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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			01	FORM APPROVED 4B NO. 0938-0391	
		& MEDICAID SERVICES	(X2) MIT T	IPLE CONSTRUCTION	galanteen mande () de com commence de l'étatement man plante manue année () de l'est en en en en en en en en e	(X3) DATE SURVEY	
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{F 000}	INITIAL COMMEN	TS	(F 00	0}		01/27/2017	
	standard survey co 11/10/16, was cond 01/11/17. One con this survey. Correct compliance with 42 Term Care Require deficiencies are ide Corrected deficient 2567-B.	Medicare/Medicaid revisit to the inducted 11/08/16 (hrough ducted 01/10/17 through inplant was investigated during tions are required for 2 CFR Part 483 Federal Longements. Uncorrected entified within this reporticies are identified on the CMS					
F 167 SS=C	96 at the time of the consisted of 14 cui (Residents #1 thro and #15) and 1 clo #13).	120 certified bed facility was e survey. The survey sample rrent Resident reviews ugh #12 and Residents #14 sed record review (Resident T TO SURVEY RESULTS - SIBLE	F 1	F 167			
A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.				survey year's s corresp	1. The most recent life safety code survey and the last three preceding year's survey results with their corresponding plans of correction were placed in the survey binder on		
	The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.			1/12/17 placed buildin reception precedi	by the Administr inside the front en g. A sign was post on area indicating ing year's survey t	ator and atrance of the sted at the the last three results were	
	by: Based on observa	NT is not met as evidenced ation and staff interview, the post the results of the most ode survey and failed to post a		availab	le for review on 1 al Director of Clir	/13/17 by the	

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

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

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

Event ID: T58V12

Facility ID: VA0061

TITLE

If continuation sheet Page 1 of 30

(X6) DATE

PRINTED: UT/19/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS	S FOR MEDICARE	& MEDICAID SERVICES			(X3) DATE SURVEY		
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F 167 Continued From page 1

notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections.

The findings included.

During the initial tour of the facility on 1/10/17 at 11:45 a.m., the surveyor observed a sign on the wall in the front lobby at the receptionist's desk informing staff, visitors, and residents of the facility that the current survey results were available. The sign included a downward arrow and a white notebook titled "Survey Results" was lying on the table.

The surveyor checked the contents of the binder. The last survey found in the survey result book was dated 12/9/15. The letter sent to the administrator was dated 2/18/16. The surveyor was unable to locate the most current life safety code survey report. There was no posting or notification indicating the last three preceding year's survey results were available for review. The most recent survey report from 11/8/16 through 11/10/16 was not found in the survey result book.

A second surveyor conducted a group meeting with five (5) residents of the facility on 1/10/17 at 2.30 p.m. During this meeting the residents verbalized to surveyor #2 that they were aware of where the current survey results were kept.

The administrative staff were notified of the above concern during an end of the day meeting on 1/11/17 at 11:25 a.m.

No further information regarding this issue was provided to the survey team prior to the exit

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- 2. No resident was identified but all residents and guests have the potential to be affected by this alleged deficient practice.
- 3. The Administrator was in-serviced by the Regional Director of Clinical Services on the current regulatory requirements related to availability of survey results for public review on 1/12/17.
- 4. An audit will be conducted weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Administrator to determine compliance. The results of the audits will be presented by the Administrator to the Quality Assurance/Performance Improvement Committee monthly. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391	
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F 167	Continued From pa	age 2	F 167		,	
	conference. 483 20(d)(3), 483.	10(k)(2) RIGHT TO ANNING CARE-REVISE CP	F 280			
SS=D						
	The resident has the	he right, unless adjudged				
	incompetent or oth	nerwise found to be				
	incapacitated unde	er the laws of the State, to ning care and treatment or				
	changes in care ar	nd treatment.				
				F 280	bonoina cara	
	A comprehensive	care plan must be developed		1. Resident #110 comp	reneusive care	
	within 7 days after	the completion of the sessment, prepared by an		plan was revised by	discontinuing uic	
	adordicciolinary les	am that includes the attending		oxygen care plan on	1/11/17 by the	
	abveiciari a registi	ered nurse with responsibility		Unit Manager.		
	for the regident ar	nd other appropriate stan in			• • • • • • • • • • • • • • • • • • • •	
	- disciplings as dete	rmined by the resident's needs,		2. A 100% audit of all	resident care	
	and, to the extent	practicable, the participation of esident's family or the resident's		plans for oxygen Wa	as completed on	
	Jana concesentativ	re: and neriodically reviewed		1/25/17 by the MD:	S Registered	
	and revised by a to	eam of qualified persons after		Nurse and the MD	S Licensed	
	each assessment.			Deagtical Nurse No	other resident	
				care plans were fou	and to be affected.	
				3. All licensed nurses	were in-serviced	
	This REQUIREME	NT is not met as evidenced		on the managemen	t of oxygen care	
	buc	ation, staff interview, and clinical		nlane by the Direct	or of Nursing, and	
	record review the	facility staff failed to review and		the Assistant Direc	tor of Nursing	
	revise the compre	hensive care plan for 1 01 15		from $1/11/17 - 1/2$	5/17.	
	residents (Resider	nt #110).		11044 11 * * * - *		
	man restly sufficient	iled to review and revise the				
	The facility staff fa	iled to review and revise the tre plan when Resident #110's				
	oxygen was discor	ntinued on 8/20/16.				
	The findings include					
	The indings includ	JOU.				

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

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F 280 Continued From page 3

Resident #110 was admitted to the facility 5/9/11 and readmitted 4/1/14 with diagnoses that included but not limited to chronic obstructive pulmonary disease (COPD), heart failure, atherosclerotic heart disease, dementia with behavioral disturbances, depressive disorder, peripheral vascular disease, and gastroesophageal reflux disease.

Resident #110's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/24/16 assessed the resident with short term memory problems, long term memory problems, and as having severely impaired cognitive skills for daily decision making. Resident #110 was not assessed to have used oxygen during the look back period.

The surveyor observed Resident #110 on 1/10/17 at 1:35 p.m. Resident #110 was in bed with eyes closed. The surveyor did not observe oxygen in use. The surveyor observed Resident #110 on 1/11/17 at 7:45 a.m. Resident #110 was in bed and a certified nursing assistant was feeding the resident. No oxygen was observed to be in use.

The current comprehensive care plan dated 4/19/16 had the problem/need that Resident #110 used oxygen d/t (due to) COPD problem onset: 4/19/16 with a revision date of 7/7/16.

Approaches were to administer medications, O2 (oxygen), and treatments per MD (medical doctor) order see current MAR (medication administration record), vital signs per protocol, observe for and document complications of COPD such as increased respiration rate, decreased O2 sats (oxygen saturations), cyanosis, productive cough, and increase work at

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4. An audit of all oxygen care plans will be conducted weekly for 4 weeks. then monthly for 2 months and/or 100% compliance by the MDS Nurses. The results of the audits will be presented by the Director of Nursing to the Quality Assurance/Performance Improvement Committee monthly. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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F 280	Continued From pa	age 4					
	breathing, and obs notify MD.	erve for changes in status and					
	A review of Reside physician orders di for oxygen.	nt #110's January 2017 id not evidence a current order					
	licensed practical r	viewed the unit manager nurse #5 on 1/11/17 at 11:05 nager was asked what staff are plans. She stated MDS.					
	nurse #2 on 1/11/1 informed MDS/LPI comprehensive ca a problem/need ar for oxygen. MDS/I needed to come or	viewed MDS/licensed practical 7 at 10:35 a.m. The surveyor N #2 that the current are plan still had oxygen use as and no current physician order LPN #2 stated then the oxygen ff the care plan. MDS/LPN #2 esearch the oxygen.					
	the surveyor with a that read in part "E MDS/LPN #2 state plan.) μ.m., MDS/LPN #2 provided a telephone order dated 8/20/16 D/C (discontinue) O2 (oxygen)." ed she would update the care	ò				
	the failure of the fa	med the administrative staff of acility staff to review and revise urrent comprehensive care plan discontinued on 8/20/16 in a 7 at 11:25 a.m.	1				
(F 309) SS=D	exit conference or	CARE/SERVICES FOR	{F	309}			

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(F 309) Continued From page 5

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by

Based on staff interview and clinical record review, the facility staff failed to ensure the highest practicable well-being for 2 of 15 Residents in the survey sample, Residents #107 and #111.

- 1. The facility staff administered the physician ordered medication linzess to Resident 107 twice a day when it was ordered one time a day.
- 2 The facility staff failed to obtain vital signs every 8 hours for 5 days per physician order for Resident #111. The facility staff failed to obtain physician ordered vital signs on three (3) occasions out of 15 opportunities from 12/12/16 through 12/16/16 (5 days of vital signs ordered by the physician).

The findings included.

 The facility staff administered the physician ordered medication linzess to Resident 107 twice a day when it was ordered one time a day.

Linzess (linaclotide) is a prescription medication used in adults to treat irritable bowel syndrome

{F 309}

01/27/2017

F 309

1. Resident #107 was assessed by the Unit Manager on 1/11/17. No adverse outcomes were noted. LPN #4 was inserviced by the Director of Nursing on 1/11/17 on physician order accuracy. The physician order for Linzess was clarified and entered correctly into the electronic medication administration system to be given once daily by the Unit Manager on 1/11/17.

Resident #111 was assessed by the Unit Manager on 1/11/17. No adverse outcomes were noted. The Provider and Responsible Party were notified on 1/11/17 by the Unit Manager.

2. An audit of all physician orders to ensure accuracy was completed from 1/25/17 – 1/27/17 by the Unit Managers, the Director of Nursing, and the Assistant Director of Nursing. Issues identied were addressed immediately by the Director of Nursing.

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{F 309}	Continued From pa	ige 6	{F 3	09)		
Į,	with constination ar	nd chronic idiopathic				
	constination, "Idiop	athic" means the cause of the				
	constipation is unknown. (1)				3. Licensed Nurses were in	n-serviced on
	The record review revealed that Resident #107				physician order accurac	
	and been admitted	to the facility 01/25/13.			1/11/17 - 1/25/17 by the	
	Diagnoses included	d, but were not limited to, end			Nursing and the Assista	nt Director of
	stage renal disease	e, type 2 diabetes, heart failure, v, hypothyroidism, and			Nursing.	
	generalized anxiety insomnia.	, hypothyroleiam, and				
					4. An audit of new physic	ian orders will
	quarterly MDS (mir with an ARD (asset 10/13/16 included a mental status) sum possible 15 points, cognitively intact. S was coded (2/1) to frequently incontine incontinent of bowe was coded to indica diagnosis of consti				be conducted daily for a weekly for 3 weeks, the months and/or 100% co. The results of the audits presented monthly by the Nursing to the Quality Assurance/Performance Committee. The Quality Assurance/Performance Committee consists of a	en montly for 2 empliance. Es will be the Director of Elmprovement by Elmprovement at least the
	The Residents CCP (comprehensive care plan) included the problem area requires staff assistance with ADL's (activities of daily living). Resident #107's clinical record included a current physicians order for linzess 145 mcg give 1 capsule by mouth daily. The original order date was documented as 02/15/16 the order had been revised on 12/03/16. The diagnosis for this medication was documented as constipation.				Administrator, Director Unit Managers, Admissi Housekeeping Director, Director, Food Service I Activity Director, Social Director, Therapy Service and the Medical Director	on Director, Maintenance Director, Services Director
	A review of Reside medication adminis	nt #107's eMAR's (electronic straton records) for December				

FORM APPROVED OMB NO. 0938-0391

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į. <u>-</u> ,	a day since 12/04/16.					
	40/47/46 19/99/16	out for dialysis on 12/15/16, , 01/05/17, 01/07/17, and . and only received the linzess these days.				
	movements) for the Resident #107 had 12/16/16, 12/18/16 12/23/16, 12/25/16 12/31/16, 01/03/17 and 01/09/17. Duri	sident's BM's (bowel e last 30 days indicated that I a BM on 12/11/16, 12/14/16, I, 12/19/16, 12/21/16, 12/22/16, I, 12/27/16, 12/28/16, 12/29/16, I, 01/05/17, 01/06/17, 01/08/17, ng the clinical record review of find any information to ent had complained of any				
	01/10/17 at 1:10 p. 7:15 a.m., the residence of 1/11/17 for a day the surveyor spoke their care at the faction of the surveyor to the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the faction of the surveyor spoke their care at the surveyor spoke the surveyor spoke their care at the surveyor spoke th	s observed by the surveyor on .m and again on 01/11/17 at dent went out of the facility on trip. During these observations e with the resident regarding cility. No complaints were eyor regarding medications or to during these conversations.				
	nurse consultant w #107 had been adday when the phys	proximately 10:00 a.m. the was made aware that Resident ministered the linzess twice a sician order was for one time a entified LPN (licensed practical urse who revised Resident 2/03/16.				
	was interviewed by	proximately 1:25 p.m. LPN #4 y the surveyor. LPN #4 urveyor that some of the times nedications had been changed	n ne standard og skalende ska		14 000	tinuation sheet Page 8 of

FORM APPROVED OMB NO. 0938-0391

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{F 309}	Continued From pa	ige o	(1	40,			
	due to a conflict with dialysis and she must have inputted the wrong time frame on the computer for this medication (linzess) during the revision. During a meeting with the survey team on 01/11/17 at approximately 3 10 p.m. the administrative staff of the facility were made aware that Resident #107 had been administered their linzess twice a day when the physician order was for one time a day.						
	No further informat provided to the surronference.	ion regarding this issue was vey team prior to the exit					
	website: https://medlineplus	n was obtained from the .gov/druginfo/meds/a613007.h					
	every 8 hours for 5 Resident #111. The physician ordered v	failed to obtain vital signs days per physician order for e facility staff failed to obtain vital signs on three (3) opportunities from 12/12/16 days of vital signs ordered by					
	reviewed 1/10/17 a was admitted to the 10/22/16 with diagr	of Resident #111 was nd 1/11/17. Resident #111 e facility 7/4/16 and readmitted noses that included but not spine, cervicothoracic region, pulmonary disease, lymphoid imatoid arthritis.					
	set (MDS) with an a	orteen (14) day minimum data assessment reference date of he resident with a cognitive 15 out of 15, indicating the			II conf	nuation she	eet Page 9 of C

FORM APPROVED OMB NO. 0938-0391

DEPART	LWENT OF HEALTH	AND TOWN OF CERVICES			OMB NO. 0930-038
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
TATEMENT ND PLAN C	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER	A BUILD	ING	l R-C
			D MINIC	A THE STATE OF THE	01/11/2017
		495338	I B WING	STREE ADDRESS, CITY, STATE, ZI	P CODE
NAME OF I	PROVIDER OR SUPPLIER			600 WALDEN ROAD	
	HEALTHCARE OF AB	MINGDON		ABINGDON, VA 24210	
GRACE				SOCURED'S DI AN OF I	CORRECTION (X5)
(X4) ID PREFIX TAG	The second of th	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACT	HE APPROPRIATE DATE
	and the second of the second o			and the second section of the section o	01/27/2017
(E 200)	Continued From pa	age 9	{F 3	09}	
{F 309}	- continued r rott pe	tively intact, with no signs of			
	delirium, psychosis	s, or behaviors.			
	The clinical record	had a physician order dated			
	(Jagranea) Metanr	00 p.m.) that read "1 ? olol (1) to 25 mg (milligram) po			
	- /by mouth) bid (twi	ice a day). Z. v (check) vitais			
	q8° (every 8 hours) x 5 days."			
	Current comprehe	nsive care plan with problem 6 for use of oxygen with a			
	the managin of chron	ic obstructive pulmonary			
	disease had appro	paches that included to obtain			
	vital signs per prot	ocol.			
	The surveyor revie	ewed the vital signs			
	documented on th	e electronic flow sheet, on the nedication administration			
	second and in the	denartmental notes and was			
		II physician ordered vital signs.			
	The December 20	46 medication administration	2*		
	record had docum	entation of 12 sets of vital sign	5		
	(blood pressure, p	oulse, respiration, and n from 12/12/16 at 10:00 p.m			
	- through 19/16/16:	at 2:00 p.m. The departmentar			
	and a bad docume	antation of vital signs taken on			
	LOUISIA ON ALADO N	.m. /dunlicate documentation			
	also found on the	flowsheet for 12/13/10 dt 1.20			
	- decumentation for	1:40 a.m. (duplicate and on the flow sheet for			
	12/13/16 at 9:06 p	i.m.) and 12/15/16 at 2.16 a.m.			
	The December 20	116 electronic flowsheet for vita	ļ		
	signs from 12/12/	16 through 12/16/16 had elever	Î		
	(11) documented	sels of vital signs.			
	The staff failed in	obtain 5 days/fifteen sets of			
	vital signs for Res	ident #111. The facility stair			
	vitar orginalist	uninian ordered vital signs on			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES			OMB NO. 0938-0391					
CENTERS FOR MEDICARE & MEDICAID SERVICES		Taxassus	TINGO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COW	PLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION (40)MOEV	A BUILI	JING	Commence of the Commence of th	R	-C	
			6 4014			01/	11/2017	
		495338	B MING		ET ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIER	and the second section of the						
					WALDEN ROAD			
GRACE	HEALTHCARE OF AB	IINGDON		ABII	NGDON, VA 24210	had desired and property according to the desired		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE	
					and an analysis of the Contract of the Contrac	01	/27/2017	
			IE.	309}		01	121/2011	
{F 309}	Continued From pa	age 10	{r .	303}				
	three (3) occasions	s out of 15 opportunities from						
	12/12/16 through 1	2/16/16.						
	The surveyor inform	med the director of nursing of						
	the coocern that th	ie facility stati nau nui						
	monitored Resider	nt #111's vital signs every 8	r					
	hours for 5 days as	s ordered by the physician afte	'					
	a change in the do	se of the antihypertensive						
	medication Metopr	olol on 1/10/17 at 2:30 p.m.						
	The director of nur	sing informed the surveyor on						
	1/11/17 at 8:00 a.n	n, that the nurse practitioner						
	who ordered the vi	ital signs to be obtained was						
	informed of the res	sults of Resident #111's vital agreement that they no longer						
	signs and was in a	e; however, the nurse						
	needed to be done	to write an order to discontinue						
	practitioner falled to	r of nursing stated the staff						
	them. The directo	ate any more vital signs.						
	The curveyor infor	med the administrative staff of						
	who failure of the fa	acility staff to obtain physician						
	ordered vital signs	in the meeting on 1/11/17 at						
	11:25 a.m.							
					1			
	No further informa	tion was provided prior to the						
	exit conference or	1/11/17.						
		t there is combination						
	(1) Metoprolol is u	sed alone or in combination						
	with other medical	tions to treat high blood	t					
	pressure. It also is	s used to prevent angina (ches						
	pain) and to impro	we survival after a heart attack						
	Metoprolol also is	used in combination with other	1					
	medications to tre	at heart failure. Metoprolol is in						
	a class of medical	tions called beta blockers. It						
	works by relaxing	blood vessels and slowing						
	heart rate to impro	ove blood flow and decrease						

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DEFAIL	WILLIAM OF THE ACT.	A MEDICALD CEDMICES				OMB NO. 0938-0391
	CENTERS FOR MEDICARE & MEDICAID SERVICES			TIPLEC	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1. 1		particularly elements in a 7 - analysis and 1 (personnel particularly in a princip in mandator)	COMPLETED
ANDPUNIC	COMMETONOM				entition of the second of the	R-C
		495338	B WING		gas and asserted of the second	01/11/2017
		7,0000	1	STRE	EET ADDRESS, CITY, STATE ZIP CODE	Action to the second se
NAME OF I	PROVIDER OR SUPPLIER				WALDEN ROAD	
GRACE H	HEALTHCARE OF AB	INGDON		ABI!	NGDON, VA 24210	
and the second second second					PROVIDER'S PLAN OF CORRECT	ION (X5)
(X4) ID PREFIX TAG	CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLLIION
{F 309}	Continued From page 11 High blood pressure is a common condition and			09}		01/27/2017
	when not treated, c heart, blood vessels the body. Damage I heart disease, a he kidney failure, loss This information wa https://medlineplus. tml	an cause damage to the brain, s, kidneys and other parts of to these organs may cause art attack, heart failure, stroke, of vision, and other problems sobtained from the website: gov/druginfo/meds/a682864.h				
F 328 SS=D	483.25(k) TREATM NEEDS	ENT/CARE FOR SPECIAL	F:	328	F328	
	proper treatment ar special services: Injections, Parenteral and enter Colostomy, ureteros Tracheostomy care Tracheal suctioning Respiratory care; Foot care; and Prostheses. This REQUIREMENtly: Based on observation of the special suction of the second services of the second second services of the second services of the second services of the second services of the second second services of the second seco	stomy, or ileostomy care; ; IT is not met as evidenced ion, Resident interview, staff cument review, and clinical			1. Resident #105 was ass Unit Manager on 1/11/outcomes noted. The P discontinued on 1/09/1 Physician. LPN #1 was PICC Line Dressing Cl Director of Nursing on Resident #111 was asse Unit Manager on 1/11/outcomes noted. The pl for continuous oxygen discontinued on 1/10/10/10/10/10/10/10/10/10/10/10/10/10	17. No adverse ICC Line was 7 by the s in-serviced on hanges by the 12/30/16. essed by the 17. No adverse hysician order was
	This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility document review, and clinical record review the facility staff failed to provide the necessary care, service, and treatment for special needs for 2 of 15 Residents in the survey				discontinued on 1/10/1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	495338	B WING	and the companying of the control of the first definition of the control of the c	01/11/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS CITY STATE ZIP COL	DE
NAME OF PROVIDER OR SUPPLIEN			600 WALDEN ROAD	
GRACE HEALTHCARE OF ABINGDON			ABINGDON, VA 24210	
(A4) IO (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	THE ALL AND THE ALL AND THE ALL	HOULD BE COMPLETION
				01/27/2017
F 328 Continued From p	age 12	F:	328	

sample, Resident #105 and #111.

- 1. For Resident #105, the facility staff failed to change a PICC line dressing weekly as ordered by the physician.
- 2. For Resident #111, the facility staff failed to follow physician orders for the use of oxygen.

The findings included:

1. For Resident #105, the facility staff failed to change a PICC line dressing weekly as ordered by the physician.

A PICC line is a peripherally inserted central catheter. It is used for treatments such as intravenous fluids (IV), drugs, or blood transfusions (1)

The record review revealed that Resident #105 had originally been admitted to the facility 04/15/14. Diagnoses included, but were not limited to, diabetes, hypertension, trigeminal neuralgia, muscle weakness, and depressive disorder.

Section C (cognitive patterns) of the residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/25/16 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points, indicating the resident was moderately impaired for cognition.

The clinical record included a nursing entry dated 12/20/16 at 11:08 a.m. stating that Resident #105 was transported to a local hospital for "...PICC placement." This PICC line was to be used for IV

- 2. No current residents have PICC Lines in place on 1/25/17. An audit of all oxygen physician orders was completed on 1/20/17 by the MDS Nurses. No other residents were found to be affected.
- 3. Licensed Nurses were in-serviced from 1/11/17 - 1/25/17 on following physician orders by the Director of Nursing and the Assistant Director of Nursing.
- 4. An audit of all PICC Line Dressing Changes and Oxygen Physician Orders will be completed weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Unit Managers or designee. The results of the audits will be presented by the Director of Nursing monthly to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services

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STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		ONSTRUCTION		MPLETED R-C
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	PROVIDER OR SUPPLIER		1		ET ADDRESS, CITY STATE, ZIP CODE		
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GRACE HEALTHCARE OF ABINGDON		INGDON		ABI	NGDON, VA 24210		IVE:
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			Charles and the Charles of the Charl			01	/27/2017
F 328	Continued From pa	ge 13	F	328			
	therapy to treat a ut	rinary tract infection. The					
	clinical record also	included a physician ted 12/20/16 to change PICC y and as needed if moist or			Director, Therapy Service and the Medical Director		ector
	treatment administre 01/2017 revealed the dressing was so 12/27/16 at 7:00 au practical nurse) #1 administration block pre-printed code or administered." LPN on the eTAR that red dressing weekly as 7:00 A.M. was not at The clinical record transcribed on 12/3 that read "ADON (a came to this Nurse not being changed dressing of dry and intact. No reflushes well, MD (raware, Client aware. The facility nursing changed the PICC 01/05/17 and the PICC 01/05/17 and the PICC on the deministrative issue involving the changed during a medical processing of the piccontinued and reconstructions.	included a nursing note 10/16 at 2:26 a.m. by LPN #8 Issistant director of nursing) Ito fill out report on dressing on 12/27/16. Other Nurse on 12/29/16 Dressing clean, edden (sic) areas seen. medical doctor) and ADON a" staff documented they had line dressing again on					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1	THU C 64	ONICTRICTION	(X3) DA1	TE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		MPLETED
AND PLAN C	OF CORRECTION	DENTIFICATION NOWISE II.	A BUILD	ING		l F	₹-C
			G MING			1	/11/2017
		495338	B WING		ET ADDRESS, CITY, STATE, ZIP CODE	1	7 3 172 - 0 1 .
NAME OF I	PROVIDER OR SUPPLIER						
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GRACE	HEALTHCARE OF AB	INGDON		ABIN	NGDON, VA 24210		
(X4) ID PREFIX TAG	JEACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL (CROSS-REFERENCED TO THE APPROF DEFICIENCY)) Bt_	(X5) COMPLETION DATE
	Make allow programme to the programme are as a supplied to the programme and the project of the programme.		al participation and the second state of the s			01/	/27/2017
		44	F 3	328		01/	2//201/
F 328	Continued From pa	ige 14	, .				*
	Prior to the exit cor	nference the facility staff					
	provided the survey	yor with a copy of a					
	"MEDICATION ERI	ROR REPORT" signed and					
	dated by LPN #1 of	n 12/30/16. This medication ed that LPN #1 failed to change					
	error report reveale	C line dressing on 12/27/16.					
	Outcome to Poside	ent-No negative outcome.					
	Corrective action-d	ressing changed immediately.					
	Moscures taken in	prevent the recurrence of					
	similar error(s)-PIC	C line dressing change					
	inservice given. Co	py of policy and dressing					
	instructions given.	Confusion noted by nurses on					
	date PICC line place	ed. The facility staff also					
	provided the survey	vor with a copy of an inservice					
	education sign in sl	heet. This inservice education					
	sheet was titled "Pl	CC Line Drsg (dressing).					
	Change" and was a	also dated 12/30/16 and signed					
	by LPN #1.						
		a comment of the					
	On 01/11/17 at app	roximately 1:15 p.m. the					
	surveyor interviewe	ed Resident #105 regarding					
	their PICC line care	Resident #105 stated that					
	she never had any	problems with the PICC line					
	and that the facility	staff took care of it.					
	a charled 147 at more	reviewed by 2:50 nm, the nurse	,				
	On 01/11/17 at app	roximately 2:50 p.m. the nurse If the surveyor with a copy of					
	consultant provided	ERIPHERALLY INSERTED					
	TUGIL BOILCA HIER L	TER (PICC) DRESSING					
	CENTRAL CATTLE	licy/procedure read in part					
	" Droseina chance	es using transparent dressings					
	are performedat I	least weekly"	· r				
	are periorineoaci	occi womin.					
	On 01/11/17 at 2:54	4 p.m. the surveyor attempted					
	to contact I PN #1 \	via the phone number provided					
	by the facility. The	call went to voicemail. No					
	message was left.						
	111000030 11210 10111						

No further information regarding this issue was

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO.				0. 0938-0391			
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	[/Y')\ bal	TIPLEC	CONSTRUCTION	(X3) DA	TE SURVEY
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		JONS PROCEEDING		MPLETED R.C
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		495338	10 7711		EET ADDRESS, CITY, STATE, ZIP COD		a programme a communicação de productivos en en entre entre en re en entre ent
	PROVIDER OR SUPPLIER			1	WALDEN ROAD		
GRACE I	HEALTHCARE OF AB	INGDON		ABI	NGDON, VA 24210		
(X4) ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAG	HX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	DATE COMPLETION (XS)
F 328	conference.	vey team prior to the exit	F	328		01	/27/2017
	website:	n was obtained from the er.gov/publications/dictionaries D=689626>	/				
	2. The facility staff orders for the use o	failed to follow physician of oxygen for Resident #111.					
	reviewed 1/10/17 a was admitted to the 10/22/16 with diagr limited to fusion of change obstructive	of Resident #111 was nd 1/11/17. Resident #111 e facility 7/4/16 and readmitted noses that included but not spine, cervicothoracic region, pulmonary disease (COPD), and rheumatoid arthritis.					
	set (MDS) with an a 11/4/16 assessed to summary score of	urteen (14) day minimum data assessment reference date of the resident with a cognitive 15 out of 15, indicating the tively intact with no signs of , or behaviors.					
	with problem onset oxygen with a diagonal pulmonary disease to administer medic breathing treatmen MAR (medication a Observe for compli- such as increased	rrent comprehensive care plandated 7/21/16 for use of mosis of chronic obstructive had approaches that included cations, O2 (oxygen) and its as ordered. See current administration record). It cations r/t (related to) COPD respiratory rate, decreased O2 ations), cyanosis, SOB h), and report, and obtain vital	2				

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DEPAR [*]	TMENT OF HEALTH	I AND HUMAN SERVICES					O. 0938-0391
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	T				ATE SURVEY
CTATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			CONSTRUCTION	() ()	OMPLETED
ANDIE		H 44-14-14-14-14-14-14-14-14-14-14-14-14-1				1	R-C
		495338	B WING		TIN CODE	0	1/11/2017
NAME OF	PROVIDER OR SUPPLIER	A construction of the second s			REET ADDRESS, CITY, STATE, ZIP CODE		
		MACDON			WALDEN ROAD		
GRACE	HEALTHCARE OF AB	SINGUOIN		AB	INGDON, VA 24210	TION	(X5)
(X4) ID PREFIX TAG	JE ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	IOLD RE	COMPLETION DATE
F 328	Continued From page	age 16	F:	328		0	1/27/2017
	reviewed 1/10/17.	physician order sheet was Resident #111 had orders that 2 liters via nasal cannula					
	at 1:40 p.m. The reclosed. An oxygen the head of the bed concentrator was resaw no tubing near.	rved Resident #111 on 1/10/17 esident was in bed with eyes a concentrator was observed at d on the left side. The not turned on and the surveyor or on Resident #111.					
	at 4:05 p.m. The reclosed No oxyger approached the unnurse #5 on 1/10/1 informed the unit metals in a physician order and	esident was in bed with eyes in use. The surveyor if manager licensed practical 7 at 4:05 p.m. The surveyor manager of the current d confirmed Resident #111 diden as ordered. "You're right.					
	#4 on 1/11/17 at 7: resident had not us from the hospital in	viewed licensed practical nurse 40 a.m. L.P.N. #4 stated the sed oxygen since returning a October. The resident stated e oxygen continuous and did t the present time.					
	the failure of the fa	med the administrative staff of cility staff to follow physician of oxygen in the meeting on m.					
	exit conference on	tion was provided prior to the	ſĘ.	131}			

{F 431} 483.60(b), (d), (e) DRUG RECORDS,

{F 431}

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			O	MB NO. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	1,000,041,11	TIDLEC	CONSTRUCTION	(X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	CONTROL TO THE CONTRO	COMPLETED
AND PLAN O	F CORRECTION		1	A STATE OF THE PARTY OF THE PAR		R-C
		495338	B WING			01/11/2017
NAME OF P	ROVIDER OR SUPPLIER				EFT ADDRESS, CITY, STATE, ZIP CODE	
		MCDON			WALDEN ROAD	
GRACE HEALTHCARE OF ABINGDON			ABII	NGDON, VA 24210 PROVIDER'S PLAN OF CORRECTIO	N [X6]	
(X4) IO PREFIX TAG	COLL OFFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDERS PLAN OF COINTECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOPICIENCY)	BE COMMECTION
						01/27/2017
JE 4313	Continued From pa	nge 17	{F 4	31}		1-1/201/
SS=D	LARFLISTORE DR	UGS & BIOLOGICALS				
33.0					F431	
	The facility must er	mploy or obtain the services of			1. Resident #114 was asses	ssed by the
	a licensed pharmac	cist who establishes a system of all			Unit Manager on 1/25/1	7. No adverse
	controlled drugs in	sufficient detail to enable all			outcomes noted. The No	ovalog Insulin
	accurate reconcilia	tion: and determines that drug			vial was discarded by the	ne Unit
	records are in orde	r and that an account of all			Manager on 1/11/17.	
	controlled drugs is reconciled.	maintained and periodically				
List of the list o	, 3				Resident #115 was asse	ssed by the
	Drugs and biologic	als used in the facility must be			Unit Manager on 1/25/1	7. No adverse
	Joheled in accordar	nce with currently accepted			outcomes noted. The Pa	izeo eye drops
	professional principal appropriate access	oles, and include the			were discarded by the U	Jnit Manager
	instructions, and th	e expiration date when			on 1/11/17.	
	applicable.					
	718	State and Federal laws, the			2. All insulin vials and ey	e drops were
	In accordance with	all drugs and biologicals in			audited to ensure all we	ere dated upon
	ampropriate to the least	nis under proper temperature			opening by the Unit Ma	anagers on
	controls, and perm	it only authorized personner to			1/11/17. No other issue	s were
	have access to the	keys.			identified.	
	The facility must be	rovide separately locked,				
	comprently affixed	d compartments for storage or			3. Licensed Nurses were	in-serviced on
	controlled drugs lis	ted in Schedule II of the			dating insulin vials and	eye drops
	Comprehensive Dr	uo Abuse Prevention and			upon opening from 1/1	1/17 - 1/25/17
	Control Act of 1970	and other drugs subject to in the facility uses single unit			by the Director of Nurs	sing and the
	andrope drug distr	ibution systems in which the			Assistant Director of N	lursing.
	quantity stored is n	ninimal and a missing dose car	1			-
	be readily detected	J .				

This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		IDENTIFICATION NOMBER	A BUILL	DING	R-C
		495338	B WING	againment of the second of the	01/11/2017
NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF ABINGDON			STREET ADDRESS, CITY STATE, ZIP CODE 600 WALDEN ROAD ABINGDON, VA 24210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	RTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	COOCC DEFENSAICED TO THE APPR	JLD BE COMPLETION
{F 431}	Continued From pa	age 18	{F 4	31}	01/27/2017

facility staff failed to date medications (multi-dose

insulin and eye drops) when opened for 2 of 15 residents in the survey sample, (Resident #114 and Resident #115).

- 1. The facility staff failed to date a multi-dose vial of Novolog insulin when opened for Resident #114.
- 2. The facility staff failed to date a bottle of eye drops when opened for Resident #115

The findings include:

1. The facility staff failed to date a multi-dose vial of Novolog insulin when opened for Resident #114.

During a walk-through of the facility on 1/10/17 at 4:30 p.m., the surveyor checked the medication room on unit 1 and both medication carts. The surveyor observed a multi-dose vial of Novolog 100 unit insulin with Resident #114's name on the label in medication cart #1. The bottle of insulin had been opened. The bottle of Novolog U100 did not have a date when the vial was opened. The unit manager licensed practical nurse (L.P.N.) #7 was with the surveyor when this observation was made. L.P.N. # 7 stated "We are to date vials when opened." The unit manager stated the bottle of insulin had been delivered on 1/4/17 and she had checked all the insulins up to today 1/10/17. L.P.N. #7 stated she would find out which nurse had opened the insulin without dating the bottle.

The surveyor requested the facility policy on

4. An audit of all insulin vials and eye drops will be conducted weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Unit Managers. The results of the audits will be presented monthly by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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{F 431}	dating and labeling	age 19 medications from corporate se) #3 on 1/11/17 at 7:55 a.m	{F 431}		01/27/2017
	Storage and Expira Biologicals, Syringe The policy read in policy respect to expiration medications. Facility opened on the medication has a sopened."	ly staff should record the date dication container when the hortened expiration date once			
	Novolog from the of corporate registere at 10.25 a.m. The medication should review of the packar part under how to selections of the packar of	ested the package insert for lifector of nursing and the d nurses #3 and #4 on 1/11/17 director of nursing stated the be discarded after 28 days. A age insert for Novolog read in store Novolog "The Novolog@ u are using should be thrown, even if it still has insulin left in			
	the above concern 11 25 a.m. Both th	med the administrative staff of during a meeting on 1/11/7 at e director of nursing and the d nurse stated they would ate vials of insulin when			
	No further informat surveyor prior to the	ion was provided to the e exit conference on 1/11/17.			
	Resident #114 was with diagnoses that	admitted to the facility 11/2/16 tincluded metabolic			

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GRACE		and the second s	ID	MONUDER'S PLAN OF CO	RRECTION	IXS COMPLETION		
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	O viewed From pr	age 20	{F 4	131}	01/	27/2017		
{F 431}	Continued From pa	pe 2 diabetes mellitus,	·	•				
	aubornsclernlic hea	art disease, gout, hyperiension,						
	annuaty harrian are	istatic hypertrophy, stage 1						
	nressure ulcer righ	t heel, constipation, cardiac						
	pacemaker, and m							
	Resident #114's ac	lmission minimum data set						
	(MDS) accessmen	t with an assessment						
Interpreted the (ARD) of 11/30/16	(D) of 11/30/16 assessed the							
	resident with a brief interview for mental status a 7 out of 15 in Section C Cognitive Summary. No							
	signs of delirium, p	sychosis or behaviors were						
	assessed.							
	Resident #114 had Novolog 100 unit/n subcutaneously the and Novolog 100 unit/n (subcutaneously) (necessary) Glucag orders 71-150=No units, 201-250=3 units, 3 blood sugar in 2 hi MD (medical doctors) Resident #114 was on 1/10/17 at 4:30	0-50=See prn (whenever gon order 51-70=See prn 1x (treatment) 151-200=2 units; 251-300=4 units; 351-450=9 units and recheck rs (hours) if still over 350 notify pr) above 450=notify MD. Is administered Novolog 3 units p.m. for blood sugar of 201 ts was scheduled with meals on 1/10/17 at 4:30 p.m. and						
	drops when opene	If failed to date a bottle of eye ed for Resident #115.						
****	The surveyor chec the two medication	cked the medication room and n carts on unit 2 on 1/10/17 at			If continuation shee	et Page 21 of		

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(F 431) Continued From pa 4:45 p.m. Unit 2 m with licensed practic the observation, the opened bottle of Pafor Resident #115. open bottle of Paze "We are to date bot The clinical record of reviewed 1/11/17. If 3/13/14 with diagnor limited to glaucoma pulmonary disease, hyperlipidemia, insolving disease, hyperlipidemia, insolving dementia without be hypertension. Quarassessment with an (ARD) of 10/25/16 a cognitive summary signs of delirium, be assessed. January 2017 physis for Pazeo 0.7% eye The medication had 1/1/17 through 1/10. The surveyor requedating and tabeling corporate registered a.m.	ge 21 edication cart #1 was checked cal nurse (LPN) #3. During e surveyor observed an izeo 0.7% eye drops ordered. There was no date on the io eye drops. LPN # 3 stated alles when opened." of Resident #115 was Resident #115 was admitted ises that included but not inchronic obstructive, depressive disorder, omnia, constipation, chronic oe 2 diabetes mellitus, ehavioral disturbances, and reterly minimum data set (MDS) in assessment reference date assessed the resident with a score of 15 out of 15. No ehaviors, or psychosis were drops: both eyes once daily, if been administered daily from	{F 4	31}		01/27/2017	

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

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(F 424)	Continued From pa	ige 22	{F 4	31}		01/27/2017
{F 431}	Storage and Expira	ition of Medications.	į.	,		
	Biologicals Syrings	es and Needles" on 1/11/17				
	The policy read in 0	part "5. Once a medication or is opened, Facility should				
	follow manufacture	r/supplier guidelines with				
	respect to expiration	n dates for opened				
	medications. Facilit	y staff should record the date fication container when the				
	medication has a st	hortened expiration date once				
	opened."					
	reviewed 1/11/17. when to discard the degrees C (Celsius	for Pazeo eye drops was The insert did not specify medications only to store at 2 to 25 degrees C [36 degrees degrees F]. Keep bottle not in use.				
	the above concern 11.25 a.m. Both the corporate registere	ned the administrative staff of during a meeting on 1/11/7 at e director of nursing and the d nurse stated they would ate bottles of medications				
{F 514} SS=D	surveyor prior to the	ion was provided to the e exit conference on 1/11/17. LETE/ACCURATE/ACCESSIB	{F 5	14}		
	resident in accorda	aintain clinical records on each nce with accepted professional stices that are complete; nted, readily accessible; and nized.				
	The clinical record	must contain sufficient				

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

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(F 514) Continued From page 23

information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 3 of 15 Residents in the survey sample, Resident #106, #110, and #111.

- 1. For Resident #106, the facility failed to ensure the residents novolog insulin orders were transcribed correctly onto the POS (physician order sheet) in the paper clinical record.
- 2. Resident #110 had documentation in the departmental notes of another resident's medical information.
- 3. The facility staff failed to ensure a complete and accurate December 2016 and January 2017 physician order sheets (POS) for Resident #111. The order for a long handled fork was discontinued on 11/8/16 but remained on both the December 2016 POS and January 2017 POS.

The findings included.

1. For Resident #106, the facility failed to ensure the Residents novolog insulin orders were transcribed correctly onto the POS in the paper clinical record. The facility nursing staff had incorrectly transcribed the Residents insulin orders to read that the resident should be

{F 514}

01/27/2017

F514

1. Resident #106 Novolog insulin order was transcribed correctly on 1/11/17 by the Unit Manager.

Resident #110 departmental note was updated with an addendum noting it was documented in error by the Unit Manager on 1/25/17.

Resident #111 had the long handed flexible fork order removed from the Physician Order Summaries for November, 2016 and December, 2016 by the Unit Managers on 1/11/17.

2. All Sliding Scale order texts were audited on 1/11/17 by the Unit Managers. Issues identified were addressed.

All Physician Order Summaries with adaptive eating devices were audited 1/25/17 – 1/27/17 by the Unit Managers. No other issues identified.

All resident tray cards with adaptive eating devices were audited by the Dietary Manager on 1/25/17. No other issues were identified.

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		(F. F.	4.41	01/27/2017	
{F 514} Continued From page 24		{F 5	3. Licensed Nurses were	re in-serviced	

administered 5 units of novolog insulin for a blood sugar of 201-350, when in fact it should have read for a blood sugar of 301-350.

The record review revealed that Resident #106 had originally been admitted to the facility 09/17/13. Diagnoses included, but were not limited to, diabetes, chronic pain, hypertension, and post-traumatic stress disorder.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/20/16 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section I (active diagnoses) included an active diagnosis of diabetes. Section N (medications) was coded to indicate Resident #106 received insulin 7 out of 7 days.

The Residents CCP (comprehensive care plan) included the problem area of diabetes.

The Residents clinical record included a physician signed POS (physician order summary) that included an order for novolog insulin per sliding scale for a BS (blood sugar) of 151-200 administer 2 units, 201-250 3 units, 251-300 4 units, 201-350-5 units, 351-450 9 units and recheck in 2 hours if still over 350 notify MD.

On 01/10/17 at approximately 2:55 p.m. the nurse consultant was made aware of the conflicting orders regarding the BS readings of 251-300 and 201-350. After reviewing the order with the surveyor the nurse consultant stated that they used a prepopulated order for this physician for blood sugars; the nurse that had put the order into the computer (this order was entered

- from 1/11/17 1/25/17 on sliding scale order text accuracy, Physician Order Summary Accuracy by the Director of Nursing and the Assistant
 - Director of Nursing. The Dietary Manager was in-serviced on 1/25/17 by the Director of Nursing on tray card accuracy.
- 4. An audit of all sliding scale order texts, Physician Order Summaries related to adaptive eating devices, and tray cards with adaptive eating devices will be audited weekly for 4 weeks, then monthly for 2 months and/or 100% compliance by the Unit Managers. The results of the audits will be presented monthly by the Director of Nursing to the Quality Assurance/Performance Improvement Committee. The Quality Assurance/Performance Improvement Committee consists of at least the Administrator, Director of Nursing, Unit Managers, Admission Director, Housekeeping Director, Maintenance Director, Food Service Director, Activity Director, Social Services Director, Therapy Services Director and the Medical Director.

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

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11 2141		posed the order incorrectly	•	ĺ		
	(onto the POS in the 201-350 should act	e paper record) and that the				
	copy of this physicial copy of what the nu administer the insulfor a BS reading of	nt provided the surveyor with a an's sliding scale order and a rses would have used to in. This order was as follows 251-300 administer 4 units for -350 administer 5 units.				
	the time of the survi	ident's BS from 12/09/16 until ey revealed that the facility en administering the correct				
	inaccurate clinical re	staff were made of the ecord in regards to insulin th the survey team on mately 11:25 a.m.				
	No further information provided to the survice conference.	on regarding this issue was ey team prior to the exit				
	and accurate chnica Resident #110 had o	ailed to ensure a complete I record for Resident #110. documentation in the of another resident's medical				
	and readmitted 4/1/1 included but not limit pulmonary disease (atherosclerotic heart	admitted to the facility 5/9/11 4 with diagnoses that led to chronic obstructive COPD), heart failure, disease, dementia with ces, depressive disorder, disease, and				

gastroesophageal reflux disease.

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201711	TO FOR MEDICADE	A MEDICAID SEDVICES			ON	<u>IB NO. 0938-0391</u>
		8 MEDICAID SERVICES	(X2) MIII	TIPLE CONSTRUCTION	(X3) DATE SURVEY
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{F 514}	Continued From pa	nge 26	{F 5	4}		01/27/2017
	(MDS) assessment reference date (AR resident with short term memory proble cognitive skills for or the surveyor review notes (departmental 1/10/17. The Depart 12:44 a.m. read "BI (pulse) 56, T (tempont 18 O2 (oxygen satur Doxycycline for cell Will continue to moon the surveyor review physician orders. For current orders for Codiagnosis of cellulities. The surveyor made of the documentatic a.m. After reviewing the licensed practice the wrong chart. The surveyor informatic above concern meeting held 1/11/14 the facility policy on 3:45 p.m. The surveyor review documentation titled Documentation titled Documentation in the programment of the surveyor review documentation titled Documentation in the surveyor review documentation titled Do	e the director of nursing aware on error on 1/11/17 at 8:30 by the note, the DON stated cal nurse had documented in med the administrative staff of in documentation in the 17 at 11:25 a.m. and requested documentation on 1/11/17 at wed the facility policy on				

account of the resident's care, treatment,

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(, 0, 1)	response to the car	re, signs, symptoms, etc., as	-				
	well as the progres	s of the resident's care. To					
	provide caregivers	with clear, concise guidelines					
	for documentation of given."	of assessments and care					
	No further informate exit conference on	No further information was provided prior to the exit conference on 1/11/17.					
	and accurate Dece physician order she The order for a long discontinued on 11/	failed to ensure a complete mber 2016 and January 2017 sets (POS) for Resident #111. g handled fork was 18/16 but remained on both the DS and January 2017 POS.					
	reviewed 1/10/17 at was admitted to the 10/22/16 with diagn limited to fusion of 1	of Resident #111 was nd 1/11/17. Resident #111 e facility 7/4/16 and readmitted noses that included but not spine, cervicothoracic region, pulmonary disease, lymphoid matoid arthritis					
	set (MDS) with an a 11/4/16 assessed th summary score of 1 resident was cognit delinium, psychosis.	orteen (14) day minimum data assessment reference date of the resident with a cognitive 15 out of 15, indicating the lively intact with no signs of the or behaviors. Resident #111 limited range of motion on lies.					
	January 2017 physi	6 physician orders and the cian orders were reviewed #111 had orders to use a long					

10/26/16.

handed flexible fork with meals. Order date was

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	The surveyor obser	rved Resident #111 on 1/11/1/						
	at 7:30 a.m. Resid	ent#111 was in bed, with the wated leating cereal. Resident						
	#111 was noted to b	have regular utensits on her						
	tray and was using	a regular spoon to eat the						
	cereal. The reside	ent was asked about the use						
	of the long handed	sed that fork for a while The						
	surveyor reviewed	the meal ticket. Under						
devices, there	devices, there was	nothing listed. The surveyor						
	discussed the curre	ent physician order with						
	7:40 am L.P.N.#	4 stated she would tell rehab						
	(rehabilitation) that Resident #111 did not have a long handled flexible fork for her meals.							
	practical nurse #5 0	on 1/11/17 at 8:15 a.m. of the						
	The director of nurs	sing provided the surveyor with 8/16 that read "D/C						
	(discontinue) lana l	nandled fork per patient						
	request." The direct	ctor of nursing stated on the						
	December 2016 PC	r the long handled flexible fork						
need to be removed. The surveyor informed the administrative staff of		d.						
		and the administrative staff of						
		ntation concern in a meeting						
	on 1/11/17 at 11:25	a.m. The surveyor requested						
	a copy of the facility	y policy on documentation on						
	1/11/17 at 3:45 p.m							
	The surveyor review	wed the facility policy on						
	documentation titled	d "Charting and						
	Documentation; Nu	aintain a complete account of						
	in part Policy to mi	annan a complete account of		C 104 165 14	/A 006 1	If continuation	n sheet Page 2	9 of 30

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

PRINTED: 01/19/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			(X3) DATE SURVEY
CTATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			COMPLETED
AND PLAN U	FCORRECTION	DENTA IOMIO. (Monisconi	A BUILU	JHAG	2 and an a needed continued and other property and an analysis and an analy	R-C
		495338	B WING			01/11/2017
NAME OF F	PROVIDER OR SUPPLIER	to the second se			STREET ADDRESS, CITY, STATE, ZIP CODE	
		INCOON!		1	600 WALDEN ROAD	
GRACE I	HEALTHCARE OF AB	INGDON		<u> </u>	ABINGDON, VA 24210	Al Control
(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	3 BE COMPLETION
and the second	care, signs, sympto progress of the resi caregivers with clea documentation of a	treatment, response to the ims, etc., as well as the dent's care. To provide ar, concise guidelines for ssessments and care given." on was provided prior to the	{F 5	514		01/27/2017