylococcus	:					
		and B streptococcus, and					•	
		III. The solution is quite simple.	:					
		ers swab the scissors with						
		use, they will virtually eliminate sion of microorganisms. In the	•					
		d scissors were effectively	:					
		abbing the scissors with	:				:	
	alcohol.							
	Reference:	Mark and the Anti-Colonia and a	•					
		McLeod J, et al. Scissors as a nosocomial infection?					:	
		h Decennial International	:					
	Conference on Nos		:					
	· · · · · · · · · · · · · · · · · · ·	ated Infections. Atlanta; March	•					
	8, 2000							
	No further informat	ion was provided prior to exit.						

DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDIC, AD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		COL	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			i	/09/2017
	PROVIDER OR SUPPLIER	REALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION OATE
F 514	(i) Medical records (1) In accordance standards and pra maintain medical are- (i) Complete; (ii) Accurately doc (iii) Readily acces	PLETE/ACCURATE/ACCESSIB s. with accepted professional actices, the facility must records on each resident that umented; sible; and	!	514	1. A) Non-pharmacological interventions are being documented prior to administrating-prn-pain medications for residents #3 B) Documentation has been completed for the pressure wound on resident #3. C) Bl pressure results are being documented for resident #6 the EMAR. D) Resident #6 her heel protectors on.	ood 6 on	
	(iv) Systematically (5) The medical re	organized ecord must contain-	:		Each residents has the potential of being affected		
	.,	nation to identify the resident;			 Licensed staff will be re- educated on the documentation policy 		
	`,	ensive plan of care and services			regarding: A) using non- pharmacologic interventio prior to administering prn		:
	and resident revie	any preadmission screening we evaluations and inducted by the State;			medication; B) the policy of proper documentation regarding pressure wound	n .	
	(v) Physician's, nu professional's pro	urse's, and other licensed gress notes; and			the policy on proper documentation regarding	blood	:
	services reports a This REQUIREMI by:	diology and other diagnostic is required under §483.50. ENT is not met as evidenced interview, staff interview,			pressures; D) the policy or proper documentation for protectors.		i :

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

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STATEMENT AND PLAN O	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		495299	B. WING			0:	3/09/2017	
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 514	review, it was dete to maintain a com record for three of sample, Resident	ew, and facility document ermined that facility staff failed plete and accurate clinical 29 residents in the survey #10, #3 and #6.	F !	514	4. Audits will be conducted of the use of A)non-pharmacol interventions prior to administering prin pain	ogic		
	 For Resident #10, facility staff failed to document non-pharmacological interventions attempted prior to the administration of prn (as needed) pain medication on several occasions in February and March of 2017. The facility staff entered the staging of Resident #3's pressure sore into the initial note, three days after the initial note identifying the area was written and based the staging on an assessment completed three days after the area was found. The facility staff failed to document physician 			medication; B) pressure documentation; C) blood pressure documentation heel protector documen will be conducted weekly four weeks then monthly three months. Results were wiewed at the monthly meeting for three month ensure compliance. 5. Compliance Date: 4/7		and D) ation for for l be QAPI s to		
	b. The facility starthad her heel protes The findings inclu 1. Resident #10 v 6/22/16 with diagr limited to Dement of the right femur, pressure, and ma Resident #10's me set) was a signific ARD (assessmen Resident #10 was	ff documented that Resident #6 ectors on when they were not.						

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Evert 1D; OL2511

Facility ID: VA0083

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DEPARTMENT OF HEALTH AND HUP N SERVICES CENTERS FOR MEDICARE & MEDIC, SERVICES

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILD	TIPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED C	
	PROVIDER OR SUPPLIER	495299 EALTH AND REHAB	B. WING 03/09/2017 STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 514	for Mental Status) coded as requiring transfers, dressing	age 85 5 on the BIMS (Brief Interview exam. Resident #10 was supervision only with geating, toileting, bathing, and independent with locomotion.	F :	514			
	sheet) signed and following order, "P (milligrams) Give 2 as needed for pair tailbone related to INITIAL ENCOUN	at #10's POS (physician order dated 2/4/17 revealed the ercocet Tablet [2] 5-325 MG tablet by mouth every 6 hours of treated to) fracture of FRACTURE OF COCCYX, TER FOR CLOSED s order was initiated on					
	March 2017 MARS Record) document "Percocet Tablet 5 (Oxycodone-Aceta mouth every 6 hou (related to) fractur Further review of t	at #10's February 2017 and G (Medication Administration ted the following order" -325 MG aminophen) Give 1 tablet by ars as needed for pain r/t e of tailbone related to PAIN" he MARS revealed that ived Percocet 5/325 mg on the					
	2/15/17 at 6:32 p.r 2/17/17 at 9:37 p.r 2/23/17 at 6:04 p.r 2/25/17 at 10:57 p	m., 2/10/17 at 1:59 a.m., m., 2/16/17 at 8:38 p.m., m., 2/21/17 at 1:55 a.m., m., 2/24/17 at 11:09 p.m., and .m., 3/4/17 at 1:29 a.m., 3/6/17 :58 p.m., and 3/7/17 at 10:19					
	that non-pharmac	ld not be found documenting blogical pain interventions were the administration of Percocet.				:	

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Event ID: OL2511

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

PRINTED: 03/16/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING	j	03	C / 09/2017	
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 514	conducted with R stated that staff w	page 86 0 a.m., an interview was esident #10. Resident #10 will attempt other things for her administer pain medication.	F:	514			
	conducted with L 7. When asked a to administering I medication, LPN resident to rate the and then docume would attempt no prior to administer massage and rep would document interventions atter no place to document	O a.m., an interview was PN (licensed practical nurse) # about the process followed prior PRN (as needed) pain #7 stated, "I would ask the pain, and where the pain is ent." LPN #7 stated that she n-pharmacological interventions wing medication such as positioning. When asked if she non-pharmacological mpted, LPN #7 stated, "There is ment unless it's in a nursing treally done that. We don't t."					
	conducted with L process followed pain medication, attempt non-phar but she would no interventions atte	12 a.m., an interview was PN #9. When asked about the prior to administering a PRN LPN #9 stated that she would macological interventions first, t document non-pharmacological mpted. LPN #9 stated, "We nent interventions."					
	conducted with L followed prior to a medication, LPN resident their pair 1-10. LPN #6 state cognitively intact, cues for pain successions.	19 a.m., an interview was PN #6. When asked the process administering a PRN pain #6 stated that she would ask the n level using a pain scale from ated that if the resident was not she would look for non-verbal th as grimacing. LPN #6 stated wother interventions to relief pain					

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Event ID: OL2511

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DEPARTMENT OF HEALTH AND HUP N SERVICES CENTERS FOR MEDICARE & MEDIC. ... SERVICES

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С	
		495299	B. WING			03/	09/2017
	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD ILEN ALLEN, VA 23060		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	IX5) COMPLETION OATE
F 514	that these interven the nursing notes.	age 87 ng medication. LPN #6 stated tions should be documented in a.m., an interview was	F	514			
	conducted with LP would assess a rescale and ask for the stated that if a resistant would assess LPN #11 stated that such as reposition administering pain interventions shoundte. On 3/8/17 at 5:20 processes a rescale and ask for the stated that if a resistant would assess the stated that it is a reposition administering pain interventions shoundte.	N #11. LPN #11 stated she sident's pain by using the 1-10 he location of pain. LPN #11 dent was not cognitively intact, for non-verbal cues for pain. At she would try interventions and distraction prior to medication. LPN #11 stated ld be documented in a nursing o.m., ASM (administrative staff	The state of the s				
	DON (Director of N	dministrator and ASM #2, the lursing) were made aware of s. No further information was exit.					
	regarding docume "Documentation is is relied on as recopersons. Docume record is a vital as Nursing document comprehensive, as critical data, maint	ins a quotation on page 477 ntation as follows: anything written or printed that ord or proof for authorized ntation within a client medical pect of nursing practice. ation must be accurate, nd flexible enough to retrieve ain continuity of care, track nd reflect current standards of					
·	deposits of a prote brain. These depo chemicals in the b	ease associated with abnormal bin called alpha-synuclein in the sits, called Lewy bodies, affect rain whose changes, in turn, ms with thinking, movement,					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARIO, 1) SERVICES

	of Deficiencies of Correction	DENTIFICATION NUMBER:	` '	ING		MPLETED C
		495299	B. WING		03	3/09/2017
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, Z 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 514	obtained from The https://www.nia.ni	page 88 od." This information was e National Institutes of Health. h.gov/alzheimers/publication/le h/basics-lewy-body-dementia.	F 5	514		
	severe pain. This The National Insti	reliever that treats moderate to information was obtained from tutes of Health. Ilm.nih.gov/pubmedhealth/PMH				
	Resident #3's pres three days after the was written and ba	f entered the staging of ssure sore into the initial note, he initial note identifying the area ased the staging on an olleted three days after the area				
	with diagnoses that to: dementia, deep	admitted to the facility on 2/7/17 at included but were not limited p vein thrombosis (blood clot), ion, vitamin D deficiency, and I reflux disease.		: :		
	assessment, a sig with an assessme coded the residen make daily cogniti coded as being de	MDS (minimum data set) gnificant change assessment, ent reference date of 2/14/17, et as being severely impaired to eve decisions. The resident was ependent or requiring extensive If of her activities of daily living.				
	documented, "7 p CNA (certified nur area left buttocks, (medical doctor) &	dated, 2/5/17 at 11:43 p.m. m (7:00 p.m.) called to room, rsing assistant) noted pinpoint no drainage noted, MD & RP (responsible party) ment order 97.6 (temperature) -				

DEPARTMENT OF HEALTH AND HU! N SERVICES CENTERS FOR MEDICARE & MEDIC. ... SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		C 03/0 9/2 017		
NAME OF	PROVIDER OR SUPPLIER	J	1	STREET ADDRESS, CITY, STATE, Z			
E1 I7 ARE	TH ADAM CRUMP H	EΔ1 TH ΔΝΩ REHΔR		3600 MOUNTAIN ROAD			
LLIZADI	THADAM ONOUN TH	LAL, ITARO REITAD		GLEN ALLEN, VA 23060			
(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 APPROPRIATE	(X5) COMPLETION OATE	
F 514	Continued From pa	age 89	F	514			
	70 (pulse rate) - 18	(respiration rate) - 110/68					
		Resident turned frequently."				:	
	first observed - 02/	r Record documented, "Date 05/17. Site - Coccyx. Stage III				:	
		oint. Drainage - no. Odor - no.''		The state of the s			
	There was no signated this form	ature of the nurse who n.	:				
	Full-thickness loss is visible in the ulce epibole (rolled wou Slough and/or eschof tissue damage vareas of significant wounds. Undermir Fascia, muscle, ter	njury: Full-thickness skin loss of skin, in which adipose (fat) er and granulation tissue and and edges) are often present. The depth varies by anatomical location; adiposity can develop deep and tunneling may occur. Indon, ligament, cartilage of exposed. If slough or eschar					
		nt of tissue loss this is an				i	
	The Pressure Ulce "Date: 2/8 (2017) Stage: 3	r Record documented:					
	Length X width: 2 > Depth: 0.1		:			·	
	Drainage: SS (sero Odor: (zero with a Tunneling: (zero w 'No')	ine through it indicating 'No') with a line through it indicating				:	
		emarks: New 80 G in." These notes were I (registered nurse) #1.					
	An interview was cassistant director of	onducted with RN #1, the of nursing, and LPN (licensed				;	
		on 3/8/17 at 10:40 a.m. The ord and the nurse's notes of	:			. :	

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Facility ID: VA0083

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DEPARTMENT OF HEALTH AND HUY N SERVICES CENTERS FOR MEDICARE & MEDIC. ... SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	COV	(X3) DATE SURVEY COMPLETED C	
		495299	B. WING	i		09/2017	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE	
F 514	When asked about Stage 3 pressure measured it on 2/ the Stage III on the (name of wound of 2/8/17." RN #1 was and entered this f was asked if staff something in on a "No, I guess not, #1 stated, "It was leave it blank." W wound on 2/5/17, asked if staff is all documents, RN # An interview was staff member (AS on 3/8/17 at 2:08 go backwards and three days before pressure ulcer for	wed with RN #1 and LPN #2. It staging a pinpoint area as a ulcer, RN #1 stated, "! 8/17 and went back and put in the form based on what the care doctor) assessed on as asked, if she had gone back or the 2/5/17 dated note and were allowed to go back and fill a clinical record. RN #1 stated, if shouldn't have done that." RN blank and I didn't think I could hen asked if she had seen the RN #1 stated, "No." When slowed to backdate and fill in 1 stated, "No, Ma'am." conducted with administrative and fill in blank on a form dated, ASM #2 stated, "No." The mand discussion with RN #1 ASM #2. A policy was requested	F	514			
	documented in pa presence of skin related to Pressur weekly thereafter a Pressure Ulcer impairment that is the pressure area identifying the site observed. 4. Ente ulcer. 5. Enter th	"Pressure Ulcer Record Policy" art, "Policy: To document the impairment/new skin impairment re when first observed and. Procedure: 1. Residents have Record completed for each skin is related to Pressure. 2. Mark is on the body description e. 3. Enter the date first art the stage of the pressure e size of the pressure ulcer epth in centimeters. 6. Enter the					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
WIAD LEWIN C	N GONNEON DIN	DETTRION TORROLL.	A. BUILD	DING		C	
		495299	B. WING	s	03	/09/2017	
	NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE	
F 514	the ulcer. 8. Enter the current treatme pressure ulcer. 10 (doctor) progress r 11. Each week the the following inform Date. b. Stage. c. I	age 91 Ulcer. & Enter the drainage of the odor of the ulcer. 9. Enter ent plan at the initiation of the . Enter the date of the last Dr. note regarding Pressure ulcer. ulcer is to be assessed and nation collected on this form: a. ength x width. d. Depth. e. g. Progress/remarks - i.e.	F:	514			
	"Records need to rethe time frame of eaccomplished when observations and a	type, schedule etc." reflect the accountability during					
	Perry's Fundamen (2005, p. 477): "D written or printed the proof for authorize within a client med nursing practice. If accurate, comprehensive critical dat track client outcoms standards of nursing client record provide level of quality of composition of potter and Perry (2 following informatic care team, nurses)	ation is found in Potter and tals of Nursing 6th edition ocumentation is anything nat is relied on as record or d persons. Documentation ical record is a vital aspect of Nursing documentation must be tensive, and flexible enough to a, maintain continuity of care, and reflect current ag practice. Information in the des a detailed account of the are delivered to the clients." 2005) also includes the on: "As members of the health need to communicate clients accurately and in a anner."					
	The administrator concern on 3/8/17	was made aware of the above at 5:15 p.m.					

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO		
		495299	B. WING				C / 09/2017
,	PROVIOER OR SUPPLIE	_l		360	EET AOORESS, CITY, STATE, ZIP COOE 0 MOUNTAIN ROAD EN ALLEN, VA 23060	1 00.	00.0011
(X4) ID PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LO BE	(X5) COMPLETION OATE
F 514	Continued From p	page 92	F	514			
	No further informa	ation was provided prior to exit.		٠			
	This information was obtained from the following website:						
	clinical-resources 3. a. The facility s ordered blood pre January and Febr records (MARs) for						
	10/5/06 and readres that included but a pressure, Parkins irregular heart beaminimum data set an assessment rethe resident as hamemory problems make daily decision.	admitted to the facility on mitted on 5/1/12 with diagnoses were not limited to: high blood on's disease (1), dementia, at and arthritis. The most recent t, a quarterly assessment, with afterence date of 2/2/17 coded awing long and short term as and as impaired cognitively to ons. The resident was coded as acce from staff for all activities of					
	"Focus Impaired (Dx (diagnosis) of	nt #6's care plan documented, Cardiovascular status related to: A-fib (atrial fibrillation 2), HTN nterventions Observe for ns and report."					
	documented, "BP (every week) in th	vsician orders dated 3/1/17 (blood pressure) and pulse qwk le afternoon every Sun (Sunday) TIAL HYPERTENSION (high					
	Review of the Jar	nuary 2016 MAR documented,					!

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DEPARTMENT OF HEALTH AND HUL SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` <i>'</i>	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	,	495299	B. WING		03	C 3/ 09/2017
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	IX5) COMPLETION DATE
F 514	in the afternoon endes ESSENTIAL HYP pressure)." Revie	very and pulse qwk (every week) very Sun (Sunday) related to ERTENSION (high blood w of the MAR for 1/15/17 did umentation of the blood	F t	514		
	Review of the Feb (blood pressure) a the afternoon evel ESSENTIAL HYP pressure)." Review 2/19/17 did not ev Resident #6's blood On 3/8/17 at 5:15	oruary MAR documented, "BP and pulse qwk (every week) in ry Sun (Sunday) related to ERTENSION (high blood w of the MAR for 2/12/17 and idence documentation of od pressure or pulse.				
	(administrative state administrator. A telephone interviols 10:53 a.m. with LF #13, the nurse who pressure or pulse did a blank space stated, "It can be wasn't done or it wasked if she had of stated she had. With LPN #13 she with the vital signs pressure (on Resident a.m. with ASM (active director of nur important for staff record, ASM #2 statement in the stat	aff member) #1, the riew was conducted on 3/9/17 at PN (licensed practical nurse) to did not document the blood on 2/6/17. When asked what on the MAR mean, LPN #13 one of two things. Either it vasn't documented," When cared for Resident #6, LPN #13 //hen the MAR was reviewed stated, "I always keep a book is. I remember taking the blood ident #6) but I didn't chart it." conducted on 3/9/17 at 11:20 dministrative staff member) #2, rsing. When asked why it was to chart on the resident's tated, "To follow the doctor's stated in look at it (the				

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OFNITEDO EOD MEDICADE & MEDIÓN	U SEDVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495299		I ' -		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 03/09/2017	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		360	REET ADDRESS, CITY, STATE, ZIP CO DO MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	IX5I COMPLETION DATE
F 514	Continued From documentation).		F	514			
anning additional deal of the contro	ASM #2 was made aware of the findings at that time. An additional request was made for a policy on clinical documentation.					tame kina sankan makada da sa Siskaka sa sa sa masa sa	
	administrator sta	32 p.m. ASM #1, the ted, "We have exhausted all of ate those policies." No policies		:			
	No further inform	nation was provided prior to exit.					
	Perry's Fundame (2005, p. 477): 'written or printed proof for authorize within a client me nursing practice. accurate, compretrieve critical datrack client outcome.	otation is found in Potter and entals of Nursing 6th edition Documentation is anything I that is relied on as record or zed persons. Documentation edical record is a vital aspect of Nursing documentation must be ehensive, and flexible enough to ata, maintain continuity of care, omes, and reflect current sing practice. Information in the					
	client record pro- level of quality of Potter and Perry following informa- care team, nurse	vides a detailed account of the f care delivered to the clients." (2005) also included the ation: "As members of the health es need to communicate ut clients accurately and in a					
	(PD) is a type of when nerve cells enough of a brai Sometimes it is	disease Parkinson's disease movement disorder. It happens s in the brain don't produce n chemical called dopamine. genetic, but most cases do not					

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the environment might play a role. This

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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	
		495299	B. WING			3/09/2017	
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 514	Continued From printed information was continued in https://medlineplu	·	F 5	514.			
	with the speed or	n - An arrhythmia is a problem rhythm of the heartbeat. Atrial the most common type of					
	arrhythmia. The celectrical system.	cause is a disorder in the heart's. This information was obtained lineplus.gov/atrialfibrillation.html					
		aff documented that Resident #6 boots on when they were not.					
	of Resident #6. T	ras made on 3/7/17 at 3:35 p.m. The resident was in bed. The wearing any heel boots.					
	of Resident #6. T	ras made on 3/8/17 at 8:55 a.m. The resident was sitting in the was wearing a white pair of					
	of Resident #6. T	ras made on 3/8/17 at 4:25 p.m. The resident was in the was wearing the white shoes.					
	of Resident #6. T	vas made on 3/9/17 at 9:30 a.m. The resident was sitting up in a bed. She was wearing the white					
	documented, "Pr	ysician's orders dated 9/27/16 evalon boots to bilateral feet at for hygiene and skin checks					
	revised on 2/15/1	re plan initiated on 12/15/11 and I7 documented, "Focus At risk er due to: requires Assist with bed					

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DEPARTMENT OF HEALTH AND HU(SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I , .	TIPLE CONSTRUCTION PING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		0:	C 03/09/2017	
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB				STREET ADDRESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		(X5) COMPLETION DATE		
F 514	(extremities). Integral times except for Review of the Ma	page 96 ingedema to lower ext's rventions. Prevalon Boots on at or hygiene and bathing." rch 2017 treatment cord documented, "Prevalon	F 5	514			
	boots to bilateral the hygiene and skin shift it was docum were on.	feet at all times, remove for checks every shift." For each tented that the heel protectors conducted on 3/8/17 at 4:25					
	p.m. with ASM (ac the director of nur #1, the assistant of made an observa Resident #6 without asked if the reside on, ASM #2 states	dministrative staff member) #2, sing and RN (registered nurse) director of nursing. ASM #2 tion of the above observation of out heel boots in place. When ent was to have protective boots d, "(RN #1) is she to have ated, "Yes. She had a heel sore					
	a.m. with LPN (lic nurse caring for F resident was to ha stated, "Let me ch when the protect stated, "At all time if the heel protect "You're going arou (medication) pass they have everyth informed about th	conducted on 3/9/17 at 9:45 ensed practical nurse) #12, the Resident #6. When asked if the ave heel protectors on, LPN #12 neck. Yes she is." When asked ors should be on, LPN #12 es." When asked how staff knew ors were on, LPN #12 stated, and when you're doing your med and checking to make sure hing they need." LPN #12 was be observations of Resident #6 eel protectors and informed that					
	staff documented being on Residen	the heel protectors (boots) as t #6 on the treatment cord. LPN #12 stated it was					

	MENT OF HEALTH	AND HU I SERVICES			(FORM A	03/16/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495299	B. WING	i		1	09/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABETH ADAM CRUMP HEALTH AND REHAB			3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 97		514			
	a.m. with ASM (adn	nducted on 3/9/17 at 11:20 ninistrative staff member) #2, ing. When asked why it was o accurately chart on the		:			-
	resident's record, A doctor's orders and	SM #2 stated, "To follow the to be able to look at it (the SM #2 was made aware of the				UMANAKANIA AMANAN MANAN MANAN	
	No further informat	ion was provided prior to exit.					:
							:
			i				
			:				
							:
						RECE MAR 3 (VDH/C	IVED 2017
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