STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 8/31/2017. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The census in this 216 certified bed facility was 215 at the time of the survey. The survey sample consisted of three current Resident reviews (Residents # 1 through 3).	F 000		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of	F 225		10/14/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1	F 225		

actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

(2) Have evidence that all alleged violations are thoroughly investigated.

(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on complaint investigation, clinical record review, staff interview, and resident interview, the facility staff failed to report a non-injury incident of resident-to-resident abuse in a timely manner. The facility failed to report an incident of resident-to-resident abuse involving Residents # 1 and 2, to the State Agency (Office of Licensure and Certification) immediately but not later than 2 hours after the allegation. The findings were: Resident # 1 in the survey sample, a 99 year-old female, was admitted to the facility on 8/14/17 with diagnoses that included asthma, congestive heart failure, hypertension, atrial fibrillation, macular degeneration, gastroesophageal reflux disease, repeated falls, insomnia, polyneuropathy, and generalized muscle weakness. According to an Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/21/17, Resident # 1 was assessed under Section C (Cognitive Patterns) as being moderately cognitively impaired, with a Summary Score of 10 out of 15. The Nurse's Notes in Resident # 1's clinical record included the following entry: 8/21/17 - 6:40 p.m. "POA/son (Power of Attorney) notified of incident that transpired where another resident ran up behind res (resident) in hallway and began hitting her on shoulders and on face, cursing at her. This writer took resident to room and inquired how she felt, was she hurt. Res. stated she was not hurt but that 'I didn't know there were people like that over here.'	F 225	Corrective Action: Facility Administration responded with immediate intervention(s) to ensure resident safety in regards to the 8/21/17 incident. Resident to resident incident did not result in any physical injury and was without need of physician intervention. Information in response to the incident was sent to the required state agencies on 8/23/17 in response to complaint received. Identification: Facility residents involved in resident to resident incidents have the potential to be affected by this practice. Changes: Facility Administration will review policy titled, "Abuse" and ensure that appropriate references to reporting guidelines are in compliance with regulation. Facility staff will be re-educated on abuse and any corresponding facility policy changes. Monitoring: Director of Nursing or designee will be notified of facility incident reports, specifically those involving resident to resident type incidents, to ensure proper reporting occurs in accordance to regulation required timeframes. An audit comprised of resident to resident activity	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 Nurse manager, DON (Director of Nursing) Dr. made aware." At 11:30 a.m. on 8/31/17, Resident # 1 was interviewed regarding the incident on 8/21/17. At the time of the interview, the resident was seated in her reclining chair. Asked if she recalled the incident on 8/21/17, the resident replied, "Oh yes." Continuing, Resident # 1 said, "The man (identified as Resident # 2 in the survey sample) was in the hall. He was very angry and yelling. He knocked the meal trays out of the man's hands (staff serving meals)." Asked what happened then, Resident # 1 said, "He came up behind me and like to scared me to death. He started slapping me around my head." Resident # 1 went on to say that the husband of another resident stepped in and stopped the male resident. Asked if she was hurt, Resident # 1 said, "I wasn't hurt, he just scared me." Resident # 2 in the survey sample, an 87 year-old male, was admitted to the facility on 5/5/17 with diagnoses that included aortic stenosis, dementia with bipolar features, coronary artery disease, arthritis, hallucinations, and delusions. According to an Admission MDS with an ARD of 5/11/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired daily decision making skills. On the most recent Quarterly MDS with an ARD of 8/9/17, the resident was assessed as having short and long term memory problems with severely impaired daily decision making skills.	F 225	will be completed monthly. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4	F 225		

The Nurse's Notes in Resident # 2's clinical record included the following entry:

8/21/17 - 6:30 p.m. "Res came out of his room and up to nurse's station yelling 'I'm going to kill the mother fuckers!' then quietly turned and started walking down the hall. Then yelled out and began running. Res ran up grabbed another res wheelchair and began hitting female resident on the head and in the face, yelling 'I will kill you.' Staff got the wheelchair with female away from resident. Resident is currently sitting quietly in his room."

Resident # 2 was placed on one-to-one observations, and was subsequently moved to the facility's secure dementia unit. There were no further interactions between Resident # 1 or other residents.

As a part of the investigation, the Administrator furnished the surveyor with a copy of a letter, dated August 23, 2017, that was sent to the State Agency (Office of Licensure and Certification) by way of a FAX. The date and time stamp on the FAX was August 23, 2017 at 4:27 p.m. The letter was in response to a complaint filed by the daughter of the man who stepped in to stop the incident, and set forth the events of 8/21/17, as well as steps taken by the facility in response to the incident. The letter was also forwarded to the Local Ombudsman and Adult Protective Services.

During the Exit Conference, which included the Administrator, the DON, and the surveyor, the timing of the letter to the State Agency was discussed. The Administrator indicated that since there were no physical injuries, the two hour time frame for reporting did not apply. Further, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 08/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	**103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 Administrator indicated that since there were no injuries, and since the report (letter) was filed within the five day time frame for reporting the results of an investigation, that the facility was in compliance with the requirements for reporting.	F 225		