IN LATER MARKET	NE OF DEPICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/٧0) 3.4			OMB N	RM APPROV VO. 0938-00
ANG PLAM	NOF CORRECTION	DENTIFICATION NUMBER:			ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
***************************************		495123	B. WING			İ	R
NAME O	F PROVIDER OR SUPPLIE	₹	<u> </u>		ET ADDRESS, CITY, STATE, ZIP CO	(7/20/2016
HOPEV	VELL HEALTH CARE	Transaction (d.		905 0	COUSINS AVENUE EWELL, VA 23860	JUE.	
(X-1) ID PREFIX TAG	ISAVE DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	TO THE LEW ALL	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	LICH IN ME	(X5) COMPLETE DATE
(F 000)	NITIAL COMMEN	ITS	{F 00	O }:			A STATE OF THE PARTY OF THE PAR
	6/6/16 and 6/8/16 of 7/20/16. Correction with 42 CFR Part 4 Requirements. Unidentified within this deficiencies are ide	taid revisit to the standard through 6/1/16 to 6/3/16 and was conducted 7/19/16 through ons are required for compliance 183 Federal Long Term Care accorrected deficiencies are seport. Corrected entified on the CMS 2567-B. the investigated during the					
(F 2 79) SS=D	consisted of 11 cur	130 certified bed facility was survey. The survey sample trent Resident reviews bugh 111) and no closed	{F 279}	ļ.			
	A facility must use the develop, review a comprehensive plan	ne results of the assessment and revise the resident's of care.					
! (!	plan for each resider Objectives and timeta medical, nursing, and	relop a comprehensive care int that includes measurable ables to meet a resident's dimental and psychosocial fied in the comprehensive					
h p: • • • • §	o be rumished to atta ighest practicable ph sychosocial well-beil 483.25; and any sen e required under 648	describe the services that are ain or maintain the resident's hysical, mental, and ng as required under vices that would otherwise 33.25 but are not provided exercise of rights under	••••				No

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide 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

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

Event ID: MQU712

Facility ID: VA0128

TITLE

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(X6) DATE



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

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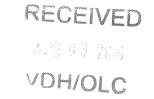
		& MEDICAID SERVICES	·		<u>OMB NO. 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495123	B. WING	3	R-C 07/20/2016
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	
HODEWI	ELL LIEALTH CARE C	CHTCO		905 COUSINS AVENUE	
HOPEWI	ELL HEALTH CARE C	ENIER		HOPEWELL, VA 23860	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	DECTION
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	IX (EACH CORRECTIVE ACTION S	SHOULD BE COMPLETION
{F 279}	Continued From pa	ge 1	{F 2	(79)	
	§483.10, including t	the right to refuse treatment	·	F279	
	under §483.10(b)(4).	!	R#111 CP has been revie	ewed and
				updated. Physician orde	r
		NT is not met as evidenced		obtained with measurea	
	by:	ion, staff interview, facility		objectives and time tab	
	documentation revie	ew, and clinical record review	,	heel wound pressure red	
	the facility staff faile	ed to develop a comprehensive		boot device.	
		wound pressure reduction dent (Resident #111) in a			
	survey sample of 11			Residents that also have	!
	The facility staff faile	ed to develop a care plan with	2	pressure reduction boot	device
		ves and time tables for a boot device for Resident #111		have been identified at r	risk from
	Findings included:	500t device for Resident #111		this alleged deficient pra	actice.
	Resident #111 was	admitted to the facility on			
		s included diabetes, dementia, o-esophageal refux disease		Nurse Managers and Lice	
	(GERD), dysphagia,	, anemia, and depression.		Nurses shall be in-service	·
	Resident #111's mo	st recent MDS (Minimum		DON/desginee on prope	
		RD (Assessment Reference as coded as an admission full		Planning process related	
	assessment. Resid	ent #111 was coded a BIMS		pressure reduction boot	device.
		lental Status) score of 1,		The DNS/designee shall	audit up
		gnitive impairment. Resident das needing extensive to		to 5 resident CP's weekly	
	total assistance of o	ne staff member for activities		measurable objectives f	•
		being always incontinent of		weeks then monthly for	
		Futher the Resident was limitation in range of motion		months. Concerns ident	I
		r extremities. At section "M"		shall be taken to the faci	
	skin assessment, the	e Resident was coded as			
		oressure ulcer that was 100%		for follow up and resolut	.ion.
		oon admission. This was linical record as a sacral		Date of Compliance 8-4-	-16
a manufacture with the state of	pressure ulcer.			e de la companya de la constanta de la constan	A TO A CONTRACTOR OF THE CONTR
	On 7-20-16 at 11:00				
	Resident's clinical re	cord was conducted. This			

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Event ID: MOU712

Facility ID: VA0126

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wound".
Review of the July 2016 TAR (Treatment Administration Record), telephone orders, and physician's orders sheet (POS) did not reflect any orders for offloading or floating of heels, and gave no instruction to staff on how to accomplish this or what devices to be used, nor time applied. A complete review of the clinical record did not reveal any documentation regarding the application of the heel boots, what heel boots were to be used, or what schedule the boots would remain in place.

completed by the doctor for Resident #111's wound care revealed that the orders given by the wound care doctor's "Assessment and plan" included a change in treatment for the wound, and also to "float heels in bed", and to "off load

"Body audit" records, revealed no documentation of pressure reducing heel boots, however, on the "Pressure ulcer record" "Prevalon Boots to bilateral lower extremities" was documented on 7-4-16, and "boots" were documented on 7-11-16, and 7-18-16.

On 7-20-16 an interview was conducted with Resident #111 at 11:30 a.m., and the Resident was beginning to eat lunch. The Resident was talkative, responsive, and confused. The Resident was sitting on top of the dressed bed with street clothing on. The Residents feet were easily visualized uncovered at the foot of the bed, and wearing blue ankle top quilted booties with 3

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					D: 07/25/20
		& MEDICAID SERVICES					MAPPROV
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	t .	(X2) MULTIPLE CONSTRUCTION A. BUILDING			D. 0938-03 TE SURVEY MPLETED
		495123	B. WING		***************************************	1	R-C 7/20/2016
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CI 905 COUSINS AVENI HOPEWELL, VA 2	UE		720/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORF	R'S PLAN OF CORREC RECTIVE ACTION SHO RENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
	velcro straps holdin was turned outward body, and the left for the heel of the right heels and partly on inner (Left foot) side her feet hurt, and sher feet feet feet foot side her feet feet foot side her feet foot she feet foot she feet foot she feet feet foot strapped feet feet feet feet feet feet feet fe	g them closed. The right foot away from the midline of the out was turned inward toward foot, both laying partly on the the their outer (Right foot) and es. The Resident was asked if he replied "yes". Licensed N) B (one of 2 nurses on duty for Resident #111 daily) was hursing station, after seeing sked when the Resident was not what kind of boots were to the think the transport of answer this question by the otes revealed no reding the application, order or devices were to be applied to other than "Boots". Eximately 1:30 p.m. the DON), and the "Director of all Therapist" supplied the ructions for Use" guide on the Relieving Heel Protector with the g stabilizer wedge". This bot with a wedge which diprevented the foot from The boots Resident #111 hig had no wedge stabilization dent's heels were not (the Rehab Director) stated ization device was not #111, because the Resident	· · · · · · · · · · · · · · · · · · ·	79}			

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Prevalon" manufacturer site revealed 4 different kinds of Prevalon boots that were available from the company. No assessment or order revealed

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Facility ID: VA0126

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

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CENTER	RS FOR MEDICARE	: & MEDICAID SERVICES			OMB N	O. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTRUCTION	(X3) D.	(X3) DATE SURVEY COMPLETED	
		495123	B. WING		- 0	R-C 7/20/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		.,,20,20,10	
HODEWI	ELL HEALTH CARE C			905 COUSINS AVENUE			
HOPEWI	ELL HEALTH CARE C	CNICK		HOPEWELL, VA 23860			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE	
{F 279}	doctor had prescrib appropriate for this did recommend that all times when the intheir feet and legs is posture, such as ly device restricts foothe wearer is sleep relaxed position, as drop or roll while reflexed position, as drop or roll while reflexed on 7-11-16 "heel lift boots as to as able", "use pillow as needed." The side staff, and no indicate were to be worn was the boots nor when given. There were time tables to describe to be furnished could provide those way. The Director of Nursa: 3:00 p.m. on 7-20-1 with 4 surveyors, ar were not individualize goals, her response very generic." She mot put the kind of bothe boot should be disimple. She was as use measurable goals.	had been assessed for, or a beed which device was Resident. The manufacturer at the boot should be worn at individual wearing them had in a pressure producing and down. The stabilization at drop and foot rolling, while a tit is normal for the foot to laxed. The recent skin care plan last are recent skin care plan last are revealed interventions for olderated, "suspend/float heels are and/or positioning devices and/or positioning devices are plan was instituted on an of what type of boot or than "Prevalon" was given to be a signer, nor how to care for to check or release them was no measurable objectives or a be or guide the services that do to the Resident, so that staff services in a comprehensive as and had measurable was "We keep the care plans went on to say that they do oot, or time of day, or when on, or off, they like to keep it sked if it is appropriate to not als like quantity of time for		79}			
		idual needs, and her I see what you mean, Like at					

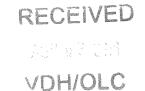
FORM CMS-2567(02-99) Previous Versions Obsolete

all times, or on at blank hour, and off at blank

Event ID: MOU712

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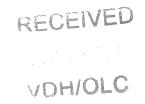
		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 07/25/2016 RM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3)	NO. 0938-0391 DATE SURVEY COMPLETED
		495123	B. WING			R-C
	PROVIDER OR SUPPLIER ELL HEALTH CARE C	ENTER		STREET ADDRESS, CITY, S 905 COUSINS AVENUE HOPEWELL, VA 23860	TATE, ZIP CODE	07/20/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
{F 281}	indicate when the becare for the boots, of was to be used. The or assessment to clear boot treatment, and treatment was performed to the facility policy endentification and Property in the facility policy endentification and Property in the facility policy endentification and Impleme And under item #5, interdisciplinary, reswill be developed an identified risks and item breakdown and treatexisting ulcers. The interventions will be care will be reviewed The Administration on 7-20-16 at 4:00 p. No further information 483.20(k)(3)(i) SERVEROFESSIONAL STATESTIONAL STATESTION	existed in the clinical record to coots were applied, how to or what type of Prevalon boot are staff did not obtain an order arify the pressure reduction did not document that the ormed consistently. Intitled "Skin Integrity Program: revention" stated the following: nt Care" "A comprehensive, ident centered plan of care and implemented based on individual needs, to avoid skin at impaired skin integrity and effectiveness of the evaluated and the plan of and revised as needed". In at the end of day debrief. In was provided wices provided wices provided wices provided wices provided with a standards of quality. The is not met as evidenced on, staff interview and clinical cility staff failed for 2 \$\frac{1}{2}\$107 and \$\frac{1}{2}\$111) of 11 by sample to follow dis of nursing for medication.	{F 28			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			ľ	FORM APPROV 20-88-03 DMB NO
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495123	B. WING			R-C 07/20/2016
NAME OF I	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 0112072010
HOPEW	ELL HEALTH CARE C	ENTER			COUSINS AVENUE PEWELL, VA 23860	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	DBE COMPLETI
{F 281}	Continued From pa	age 6	{F 28	31}		
	correctly transcribe administer Vitamin (medication adminidocumented to adminidocumented to adminidocumented to adminidocumented to adminidocumented to administer vitaminister vitaminister vitaminister every other correctly administer every	ninister every other day. I.1, the facility staff failed to a order for, or to clarify the of "Prevalon Boots" to be worn protect the Resident's heels ther there were no directions the Resident would wear the of "Prevalon boots" should be ed: O7, the facility staff failed to the physician order to C every day. The MAR stration record) had to her day. B year old, was admitted to the His diagnoses included ge renal disease, diabetes, nee amputation,			F281 R#107 & R#111 clinical record has been updated with clarification orders and plans care reflect current needs of the residents. Current Residents that have Supplements and Pressure reduction boots ordered by their physician were identified those at risk from this alleged practice.	of ne
	assessment was a dassessment referen #107 was coded with	st recent Minimum Data Set quarterly assessment with an ce date of 4/20/16. Resident h a Brief Interview of Mental ndicating moderate cognitive			The nurse managers, and Licensed Nurse) shall be educated on accurately transcribing physician orders.	

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Event ID: MOU712

impairment. He required extensive assistance with his activities of daily living.

Resident #107's clinical record included a

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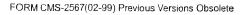
If continuation sheet Page 7 of 14



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

PRINTED: 07/25/2016 FORM APPROVED OMB NO. 0938-0391

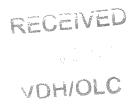
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495123	B. WING		R-C 07/20/2016
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 905 COUSINS AVENUE HOPEWELL, VA 23860	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
	order read "Vitamin mouth) QD (every of the order was included and explanation and included and in	ted 7/13/16 for Vitamin C. The C 500 mg (milligram) po (by day) x 90 d (day)." Ided on the July 2016 tration Record (MAR) as (milligram) po (by mouth) qod According to the July MAR sident #107 received Vitamin 16, and 7/18/16. Le was reviewed with Licensed LPN A) on 7/20/16 at 12:45 at she would notify the and Wilkins, Fundamentals mbler, PA, page 181 reads at deal of responsibility for the right drugs at a right dose and by the right es accurate documentation	{F 28	Audits of Physican orders for accuracy and directions for us shall be completed for up to 1 records weekly for 4 weeks th monthly for 3 months by the DON/designee. Concerns identified from the audits shall be taken to the facility QAPI Committee for follow up and resolution. Date of Compliance 8-4-16	e .0
			-		Surger Le describe amount the collaborated describes and considerate and





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If continuation sheet Page 8 of 14



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

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CENIE	RS FOR MEDICARE	= & MEDICAID SERVICES			(OMB NO	O. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495123	B. WING	,		1	R-C 7/20/2016
	PROVIDER OR SUPPLIER ELL HEALTH CARE C			905	REET ADDRESS, CITY, STATE, ZIP CODE 5 COUSINS AVENUE DPEWELL, VA 23860		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 281}	Continued From pa	age 8	{F 28	81}		Part Married Control	
	obtain a physician's directions for use, of by the Resident to perform pressure. Fur to staff as to when the boots, or what type applied.	11, the facility staff failed to sorder for, or to clarify the of "Prevalon Boots" to be worn protect the Resident's heels rther there were no directions the Resident would wear the of "Prevalon boots" should be					
	4-14-16. Diagnoses hypertension, gastro (GERD), dysphagia Resident #111's mo Data Set) with an Al Date) of 4-20-16 was assessment. Resid (Brief Interview of Mindicating severe could total assistance of of daily living and as bowel and bladder. coded as having no in the upper or lower skin assessment, the having one stage 2 granulation tissue up documented in the oppressure ulcer. On 7-20-16 at 11:00 review of the Reside	admitted to the facility on as included diabetes, dementia, ro-esophageal refux disease a, anemia, and depression. Ost recent MDS (Minimum ARD (Assessment Reference as coded as an admission full dent #111 was coded a BIMS Mental Status) score of 1, ognitive impairment. Resident as needing extensive to one staff member for activities as being always incontinent of Further the Resident was a limitation in range of motion or extremities. At section "M" he Resident was coded as pressure ulcer that was 100% pon admission. This was clinical record as a sacral					
	physician's orders sh certified by the physi revealed wound trea	view revealed current heet (POS) signed and ician on 7-18-16. The POS atment orders (for a Right heel be discontinued after the		·			·

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

PRINTED: 07/25/2016 FORM APPROVED OMB NO. 0938-0391

A 100-4-10-10-10-10-10-10-10-10-10-10-10-10-10-	THE SEMILEDIOTIES OF TANGES			OND INC	<u>). U930-</u> U39	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED	
				F	R-C	
	495123	B. WING			/20/2016	
HOPEWELL HEALTH CAR			STREET ADDRESS, CITY, STATE, ZI 905 COUSINS AVENUE HOPEWELL, VA 23860	CITY, STATE, ZIP CODE NUE		
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAC	EX (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
doctor, which on The wound care completed by the wound care review and care doctored included a chart and also to "flow wound". Review of the Jack Administration physician's orders for offlow orders for offlow orders for offlow orders for offlow or what devices A complete reviewed any doctored application of the were to be used would remain in "Body audit" recompleter and wearing blue with street clothe easily visualized and wearing blue velcro straps how was turned outwoody, and the letter the heel of the recompleter would remain in "Body audit" recompleters and wearing blue velcro straps how was turned outwoody, and the letter the heel of the recompleters would remain in "Body audit" recompleters and wearing blue velcro straps how was turned outwoody, and the letter the heel of the recompleters would remain and wearing blue velcro straps how was turned outwoody, and the letter the heel of the recompleters would remain and wearing blue velcro straps how was turned outwoody, and the letter the recompleters where the recompleters were recompleters where the recompleters was turned outwoody, and the letter the recompleters where the recompleters was turned outwoody, and the letter the recompleters was turned outwoody.	een by the wound specialist occurred on 7-18-16. The specialist evaluation form, are doctor for Resident #111's realed that the orders given by the stor's "Assessment and plan" are in treatment for the wound, at heels in bed", and to "off load and well 2016 TAR (Treatment Record), telephone orders, and are sheet (POS) did not reflect are adding or floating of heels, and gare staff on how to accomplish this at to be used, nor time applied, ew of the clinical record did not amentation regarding the see heel boots, what heel boots in place. Cords, revealed no documentation ucing heel boots, however, on the record "Prevalon Boots to extremities" was documented on oots "were documented on oots" were documented on	ny ve :	281}		2 ***2********************************	

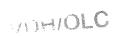
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Event ID: MOU712

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FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		ATE SURVEY MPLETED
		495123	B. WING	3	1	R-C 7/20/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 905 COUSINS AVENUE HOPEWELL, VA 23860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EIX (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 281}	Continued From p	_	; {F 2	281}		
	her feet hurt, and Practical Nurse) Le that day who care approached at the the Resident, and to wear the boots, ordered for Resident's feet on't know, I will he staff were able time of survey exi Nursing progress documentation reinstructions on whethe Resident's feet On 7-20-16 at appropriector of Nursin Rehab" Occupation and the Resident's feet on the stabilized the legal rolling onto it's sid was observed were device, and the Restabilized. Admin that the wedge staneded by Reside could move her feesearch conductive Prevalon manufations of Prevalon the company. No that Resident #11 doctor had prescriptions.	ides. The Resident was asked if she replied "yes". (Licensed LPN B (one of 2 nurses on duty ed for Resident #111 daily) was e nursing station, after seeing dasked when the Resident was and what kind of boots were lent #111. LPN B responded "I have to ask someone." None of e to answer this question by the it. In notes revealed no egarding the application, order or hat devices were to be applied to et, other than "Boots". proximately 1:30 p.m. the ng (DON), and the "Director of onal Therapist" supplied the instructions for Use" guide on the interest of the end of the				

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

Event ID: MOU712

Facility ID: VA0126

If continuation sheet Page 11 of 14



FORM APPROVED 1

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495123	B. WING			l	R-C 7/20/201 6
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
HOPEWI	EL L HEALTH CARE C	ENTER			5 COUSINS AVENUE DPEWELL, VA 23860		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 281}	their feet and legs is posture, such as ly device restricts foothe wearer is sleep relaxed position, as drop or roll while re Review of the most updated on 7-11-16 "heel lift boots as to as able", "use pillow as needed." The side of the staff, and no indicated the staff, and no indicated were to be worn was the boots nor when given. There were time tables to describe were to be furnished could provide those way. The Director of Nur 3:00 p.m. on 7-20-1 with 4 surveyors, ar were not individuality goals, her response very generic." She not put the kind of bothe boot should be simple. She was as use measurable goseach residents individuality response was "Oh, all times, or on at ble hour." "We don't do the simple." "We don't do the simple.	ing down. The stabilization to drop and foot rolling, while ing, or laying down in a sit is normal for the foot to laxed. It recent skin care plan last or revealed interventions for olerated", "suspend/float heels we and/or positioning devices kin care plan was instituted on on of what type of boot or than "Prevalon" was given to tion of what times the boots as given, nor how to care for to check or release them was no measurable objectives or ribe or guide the services that d to the Resident, so that staff e services in a comprehensive sing (DON) was interviewed at 6, in the conference room and asked why the interventions are and had measurable was "We keep the care plans went on to say that they do not, or time of day, or when on, or off, they like to keep it sked if it is appropriate to not als like quantity of time for ridual needs, and her I see what you mean, Like at ank hour, and off at blank		81}:			

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indicate when the boots were applied, how to care for the boots, or what type of Prevalon boot was to be used. The staff did not obtain an order

Event ID: MOU712

Facility ID: VA0126

If continuation sheet Page 12 of 14



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

PKINTED: 07/25/2016 FORM APPROVED OMB NO. 0938-0391

	TOT ON MILDIOMILE	TO MEDIOWID OF LAIDED	-			OINI DIVI	<u>U. 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY OMPLETED
		495123	B. WING	j		i	R-C 7/20/2016
NAME OF P	PROVIDER OR SUPPLIER	4		STR	REET ADDRESS, CITY, STATE, ZIP CO		1/40/40 10
· · · · · · · · · · · · · · · · · · ·	سويمو پر يم يا دست د د سده د د		1	i	COUSINS AVENUE	***	
HOPEWE	ELL HEALTH CARE C	ENTER		1	PEWELL, VA 23860		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	l		PROVIDER'S PLAN OF CORF	PECTION	- N. C.
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(×5) COMPLETION DATE
{F 281}	Continued From pa	age 12	{F 28	:81}			
•		clarify the pressure reduction	¢.	٠.,			
		d did not document that the					
	treatment was perfo						
		ppincott as the resource used					
	for professional nur	rsing standards references.					
	Guidance was give						
		lursing, which states that					
		cation and treatment errors, is					
		ng the "8 rights of any					
		lication administration					
		time Lippincott refers to the on administration in the					
		aradigm for treatments."					
		at these rights are a nursing					
		for both treatments and					
		stration. Lippincott goes on to					
		rs can be linked, in some way,					
	to an inconsistency	in adhering to these rights.					
	These rights follow:	:					
	"Rights of Medication						
		heck the name on the order					
	•	e 2 identifiers, Ask patient to					
		self, When available, use					
		imple, bar-code system).					
		- Check the medication label,					
	Check the order.	and the order Confirm					
		eck the order, Confirm the dose using a current					
		sary, calculate the dose and					
		calculate the dose and calculate the				•	
		in, check the order and					
		the route ordered, Confirm					
	that the patient can						
	medication by the or						
		ck the frequency of the					
		, Double-check that you are					
		lose at the correct time,		*		₹.	* * * * * * * * * * * * * * * * * * * *
	Confirm when the la						

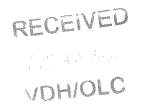
FORM CMS-2567(02-99) Previous Versions Obsolete

6. Right documentation - Document

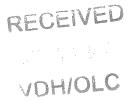
Event ID: MOU712

Facility ID: VA0126

If continuation sheet Page 13 of 14



CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			0		D. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495123	B. WING	· · · · · · · · · · · · · · · · · · ·		1	R-C 7/ 20/2016	
NAME OF	PROVIDER OR SUPPLIEF	र		STI	REET ADDRESS, CITY, STATE, ZIP CODE			
HOPEWI	ELL HEALTH CARE	CENTER			5 COUSINS AVENUE			
				НС	PPEWELL, VA 23860			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
{F 281}	Continued From p	age 13	{F 2	041				
(1	Iministration AFTER giving the ordered						
	medication, Chart	the time, route, and any other						
		n as necessary. For example,						
		ction or any laboratory value or ded to be checked before giving						
the drug. 7. Right reason - Confirm the rationale for the								
	ordered medication, What is the patient 's history? Why is he/she taking this medication?							
	Revisit the reason	s for long-term use.						
	8. Right response	. Right response - Make sure that the drug led to ne desired effect. If an antihypertensive was iven, has his/her blood pressure improved? Be						
	sure to document your monitoring of the patient and any other nursing interventions that are applicable."							
	The Administration	was informed of the findings						
		p.m. at the end of day debrief.						
	No further informa	tion was provided						
					•			





COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Fax (804) 527-4502

July 25, 2016

Mr. Frederick Storck, Administrator Hopewell Health Care Center 905 Cousins Avenue Hopewell, VA 23860

RE:

Hopewell Health Care Center

CCN: 495123

Dear Mr. Storck:

Based on deficiencies cited during the survey ending June 8, 2016, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On July 19 through July 20, 2016, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

1::NEC 10:0 .PG41 367-2102 HOUTE CARE

1003855 18**04) 367-2126**



CHIPLAINTS

CONG TERM CARRE TEMP MET 2 100

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VOH/OLC

Mr. Frederick Storck, Administrator July 25, 2016 Page 2

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The July 20, 2016 revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of D), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Elaine Cacciatore, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered acceptable, the PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
- 5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

Mr. Frederick Storck, Administrator July 25, 2016 Page 3

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through Officer's Resolution Informal which Dispute Process, may http://www.vdh.state.va.us/OLC/longtermcare/ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the June 8, 2016 survey were forwarded to you under the June 21, 2016 initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the July 20, 2016 revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20responsee%20form.pdf We will appreciate your participation.

Mr. Frederick Storck, Administrator July 25, 2016 Page 4

If you have any questions concerning the content of this letter, please contact me at 804/367-2100.

Sincerely,

Elaine Cacciatore, LTC Supervisor
Division of Long Term Care Services

Enclosures

cc:

Joani Latimer, State Ombudsman Jaime Desper, D M A S (Sent Electronically)

	POST-C	ERTIFICA	ATION REVISIT	REPOR	RT				
PROVIDER / SUPPLIER / CLIDENTIFICATION NUMBER 495123	MULTIPLE CON A. Building B. Wing	STRUCTION			R (7/20)	OF REVISIT			
NAME OF FACILITY HOPEWELL HEALTH (CARE CENTER		STREET ADDRESS 905 COUSINS AVE HOPEWELL, VA 23	ZIP CODE 4. *3					
program, to show those decorrected and the date su	eficiencies previously ch corrective action	reported on the (was accomplished	dicare, Medicaid and/or Clir CMS-2567, Statement of De . Each deficiency should be own on the CMS-2567 (pre	ficiencies and fully identifie	ry Improvement Amend I Plan of Correction, the ed using either the requ	lments at have been lation or LSC			
ITEM	DATE	ITEM	DATE	ITEM		DATE			
Y4	Y5	Y4	Y5	Y4		Y5			
ID Prefix F0225	Correction	ID Prefix F0252	Correction	ı ID Prefix	F0280	Correction			
Reg. # 483.13(c)(1)(ii)-(iii) - (4)	, (c)(2) Completed	Reg. # 483.15(h)(1) Complete	d Reg.#	483.20(d)(3), 483.10(k) (2)	Completed			
LSC	07/13/2016	LSC	07/13/2016	LSC		07/13/2016			
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ı ID Prefix	F0314	Correction			
Reg. # 483.25	Completed	Reg. # 483.25(a)(3) Complete	d Reg.#	483.25(c)	Completed			
LSC	07/13/2016	LSC	07/13/2016	LSC		07/13/2016			
ID Prefix F0323	Correction	ID Prefix F0325	Correction	ID Prefix	F0329	Correction			
Reg. # 483.25(h)	Completed	Reg. # 483.25(i) Completed	i Reg.#	483.25(I)	Completed			
LSC	07/13/2016	LSC	07/13/2016	LSC		07/13/2016			
ID Prefix F0367	Correction	ID Prefix F0386	Correction	ID Prefix	F0425	Correction			
Reg. # ^{483.35(e)}	Completed	Reg. # 483.40(l	completed	Reg.#	483.60(a),(b)	Completed			
LSC	07/13/2016	LSC	07/13/2016	LSC		07/13/2016			
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix	F0514	Correction			
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. #	483.75(l)(1)	Completed			
LSC	07/13/2016	LSC	07/13/2016	LSC	· · · · · · · · · · · · · · · · · · ·	07/13/2016			
	EVIEWED BY NITIALS)	DATE/ 7/25/16	SIGNATURE OF SURVEYOR	(acc	DATE 7/0	5/16			
	EVIEWED BY NITIALS)	DATE //	TITLE		DATE				
FOLLOWUP TO SURVEY C 6/8/2016	OMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							