		I AND HUMAN SERVICES		(-	ERIJB	FOR	M APPROVED <u>D.</u> 0938-0391
STATEMEN	TOF DEFICIENCIES DF CORRECTION	SERVICES [X1] PROVIDE SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILD	TIPLE CONSTRUCTIO		(X3) DA	ATE SURVEY DMPLETED
		495338	B WING			1.	C 1/10/2016
NAME OF	PROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS C			
GRACE	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD ABINGDON, VA 2			· ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	x JEACH COR CROSS-REFE	R'S PLAN OF CORREC RECTIVE ACTION SHI RENCED TO THE APP DEFICIENCY)	DULD BE ROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	FO	00			12/09/16
	survey was conducted Two complaints were survey. Corrections with 42 CRF Part 48 Long Term Care factors	Medicare/Medicaid standard ted 11/8/16 through 11/10/16, re investigated during the are required for compliance 33 Requirements for Federal cilities. The Life Safety Code					in musikan na ma
F 155 SS=D	101 at the time of the consisted of 20 cur (Residents 1 throug reviews (Residents	TO REFUSE; FORMULATE	F 1	55			
	refuse to participate and to formulate an	e right to refuse treatment, to in experimental research, advance directive as ph (8) of this section.					
	specified in subpart related to maintainin procedures regardin requirements include provide written infor- concerning the right or surgical treatment	nply with the requirements I of part 489 of this chapter g written policies and g advance directives. These e provisions to inform and mation to all adult residents to accept or refuse medical t and, at the individual's advance directive. This	Dr	- 050/50			
	includes a written de	scription of the facility's tadvance directives and	HE	CEIVED			
	applicable State law.		DE	C 0 5 2016			
			V	DH/OLC			
BORATORY	DIRECTOR'S DR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN		DH/OLC	LE		(x6) DATE

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 program participation.

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Facility ID VA0061

		AND HUMAN SERVICES			FORM APPROVED
		& MEDIG SERVICES	1		MB NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVÍL. VSUPPLIER/CLIA IDENTIFICATION NUMBER	1	CONSTRUCTIÈ	(X3) DATE SURVEY COMPLETED
		495338	B WING		C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	
			600	WALDEN ROAD	
GRACE	HEALTHCARE OF AB	INGDON	AB	INGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
			 		
F 155	Continued From page	ge 1	F 155		12/09/16
		IT is not met as evidenced		 Resident #19 is no longer a resident facility. 	t of the
	by:	cord review and staff		2. A facility wide audit of the Virginia	
		ff failed to ensure a complete		Department of Health DDNR was com	pleted
		(durable do not resuscitate)		on 11/30/16. Four DDNRs were corre	
	for 1 of 25 Resident				
. 1 1				3. The Admissions/Marketing Director serviced 11/28/16 by the Director of I	
	The findings include	0.		on ensuring all sections of the Virginia	
	For Resident #19 th	e facility staff failed to		Department of Health DDNR are chec	
	accurately complete	a Virginia Department of		completed.	
	DDNR were not com	Sections 1 and 2 of the		The Admissions/Marketing Director/c	lesignee
	DDMV were not con	ipiete.		will complete an audit of the Virginia	_
	Resident #19 was ad	dmitted to the facility on		Department of Health DDNR of 5 resident	
		itted on 10/14/16. Diagnoses		weeks, 3 residents x4 weeks, and 1 re	sident
	· · · · · ·	ed to Alzheimer's disease.		x4 weeks.	
	,	izophrenia, insomnia,		4. The Admissions/Marketing	
	constipation and cold	on cancer.		Director/designee will report audit fir	ndings to
	The most recent MD	S (minimum data set) with		the monthly Quality Assurance and	_
		t reference date) of 10/21/16		Performance Improvement Committe	
	\	as 2 out of 15 in section C,		months or until substantial compliand	e is
		nis is a quarterly MDS.		achieved. The QAPI Committee include	les but is
				not limited to the Medical Director,	- ,
		al record was reviewed on		Administrator, Director of Nursing, 5c	ociai
		d a Virginia Department of		Services Director, Activities Director, Maintenance Director, MDS Coordina	ator.
	Heaith DDNR form w	пісн теао ін рап.		Admissions/Marketing Director, Dieta	
	"I further certify that [must check 1 or 2]:		Director, HR Director, and Business O	
	[] 1. The patient is C.	APABLE of making an		Manager.	
	informed decision				
	[] 2. The patient is IN informed decision	CAPABLE of making an			
[] A. While capable o	ve, check A, B or C below f making an informed has executed a written			

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Facility ID: VA006 I

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, and a		(FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		(X3) DATE SURVEY COMPLETED
495338	B. WING		C 11/10/2016
	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
NGDON	I		
MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DELICIENCY)	ULD BE COMPLÉTION
		DEI ICIETY	
which directs that dures be withheld of making an informed had executed a written which appoints a "Person nt on the Patient's Behalf" s not executed a written	F 155		12/09/16
ncomplete DDNR form was on of the administrative staff 11/10/16 at approximately in was provided prior to exit. Y OF CHANGES ROOM, ETC) Stately inform the resident; ent's physician; and if ident's legal representative y member when there is an exception requiring physician cant change in the resident's sychosocial status (i.e., and mental, or psychosocial reatening conditions or an ed to alter treatment due to adverse commence a new form of ion to transfer or discharge	F 157		
	IDENTIFICATION NUMBER:	**MEDIC SERVICES **(X1) PROVIDE A'SUPPLIER/CLIA IDENTIFICATION NUMBER: **495338 **NGDON **TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE WIND MADE TO THE PRECEDED BY FULL CIOENTIFYING INFORMATION) **TEMENT OF DEFICIENCIES MUST BE WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES MUST BE WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES AND WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES AND WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES AND WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES AND WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES AND WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES AND WIND MADE TO THE PRECEDED BY FULL CIOENTIFY INFORMATION) **TEMENT OF DEFICIENCIES AND WIND MADE TO THE AND MADE TO	### MEDIQ SERVICES ### (X1) PROVIDEN/SUPPLIERICINA IDENTIFICATION NUMBER: ### 495338 ### A95338 ### A95338 ### A95338 ### B WING ### STREET ADDRESS, CITY, STATE, ZIP CODE 600 WALDEN ROAD ABINGDON, VA 24210 ### PROVIDER'S PLAN OF CORREC GROSS REFERENCED TO THE APPR ### CROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ### A95338 ### B WING ### OR OWALDEN ROAD ABINGDON, VA 24210 ### PROVIDER'S PLAN OF CORREC GROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ### A95338 ### B WING ### PROVIDER'S PLAN OF CORREC GROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ### A95338 ### A95338 ### B WING ### PROVIDER'S PLAN OF CORREC GROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ### A95338 ### A95338 ### B WING ### PROVIDER'S PLAN OF CORREC GROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ### A95338 ### A95338 ### B WING ### PROVIDER'S PLAN OF CORREC GROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ### A95338 ### A95338 ### B WING ### PROVIDER'S PLAN OF CORREC GROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ### A95338 ### B WING ### A95338 ### B WING ### A95338 ### B WING ### CROSS REFERENCED TO THE APPR ### DEFICIENCY] ### A95338 ###

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DEC 0 5 2016 VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDI() SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING C 495338 11/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 12/09/16 F 157 Continued From page 3 F 157 The facility must also promptly notify the resident 1. Resident #19 is no longer a resident in the and, if known, the resident's legal representative facility. or interested family member when there is a change in room or roommate assignment as 2. A facility wide skin sweep was complete on specified in §483.15(e)(2); or a change in 12/3/16 by the Director of Nursing, QA Nurse, resident rights under Federal or State law or and Unit Managers to assess for dermatology regulations-as-specified in paragraph (b)(1) of tssues. No other residents were found to be this section. affected. The facility must record and periodically update 3. The Chief Nursing Officer in-serviced the the address and phone number of the resident's Administrator and Director of Nursing on legal representative or interested family member. 11/28/2016 regarding proper notification to the Virginia Department of Health of a communicable disease. This REQUIREMENT is not met as evidenced The Director of Nursing/designee will complete Based on staff interview, facility document skin sweeps to identify dermatology issues 5 review, and clinical record review the facility staff residents x 4 weeks, 3 residents x 4 weeks, and failed to notify appropriate agencies of a 1 resident x 4 weeks. communicable disease that affected 1 of 25 Residents, Resident #19 and 1 facility staff. 4. The Director of Nursing/designee will report audit findings to the monthly Quality The findings included: Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee

The facility staff failed to notify the Virginia Department of Health that one Resident, Resident #19 and one staff member had contracted the communicable disease scabies.

Resident #19 was admitted to the facility on 09/06/12 and readmitted on 10/14/16. Diagnoses included but not limited to Alzheimer's disease, bipolar disorder, schizophrenia, insomnia, constipation and colon cancer.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/21/16 coded the Resident as 2 out of 15 in section C,

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Manager.

If continuation sheet Page 4 of 70

includes but is not limited to the Medical

Director, Administrator, Director of Nursing,

Social Services Director, Activities Director, Maintenance Director, MDS Coordinator,

Admissions/Marketing Director, Dietary

Director, HR Director, and Business Office

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

Event ID: T58V11

DEC 0.5 2016

	TMENT OF HEALTH	AND HUMAN SERVICES			Ć		FORM APPROVED MB NO. 0938-0391
STATEMEN	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	1 (ONSTRUCTION		(X3) OATE SURVEY COMPLETEO
		495338	B WING				C 11/10/2016
	PROVIDER OR SUPPLIER HEALTHCARE OF AB	INGDON		600 \	ET AOORESS CITY, STATE, ZII WALOEN ROAD NGDON, VA 24210	² COOE	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCEO TO TH OEFICIENCY	ON SHOULO HE APPROPR	BE COMPLETION
F 157	Continued From page	ge 4 This is a quarterly MDS.	F	157		<u> </u>	12/09/16
	11/09/16. It containe						
	the Virginia Departm 11/10/16 at approximate reporting of scabies that an initial case of reportable unless it is host to infect 1 or metals.	with the epidemiologist from ment of Health in Richmond on mately 0835 regarding the . The epidemiologist stated f scabies is not considered moves beyond the original ore individuals. Then it is preak and should be reported epartment.					·
	nurse on 11/10/16 at regarding Resident # infection control nurs of scabies. The infection scabies was consider asked infection contribute facility had con-	with the infection control approximately 1030 with the surveyor asked the se about Resident #19's case ction control nurse stated that ered an infection. Surveyor rol nurse if any other person stacted scabies and the se stated that the SW (social red scabies.					
	approximately 1115. she had contracted s that she had tested p stated that she believ Resident #19, since sontact with Residen	with the SW on 11/10/16 at Surveyor asked the SW if scabies and the SW stated positive for scabies. SW also wed she had caught it from she had been in close the during the time Resident rked informed surveyor that					

approximately 2 weeks prior to Resident testing positive for scabies, it was reported that a family

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If continuation sheet Page 5 of 70

DEC 0 5 2016 VDH/OLC

	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES			C		RINTED: 11/22/2016 FORM APPROVED MB NO. 0938-0391
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495338	B WING	;			C 11/10/2016
NAME O	F PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP	CODE	·
00405		INCOON		600	WALDEN ROAD		
GRACE	E HEALTHCARE OF AB	INGDON		ABI	NGDON, VA 24210		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF LAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPE	BE COMPLETION
F 157	Continued From pa- member of the Resi scables.	ge 5 dent had a confirmed case of	F ·	157			12/09/16
	regarding Resident outbreak of scabies local health departm administrator stated	with the interim administrator #19. Surveyor asked if the had been reported to the tent and the interim that since it was only one to be reported. Surveyor	· · · · · · · · · · · · · · · · · · ·	<u> </u>			<u> </u>
	then asked interim a having contracted so interim administrator treated by a physicial facility MD, but he w	administrator about SW cabies from Resident #19 and r stated "SW wasn't actually an, we wanted her to see the as already gone that day phylactically based on her					
	11/10/16 at approximate SW if she had be scabies and SW state gone and she used "that she took a picture the physician could see diagnosed and present the concern of not reinfectious disease to was discussed during	ribed freatment via the reporting an outbreak of an the appropriate agencies					
F 164 SS=D	483.10(e), 483.75(l)(4	n was provided prior to exit. 4) PERSONAL NTIALITY OF RECORDS	F 1	64			
		right to personal privacy and or her personal and clinical					

EvenI ID. T58V11

Facility ID VA0061

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	TMENT OF HEALTH	AND HUMAN SERVICES & MEDIO SERVICES		(PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	F	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495338	B WING_		C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE
GRACE	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD ABINGDON, VA 24210	-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC_IDENTIFYING INFORMATION)	ID PREFIX JAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION RE APPROPRIATE OATE
F 1 64	Continued From parecords.	ge 6	F 16	64	12/09/16
	Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private			1. No specific resident v alleged deficient practic 2. A facility wide audit v 11/30/16 by the Activit disruption of group me	e. vas complete on ies Director regarding
<u> </u>	section, the resident	in paragraph (e)(3) of this may approve or refuse the and clinical records to any		voiced concern regarding practice. 3. Staff were in-serviced Administrator regarding meetings were not to be	ng this alleged deficient d 11/28/16 by the g group resident
	and clinical records resident is transferre institution; or record. The facility must kee contained in the resithe form or storage release is required bealthcare institution.	to refuse release of personal does not apply when the ed to another health care release is required by law. Exp confidential all information dent's records, regardless of methods, except when by transfer to another it law, third party payment		Do not disturb signs wi resident meetings. The Activities Director/ residents x 4 weeks, 3 to 1 resident x 4 weeks. 4. The Activities Director audit findings to the massurance and Perforn Committee x 3 months	designee will audit S residents x 4 weeks, and or/designee will report onthly Quality nance Improvement
	by: Based on observation facility staff failed to group meeting. This	T is not met as evidenced on and staff interview the provide privacy during a meeting was attended by six Residents of the facility.			d. The QAP) Committee ted to the Medical r, Director of Nursing, r, Activities Director, MDS Coordinator, g Director, Dietary

staff entered the area disturbing the group
FORM CMS-2567(02-99) Previous Versions Obsolete Event

The findings included.

During a group meeting held on 11/09/16

beginning at approximately 11:00 a.m. two facility

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If continuation sheet Page 7 of 70

DEC 0 5 2016 VDH/OLC

CENTERS FOR MEDICARE & MEDIC SERVICES		SERVICES	OMB NO. 0938-0				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	R/SUPPLIER/CLIA ATION NUMBER:	' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
	İ	4	95338	B WING		C 11/10/2016	
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
GRACE	HEALTHCARE OF ABI	INGDON			600 WALDEN ROAD ABINGDON, VA 24210		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		EDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIV X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
					DE JOIL TO . ,		
F 164	Continued From pagmeeting.	ge 7		F 1	64	12/09/16	
	The group meeting side one of the facili		ne dining area on				
	During this meeting entered the area dis	sturbing the gi	roup meeting.				
	Both of these staff p uniforms.	eople were w	rearing tan	<u> </u>		<u> </u>	
	The administrative s interruptions during team on 11/09/16 ar	meetings with	h the survey				
	On 11/10/16 the faci surveyor with a copy titled "Residents Rig read in part. "It is or resident have the rig standards of care an facility. You have the respected by all emp	y of their police The police	cy/procedure cy/procedure t you as a certain ions while at our				
F 226	No further informatio provided to the surve conference. 483.13(c) DEVELOP ABUSE/NEGLECT, I	ey team prior P/IMPLMENT	to the exit	F 22	26		
	The facility must devi policies and procedu mistreatment, neglect and misappropriation	ires that prohi ct, and abuse	ibit of residents	i	RECEIVED DEC 0.5 2016		
	This REQUIREMENT by:	Γ is not met a	as evidenced		VDH/OLC		

Facility ID: VA0061

PRINTED: 11/22/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDIC → SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING B WING 11/10/2016 495338 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX

F 226 Continued From page 8

PREFIX

Based on staff interview and facility document review, the facility staff failed to verify 2 of 5 new employees professional licenses (employees #2 and #3) and failed to obtain reference checks on 1 of 5 new employees (employee #2).

REGULATORY OR LISC IDENTIFYING INFORMATION).

The findings included.

The facility failed to verify the professional licenses for employee #2 and employee #3 and failed to obtain reference checks for employee #2.

The surveyor reviewed 5 employee records on 11/09/16.

Employee #2 was hired at the facility as a CNA (certified nursing assistant) on 07/12/16. When reviewing employee #2's employee record the surveyor was unable to locate any reference checks. The facility did not verify employee #2's professional license until 09/14/16.

Employee #3 was hired at the facility as an RN (registered nurse) on 09/27/16. The facility had verified the license on 09/27/16. However, the license had an expiration date of 09/30/16. The license wasn't verified again until 11/09/16 the day the surveyor had requested the employee files.

On 11/09/16 at approximately 3:55 p.m. human resource employee #1 verbalized to the surveyor they did not have documentation to indicate employee #2's license had been verified prior to 09/14/16 and did not have any references for employee #2.

When asked about employee #3's professional

F 226

12/09/16

OATE

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1. Employee #3's professional license was verified on 11/09/16.

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

Employee #2's reference checks were completed on by the HR Director on 12/2/16.

- 2. A 100% audit of employee files by the HR Director was completed on 11/29/16 for verification of licensure and references. Items missing were corrected immediately.
- 3. The Administrator in-serviced the HR Director on 11/25/16 regarding obtaining reference checks and license verification before employees begin work.

The HR Director/designee will audit employee files to verify reference checks and license verification on 5 employees x 4 weeks, 3 employees x 4 weeks, and then 1 employee x 4 weeks.

The Administrator will review and sign the audit weekly.

4. The Activities Director/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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

EvenI ID T58V1 RECEIVED 0061

DEC 0 5 2016

	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES & MEDI SERVICES		(1	NTED: 11/22/2016 FORM APPROVED B NO. 0938-0391
_	NT OF OEFICIENCIES NOF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER] "	ILTIPLE CONSTRUCTION OING		(3) OATE SURVEY COMPLETEO
		495338	B WING	<u> </u>		C 11/10/2016
	F PROVIOER OR SUPPLIER HEALTHCARE OF ABI	INGDON	- 	STREET AOORESS, CITY, STATE, ZIP CO 600 WALDEN ROAD ABINGDON, VA 24210	OE	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		SHOULO BE	
F 226	had checked the lice had not printed out a	urce employee #1 stated she ense after it had expired but any documentation.	F2	226		12/09/16
· · · · · · · · · · · · · · · · · · ·	above issues with th	taff were made aware of the employee files during a vey team on 11/10/16 at				
	their policy/procedure PREVENTION POLI policy and procedure "Pre-Employment is new employee is confollowing steps shoul applicant is suitable the License/Certificate" applicable positions References(s)-Referencendidate's prior employment is prior employment.	CY & PROCEDURE." This e read in part Screening-When a potential asidered for hire, each of the ld be taken to assure that the for hireVerification of will be obtained for all .Prior Employment				
F 241 SS=D		n regarding this issue was y team prior to the exit ND RESPECT OF	F 24	41		
	manner and in an env	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality.		DEC 0 5 2016		
	This REOUREMENT	is not met as evidenced		VDH/OLC		

by:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

CLIVILIY	3 FOR MILDIOAR	L & MLDIC / OLIVICES			CIVIC	140. 0330-033
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL' A. BUILDI	MULTIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495338	B. WING			C 11/1 0/2 016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GRACE HI	EALTHCARE OF A	BINGDON		600 WALDEN ROAD ABINGDON, VA 24210		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION OF THE CORREST OF THE CORRE	ON SHOULD BE	(X5) COMPLETION DATE
				DEFICIENCY	")	
				DEFICIENCY) 	

F 241 Continued From page 10

Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide dignity during wound care and dated and initialed the dressing after the dressing had been applied to the resident 's buttocks for 1 of 25 residents (Resident #5). The findings include:

For Resident #5, the facility staff failed to ensure the dignity for the resident when she dated and initialed the wound care dressing after the dressing had been applied to the resident 's buttocks.

Resident #5 was admitted to the facility 3/17/06 and readmitted on 8/29/16 with diagnoses that included but not limited to high blood pressure, thyroid disorder, heart failure, esophageal reflux disorder, compression, depression, and manic depression.

Resident #5 's comprehensive care plan revised 7/15/16 for her cognitive status. Under problem onset it read in part: Resident #5 has cognitive impairments and is at risk for alteration in communication due to dementia and unclear speech. She has short term and long term memory and decision making deficits. She is alert and sometimes able to make her needs known. She communicates best when using simple, direct communication.

A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 8/10/16, the facility staff assessed the resident to understand and to usually be understood. She was assessed to have a cognitive summary score of 03.

On 11/9/16 at 10:30 am, the surveyor observed

F 241

12/09/16

- 1 .Resident #S's wound care was observed by the Director of Nursing on 11/30/16 to ensure dignity was maintained.
- 2. The Unit Managers completed an audit of residents receiving wound care on 12/2/16-to ensure dignity is upheld during wound care. No issues were identified of this alleged deficient practice.
- 3. The Director of Nursing in-serviced the Wound Care Nurse on 11/21/16 regarding providing dignity during wound care by dating and initialing the dressing before placement on the resident.

The Director of Nursing/designee will audit wound care on 5 residents a week x 4 weeks, 3 residents a week x 4 weeks, and then 1 resident a week x 4 weeks.

4. The Director of Nursing/designee will report audit findings to the monthly Quality Assurance and Performance Improvement Committee x 3 months or until substantial compliance is achieved. The QAPI Committee includes but is not limited to the Medical Director, Administrator, Director of Nursing, Social Services Director, Activities Director, Maintenance Director, MDS Coordinator, Admissions/Marketing Director, Dietary Director, HR Director, and Business Office Manager.

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RECEIVED Facility ID: VA0061

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

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	JILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495338	B WING	3	C
		495336	D VVIIVO		11/10/2016
	PROVIDER OR SUPPLIER HEALTHCARE OF AB	INGDON		STREET ADDRESS, CITY, STATE, ZIF 600 WALDEN ROAD ABINGDON, VA 24210	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EX (EACH CORRECTIVE ACTION	ON SHOULD BE COMPLETION HE APPROPRIATE OATE
F 241	hands, applied a pathen proceeded to refrom Resident #5's of dressing and the distance bag. She then procupon completion of the marker and place the dressing after it resident. When asked the dressing after it the wound, the wour normally would have	ound care nurse washed her ir of non-sterile gloves. She emove the soiled dressing wound and placed the soiled sposable gloves in a plastic eeded to clean the wound. The wound care, she took out the date and her initials on had been applied to the ed why she initialed and dated was placed on the resident and care nurse said."		241	12/09/16
SS=E	administrator, directe administrative staff. Prior to exit on 11/10 was discussed with the director of nurses. 483.15(h)(1) SAFE/CLEAN/COMFENVIRONMENT The facility must provide comfortable and how the resident to use his to the extent possible. This REQUIREMENT by: Based on observation staff failed to maintain sanitary environment.	nelike environment, allowing is or her personal belongings e. This not met as evidenced in, staff interview, the facility in a clean, comfortable, and	F2	1 .No residents were of deficient practice. 2. All residents have the affected by the allege On 11/09/16 the bars shampoo were remove room. The tub in show shower chair were clestalls were washed. The cords were replaced by on 12/2/16.	he potential to be d deficient practice. of soap and bottle of yed from the shower wer room 2 and the eaned. The shower he red emergency call

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failed to ensure the Resident shower rooms were

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VDH/OLC

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_	RTMENT OF HEALTH ERS FOR MEDICARE	HAND HUMAN SERVICES E & MEDIC			PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	İ	495338	B WING		C 11/10/2016
NAME OF	F PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	
GRACE	E HEALTHCARE OF ABI	INGDON		600 WALDEN ROAD ABINGDON, VA 24210	
(X4) ID PREFIX 	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX JAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 252	2 Continued From pag	ge 12	F 2	52	12/09/16
	along with unit 1 may shower room 1. Surveyor observed stall walls and on emulations of the shower of shower disinfers on the shower room, should not, and process. Surveyor, along with shower room 2 on 10930. Surveyor observed shower wall divider. The shower wall divider of surveyor observed stall walls and on emulation.	shower room on unit 2 of the it approximately 0945. black substance on shower nergency pull cord. Also		3. On 11/17/06 the Housekee in-serviced the housekeeping the shower rooms. On 11/22/06 the Administrat Housekeeping Supervisor on cleanliness of the shower rooms. On 11/28/16 the Director of serviced nursing staff on a cleand sanitary environment in rooms. The Director of Nursing/design the shower rooms S x week x week, x 4 weeks, and then 1x 4. The Director of Nursing/deaudit findings to the monthly Assurance and Performance Committee x 3 months or un compliance is achieved. The	or in-serviced the monitoring the oms
	Concerns of the clea	debris in bottom of tub. Inliness of the shower rooms the administrative team 11/09/16 at approximately		includes but is not limited to Director, Administrator, Dire Social Services Director, Activ Maintenance Director, Admis Director, Dietary Director, H Coordinator, and Business O	ctor of Nursing, vities Director, ssions/Marketing IR Director, MDS
SS=D	483.15(h)(2) HOUSE MAINTENANCE SER		F 25	31. No residents were cited for deficient practice.	· this alleged

maintenance services necessary to maintain a

sanitary, orderly, and comfortable interior.

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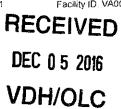
Facility ID. VA0061

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2. All residents who utilize unit 2 shower

alleged deficient practice.

room have the potential to be affected by this



door. He informed the surveyor that the door was missing a pin at the top, allowing it to move up and down, preventing the door from latching properly.

The concern of the shower door not functioning properly was brought to the attention of the administrative staff on 11/09/16 at approximately 1410.

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Director, HR Director, and Business Office

Manager.

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Event ID: T58V11

	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDIO SERVICES			(RINTED: 11/22/2016 FORM APPROVED MB NO: 0938-0391
STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,	LTIPLE CONS			IX3) DATE SURVEY COMPLETED
		495338	B WING				C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER		,	STREET	ADDRESS, CITY, STATE, 2	ZIP CODE	
GRACE	HEALTHCARE OF AB	INGDON			LDEN ROAD DON, VA 24210		
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F 253	Continued From pa	ge 1 4 on was provided prior to exit	F 2	253			12/09/16
	483.20(g) - (j) ASSE	· · · · · · · · · · · · · · · · · · ·	F 2	278			
30- 3		ust accurately reflect the			Resident #8's MDS vector rected related to the weighed.		_
	each assessment w participation of heal				Resident #3 bowel and completed by the MD: and is reflective on the assessment dated 7/30	S Coordinato e most recen	r 11/21/16
		completes a portion of the ign and certify the accuracy of			 A facility wide audit documenting weight a function was complete Nursing on 11/21/16. I identified were correct 	ind bowel an by the Dire MDS assessn	d bladder ctor of
	willfully and knowing false statement in a subject to a civil mor \$1,000 for each asso	d Medicaid, an individual who ply certifies a material and resident assessment is ney penalty of not more than essment; or an individual who			A facility wide audit of documenting weight a function was complete Coordinators on 11/22 identified were correct	nd bowel and by the MDS 2/16. MDS as	d bladder
	to certify a material a resident assessmen	lly causes another individual and false statement in a t is subject to a civil money than \$5,000 for each			3. On 11/18/16 the Reg Compliance in-serviced Director of Nursing, Die Director, Social Service Administrator regardin	d the MDS Co etary Manag s Director, a	oordinators, er, Activities nd
	Clinical disagreemer material and false st	nt does not constitute a atement.			The MDS Coordinator/dashes on the MDS by	designee wil	
	by:	T is not met as evidenced view and clinical record			weeks, 3 residents x 4 v resident x 4 weeks.		

review, the facility staff failed to maintain a complete an accurate MDS (minimum data set)

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	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDIO SERVICES		(PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391
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NAME OF	PROVIDER OR SUPPLIER		' 	STREET ADDRESS, CITY, STATE, ZIP CODE	
				600 WALDEN ROAD	
GRACE	HEALTHCARE OF AB	NGDON	ļ	ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC LDENTIFYING INFORMATION)	ID PREFIX 		ULD BE COMPLETION
F 278	Continued From page	ge 15	F 27	78	12/09/16
		25 Residents, Resident #8			•
	and #3.			4. The MDS Coordinator/design	مميينال حميم
				audit findings to the monthly Q	•
	The findings include	ed.		and Performance Improvement	
				months or until substantial com	
		the facility staff failed to		achieved. The QAPI Committee	•
		ents weight on the Residents		not limited to the Medical Direc	· ·
	annual MDS assess	ment.		Administrator, Director of Nursi	
	The read contour of	succeed that Docidant #9 was		Services Director, Activities Dire	_
		evealed that Resident #8 was		Maintenance Director, MDS Co	ordinator,
		ty 07/15/04. Diagnoses ot limited to, dementia, heart		Admissions/Marketing Director,	
	failure, osteoporosis			Director, HR Director, and Busin	
	ialitie, usteoporosis	, and consupation.		Manager.	
	annual MDS assess (assessment referer a BIMS (brief intervie	patterns) of the Residents ment with an ARD nce date) of 03/17/16 included ew for mental status) out of a possible 15.			
	documented height of	g/nutritional status) had a of 60 inches. For the area of off had placed dash marks (-)			
	pounds. The quarter	sment prior to this ocumented weight of 89 ly assessment after this ocumented weight of 90			
	weight on 11/09/16 a	sked about the missing t approximately 10:00 a.m. inical record MDS nurse #1			

verbalized to the surveyor that she was unable to locate any documentation stating the Resident had refused to be weighed and she did not know

why the weight was not documented.

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Facility ID: VA0061

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	RTMENT OF HEALTH	HAND HUMAN SERVICES E & MEDI () SERVICES			ć -	F	NTED: 11/22/2016 ORM APPROVED 3 NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		3) DATE SURVEY COMPLETED
		495338	B WING				C 11/10/2016
	PROVIDER OR SUPPLIER HEALTHCARE OF AB	INGDON		600 V	ET ADDRESS. CITY, STATE, ZIP VALDEN ROAD IGDON, VA. 24210	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	Х	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIAT	
F 278	The administrative missing weight duri team on 11/09/16 a	staff were notified of the ng meetings with the survey	F2	278			12/09/16
A	(Minimum Data Set Resident #3 was rea 7/27/16 with the following to high blood dementia, depression	admitted to the facility on owing diagnoses of, but not pressure, diabetes, on and osteoporosis. The		n marine esta			
	ARD (Assessment F having a BIMS (Brie an assessment tool) score of 15. Reside	on the quarterly MDS with an Reference Date) of 7/30/16 as f Interview for Mental Status, score of 5 out of a possible at #3 was also coded as assistance of 1 staff member sonal hygiene.					
	Resident #3 's clinic surveyor noted that i and Bowel of the ME	cted a chart review of cal record on 11/9/16. The under Section H: Bladder OS with an ARD of 7/30/16, aced in the box under H0400:					
	documented findings 3:30 pm.	taff was notified of the above on 11/9/16 at approximately			CEIVED C 0 5 2016	·	
	Nurse) #1 stated to t	pm, LPN (Licensed Practical he surveyor "I didn 't know bowel movements so I put a		V	OH/OLC		

No further information was provided to the

DEPAF	RTMENT OF HEALTH	HAND HUMAN SERVICES					APPROVED
CENTE	ERS FOR MEDICARE	E&MEDI(ISERVICES			(0938-039
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		495338	B. WING	3		1	C 40/2040
NAME OF	F PROVIDER OR SUPPLIER	<u> </u>	10		EET ADDRESS, CITY, STATE, ZIP CODE		10/2016
			!		ET ADDRESS, CITY, STATE, ZIP CODE WAŁDEN ROAD	=	
GRACE	HEALTHCARE OF AB	INGDON		1	NGDON, VA 24210		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(XS) COMPLETION DATE
					DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·	
F 278	Continued From page	**	F2	278			12/09/16
3 7.	- · · · · · · · · · · · · · · · · · · ·	e exit conference on 11/10/16.					
	483.20(d), 483.20(k)		F 2	<u>2</u> 79			
SS=D	COMPREHENSIVE	. CARE PLANS			1. Resident #10's comprehensive		
	∆ facility must use th	the results of the assessment			completed by the MDS Coordinat	tor on	
		and revise the resident's			11/11/2016.		
	comprehensive plan				2. A facility wide audit of compre	hensive care	
					plans was complete by the Direct		and the second discount
		velop a comprehensive care			on 11/21/16. There were no addi	-	
		ent that includes measurable			comprehensive care plans identif		
		tables to meet a resident's			completed timely.		
	-	nd mental and psychosocial			•	•	
	needs that are identi assessment.	tified in the comprehensive			3. On 11/30/16 the Regional Dire		
	assessment.				Clinical Compliance in-serviced th		
	The care plan must	describe the services that are			Coordinators, Director of Nursing	-	
	•	tain or maintain the resident's			Social Services Director, Activities		
		physical, mental, and			Dietary Director, and Administrat the development of comprehensi	-	
		eing as required under			the development of comprehensi	ive care pians.	
		ervices that would otherwise			The MD Coordinator/designee wi	ill audit for	
	be required under §4	483.25 but are not provided .			timely completeness of the comp		
		exercise of rights under			care plan by reviewing 5 residents		
		ne right to refuse treatment			residents x 4 weeks, and then 1 re	esident x 4	
	under §483.10(b)(4).				weeks.		
					4. The MDS Coordinator/designee	e will report	
-	This REQUIREMENT	T is not met as evidenced			audit findings to the monthly Qua	· · · · · · · · · · · · · · · · · · ·	
	by:	7 10 1101 11101 00 07.11.11.11.11			Assurance and Performance Impr	•	
		view and clinical record			Committee x 3 months or until su		
		aff failed to develop a CCP			compliance is achieved. The QAPI	l Committee	
((comprehensive care	e plan) for 1 of 25 Residents,			includes but is not limited to the I		
	Resident #10.	•			Director, Administrator, Director		
_					Social Services Director, Activities	· - :	ļ
7	The findings included:	T:			Maintenance Director, MDS Coor	rdinator,	
					Admissions/Marketing Director, E	Dietary	

admission.

For Resident #10 the facility staff failed to develop

a CCP within the allotted timeframe after

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VDH/OLC

Manager.

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Director, HR Director, and Business Office

	RTMENT OF HEALTH ERS FOR MEDICARE	I AND HUMAN SERVICES E & MEDIQ SERVICES		(FO	ED: 11/22/2016 RM APPROVED VO. 0938-0391
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION NG	(X3) [DATE SURVEY COMPLETED
		495338	B WING_			C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C		11710/2010
10 11012			-	600 WALDEN ROAD		
GRACE	HEALTHCARE OF AB	INGDON		ABINGDON, VA 24210		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX		N SHOULD BE	(X5) COMPLETION DATE
1AG				DEFICIENCY)		
F 279	Continued From pa	ge 18	F 27	79		12/09/16
•	08/31/16. Diagnose atrial fibrillation, core hypertension, thyroi					
	osteoporosis, hemir anxiety and depress	olegia, seizure disorder, sion.				
·· -	an ARD (assessmer coded the Resident	DS (minimum data set) with nt reference date) of 09/07/16 as 14 out of 15 in section C, his is an admission MDS.			,	
	11/09/16. It containe	cal record was reviewed on d an interim care plan dated yor could not locate a				
	11/09/16 at approxin	with the MDS coordinator on nately 1350. When asked MDS coordinator stated "It poked it".				
		nissing CCP was discussed ve team during a meeting on nately 1410.				
F 281 SS=E		n was provided prior to exit. /ICES PROVIDED MEET ANDARDS	F 28	1		
		d or arranged by the facility nall standards of quality.		RECEIVED		
				DEC 0 5 2016		
	by:	ris not met as evidenced riew, facility document review		VDH/OLC		

1. The facility staff failed to follow professional standards of nursing practice in documenting the frequency of a medication on the monthly physician orders for Resident #3.

Resident #3 was readmitted to the facility on 7/27/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, depression and osteoporosis. The resident was coded on the quarterly MDS with an ARD (Assessment Reference Date) of 7/30/16 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 5 out of a possible score of 15. Resident #3 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

A review of Resident #3 's clinical record was performed by the surveyor on 11/9/16. During this review, it was noted by the surveyor that on the monthly physician orders for November, 2016, the following: "Famoidine 20 mg (milligram) Tablet Give 1 Tab (tablet) by mouth every". The surveyor noted that there was no frequency of the medication documented in which the medication was to be given to the resident.

The administrative staff was notified of the above documented findings on 11/9/16 at approximately 3:30 pm. The surveyor asked for a copy of the standards of nursing in which the facility holds

Resident #25 no longer resides at the facility,

LPN #10 is no longer employed by the facility.

Resident #23 no longer resides at the facility.

2. The Director of Nursing, QA nurse, and Unit Managers completed a facility wide on 12/2/16 MAR audit to ensure all orders are complete.

Verification of orders identified were corrected.

The Director of Nursing, QA Nurse, and Unit Managers completed a facility wide audit on 12/2/16 of weekly head to toe skin inspections to ensure all residents with impaired skin areas have appropriate treatment orders in place, which are being followed according to physician orders. Appropriate treatment orders not in place were corrected.

The facility currently has no residents with PICC lines.

The Director of Nursing in-serviced licensed nursing staff 11/28/16 on PICC line dressing change.

The Director of Nursing in-serviced licensed nursing staff on 11/28/16 on proper documentation of wound care.

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

Event IO: T58V11

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PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDIC **SERVICES** (X3) OATE SURVEY (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF OFFICIENCIES COMPLETEO IOENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILOING С 495338 B WING 11/10/2016 NAME OF PROVIOER OR SUPPLIER STREET AOORESS, CITY, STATE, ZIP COOE 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF OFFICIENCIES Ю (X4) IO COMPLETION DATE (EACH CORRECTIVE ACTION SHOULO BE (EACH OFFICIENCY MUST BE PRECEOED BY FULL PRFFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC JDENTJEYING INEORMATION). ---TAG-OEFICIENCY) 12/09/16 F 281 Continued From page 20 F 281 each nurse accountable for when documenting medication orders. The Director of Nursing in-serviced licensed nursing staff on 11/28/16 concerning the On 11/10/16 at 8:30 am, the director of nursing completion of physician orders and the 5 Rights (DON) gave the surveyor a copy of a policy titled of medication administration. " Medication Orders and Review " in which the surveyor noted the following under Section "B: The Director of Nursing/designee will audit Recording Orders " physician orders for MAR accuracy 5 residents a " 1. Medication Orders: week x 4 weeks, 3 residents a week x 4 weeks. When recording orders for medication and then 1 resident a week x 4 weeks. specify: The type, route, dosage, frequency and The Director of Nursing/designee will audit strength of the medication ordered ... weekly head to toe skin inspections 5 residents x The surveyor asked the DON what was expected 4 weeks, 3 residents x 4 weeks, and 1 resident x of a nurse to document when ordered a 4 weeks. medication and the DON stated, "The nurse will document the name of the medication, the route. 4. The Director of Nursing/designee will report frequency and the strength of the medication. " audit findings to the monthly Quality Assurance The surveyor asked the DON what was the and Performance Improvement Committee x 3 standard that the facility used to hold each nurse months or until substantial compliance is accountable for the correct documentation when achieved. The QAPI Committee includes but is documenting medications and the DON stated " not limited to the Medical Director, The nurses are held accountable to what this Administrator, Director of Nursing, Social policy states to document when ordering Services Director, Activities Director, medications. " Maintenance Director, MD5 Coordinator, Admissions/Marketing Director, Dietary Director, On 11/10/16 at approximately 3 pm, the QA HR Director, and Business Office Manager. (Quality Assurance) nurse #1 was interviewed by the surveyor. The QA nurse #1 stated that " mandatory staff training was provided back in October on writing physician orders ". The surveyor asked QA nurse #1 if she could provide RECEIVED documentation of this mandatory staff training. QA nurse #1 stated " Let me go to my office and

In the handouts that were provided to the

I can get this for you. " QA nurse #1 returned to

the conference room with the mandatory training in service sign in record dated for 10/28/16 and a

copy of the in service topics that were discussed.

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	· · · · · · · · · · · · · · · · · · ·		(PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
·	495338	B. WING_		C 11/10/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GRACE HEALTHCARE OF AB	NGDON		600 WALDEN ROAD	
			ABINGDON, VA 24210	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 281 Continued From page	ge 21	F 28	31	12/09/16
surveyor, it was noted discussed with the sorders: "Physician 1. Medication 2. Dose 3. Route	ed that the following was staff regarding physician 's Orders Should Contain:			
2. The facility staff standards of nursing nursing documentati Indwelling Central C for Resident #25. Resident #25 was re 12/17/14. The residing diagnoses of, but no blood pressure, diab disorder and schizop MDS (Minimum Data (Assessment Refere Resident #25 was controlled in the controlled for Mental score of 0 out of a poresident was also condependent on 2 or material personal hygiene and A complaint was recent in the complaint was recent for Mental score of Centrolled for Mental score of	nce Date) of 7/29/16, oded as having a BIMS (Brief Status, an assessment tool) ossible score of 15. The ded as being totally ore staff members for d bathing. Evived in the Office of cation on 8/9/16. The omplainant alleges	,	IECEIVED DEC 0 5 2016 VDH/OLC	

	TMENT OF HEALTH	AND HUMAN SERVICES & MEDIC SERVICES			(RINTED: 11/22/2016 FORM APPROVED MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		(X3) DATE SURVEY COMPLETED
	,	495338	B. WING	i <u>· </u>			C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE,	ZIP CODE	
				600 1	WALDEN ROAD		
GRACE	HEALTHCARE OF AB	NGDON		ABII	NGDON, VA 24210		
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI JAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD I	BE COMPLÉTION
TAG					DEFICIEN		
F 281	Continued From page	ge 22	F 2	281			12/09/16
	Resident #25 on 11/ that on the monthly 2016 the following o change q (every) we reviewed the Treatm	ved the clinical record of 10/16. The surveyor noted physician orders for August, rder: "PICC line dressing sek " The surveyor also nent Administration Record					
<u></u>	(TAR) for the month	of August, 2016. It was				<u> </u>	and the second of the second of the second
	noted that on 8/9/16	and 8/16/16, LPN #10					
	initialed these dates	that indicated that the PICC					
	line dressing change	e for that date was performed.					
	interviewed by the si approximately 2:30 p The QA nurse #1 washe knew anything a wound care nurse no " or " falsified document The QA nurse #1 stateducation on proper providing wound care get the in service trainurse #1 returned to the sign in sheet and provided to the staff						
; ; ; ; ;	surveyor on 11/10/16 the conference room corporate nurse of the allegations that were corporate nurse state called into the corpor me go and look into the concerning this matter returned to the confe	was interviewed by the at approximately 2:45 pm in . The surveyor notified the e above documented called into the office. The ed that there was a complaint ate hot line on this and "let he documentation er." The QA nurse #1 rence room at approximately this is the documentation of					

the complaint that was called into the corporate

Event ID: T58V11

If continuation sheet Page 23 of 70

DEC 0.5 2016 VDH/OLC

RECEIVED

	TMENT OF HEALTH	HAND HUMAN SERVICES E & MEDIC SERVICES			(FOF	ED: 11/22/2016 RM APPROVED IO: 0938-0391
STATEMEN	T OF OFFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			ONSTRUCTION		DATE SURVEY COMPLETEO
		495338	B. WING	è		1	C I1/10/2016
NAME OF	PROVIOER OR SUPPLIER	<u> </u>	1-	STRE	ET AOORESS, CITY, STATE, ZIP	COOE	
GRACE	HEALTHCARE OF AB	BINGDON		i	WALDEN ROAD NGDON, VA 24210 _		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SCIDENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULD BE E APPROPRIATE	IX5) COMPLETION OATE
F 281	Continued From pa	age 23	F	281			12/09/16
. –	hot line on this com	plaint." The surveyor					
	from the facility. The	nentation that was received ne.following documentation					
	was noted: " On 8/	18/16, it was brought to my ent (name of resident)					
	family member stat	ed her PICC line dressing was					
		_ (name of nurse)signed change as being done and		 -		New Control of the Asset Control of the Control of	
	completed. On 8/1	6/16 (name of nurse)					-
	stated she was sick	and another nurse was going					:
	to change for her b	ut the dressing was not					
		CC line was completed on ment nurse immediately."					
	8/18/16 by the treat	ment horse ininediately.					
	The surveyor also r	eviewed the Facility Reported					
	Incident (FRI) that t	he facility sent into the Office					
		ertification dated September 3,					
		was noted by the surveyor in					•
	this report: "Resid	lent #2687 (which is Resident					
	#25) complaint alleg	ges false documentation by N). Through interviews with					
		ector of nursing) and					
	name of LPN) it was	is substantiated that					1
		itted to documenting in error.					
		he PICC line was changed by					
) when in fact it was not.					
	(name of LPI	N) documented that she					ì
	changed resident #2	2687 (which is resident #25 in					ļ
	survey sample) PIC	C line dressing on August 17,					İ
		ection of PICC line showed a					ļ
	date of August 9, 20	116. This clearly indicated that					ļ
	aressing was not on	anged (name of LPN) action for her error in the			RECEIVED		
	received disciplinary	en reprimand under the					
	professional standa	rds of practice. "			DEC 0 5 2016		
	The director of nursi	ing (DON) at the time of this			VDH/OLC		
	complaint was not in	nterviewed due to no longer			VDITIOLO		-

being employed by the facility.

	MENT OF HEALTH	AND HUMAN SERVICES & MEDIQ SERVICES			(FORM A	11/22/2016 PPROVED)938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE : COMPL	
		495338	B. WING	S		1	C 11/10	0/2016
	ROVIDER OR SUPPLIER	NGDON		600	EET ADDRESS, CITY, STATE WALDEN ROAD NGDON, VA 24210	, ZIP CODE	 -	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION OATE
	Continued From page	ge 24 staff was notified of the above	F2	281			12	2/09/16
	documented finding approximately 2:50 asked by the survey of practice that they		·					
; ; ; ; ;	room and gave the stitled "Catheter Instated, "This serve "Under the section the following was stated "1. Change mid 5-7 days" Under the section of following was stated "1. the following ecorded in the reside. Date and time d	line catheter dressingevery " Documentation " the						
s 3 c u fa	surveyor prior to the This is a COMPLAIN B. For Resident #23, obtain treatment ordulaters when the Respeciality.	the facility staff failed to ers for unstageable pressure ident was admitted to the cord review the Resident had			ECEIVED			
F	Resident #23 was ad omplaint. The facilit	ded to the sample due to a y had completed an internal the survey and substantiated			EC 0 5 2016 DH/OLC			

	TMENT OF HEALTH	AND HUMAN SERVICES			(RINTED: 11/22/2016 FORM APPROVED MB NO. 0938-0391
STATEMEN	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '		DNSTRUCTION		(X3) OATE SURVEY COMPLETEO
		495338	B. WING				C 11 /1 0/2016
NAME OF	PROVIOER OR SUPPLIER		<u> </u>	STRE	ET AOORESS, CITY, STATE	ZIP COOE	
GRACE	HEALTHCARE OF ABI	INGDON			VALDEN ROAD IGDON, VA 24210		
(X4) IO PREFIX — JAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T OEFICIE	CTION SHOULO O THE APPROPE	BE COMPLETION
F 281	(licensed practical n treatment orders aft admitted to the facili unstageable pressu re-educated the nur-	ge 25 e treatment nurse LPN urse) #10 had failed to obtain er the Resident had been ity and identified as having re ulcers. The facility se on professional standards ng appropriate treatments for	F 2	281			12/09/16
	identified skin issue:	9	and the consequen	, , , , , , , , , , , , , , , , , , ,			
	had been admitted to Diagnoses included, unstageable pressure neoplasm of bronchindisorder, and hyperto Section C (cognitive admission MDS (mirwith an ARD (assess 08/15/16 was coded Resident had problememory and was sessills for daily decision (functional status) has mobility indicating the extensive assistance this activity. Section is coded to indicate the developing pressure	patterns) of the Residents and the sension. patterns) of the Residents as a sessment as a set as a sessment as a set at a sessment as a set at a s					
	The Residents CCP	(comprehensive care plan)		RI	ECEIVED		
l	breakdown R/T (relat	area "at risk for skin red to) functional status and		Di	EC 0.5 2016		
	ADLs (activities of da	uires staff assistance with ill living) and is incontinent.			DH/OLC		
		n multiple pressure ulcers" , but were not limited to,		V	חווטנט		

"Provide treatments as ordered...Observe and

	RS FOR MEDICARE	E& MEDIC SERVICES		$C^{\prime\prime}$	FORM APPROVED OMB NO. 0938-0391
	T OF OEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA	(V2) MIII	TIPLE CONSTRUCTION	(X3) OATE SURVEY
	OF CORRECTION	IOENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	COMPLETEO
		495338	B. WING		C 11/10/2016
NAME OF	PROVIOER OR SUPPLIER		·	STREET AOORESS, CITY, STATE, ZIP	
CDACE	UEALTUCADE OF AD	INCDON	1	600 WALDEN ROAD	
GRACE	HEALTHCARE OF AB	INGDON		ABINGDON, VA 24210	··
(X4) IO	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL		10	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFI: TAG	CROSS-REFERENCEO TO THE	E APPROPRIATE DATE
				OEFICIENCY)	
F 281	Continued From pag	no 26	F 2	201	12/09/16
1 201	' `	nptoms) of skin breakdown,	ΓΖ	.01	
		nattress to bed and cushion to			
	w/c (wheelchair)."				
	The Residents "Nurs	sing Admission Assessment"			
		on 08/09/16 and had been			
	signed by LPN #1. T	his nursing assessment			
i - 1 a 1		g-pressure ulcer of sacral			and the state of t
		pressure ulcer of left pressure ulcer of right			
		pressure ulcer of left heel,			
		re ulcer of left ankle,			
	•	re ulcer of other site,			
	unstageable.				
	The clinical record a	lso included wound			
		dated 08/09/16 that identified			
	the following.	avenue to d DTI (does tissue			
		suspected DTI (deep tissue rright bottom of foot, 4.0 cm			
	length X 1.5 cm widt				
	Unstageable due to s	suspected DTI pressure ulcer			
		.5 cm length X 3.5 cm width.			
		suspected DTI pressure ulcer .5 cm length X 2.5 cm width.			
		suspected DTI pressure ulcer			
		s. 3 cm length X 1 cm width.			
		suspected DTI pressure ulcer			
		2.25 cm length X 1.5 cm			
	width. Unstageable due to s	suspected DTI pressure ulcer			
	coccyx. 1 cm length >	·		DE0=	
{	Jnstageable due to s	uspected DTI pressure ulcer		RECEIVED	
Į,	eft buttock. 3 cm leng	gth X 1.25 cm width.		ከ ሮሮ ለ ድ ባለፈላ	
٦	These wound assess	ments were electronically		DEC 0.5 2016	
S		nd the previous DNS		VDH/OLC	
	on⇔cior or nurcina se	-1.00 #>1			

(director of nursing services).

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		I AND HUMAN SERVICES			É		FORM APPROVED IB NO. 0938-0391
	RS FOR MEDICARE		0/01 14:41	TIPLE CONSTRU	UCTION -		X3) DATE SURVEY
STATEMEN' AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-	ING			COMPLETED
		495338	B. WING				11/10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP	CODE	
		INCOON		600 WALDE	N ROAD		
GRACE	HEALTHCARE OF AB	INGDON			N, VA 24210		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION	ORRECTION	tX51 SE COMPLETION
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	"·	SS-REFERENCED TO TH	E APPROPRI	ATE DATE
TAG	N GDLANDOL DILE				DEFICIENCY))	
							12/09/16
F 281	Continued From pa	ge 27	F 2	281			
	Definition of unstag	eable and DTI from the					
		Jicer Advisory Panel					
	http://www.npuap.o						
	Unstageable Pressi	ure Injury: Obscured and tissue loss. Full-thickness					
		in which the extent of tissue					
		ulcer cannot be confirmed					
		red by slough or eschar. If					<u> </u>
		removed, a Stage 3 or Stage					
	4 pressure injury wi	ll be revealed.					
		ure Injury: Persistent					
		p red, maroon or purple					
		or non-intact skin with					
		rsistent non-blanchable deep					
	red, maroon, purple	discoloration or epidermal g a dark wound bed or blood					
	Separation revealing	nd temperature change often					
	nrecede skin color (changes. Discoloration may					
	appear differently in	darkly pigmented skin. This					
	injury results from in	ntense and/or prolonged		*			
	pressure and shear	forces at the bone-muscle					
	interface. The woun	d may evolve rapidly to reveal					
		tissue injury, or may resolve					
	without tissue loss.						
	subcutaneous tissue	e, granulation tissue, fascia,					
	muscle or other und	erlying structures are visible, hickness pressure injury					
	(Hastogoable Stage	e 3 or Stage 4). Do not use					
	DTPI to describe va	scular traumatic					
		natologic conditions.					
		ments ordered when the					
	Resident was admit	ted to the facility. The		RECE	IVED		
	following treatments	were obtained during the		ILUL			
	Residents stay at the	e facility (08/08-09/04/16)		DEC 05	s 2016		
	08/09/16-Comfort C			DFC 0 4	, 2010		
		both ankle wounds.		VDH/	OLC		

08/18/16-Discontinue betadine to buttocks heels

everyday.

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		AND HUMAN SERVICES		7		KM APPROVED
CENTE	RS FOR MEDICARE	& MEDID SERVICES			OMB N	O. 0938-0391
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILOING	E CONSTRUCTION		ATE SURVEY OMPLETEO
		495338	B. WING		1	C 1/10/2016
		+30330	1	TOTAL CONTROL OF A STATE 7/D C/		1/10/2016
NAME OF	PROVIOER OR SUPPLIER		į	REET AOORESS, CITY, STATE, ZIP CO	JUE	
CDACE	HEALTHCARE OF AB	INGDON	l	0 WALDEN ROAD		
GNACL	HEALIHOANE OF AB		At	BINGDON, VA 24210		
(X4) IO	SUMMARY STA	TEMENT OF OEFICIENCIES	10	PROVIOER'S PLAN OF COR	RECTION	(X5)
PREFIX		MUST BE PRECEOEO BY FULL	PREFIX	(EACH CORRECTIVE ACTION	SHOULO BE	COMPLETION DATE
JAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCEO TO THE A OEFICIENCY)	(PPROPRIATE	DATE
						12/09/16
F 281	Continued From page	ge 28	F 281			-~,05/10
	and ankles Cleanse	e coccyx wound with normal				
		with 1/4 strength dakins				
		with secondary dressing twice				
	a day.	vitir secondary dressing twice				
		to right and left heel wounds				
		with secondary dressing if				
		o right inner and outer ankle				
		ay cover with secondary	<u></u>			
	dressing if needed f					
		to left inner and outer ankle				
		with secondary dressing for				
	skin protection daily					
		ctors to bilateral feet as				
	resident will allow.	3.0.0 10 2.10.0 2.1 100.1 20				
	08/18/16-Low air los	s mattress to aid in				:
	prevention of skin br					
		to wounds to bilateral feet.				
		endary dressing for skin				ļ
	protection everyday.	,	*			
		o left hip discoloration. May				
		y dressing for skin protection				
	everyday.	,				
		o red area left lower leg. May				
	cover with secondary	y dressing everyday for skin				
	protection.					
	08/26/16-Change sa	cral wound twice a day with				
	1/4 dakins solution. (Crush 1 500 mg flagyl				
	(antibiotic) tablet and	i sprinkle over wound at				
	dressing change.					
	<u> </u>					
	The clinical record in	cluded documentation by the				j
		ed the Resident had multiple	R	ECEIVED		
	wounds that were un		11			
		ry to terminal illness and	r	אבר אוב אוופ		ļ
	decreased nutrition		Ł	DEC 0.5 2016		
			•	DUOL6		-
(On 11/10/16 at appro	ximately 12:45 p.m. the	V	/DH/OLC		
		LPN #1 LPN #1 was shown				

her electronic signature on the admitting

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			· · ·			ED: 11/22/2016 RM APPROVED
	RS FOR MEDICARE						OMB N	O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONS				OMPLETED
		495338	B. WING	S			1	C 1/10/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET	AODRESS, CIT	Y, STATE, ZIP CODE		
		INCOON		Į.	DEN ROAD			
GRACE	HEALTHCARE OF ABI	INGDON		ABING	ON, VA 24:			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREF	ΊV	PROVIDER'	S PLAN OF CORRECT ECTIVE ACTION SHO	TION ULD BE	(X5) COMPLETION
PREFIX TAG		SC-IDENTIFYING INFORMATION)	TAG		ROSS-REFERE	NCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
							•	
F 281	Continued From page	ge 29	F	281				12/09/16
	assessment and as	ked why treatment orders						
		when the Resident had been						
		tated she did not remember nent and stated this was the						
	first time she had co	ompleted an admission and						
	she had only assiste	ed another nurse as this was						
	not her Resident. Li	PN #1 added that the ve any open areas on						<u> </u>
	admission the areas							
	LPN #10 was not wo	orking during the course of						
	the survey. The facil	lity attempted to contact her						
	via phone but was u	insuccessful. The DNS that e wound assessments was						
	no longer employed	at the facility and per the						
	current administrato	r the investigation was						
		evious administrator.						
	The facility staff prov	vided the surveyor with copies						
	of their facility policie	es/procedures titled "Wound and "Physician Orders." The						
	nolicy title "Wound C	Care Management" read in						
	part "Each resident r	receives the care and						
	services necessary f	to retain or regain optimal						
	skin integrity to the e	extent possibleNotify the cian and responsible party of						
	the presence of the	wound" The policy titled						
	"Physician Orders" r	ead "Purpose Physician						
	orders are obtained the care of the reside	to provide a clear direction in						
	the care of the reside	CIII						
	The facility also prov	rided the surveyor with a copy		RECE	IVED			
	of their standard of p	practice in regards to wounds		מבר מי	5 2016			
	rrom Lippincott Nurs edition Consult with	sing Procedures seventh n your facility's wound,		DEC 0	J ZUIO			
(continence, and osto	omy nurse; nutritionist or		VDH/	OLC			
1	registered dietician; a	and physician or occupational		A 17 1 1/1	~~~			
1	therapist as indicated prevention requires a	d, because pressure ulcer						
		- · · · · · · · · · · · · · · · · · · ·						

	RTMENT OF HEALTH	AND HUMAN SERVICES 8 MEDIO SERVICES			(RINTED: 11/22/2016 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	LTIPLE CON		JX3) DATE SURVEY COMPLETED		
		495338	B. WING	÷			C 11/10/2016	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET	ADDRESS, CITY, STATE, ZIF	CODE		
GRACE	HEALTHCARE OF AB	INGDON			LDEN ROAD DON, VA 24210			
(X4) ID PREFIX —TAG	(EACH DEFIC)ENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF JAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD SE APPROPI	BE COMPLETION	
F 281	Continued From pa	-	F:	281	DEFICIENCE	,	12/09/16	
	approachIf left un produce ischemia a	treated, pressure ulcers may nd local infection"						
·	administrative staff	oximately 3:10 p.m. the were made aware of the the absence of treatment # 23.	::::::::::::::::::::::::::::::::::::::					
		on regarding this issue was ey team prior to the exit						
F 309 SS=G	THIS IS A COMPLAINT DEFICIENCY. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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.		F3	309				
					 Resident #19 no long facility. 	er resides a	at the	
					Resident #10 assessed be 11/10/16 and found to protocol in place with mursing staff and found negative outcomes as a deficient practice.	be stable w nonitoring l to be stabl	vith BM by licensed e with no	
	by: Based on staff interveview, clinical record a complaint investigation provide treatment for	T is not met as evidenced view, facility document d review and in the course of ation the facility staff failed to the highest practicable level 25 Residents, Residents #3, #25, #5 and #14.	RE	CEIVI	Resident #16's physicial failure to follow MD ord of Pyridium and Motrin assessed by licensed nu found to be stable with as a result of the alleged	ders for adr as ordered irse on 12/2 no negativ	ministration I. Resident 2/16 and e outcomes	
	The findings included	i:	DEC 0 5 2016					
	1. For Resident #19 the facility staff failed to accurately assess and diagnose the			VDH/OLC				

Event ID: T58V11

PRINTED: 11/22/2016 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICA SERVICES			(10	MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLÍA IDENTIFICATION NUMBER:		LTIPLE CONSTRUC			IX3) DATE SURVEY COMPLETED
							С
		495338	B. WING				11/10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDR	ESS, CITY, STATE, ZIP C	ODE	
				600 WALDEN	ROAD		
GRACE	HEALTHCARE OF AB	INGDON		ABINGDON,	VA 24210		
X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF	ix (EAC	ROVIDER'S PLAN OF COF CH CORRECTIVE ACTION S.REFERENCED TO THE DEFICIENCY)	SHOULD	BE COMPLETION
	<u> </u>						
F 309	Continued From pa	ge 31	F 3	309			12/09/16
1 000	·	ase, scabies, resulting in a					
	delay of treatment.	ase, scables, resulting in a		Reside	ent #23 is no longer a re	esident o	f the
	delay of treatment.			facility	y.		
	Resident #19 was a	dmitted to the facility on		01-1	4 . U.D L K		
	09/06/12 and readm	nitted on 10/14/16. Diagnoses			ent #3 assessed by licer 0/16 and found to be sta		
		ited to Alzheimer's disease,		· · · · · · · · · · · · · · · · · · ·	col in place with no neg		
		nizophrenia, insomnia,	<u>.,</u>	proto	corni piace with no neg	,acive out	come.
	constipation and co	ion cancer.		Reside	ent #25 is no longer a re	esident o	f the
	The most recent ME	OS (minimum data set) with			y. LPN #10 is no longer	employe	d at the
		nt reference date) of 10/21/16		facility	y.		
		as 2 out of 15 in section C,		Reside	ent #14 assessed by lice	ensed nur	rse on
	cognitive patterns. T	his is a quarterly MDS.			1/16 and found to be in		
		mprehensive care plan)		-	no negative outcomes a		
	reviewed at this time	9.		receiv	ing inaccurate Calcium	supplem	ent. The
	D 11 -1-440111-11			physic	cian was notified on 11,	/10/16 by	y licensed
	· · · - - · · · · · · · · · · · · · · · · · · ·	cal record was reviewed on d the following nurse's notes		nurse.			
	which read in part:	d the following harse's hotes		Docide	ont #E was assessed by	licopcod	nurco an
		M On 9-2-16 at 11:00pm			ent #5 was assessed by 0/16 and found to be sta		
		urses med cart crying.	-	•	ive outcomes as a resul		
		ained of) itching all over.		_	eing administered accor		
		tching and its driving me			cians order. The physicia		
		s like something crawling			ed nurse 11/10/16 and		•
		(sic) has a few small raised		receiv	red.		
		ner left back. No rash noted					
		body. Called on call Dr			acility wide skin sweep		
		v order noted for Vistaril prn (as needed). RP			16 by the Unit Manager		
	zsmg every 6 noors (responsible party) n				ng, and the QA Nurse. N		
	(responsible party) ii	otinos.			found to be affected by ent practice.	tile alleg	seu .
	"9/10/2016 6:58	AM Resident continues to		uentie	ent practice.		
		tching and is requesting to be		A facil	lity wide Bowel and Bla	dder aud	it was
:	seen by MD. Given \	/istaril per prn order. Res		compl	leted on 12/2/16 by the	2 Director	r of
ı	(sic) states 'It helps b	out doesn't make it stop'."		Nursir	ng, QA nurse, and Unit I	Manager:	s.
		•		Identi	fied residents were plac	ced on th	ne Bowel
"9/16/2016 6:31 AM Medication follow-up-				and Bl	ladder Protocol.		

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

Medication was effective."

(VISTARIL 25 MG CAPSULE 1 cap by mouth ev)

Even(ID: T58V11

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If continuation sheet Page 32 of 70

DEC 0 5 2016 VDH/OLC

	TMENT OF HEALTH	AND HUMAN SERVICES 8 MEDIO SERVICES		C	PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (XI) PROVIDER/SU		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495338	B. WING_		C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/10/2010
GRACE	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 309	Continued From page	ge 32	F 30	9	12/09/16
	c/o of itching all ove red spots on right th Vistaril per prn orde	AM Resident continues to r. Resident has several small igh and back of neck. Given r. MD made aware." PM NO (new order):		A facility wide weekly skin inspections completed on 12/2/16 by the Director QA nurse, and Unit Managers to ensure current residents with skin impairment appropriate treatment order in place. I	of Nursing, e all s have an
	CHANGE VISTA	RIL TO 50MG PO (by mouth)	writer and a second	residents were found to be affected.	VO OUIEI
	UTI. No adverse readry. Continues to c/c	PRN." PM Continues on Cipro for ctions noted. Skin warm and itching at times. No acute ight and PO fluids within		A facility wide MAR audit was complete 12/2/2016 by the Director of Nursing, Cand Unit Manager to ensure each curre physician order is completed with medidosage, route, and frequency. No other were identified to be affected through.	QA nurse, ent ication, r residents
		PM Medication Follow-up - APSULE BY MOUTH EVERY fective."		Currently there are no residents in facility with a PICC line. 3. The Director of Nursing in-service	
		PM Medication Follow-up - APSULE BY MOUTH EVERY fective."		licensed nursing staff 11/28/16 on e physician orders to include the 5 Rig medication administration.	entering
(complaint of nervous	AMvisteral (sic) for ness. Res. slept til this time, nad visteral (sic) earlier at		The Director of Nursing in-serviced l nursing staff 11/28/16 on changing dressing.	
		AM 4am Res. was up in of itching and sharp pain in		The Director of Nursing in-serviced I nursing staff 11/28/16 on the bowel protocol.	
7	"10/15/2016 NEW RIAMCINIOLONE 0 HIGH BID X 7 DAYS VAL"	.1% APPLY TO AFFECTED		On 12/2/16 the Medical Director discont 8 awel and 8 ladder Protocol.	tinued the

"10/18/2016 12:12 AM Resident had

Event ID; T58V11

Facility ID: VA0061

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VDH/OLC

		AND HUMAN SERVICES			r	OI	FORM APPROVED MB NO. 0938-0391
		& MEDIC/ SERVICES	T	EID E CONSTRU	·CTIO	- 0,	(X3) DATE SURVEY
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	LTIPLE CONSTRU DING			COMPLETED
		495338	B. WING	·			11/10/2016
NAME OF	PROVIDER OR SUPPLIER		i		RESS, CITY, STATE, ZIP C	CODE	
GRACE	HEALTHCARE OF AB	NGDON		600 WALDEN ABINGDON			,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EAC CROS	ROVIDER'S PLAN OF CO CH CORRECTIVE ACTION S-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE COMPLETION RIATE DATE
F 309	Continued From pa	ge 33	F 3	309			12/09/16
	complained with itch administered Vistril "10/19/2016 2:0 itching and Residen	ning and this nurse (sic) @ approx. 8 pm" 4 AM Resident complaining of t was saw by staff her elf. This nurse administered		r ii c	The Director of Nursin nursing staff 11/28/16 including identificatio documentation, and t care.	6 on wou on, stagin	nd care g,
			<u> </u>	<u></u>	LPN #10 is no longer e	<u>employed</u>	dat the
	CAPSULE BY MOU itching." "10/20/2016 10: - (VISTARIL 50 MG EVERY 6) Medication "10/28/2016 12 - (VISTARIL 50 MG EVERY 6) Medication "10/28/2016 9:3' Permethrin 5% extended to soles of feet	20 AM Medication Follow-up CAPSULE BY MOUTH on was effective." 7 PM New order for ream apply to skin from and wash off after 8 hours.		t r a T e r a	facility. The Director of Nursing the bowel movement residents x 4 week, 3 and then 1 resident x. The Director of Nursing the physician residents x 4 weeks, 3 and then 1 resident x. The Director of Nursing the Director of Nursing the Director of Nursing the Director of Nursing the Director of Section 1 and 1 resident x.	protocol residents 4 weeks. ng/design orders or 3 resident 4 weeks. ing/design dents x 4	I for 5 s x 4 weeks, nee will audit n the MAR 5 ts x 4 weeks, nee will audit
; ; ;	shower and premethentire body per ordershift." Resident #19's clinic following physician's part: "9/21/16 Cc (chiefurinary tract infections good, was sent to E	this order." AAM At 2:00am Given rin (sic) cream applied to rs. Reported to oncoming all record contained the progress notes which read in ef complaint): Acute UTI n). Pt stated she dropped her R for S/S (signs/symptoms) she was sent back to facility		v v r r F r	residents x 4 weeks, a weeks. The Director of Nursinweekly skin inspectionweeks, 3 residents x 4 resident x 4 weeks. The Director of Nursin PICC line changing, as residents x 4 weeks, 3 and then 1 resident x	ng/design ns of 5 re 1 weeks, s ng/design s needed, 3 resident	nee will audit esidents x 4 and then 1 nee will audit of 5 ts x 4 weeks,

s (without) any new orders." Resident's

EvenIID, T58V11

If continuation sheet Page 34 of 70

		AND HUMAN SERVICES			FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDIC SERVICES	,		OMB NO. 0938-0391
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVID SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIÓ	(X3) DATE SURVEY COMPLETED
		495338	B. WING		C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER		١	STREET ADDRESS, CITY, STATE, ZIP C	ODE
				600 WALDEN RDAD	
GRACE	HEALTHCARE OF AB	INGDON		ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CDF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION APPROPRIATE DATE
					12/09/16
E 200	Continued From pa	ae 34	F 3	na	12,00,10
F 309	•	=	1 3		القيم و حرارة القيم و حرارة القيم و حرارة المرارة المرارة المرارة المرارة المرارة المرارة المرارة المرارة المر
	complaints of itening	g were not addressed.			ng/designee will audit
	"0/20/16 Cc: Re	cert". Resident's complaints		wound care on 5 resi	
	of itching were not a			residents x 4 weeks, a 4 weeks.	and then 1 resident x
	"10/6/16 Cc: Re	admitt to(name omitted)		4. The Director of Nu	rsing/designee will
	s/p (status post) fall	"-Complaints of itching not		report audit findings	
	addressed-			Quality Assurance an	
				Improvement Comm	
		ırnNo sig (sic) rash noted			
	scant petechiae whi	ch appear age related".		until substantial com	
	"10/15/16 Cc: P	t c (with) rash B (bilaterally)		The QAPI Committee	1
		Has had x > (greater than)		limited to the Medica	· ·
	30 d had (writing	illegible) has grandchild c		Administrator, Direct	
	rect (recent) Dx (dia	gnosis) of scables.		Services Director, Ac	
	-scant 0 erythematic	rash trunk, LE (lowere		Maintenance Directo	
	extrimities) B (bilate	rlly), 0 raised, flat, no		Admissions/Marketir	1
	(writing illegible). As	sessment: Rash-does not		Director, HR Director	r, and Business Office
	appear to be scabie	s 0 classic (illegible) Re		Manager.	
	(Red raised rash cit	unneling) Rec. derm eval."			
	#40/47/46 Co. fu	(follow up) rash. Flat light			+
		ed, 0 rash 0 raised 0			
	/illegible) Assessme	ent: Rash- No(illegible) c			
	(with) scables 0 red.	0 raised, 0 tunnelling.			
	Although I may not b	e correct. Therefore given			
		c scabies, will ask for derm.			ļ
	eval + scraping to se	e what is cause. If it is			
	scabies certainly not	classic presentation."			
	"10/28/16 Cc: Pt	c derm evl today, scraping +		RECEIVED	
	scables"			DEC 0 5 2016	
	Resident #19's clinic	al record contained a "Report		DEG 0 3 2010	
	of Consultation" date	d 10/28/16 which read in		VDH/OLC	
	part "Chief complaint	: 1) Itching all over-2		4 DI II OLO	
	months. History of Pi	resent Illness: Patient			ļ
	presents today for ev	valuaton of a severely pruritic			

Event ID. T58V11

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUN `! SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC OMB NO. 0938-0391 SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 495338 B. WING 11/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREEIX DATE ROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION -TAG DEFICIENCY) 12/09/16 F 309 Continued From page 35 F 309 rash that has been occurring on her wrists and ankles and upper back for the past 2 months. Multiple family members have been diagnosed and treated for scabies. No prior treatment for scabies per patient. No other skin complaints. Patient lives at(name omitted). Physical exam: Burrows on wrists bilaterally. Few excoriations on the upper back. Assessment: "Scables". According to the Virginia Department of Health epidemiology fact sheet, scabies is a "disease of the skin caused by a mite. Scabies mites burrow into the skin, producing pimple-like irritations or burrows". Symptom of scabies include "intense itching, especially at night" with areas affected to include "wrists, elbows, armpits, waist, thighs....".

Surveyor spoke with the administrative team on 11/10/16 at approximately 1515 regarding Resident #19. Surveyor asked administrative team how soon after a request is made by a Resident to see the physician should the Resident be seen. The interim DON (director of nursing) stated when a Resident requests to be seen by the physician, they should be seen with 24 hours or as soon as is reasonably possible if request is made on weekend.

Surveyor requested and was provided with a copy of facility policy entitled "Residents Right" which read as follows:

"A. Residents Rights:

It is our belief that you as a Resident have the right to expect certain

standards of care and considerations while at our facility. You have the right to:

Expect reasonable responses to requests to services within our

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DEPARTMENT OF HEALTH AND HUNC'L SERVICES

PRINTED: 11/22/2016 FORM APPROVED

	DO COD MEDICADE	SERVICES SERVICES		1		. 0938-0391
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MIII	LTIPLE CONSTRUCTION	- 1	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DING		MPLETED
,						C
ĺ		495338	B. WING			10/2016
NAME OF	PRDVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ξ	
GRACE	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD		
GRACE				ABINGDON, VA 24210		
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFI	PRDVIDER'S PLAN OF CORRE IX (EACH CORRECTIVE ACTION SH		IX5) COMPLETION
PREFIX TAG		SCIDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP		
				DEFICIENCY)		
-						12/09/16
F 309	Continued From page	ge 36	, F 3	309		,
		pacity, our stated mission and				
	applicable law and r	egulation."				
	Surveyor snoke with	n the FNP (family nurse				
		016 at approximately 1730				
		#19. FNP stated the he				
		nt due to complaints of itching	<u></u>	and the second s		
		NP stated that Resident had				
		ae on both thighs. FNP stated				
		ourse's aide) told him that the prominent when Resident				
		ed that Resident was initially				
		for the itching. After 1 week,				
		more rash. FNP stated that				
		eeks, the Resident's rash				
		but no worse. FNP stated				
		Vistaril and triamcinolone				
		hat Resident had grandchild tive for scabies. FNP stated				
		did not look like scabies and				
	- T	cal director agreed, but sent				
		sult to be sure. Surveyor				ļ
		ident had not been seen by				
		and FNP stated that since				
	Resident has demer	ntia, he did not want to send				
	her out and disrupt h	ner regular routine. FNP				ļ
	=: :	he rash seemed better with				
	treatment.					
,	The concern of the d	lelay in treatment was				
1	discussed with the a-	dministrative staff during a		חביינייים		
	meeting on 11/10/16	at approximately 1515.		RECEIVED		
		and the interior DON		DEC 0.5 2016		
		ice, the interim DON		DEC 0.5 2016		
	providea ine surveyo	or with copies of physician's				Į.

progress notes which were not included in Resident's clinical record at time of surveyor review. These progress notes read in part: "9/12/16 Pt c rash R anterior thighs, tx

VDH/OLC

Facility ID: VA0061

DEPARTMENT OF HEALTH AND HUM : SERVICES CENTERS FOR MEDICARE & MEDIC SERVICES

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDIC> (SERVICES			<u>OMB NO. 0938-0391</u>
	IT OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETEO
		495338	B. WING	S	C 11/10/2016
NAME OF	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	
	HEALTHCARE OF AB	ilngdon		600 WALDEN ROAD ABINGDON, VA 24210	
	STAMMADV STA	ATEMENT OF OEFICIENCIES	10	PROVIOER'S PLAN OF CORRECTI	ION IX51
(X4) IO PREFIX	(EACH OEFICIENCY	Y MUST BE PRECEOEO BY FULL	PREF	IX (EACH CORRECTIVE ACTION SHOULD	LO BE COMPLETION
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO OEFICIENCY)	DPRIATE DATE
F 309	Continued From page	ge 37	F:	309	12/09/16
	(treatment) with Vis fu (follow up) 1 wee	staril for itching Plan: Observe, ek".			
	Assessment: Rash.	rash(writing illegible) (illegible) Plan:(illegible) ?			
	need for scraping."				· · · · · · ·
	No further informati	on was provided prior to exit.	<u> </u>		
		the facility staff failed to ished bowel protocol.			
	08/31/16. Diagnoses atrial fibrillation, cord hypertension, thyroid	olegia, seizure disorder,			
	an ARD (assessment coded the Resident a	DS (minimum data set) with nt reference date) of 09/07/16 as 14 out of 15 in section C, his is an admission MDS.			
,	11/09/16. It contained order summary) date	cal record was reviewed on ed a signed POS (physician's ed 10/31/16 which read in r-Give 17gm by mouth daily			
		e's (medication administration hs of September and October		RECEIVED	
	2016 were reviewed.	The MAR for September which read in part "Miralax		DEC 0 5 2016	
		by mouth daily". This entry			
		having been administered as		VDH/OLC	

ordered. The MAR for October contained an entry which read in part "Miralax Powder, Give 17gm by

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE

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CENTE	RS FOR MEDICARE	- & MEDIC - J SERVICES			<u>OMB NO. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495338	B. WING		C 11/1 0 /2016
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
			1	600 WALDEN ROAD	
GRACE	HEALTHCARE OF AB	INGDON		ABINGDON, VA 24210	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	(1.00)
PREFIX	-	' MUST BE PRECEDED BY FULL SCHDENTIFYING INFORMATION)	PREFI	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION PRIATE DATE
TAG	, MEGGEN OM GNE		170.	DEFICIENCY)	
F 309	Continued From pa	ge 38	F 3	09	12/09/16
	,	tinue date 10/17/16". This	, ,		
	entry had been sign				
		lered. The MAR for October			
		ntry which read in part			
		ve 17gm by mouth daily as			
		: 10/17/16. This entry had not			
	been signed as hav	ing been administered.		· · · · · · · · · · · · · · · · · · ·	
	Desident #10's sless	tronia record contained "DM			***************************************
		tronic record contained "BM			
		Record Roster" for the months october 2016. For the month			
	•	M roster indicated a period of			
		/16) and a period of 5 days			
		h no recorded BM for			
		e month of October, the BM			
	roster indicated a pe	riod of 5 days (10/25-			
	10/30/16) and a peri	od of 4 days (10/30-11/04/16)			
	with no recorded BM	l.			
		cal record also contained			
		Bowel Protocol" which read in			
		s-Please administer 30ml i.s. x 1 at bedtime. No BM x 3			
		ster Dulcolax suppository x 1			
		4 days-Please administer			
		bedtime. Bowel movement			
		e reviewed by the 2-11			
		ch unit and medication			
		iew of the BM record for			
6	each Resident. All la:	xatives will require			
(documentation on Ma	AR fro (sic) that Resident."			
				RECEIVED	
		ot locate any supporting			
		icate that the bowel protocol		DEC UE 3046	
ŀ	nad been instituted fo	n Kesideni #/.		DEC 0 5 2016	
٦	The concern of not fo	llowing the bowel protocol		VDH/OLC	

was discussed with the administrative team during a meeting on 11/09/16 at approximately

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

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDIC J SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
1				С
	495338	B. WING		11/10/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GRACE HEALTHCARE OF AB	INGDON	1	500 WALDEN ROAD ABINGDON, VA 24210	
				TION
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO	OULD BE COMPLETION
TAG REGULATORY OR L	SC-IDENTIFYING-INFORMATION)	TAG	GROSS-REFERENCED TO THE APPL DEFICIENCY)	GERIALE
				17/00 /
F 309 Continued From pa	ae 39	F 309		12/09/16
1410.	ge 55	1 303		
1410.				
No further informati	on was provided prior to exit.			
	i, the facility staff failed to			
	cations pyridium and motrin			!
as ordered by the p	nysician.			!
The record review r	evealed that Resident #16			tar. M.E. ada V.a. di e corè e come grappena dell'adiante e considera que l'accessive e consideration de l'accessive de l'acce
had been admitted t	to the facility 01/23/13.			
	, but were not limited to, end			
9	, diabetes, heart failure,			
anxiety, insomnia, a	nd hypothyroldism.			
Section C (cognitive	patterns) of the Residents			
quarterly MDS (mini	mum data set) assessment			
	sment reference date) of			
	BIMS (brief interview for			
points.	e of 14 out of a possible 15			
points.				
Resident #16's clinic	cal record included the			
following physician '				
	ium 100 mg 1 PO (by mouth)			
	72 hours for dysuria. For a			
total of 9 doses.	n 500 mg 1 TID (three times			
	ooth extraction. For a total of			
6 doses.				
	84018445-7-1		·	
	: #16's eMAR (electronic			
	ration records) indicated that byridium and 4 doses of the		RECEIVED	
motrin had been adn				ļ
			DEC 0 5 2016	
	oximately 8:25 a.m. the			
surveyor and the QA	(quality assurance nurse)		VDH/OLC	

reviewed the Residents pyridium and motrin orders. After reviewing the orders and eMAR the QA nurse verbalized to the surveyor that the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE

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CENTE	RS FOR MEDICARE	& MEDIC J SERVICES			OMB NO.	0938-039
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO	LTIPLE CONSTRUCTION DING	СОМІ	E SURVEY PLETED
		495338	B. WING	i	11/1	C 10/2016
NAME OF	PROVIOER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		10/2010
CDACE	HEALTHCARE OF AB	INCOON		600 WALOEN ROAO		
GRACE		INGDON		ABINGDON, VA 24210		
[X4) ID PREFIX ——TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC-IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
				DEFICIENCY)		
E 300	Continued From	10	- /		·	12/09/16
F 309	Continued From pa	ge 40 ceive enough doses of either	FS	309		
	medication.	ceive enough doses of either				
		identified by the surveyor the				
	Resident was out for be interviewed.	r dialysis and was unable to				
	be interviewed.					
		staff were notified of the above e survey team on 11/10/16 at p.m.				
		on regarding this issue was ey team prior to the exit				
	obtain treatment ord	the facility staff failed to ers for unstageable pressure ident was admitted to the				
	This was a closed re expired at the facility	cord review the Resident had				
i a (t a t i i	complaint. The facility investigation prior to an ailegation that the clicensed practical nursatment orders after admitted to the facility instageable pressure-e-educated the nurs	e on professional standards g appropriate treatments for		RECEIVED DEC 0 5 2016 VDH/OLC		
7	he record review re	vealed that Resident #23		4 10 1 11 2 2 2		

had been admitted to the facility 08/08/16. Diagnoses included, but were not limited to,

		AND HUMAN SERVICES		ſ	FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDIC SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495338	B. WING		C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē
GRACE	HEALTHCARE OF ABI	NGDON		600 WALDEN ROAD ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCHDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE COMPLETION
				DEFICIENCY)	
F 309		re ulcers, malignant	F 3	09	12/09/16
•	neoplasm of bronch disorder, and hyperf	us/lung, chronic pain, anxiety tension.			
		patterns) of the Residents nimum data set) assessment			
		sment reference date) of	· · · · · · · · · · · · · · · · · · ·		
	Resident had proble memory and was se skills for daily decision (functional status) had mobility indicating the extensive assistance this activity. Section coded to indicate the developing pressure unstageable deep tis. The Residents CCP included the problem breakdown R/T (relaincontinence. He recapited the was admitted with Approaches included "Provide treatments report s/s (signs/symmemory) and was set included the problem that the was admitted with Approaches included "Provide treatments report s/s (signs/symmemory) and was set included the problem that the was admitted with Approaches included the provide treatments report s/s (signs/symmemory).	in 1/1/3 to indicate the image with long and short term everely impaired in cognitive on making. Section G and been coded 3/2 for bed are Resident required are of two persons to perform M (skin conditions) was a Resident was at risk for all ulcers and had 6 as up pressure ulcers. (comprehensive care plan) in area "at risk for skin breakdown, arattress to bed and cushion to			
,	The Residents "Nurs	ing Admission Assessment" on 08/09/16 and had been	ļ	RECEIVED	
: i	signed by LPN #1. T included the following	his nursing assessment g-pressure ulcer of sacral		DEC 0 5 2016	
	buttock, unstageable	pressure ulcer of left pressure ulcer of right pressure ulcer of left heel,		VDH/OLC	

unstageable, pressure ulcer of left ankle,

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

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

CENTEROTORINE	C WILDION IID OLIVINOLO	-,			
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	ILTIPLE CONSTRUCTION DING	(X	(3) OATE SURVEY COMPLETEO
					С
	495338	B. WING	·		11/10/2016
NAME OF PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COO	DE	
			600 WALDEN ROAD		
GRACE HEALTHCARE OF AB	BINGDON		ABINGDON, VA 24210		İ
CHANG OF	ATEMENT OF OFFICIENCIES		PROVIOER'S PLAN OF CORR	ECTION	
(24)10	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL	. IO PREF			(X5) COMPLETION
	SC IOENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF	PROPRIA	TE DATE
			OEFICIENCY)		
					22/00/25
F 309 Continued From pa	age 42	F:	309		12/09/16
·	ure ulcer of other site,				
unstageable, press	are dieer of other site,				
unstageable.					
The clinical record :	also included wound				
	s dated 08/09/16 that identified				
the following.	s dated coreor to that identified				
	suspected DTI (deep tissue				
injury)-pressure ulc	er right bottom of foot. 4:0 cm				
length X 1.5 cm wid					
	suspected DTI pressure ulcer				
	2.5 cm length X 3.5 cm width.				
	suspected DTI pressure ulcer				
	3.5 cm length X 2.5 cm width.				
	suspected DTI pressure ulcer				Ì
	us. 3 cm length X 1 cm width.				
	suspected DTI pressure ulcer				
	s. 2.25 cm length X 1.5 cm				i
width.	Ũ				
	suspected DTI pressure ulcer				
coccyx. 1 cm length					
	suspected deep tissue injury				
	uttock. 3 cm length X 1.25 cm				
width.	-				
These wound asses	sments were electronically				
signed by LPN #10 a	and the previous DNS				
(director of nursing s	services).				
	eable and DTI from the				
National Pressure U	•				
http://www.npuap.org			DECEIVED		
Unstageable Pressu			RECEIVED		
	nd tissue loss. Full-thickness		DEC 4 - 0010		
• · · · · · · · · · · · · · · · · · · ·	in which the extent of tissue		DEC 0.5 2016		
	Icer cannot be confirmed				
	ed by slough or eschar. If		VDH/OLC		
slough or eschar is n 4 pressure injury will	emoved, a Stage 3 or Stage be revealed.				

Deep Tissue Pressure Injury: Persistent

Facility IO: VA0061

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **SERVICES** CENTERS FOR MEDICARE & MEDIC OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495338 B. WING 11/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY-OR-LSCHDENTIFYING-INFORMATION DEFICIENCY 12/09/16 F 309 Continued From page 43 F 309 non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly-pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue. subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible. this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. There were no treatments ordered when the Resident was admitted to the facility. The following treatments were obtained during the Residents stay at the facility (08/08-09/04/16) 08/09/16-Comfort Care 08/10/16-Betadine to both ankle wounds. Betadine to both heels and buttocks wound everyday. 08/18/16-Discontinue betadine to buttocks heels and ankles. Cleanse coccyx wound with normal

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DEC 0 5 2016

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VDH/OLC

a day.

saline pat dry. Pack with 1/4 strength dakins solution and cover with secondary dressing twice

08/18/16-Skin prep to right and left heel wounds

everyday may cover with secondary dressing if needed. Skin prep to right inner and outer ankle

08/18/16-Skin prep to left inner and outer ankle wounds may cover with secondary dressing for

wounds everyday may cover with secondary dressing if needed for skin protection.

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

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

CLIVILITOTOTIVILIBIOAN	L & MEDIO. J OLIVIOLO			OMB 140. 0000-0091
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETEO
				С
	495338	B. WINC	·	11/10/2016
NAME OF PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	
			600 WALDEN ROAD	
GRACE HEALTHCARE OF AE	BINGDON		ABINGDON, VA 24210	
(//-) 10	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL	IO PREF	PROVIOER'S PLAN OF CORRECT IX (EACH CORRECTIVE ACTION SHOU	11
	SCIDENTIFYING INFORMATION)	TAG		
			OEFICIENCY)	
F 309 Continued From pa	120 11	۲,	200	12/09/16
	=	۲,	309	, -, -
skin protection daily				
·	ectors to bilateral feet as			
resident will allow.				
	ss mattress to aid in			
prevention of skin b				
	to wounds to bilateral feet.			
	ondary dressing for skin			
protection everyday				
	to left hip discoloration. May			
	ry dressing for skin protection			
everyday.	Ad 1. fc l			
	to red area left lower leg. May			
	y dressing everyday for skin			
protection.				
	acral wound twice a day with			
	Crush 1 500 mg flagyl			
• • •	d sprinkle over wound at			
dressing change.				
se to a la final accessor de fin			•	
	cluded documentation by the			
	ted the Resident had multiple			
wounds that were ur				
•	ary to terminal illness and			
decreased nutrition.				
0 44/40/40 -1 -				
	oximately 12:45 p.m. the			
	LPN #1. LPN #1 was shown			
her electronic signat				
	ed why treatment orders			
	hen the Resident had been			1
	ated she did not remember		DEALIVED	
0 0	ent and stated this was the		RECEIVED	
	mpleted an admission and			
	d another nurse as this was		DEC 0.5 2016	
not her Resident. LP			-	
	n areas on admission that		VDH/OLC	
the areas were just re	ea.		A DI II OFO	

LPN #10 was not working during the course of

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC OMB NO. 0938-0391 SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ С B. WING 495338 11/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ΙD (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR ISCIDENTIFYING INFORMATION DEFICIENCY 12/09/16 F 309 Continued From page 45 F 309 the survey. The facility attempted to contact her via phone but was unsuccessful. The DNS that had signed off on the wound assessments was no longer employed at the facility and per the facility the investigation was completed by the previous administrator. The facility staff provided the surveyor with copies of their facility policies/procedures titled "Wound Care Management" and "Physician Orders." The policy title "Wound Care Management" read in part "Each resident receives the care and services necessary to retain or regain optimal skin integrity to the extent possible... Notify the charge nurse, physician and responsible party of the presence of the wound..." The policy titled "Physician Orders" read "Purpose Physician orders are obtained to provide a clear direction in the care of the resident..." The facility also provided the surveyor with a copy of their standard of practice in regards to wounds from "LIPPINCOTT Nursing Procedures (seventh edition)." This standard of practice included the following "... Consult with your facility's wound, continence, and ostomy nurse; nutritionist or registered dietician; and physician or occupational therapist as indicated, because pressure ulcer prevention requires a multidisciplinary approach...If left untreated, pressure ulcers may produce ischemia and local infection..."

On 11/10/16 at approximately 3:10 p.m. the administrative staff were made aware of the concerns regarding the absence of treatment orders for Resident #23.

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

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		AND HUMAN SERVICES		(FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDIO SERVICES		(OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
<u> </u>		495338	B. WING		C 11/10/2016
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
INAME OF	, no viben on oo Elen		1	600 WALDEN ROAD	
GRACE	HEALTHCARE OF AB	NGDON		AB(NGDON, VA 24210	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	
PREFIX	• -	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX	X (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP	
IAG	REGULATORT OR L	SCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)	TOT TOTAL
-					
					12/09/16
F 309	Continued From page	ge 46	F 30	09	
	conference.				
	THIS IS A COMPLA	INT DEFICIENCY.			
	E. The facility stoff t	isilad to follow the physician			
		ailed to follow the physician			
	ordered bowel proto	corror Resident #3.			
	Decident #2 was res	admitted to the facility-on			
	7/27/16 with the fell	owing diagnoses of, but not			
	limited to high blood				•
		n and osteoporosis. The			
		on the quarterly MDS with an			
		Reference Date) of 7/30/16 as			
		f Interview for Mental Status,			
		score of 5 out of a possible			
		nt #3 was also coded as			
	, 0	assistance of 1 staff member			
	for dressing and per	sonal hygiene.			
	 .	to decide a few forces			
		cted a chart review of			
		al record on 11/9/16. It was			
		r that on the Bowel report or			
		re was no bowel movements			
		linical record for the following			
		gh 10/5/16, 10/7/16 through			
		through 11/7/16. The			
		ed the standing orders for			
		The bowel protocol stated the			
	•	be followed by the nursing	•		
\$	staff:				
		novement) X (times) 2			
		ter 30 ml (milliliters) Milk of		RECEIVED	
Ŋ		night) X 1 at bedtime.			
	No BM X 3 days-	Please administer Dulcoloax		DEC A F GOIC	

DEC 0 5 2016

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enema X1 at bedtime.

suppository X1 at bedtime.

No BM X 4 days-Please administer Fleets

Bowel movement documentation will be

	MENT OF HEALTH	AND HUMAN SERVICES & MEDIO. SERVICES			PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495338	B. WING		11/10/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GRACE H	EALTHCARE OF AB	INGDON		600 WALOEN ROAD ABINGDON, VA 24210	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDEO BY FULL SCHOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUNDER) CROSS-REFERENGED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION
	BM record for each All laxatives will MAR (Medication Acresident. " The resident 's Mar dates were reviewed	ninistrated per review of the	F3		12/09/16
F 6 6 7 8 8 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	The administrative solutions of collowed for the above for the above for the above for the administrative solutions of the surveyor prior to the formation of the facility failed for the facility failed failed for the facility failed fail	on was provided to the exit conference on 11/10/16. to change a PICC elling Central Catheter) line ordered by the physician for eadmitted to the facility on ent had the following t limited to heart failure, high etes, quadriplegia, anxiety ohrenia. On the quarterly a Set) with an ARD		DECEWED.	
R Ir se	tesident #25 was conterview for Mental store of 0 out of a possident was also content was a	nce Date) of 7/29/16, oded as having a BIMS (Brief Status, an assessment tool) ossible score of 15. The ded as being totally ore staff members for		RECEIVED DEC 0 5 2016 VDH/OLC	

Facility ID: VA0061

personal hygiene and bathing. This resident was

investigation of a complaint in which the resident

added to the survey sample due to the

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDIC. SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495338 B. WING 11/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY-OR-LSC-IDENTIFYING-INFORMATION) TAG DEFICIENCY 12/09/16 F 309 Continued From page 48 F 309 was found to be in that the Office of Licensure and Certification obtained on 8/9/16 by an anonymous staff member. The surveyor reviewed the clinical record of Resident #25 on 11/10/16. The surveyor noted that on the monthly physician orders for August, 2016 the following order: "PICC line dressing change g (every) week ... " The surveyor also reviewed the Treatment Administration Record (TAR) for the month of August, 2016. It was noted that on 8/9/16 and 8/16/16, LPN #10 initialed these dates that indicated the PICC line dressing change for that date was performed. During investigation of this complaint, the QA (Quality Assurance) nurse #1 was interviewed on 11/10/16 at approximately 2:30 pm by the surveyor in the conference room. The QA nurse #1 was asked by the surveyor if she knew anything about an allegation of "wound care nurse not providing proper treatment " LPN #10. The QA nurse #1 stated "I know that I did staff education on proper documentation when providing wound care. I can go to my office and get the in service training that I did on this. " QA

The corporate nurse was interviewed by the surveyor on 11/10/16 at approximately 2:45 pm in the conference room. The surveyor notified the corporate nurse of the above documented allegation that was called into our office. The corporate nurse stated that there was a complaint called into the corporate hot line on this and

nurse #1 returned to the conference room with the sign in sheet and in service training that was

provided to the staff on 10/28/16.

stated "let me go and look into the

DEC 0 5 2016

VDH/OLC

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

PRINTED: 11/22/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARI	E & MEDIC) SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495338	B. WING		C 11/10/2016
NAME OF PROVIDER OR SUPPLIER	<u> </u>	.1	STREET ADDRESS, CITY, STATE, ZIP CODE	1177072010
MAME OF THOUBERON OUT EIER			600 WALDEN ROAD	
GRACE HEALTHCARE OF AE	INGDON		ABINGDON, VA 24210	
(Y4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ION IX51
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFD	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETION
JAG REGULATORY OR 1	SCIDENTIFYING INFORMATION)	IAG	CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	PRIAIT
E 200 Continued From po	200 40	F 3	00	12/09/16
F 309 Continued From pa	-	ГЗ	09	
	cerning this matter. " The QA			
	o the conference room at			
1.1	pm and stated "this is the			
	ne complaint that was called			
	ot line." The surveyor			
	nentation that was received			
	ne following documentation 18/16, it was brought to my			
	ent (name of resident)			
	ed her PICC line dressing was			
	(name of nurse)signed			
	change as being done and			
	6/16 (name of nurse)			
	and another nurse was going			
	ut the dressing was not			
	CC line was completed on			
	ment nurse immediately."			
0/10/10 by are a obt	none nated initioalisticity.			
The administrative s	staff was notified of the above			
documented finding				•
approximately 2:50				
, ,	'			
No further information	on was provided to the			
surveyor prior to the	exit conference on 11/10/16.			
- 0	VENOV			
COMPLAINT DEFIC				
	pass observation the facility			
staff failed to follow				
	edications for Resident #14.			
Resident #14 was a	dmitted to the facility on		RECEIVED	
	ted on 8/8/16. His diagnoses	'	The second of th	
	mited to high blood pressure,		DEC 0 5 2016	
	ebral infarction, sleep disorder		DEC 0.3 2010	
and depression			VDU/OLO	
Docidant #14'a minir	num data sot (MDS)		VDH/OLC	
	num data set (MDS) assessment reference date			

(ARD) of 10/4/16 assessed him to understand and could be understood. He was assessed to

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC OMB NO. 0938-0391 SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C B. WING 495338 11/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WALDEN ROAO GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES JX5J COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX OATE GROSS-REFERENCED TO THE APPROPRIATE-REGULATORY-OR-LSC-IDENT-IFYING-INFORMATION) DEFICIENCY) 12/09/16 F 309 Continued From page 50 F 309 have as cognitive status of 12 out of 15. His assessment revealed in section G, he needed assistance with daily activities of living. On 11/9/16 starting at 7:51a.m., the surveyor observed LPN #1 administer Resident #14 's morning medications. During the medication pass the LPN#1 administered Calcium 500 mg one-by mouth. The surveyor observed the bottle that the medication came from; it read calcium 500 mg. During physician order and medication administration review the surveyor noted that the calcium order read as follows: Calcium 500 mg +vitamin D 200, take one twice daily. LPN #1 administered Calcium 500 mg. The surveyor returned to the medication cart and asked LPN #1 to look at the Calcium bottle and the order. She stated "I thought it had vitamin D2 in it." On 11/9/16 at 3:55 pm, the surveyor discussed the above medication pass observance with the administrator, director of nurses and other administrative staff. Prior to exit, no further information was provided by the facility staff related to the medication error.

8. For Resident #5 the facility staff failed to follow physician orders for administration of her multiple vitamin.

Resident #5 was admitted to the facility 3/17/06 and readmitted on 8/29/16 with diagnoses that included but not limited to high blood pressure, thyroid disorder, heart failure, esophageal reflux disorder, depression, and manic depression.

DEC 0 5 2016 VDH/OLC

Facility ID: VA0061

	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES E& MEDIO SERVICES			(RINTED: 11/22/2016 FORM APPROVED MB NO. 0938-0391
STATEME	NT OF OEFICIENCIES I OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MU A. BUILO		CONSTRUCTION		(X3) OATE SURVEY COMPLETEO
		495338	B. WING				C 11/10/2016
NAME O	PROVIOER OR SUPPLIER	<u></u>	<u> </u>	ST	REET AOORESS, CITY, STATE, ZIP	COOE	
GRACE	HEALTHCARE OF AB	INGDON			0 WALDEN ROAD		
ONAGE				Al	BINGDON, VA 24210		
(X4) IO PREFIX		TEMENT OF OEFICIENCIES 'MUST BE PRECEOEO BY FULL	IO PREF	X	PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTIO		BE COMPLÉTION
TAG-	REGULATORY.OR.LS	SCIDENTIFYING INFORMATION).	TAG		CROSS-REFERENCED TO THE OFFICIENCY)		IATE OATE
F 309	. Continued From page	ge 51	F3	309			12/09/16
	•	t #5's clinical record revealed					
		minimum data set (MDS) with					
		rence date of 8/10/16, the					
		ed the resident to understand derstood. She was assessed					
		summary score of 03.					
	J						
		#5 's physician 's orders-					
		n order for a multiple vitamin itamin was ordered on					
		Multiple Vitamin W-Minerals					
	TB -give 1 tablet by	mouth daily x 45 days. The					
		on 9/28/16, the discontinue					
		The medication was not given					
	for the entire 45 day	5.					
	On 11/8/16 at 3:35 p	om, the quality assurance					
		as asked why the vitamin had					
		full 45 days as ordered.					
	_	she said " I don ' t see a vill check why it wasn ' t					
		the surveyor "someone has					
	stopped the vitamin						
		m, the surveyor discussed					
		n error with the administrator, dother administrative staff.					
	director of flarses an	d otter dammer dave statt.					
		er information was provided					
		ated to the medication error.					
		NUTRITION STATUS	F 3	25	RECEIVED		
SS=D	UNLESS UNAVOIDA	NDLE					
	Based on a resident's	s comprehensive			DEC 0 5 2016		
		ity must ensure that a			MDIMO: -		
	resident -				VDH/OLC		
		ble parameters of nutritional weight and protein levels,					

		I AND HUMAN SERVICES 8 MEDIQ D SERVICES		7	FURM APPROVED OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVI, JSUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ILTIPLE CONSTRUCT	(X3) DATE SURVEY COMPLETED
		495338	B. WING	S	C 11/10/2016
ALANTE OF	PRDVIDER OR SUPPLIER		٠	STREET ADDRESS, CITY, STATE, ZIP	CODE
				600 WALDEN ROAD	
GRACE	HEALTHCARE OF AB	INGDON		ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE COMPLETION IE APPROPRIATE OATE
			-		12/09/16
F 325	Continued From pa	ge 52	F;	325	
	unless the resident			1. For resident #15 th	e facility provides the
		his is not possible; and		nutritional supplemen	nt as ordered by the
	(2) Receives a ther	apeutic diet when there is a		physician.	
	nutritional problem.			The Administrator cor	ntacted the resident
				#15's son on 11/28/1	6. Reimbursement of the
				supplement was offer	red to the son.
	This REQUIREMEN	IT is not met as evidenced		2 The Interim Directo	or of Nursing completed n 11/16/16 of physician
	by:	7. 13 1101 11.01 35 5 11.00 1.00 5		a facility wide audit o	5. The Dietary Director
	Based on resident	interview, staff interview,		orgereg supplements	vide audit on 11/18/16
	clinical record revie	w and in the course of a		of physician ordered	supplements. The
	complaint investigation	ion, the facility staff failed to		facility provides all su	ipplements ordered by
	provide nutritional s	upplements as ordered by the		the physician. No oth	ner residents were
	physician for 1 of 2t	residents. (Resident #15)		identified to be affec	ted by the alleged
	The findings include	od:		deficient practice.	
	The illidings include	.u.		On 11/15/16 the Cer	stral Supply staff
	Resident #15 was a	dmitted to the facility on		inventoried the stock	k of Ensure.
	7/4/16 with the follow	wing diagnoses of, but not			
	limited to high blood	pressure, diabetes, arthritis,			ere in-serviced the facility
	chronic obstructive	oulmonary disease, chronic			ying for and providing
	pain and muscle we	akness. On the admission		physician ordered su	ipplements.
	MDS (Minimum Dat	a Set) with an ARD		3. The Administrator	in-serviced the Central
	(Assessment Refer	ence Date) of 7/11/16, oded as having a BIMS (Brief		Supply staff membe	r on 11/22/16 regarding
	totomiew for Mental	Status, an assessment tool)		appropriate stock of	
	score was 15 out of	a possible score of 15. The			
	resident was also co	ded as requiring extensive		The Dietary Director	/designee will audit that
	assistance of 1 staff	member for personal			tritional supplements as x 4 weeks, 3 residents x 4
	hygiene and bathing			ordered 5 residents weeks, and then 1 r	
		- I Dil /I inner d Densie d		·	
4	On 11/9/16 at 8:30 a	m, LPN (Licensed Practical		The Central Supply	staff member/designee
	Nurse) #1 asked to :	speak to the surveyor. LPN mily of (name of		will audit the Ensure	e for adequate availability
ī	rocident #15) has to	buy the Ensure for the		of supplements 5 x	a week x 4 weeks, 3 x
	resident to have. Th	e son told me that the		week x 4 weeks, and	d then 1 x week x 4 weeks.
	nursing home told hi	m that they could not provide			

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it for his mother and he was upset because this is

Event ID: T58V11 RECEIVED

If continuation sheet Page 53 of 70

		I AND HUMAN SERVICES				KIVI AFFRUVED NO. 0938-0391
STATEMEN	RS FOR MEDICARE T OF OFFICIENCIES OF CORRECTION	(X1) PROVID SUPPLIERICLIA IOENTIFICATION NUMBER:	ſ	LTIPLE CONSTRUCTIO	(X3) (OATE SURVEY COMPLETEO
		495338	B. WING			11/10/2016
NAME OF	PROVIOER OR SUPPLIER		1	STREET AOORESS, CITY, STATE, ZIP	COOE	
CDACE	HEALTHCARE OF ABI	INGDON		600 WALDEN ROAD		
GRACE				ABINGDON, VA 24210	OBBECTION	
(X4) IO PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		ON SHOULO BE E APPROPRIATE	COMPLETION DATE
		and the second s			and the second s	
F 325	Continued From page		F;	325		12/09/16
	very expensive for h	nim to buy. "		4. The Dietary Directo		
	1 DN #2 was intervie	ewed by the surveyor at 9:20		findings to the month		
	am. The surveyor a	asked LPN #2 if she had ever		Performance Improve		
	card for Resident #1	15 IPN #2 stated "Yes, I		months or until subst achieved. The QAPI C		
	have. " The survey	or asked LPN #2 who		not limited to the Me		ues but is
	supplied the Ensure	for the resident to have.		Administrator, Direct		ocial
	LPN #2 stated Lre	emember that the resident got for 3 days then the resident		Services Director, Act	ivities Director,	<u> </u>
	received Mighty Sha	akes. The resident didn't like		Maintenance Directo	r, MDS Coordin	iator,
	them and she reque	sted that she have Ensure. I		Admissions/Marketin		
	know the son brings	in the Ensure for the resident		HR Director, and Busi	iness Office Mar	nager.
	and places it in the r	refrigerator for us to give to		4. The Central Supply	staff, member /	/designee
		ow if he was told by the facility		will report audit findi	ings to the mont	thly Quality
	to do this. "			Assurance and Perform		
	On 11/10/16 at 8:45	am, the resident was		Committee x 3 mont		
	interviewed by the si	urveyor and the resident		compliance is achiev includes but is not lir		
	stated " My family is	s having to but the Ensure for		Director, Administrat		
	me to drink. The nu	rsing home doesn't provide pensive for my family to buy.		Social Services Direct		
	They keen it in the re	efrigerator for me and all I do		Maintenance Directo		
	is to ask for it and th	ey will bring it to me. "		Admissions/Marketii		
				HR Director, and Bus	iness Office Ma	nager.
		t #15 's clinical record was				
	performed by the sui	rveyor on 11/10/16. The ysician order for "Ensure			-	
	surveyor noted a priy twico daily ner reside	ent request " dated for				
	10/27/16 The surve	eyor reviewed the MAR				
ı	(Medication Administ	tration Record) for				
•	November, 2016. O	n this MAR, it was noted that		RECEIVED		
•	'Ensure twice daily f	per resident request " with				
1	he times of " 12.00 this to be administrat	pm and 5:00 pm "listed for ted to the resident. From		DEC 0 5 2016		
•	11/1/16 through 11/9/	/16 a nurse has initialed that		VOLUCIO		
t	he Ensure was admi	inistrated to the resident at		VDH/OLC		
	12:00 nm and 5:00 p.	m for each day.				j

The director of nursing and administrator that

DEPARTMENT OF HEALTH AND HUY 'SERVICES

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CENTERS FOR MEDICARE	= & MEDICA SERVICES		<u>(</u>	<u> </u>	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	495338	B. WING			C 11/10/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	111/10/2010
			600 WALDEN ROAD		
GRACE HEALTHCARE OF AB	BINGDON		ABINGDON, VA 24210		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPI	BE COMPLETION
F 325 Continued From pa	nge 54	F 3	25		12/09/16
-	at the time that the Ensure had	1 3	20		
	o longer employed at the				
facility. The corpora	ate nurse was interviewed on				
11/10/16 at 10:15 a	m by the surveyor. The				
	corporate nurse if Ensure was				
	ent who is responsible for that for the resident. The				
corporate nurse sta	ited "The facility is				
	ide the Ensure to the resident				
if the physician orde	ered for the resident to have it.				
	ked if the facility was paying or				
	r Resident #15 because				
	d on 10/27/16 by the porate nurse stated "The			•	
	de this for the resident. " The				
	e corporate nurse that during				
	the resident reported that the				
	oought by her family and put in				
the refrigerator for h	ner to have. The surveyor also				
notified the corpora	te nurse that during a staff				
interview the staff m	nember stated that the family				
was upset because	they had to buy Ensure for his e corporate nurse stated "I				
	e family was buying the				
Ensure for the resid this. "	ent. I will have to look into				
The dietary manage surveyor on 11/10/1	er was interviewed by the 6 at 10:30 am in the				

conference room. The dietary manager was asked by the surveyor if the facility had Ensure to give to residents when it had been ordered by the physician for the resident to have. The dietary manager stated "Yes". The dietary manage asked the surveyor if there had been a problem. The dietary manager was notified of the above documented findings regarding Ensure being bought by Resident #15's family for the resident to have. The dietary manager stated " Let me go

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Facility ID: VA0061

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUM! `' SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC. OMB NO. 0938-0391 SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ С 495338 B. WING 11/10/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER DR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION $\{X5\}$ ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX OATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 12/09/16 F 325 Continued From page 55 F 325 back to my office and see what we have down for this resident as far as any supplements that have been ordered. The dietary manager returned to the conference room and stated, "I have her down on the list to receive Ensure twice a day. " The surveyor asked who was responsible for paying or providing the Ensure to the resident. The dietary manager stated "If the physician has ordered for the resident to have it then the facility provides it for the resident. " The administrative staff was notified of the above documented findings on 11/10/16 at approximately 3:15 pm. No further information was provided to the surveyor prior to the exit conference on 11/10/16. COMPLAINT DEFICIENCY F 431 F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug

records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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DEPAR	CHAICINI OL LICATII	& MEDICA SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES	(X1) PROVID UPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTIO	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED
					C
		495338	B. WING		11/10/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	t e
CDACE	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD	
GRACE	HEALTHOAKE OF AB			ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION PROPRIATE DATE
		e version and the first of the contract of the		and the second of the second o	12/00/- 0
~ 404	0 1 15 15 15		F 4	21	12/09/16
F 431		_	r 4.	ט ו 1. No residents were cited	for this alleged
	In accordance with	State and Federal laws, the		deficient practice. The unla	
	facility must store a	II drugs and biologicals in Its under proper temperature.		was disposed by the licens	
	controls and permit	t only authorized personnel to		11/8/16.	
	have access to the				
	have access to me	,		2. On 11/15/16 the Interim	-
	The facility must-pro	ovide separately locked,		conducted an audit of med refrigerators for multi-use	
	permanently affixed	compartments for storage of		rerrigerators for moin-use vial was identified and disp	
	controlled drugs list	ed in Schedule II of the		- VIGH WES IN CHAINED DID COS	
	Comprehensive Dru	ig Abuse Prevention and and and other drugs subject to		The Director of Nursing	in-serviced licensed
	Control Act of 1976	the facility uses single unit		nursing staff on 11/28/16	regarding the
	nackane drug distrit	oution systems in which the		labeling of multi-use vials.	
	quantity stored is mi	inimal and a missing dose can		The Director of Nursing/de	signee will audit the
	be readily detected.	<u> </u>		medication rooms and refr	igerators 5 x per
	•			week x 4 weeks, 3 x per we	
				then 1 x per week x 4 week	KS.
	TI DECLUDEMEN	IT is not met as evidenced		4. The Director of Nursing/	designee will report
		IT is not met as evidenced		audit findings to the month	
	by: Resed on observati	on, staff interview and facility		and Performance Improve	
	document review, th	e facility staff failed to label a		months or until substantia	
	multi-use vial of flu v	raccine in the medication		achieved. The QAPI Comm	ittee includes but is
	room on Unit 2 of the	e facility.		not limited to the Medical	
				Administrator, Director of	
	The findings include	. •		Services Director, Activities	
		and the familiar on 11/9/16 of		Maintenance Director, Mi	
	During the initial toul	r of the facility on 11/8/16 at yor went into the medication		Admissions/Marketing Director, HR Director, and	
	room on Unit 2 In I	nis medication room, in the		Manager.	BOSITESS OTTICE
	refrigerator the surv	eyor observed a multi-use		Wallaget.	
	via! Flu vaccine that	was open but was not			
	labeled with an open	date. LPN (Licensed	B	ECEIVED	
	Practical Nurse) #10	was with the surveyor when	8 L		
	this observation was	made. LPN #10 stated "	r	DEC 0 5 2016	
•	We are to write the o	late we open the vial on it. "			
	0- 11/0/16 0+ 0 0-	the director of nursing (DON)	1	/DH/OLC	
	Un thorto at 2 pm,	pove documented findings.	*		

Facility ID VA0061

		AND HUMAN SERVICES			FUKIM APPKUVED OMB NO. 0938-0391
CTATEMEN	ERS FOR MEDICARE NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE SUPPLIER/CLIA IDENTIFICATION NUMBER.	1 ' '	TIPLE CONSTRUCTIO	(X3) OATE SURVEY COMPLETEO
		495338	B. WING		C . 11/10/2016
NAME OF	PROVIDER OR SUPPLIER	493336		STREET AOORESS, CITY, STATE, ZIP	
	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD ABINGDON, VA 24210	
(X4) IO PREFIX TAG	(FACH OFFICIENC)	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCEO TO THI DEFICIENCY)	ON SHOULO BE COMPLETION EAPPROPRIATE DATE
F 431	policy concerning la they were opened. At 2:30 pm, the DO	If the DON for a copy of the abeling multi-use vials when N returned to the surveyor	F 4	31	12/09/16
	Ampules of Injectal	olicy titled "Vials and ble Medications": Under the es." the policy states the			
	expiration date that The date opened and date are both impormultidose vialsAt must be recorded On 11/9/10 at approadministrative staff documented finding	eximately 3 pm, the was notified of the above s.			~
F 441 SS=D	surveyor prior to the	on was provided to the exit conference on 11/10/16. CONTROL, PREVENT	F 4	41	
	Infection Control Prosafe, sanitary and control prevent the confidence of disease and infection Control. The facility must est Program under which (1) Investigates, continuing the facility;	Program ablish an Infection Control h it - trols, and prevents infections		practice. 3. A facility wide skin sv 12/2/16 by the Director and Unit Managers to a issues. No other resider	we ice on Unit 1 have the I by the alleged deficient weep was complete Ir of Nursing, QA nurse, assess for dermatology
	(2) Decides what proshould be applied to	ocedures, such as isolation, an individual resident; and rd of incidents and corrective		affected.	If continuation sheet Page 58 of 70

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			FURM APPRUVED OMB NO. 0938-0391
CENTE	RS FOR MEDICARE	& MEDICA SERVICES	,		
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION.	(X3) DATE SÚRVEY COMPLETED
					C 11/10/2016
		495338	B. WING		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	t
CDACE	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD	
GRACE	HEALTHCARL OF AD			ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE ACTION SI	OULD BE COMPLETION PROPRIATE OATE
					12/09/16
F 441	Continued From pa	age 58	F٠	441	7 - 07 20
1 4-1	actions related to in			The hospitality aide is no l	onger employee at
	(b) Preventing Spre	ead of Infection			
	(1) When the Infect	ion Control Program		The DON in-serviced nurs	ing staff on 11/28/16
	determines that a re	esident needs isolation to		regarding passing ice and	dermatology issues.
	prevent the spread	of infection, the facility must		The QA Nurse/designee w	vill complete skin
	isolate the resident.			sweeps to identify derma	tology issues S
	(2) The facility must	prohibit employees with a		residents x 4 weeks, 3 res	idents x 4 weeks, and
	communicable dise	ase or infected skin lesions		1 resident x 4 weeks.	
	from direct contact direct contact will tra	with residents or their food, if			
	direct contact will the	require staff to wash their		The Director of Nursing/c	lesignee will audit
	hands after each di	rect resident contact for which		passing ice 3 x per week s	(4 weeks, 1 x per
	hand washing is inc	licated by accepted		week x 3 weeks, 3 x per v then 1 x per week x 1 we	
	professional practic			then 1 x per week x 1 we	CK.
	provide a provid			4. The Director of Nursing.	/designee will report
	(c) Linens			audit findings to the mont	hly Quality Assurance
	Personnel must har	ndle, store, process and		and Performance Improve	ment Committee x 3
		as to prevent the spread of		months or until substantia	
	infection.			achieved. The QAPI Comm	nittee includes but is
				not limited to the Medica	
				Administrator, Director of	
	This DECLUREMEN	IT is not met as evidenced		Services Director, Activitie	
		(1 13 Het Met 23 evideness		Maintenance Director, M	DS Coordinator,
	by: Resed on observati	ion, staff interview, facility		Admissions/Marketing Di	
	document review. a	nd clinical record review, the		Director, HR Director, and	Business Office
	facility staff failed to	maintain an effective		Manager.	
	infection control pro	gram on 1 of 2 units (unit 1)			
	and for 1 of 25 Resi	dents, Resident #19.			
	The findings include			RECEIVED	
	-				
	 When passing ice 	e on unit 1 (side 1) the facility		DEC 0.5 2016	
:	staff placed the ice s	scoop into the ice chest with			
1	the handle touching unattended and ope	the ice and left the ice chest n.		VDH/OLC	
		oximately 8:00 a.m. the			

FORM APPROVED

DEPARTMENT OF HEAL	TH AND HUMAN SERVICES			FORM APPRO	
CENTERS FOR MEDICA	RE & MEDI() SERVICES		(The second sec	OMB NO. 0938-0	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495338	B. WING		11/10/2016	i
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GRACE HEALTHCARE OF	ABINGDON		600 WALDEN ROAD ABINGDON, VA 24210		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLET	
hallway on unit 1. nearby this ice ch inside the chest th	d an open ice chest in the There was no staff person est. When the surveyor looked ney were able to observe ice that was lying on top of the ice	F 4	41	12/ 0 9/:	16
chest the surveyo the lid open with taide verbalized to forgotten she had not usually leave to the control nurse. Whe leave the ice scoothe chest open the No, the ice chest seemed to the chest open the chest open the chest seemed to the chest open the chest seemed to the chest seemed to the chest open the chest open the chest seemed to the ches	r asked them if they usually left ne scoop inside. The hospitality the surveyor that she had left the chest open and she did he ice scoop in the cooler. proximately 8:40 a.m. the ed the designated infection en asked if the staff should p on top of the ice and the lid to infection control nurse stated hould have been closed and ald have been placed in the				
above issue during team on 11/09/16 a The facility policy/p Prevention and Co "This facility has de infection prevention provides a safe, sa environment to help transmission of infe	staff were made aware of the a meeting with the survey and again on 11/10/16. rocedure titled "Infection netrol Program" read in part eveloped and maintains an and control program that enitary, and comfortable of prevent the development and ection"		RECEIVED DEC 0 5 2016 VDH/OLC		

conference.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARE

PRINTED: 11/22/2016 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICAR	E & MEDIL D SERVICES		<u>DMB NO. 0938-0391</u>
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING	(X3) OATE SURVEY COMPLETED
			С
	495338	B. WING	11/10/2016
NAME OF PROVIOER OR SUPPLIER	:	STREET AOORESS, CITY, STATE, ZIP COOE	
GRACE HEALTHCARE OF A	BINGDON	600 WALDEN ROAD ABINGDON, VA 24210	
(X4) IO SUMMARY ST.	ATEMENT OF OFFICIENCIES	IO PROVIDER'S PLAN OF CORRECTION)N (VE)
PREFIX (EACH OEFICIENC	Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL	O BE COMPLETION
		ber lotenery	
F 441 Continued From pa	age 60	F 441	12/09/16
·	failed to include the	F 44 I	
	ease, scabies, on the facility		
	g. Scabies affected Resident		
#19.			
Resident #19 was	admitted to the facility on		
	mitted on 10/14/16. Diagnoses		
included but not lim	nted to Alzheimer's disease,		
	hizophrenia, insomnia,		
constipation and co	non cancer.		
The most recent M	DS (minimum data set) with		
an ARD (assessme	ent reference date) of 10/21/16		
	as 2 out of 15 in section C		
cognitive patterns.	This is a quarterly MDS.		
Surveyor reviewed t	the facility "Infection Log" for		
	er. Resident #19's case of		
scabies was not fou	nd on the log.		
Surveyor spoke with	n the infection control nurse		İ
	oximately 1030. Surveyor		
	control nurse if scables was		
_	tion and infection control		
	vas. Surveyor asked infection		
	dent #19's case of scabies cluded on the infection		
	stated she had only been told		
	the infection control log.		}
	and was provided with a copy Prevention and Control	RECEIVED	
	ch read in part "This facility]
	maintains an infection	DEC 0.5 2016	
prevention and contr	ol program that provides a		
	omfortable environment to	VDH/OLC	
	elopment and transmission	• —	
	gram will: Maintain records ective actions related to		
J. 1			

		AND HUMAN SERVICES & MEDICA/^ SERVICES		/·	OMB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE JPPLIER/CLIA IDENTIFICATION NUMBER:	3	TIPLE CONSTRUCTION	(X3) DATE SURVEY CDMPLETED
		}			С
		495338	B. WING		11/10/2016
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
GRACE	HEALTHCARE OF AB	INGDON		600 WALDEN ROAD ABINGDON, VA 24210	
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)————————————————————————————————————	OULD BE COMPLETION ROPRIATE DATE
					12/00/16
F 441	Continued From pa	ge 61	F 4	41	12/09/16
	infection prevention	_			
	inicotion provention				
	The issue of not inc	luding scabies on the infection			
	control log was disc	ussed with the administrative			
	team during a meet	ing on 11/10/16 at			
	approximately 1515				
				and the second s	
		on provided prior to exit.			<u> </u>
F 502	483.75(j)(1) ADMIN	ISTRATION	F 50)2	
SS=D		the second second second			
	The facility must pro	ovide or obtain laboratory		1. Resident #1 physician not	
		e needs of its residents. The e for the quality and timeliness		being complete as ordered	
	of the services.	e lor the quality and time iness		order received 11/10/16 by	the licensed nurse.
	Of the services.			Resident #15 physician noti	fication of labs not
				being complete as ordered	
		T is not met as evidenced		order received 11/10/16 by	
	by: Based on staff inter	view and clinical record		2. A facility wide audit was o	completed on
	review the facility st	aff failed to obtain physician		11/22/2016 by the Interim	Director of Nursing
	ordered laboratory to	ests for 2 of 25 residents,		and Director of Nursing for	the past 3 months
	Residents #5, #15.			beginning September 2016.	Residents identified
				received clarification orders	from the physician.
	The finding included			- c - 111 114 114 114	· · · · · · · · · · · · · · · · · · ·
				A facility wide lab audit was	
	1. The facility staff fa	illed to obtain physician		12/2/2016 by the Director of	
	ordered laboratory to	ests a CBC (complete blood		and Unit Manager to ensur physician order is complete	
	count) and CMP (cor	mprehensive metabolic		physician order is complete dosage, route, and frequen	
	panel) lab test for Re	esident #5.		dosage, route, and frequent identified received clarificat	
	Resident #5 was adr	mitted to the facility 3/17/06			don orders not title
	and readmitted on 8/	29/16 with diagnoses that		physician.	

The Director of Nursing in-serviced licensed nursing staff on 11/28/16 regarding obtaining labs as ordered by the physician. Education included the lab process and procedure.

Event ID: T58VRECEIVED A0061

VDH/OLC

If continuation sheet Page 62 of 70

DEC 0 5 2016

included but not limited to high blood pressure,

disorder, depression, and manic depression.

thyroid disorder, heart failure, esophageal reflux

A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 8/10/16, the

CENTERS FO	R MEDICARI	E & MEDICAID	SERVICES				<u> </u>	MR NO. 0938-038
STATEMENT OF DEF	ICIENCIES	(X1) PROVID	UPPLIER/CLIA ON NUMBER:		TIPLE CONS		JX3) DATE SURVEY COMPLETED	
		10	95338	B. WING	•			C 11/10/2016
	D OD CHRRHED	43		B. Willo	STREET	ADDRESS, CITY, STAT	E ZIP CODE	1 1//10/2010
NAME OF PROVIDE	R OR SUPPLIER			ŀ		DEN ROAD	2.2. 3001	
GRACE HEALTI	HCARE OF AE	BINGDON				OON, VA 24210		
	ACH DEFICIENC	ATEMENT OF DEFI Y MUST BE PRECE SC IDENTIFYING I	DED BY FULL	ID PREFIX TAG	C	PROVIDER'S PLAN JEACH CORRECTIVE ROSS-REFERENCED DEFICII	ACTION SHOULE TO THE APPROP) BE COMPLETIO
		and the second second				V= . =		12/09/16
F 502 Contir	nued From pa	ige 62		F 5	02			
			t to understand			The Discount of A	Luccina (dociano	o will audit lab
	,		e was assessed			The Director of Norders 5 x per we		
to hav	e a cognitive	summary scor	e of 03.			weeks, and then		
On 11	/8/16 a revie	w of Resident	#5's clinical					
		it the physician						nee will report audit
		a CBC and CN				findings to the m		
	- 1							mittee x:3 months
			in Resident #5's					s achieved. The QAPI mited to the Medical
		aled no results	for the					r of Nursing, Social
labora	tory test.							ctor, Maintenance
On 11:	8/16 at 3:35 i	om, the quality	assurance					missions/Marketing
		as asked to as				Director, Dietary	Director, HR D	irector, and Business
locatin		lab test. She	said she would	•		Office Manager.		
admini	strator, and c	a meeting with lirector of nurs sing CBC and						
		pm the QA nu sn't there it's	rse informed s a missed lab.					
was ag	exit on 11/10 ain discussed actor of nurse	0/16, the above d with the adm s.	e information inistrator and					
2. The	facility staff f	ailed to obtain	physician					
ordered	l labs for Res	ident #15.			REC	EIVED		
Reside [,]	nt #15 was ad	dmitted to the	facility on					
7/4/16 v	vith the follov	ving diagnoses	of, but not		DEC	0 5 2016		
limited t	to high blood	pressure, diab	oetes, arthritis,		3 / -			
pain an MDS (M	d muscle wea Iinimum Data	oulmonary dise akness. On th a Set) with an A nce Date) of 7	e admission ARD		VDł	H/OLC		
(7.33035 RM CMS-2587(D2-99) P			Event ID: T58V11		Facility ID: V/	A0061	If continuat	ion sheet Page 63 of

	ARTMENT OF HEALTH	I AND HUMAN SERVICES 8 MEDI SERVICES		Ć.	FO	ED: 11/22/2016 RM APPROVED NO. 0938-0391
_	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING	(X3)	DATE SURVEY COMPLETED
		495338	B. WING	3		C 11/10/2016
	DF PROVIDER OR SUPPLIER E HEALTHCARE OF AB	INGDON		STREET ADDRESS, CITY, STATE, 2 600 WALDEN ROAD ABINGDON, VA 24210		
(X4) IE PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	IXSI COMPLETION DATE
F 50	Interview for Mental score was 15 out of resident was also co assistance of 1 staff hygiene and bathing During the clinical re	oded as having a BIMS (Brief Status, an assessment tool) a possible score of 15. The oded as requiring extensive member for personal .	F	502		12/09/16
	10/12/16 which state on 10/17/16 ". The electronic record as record and could not physician ordered late. The director of nursing documented findings.	ng was notified of the above at 2:30 pm on 11/10/16. 5 pm, the surveyor was		•		
	dated for 11/10/16 at Labs that were ordere Sed Rate was not ob At approximately 3:15	5 pm in the conference ive staff was notified of the				
F 514 SS=D	483.75(I)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practice	exit conference on 11/10/16. TE/ACCURATE/ACCESSIB tain clinical records on each ewith accepted professional	F 51	PECEIVED DEC 0.5 2016 VDH/OLC		

		AND HUMAN SERVICES			•	Ω	FURM APPRUVED MB NO. 0938-0391
CENTE	RS FOR MEDICARE	& MEDICA' SERVICES	~				T
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVID UPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		NSTRUCTIO((X3) DATE SURVEY COMPLETED
		495338	B. WING				C 11/10/2016
	<u> </u>	493330			T ADDRESS, CITY, STATE, ZIP CO	DE.	11/10/2010
NAME OF	PROVIDER OR SUPPLIER				ALDEN ROAD	DL	
GRACE	HEALTHCARE OF AB	INGDON			GDON, VA 24210		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD	BE COMPLETION
							12/09/16
F 514	Continued From page	ge 64	F 51	14			
	systematically organ	nized.			1. Resident #7 assessed o	n 11/1	0/16 by a
					licensed nurse and found	to be s	stable with no
		nust contain sufficient			negative outcome as a re		
		fy the resident; a record of the			deficient practice. The bo	wel pr	otocol is
		ents; the plan of care and			currently in place.		
	services provided; the	ning conducted by the State:			For resident #1 a progres	s.note.	was provided
	and progress notes.		*.		1/15/16. The resident ha		
	and progress mores.				the facility.	0 0 11 14 - 1	
	This REQUIREMEN	T is not met as evidenced			A facility wide bowel n		
	by:				complete on 12/2/16 by		
		interview, staff interview,			QA nurse, and Unit Mana		
		v and facility document review			identified to need the bo		ovement protocol
		d to ensure a complete and 2 of 25 Residents, Residents			were placed on the progr		
	#7 and #1.				A facility wide audit of pr		
					complete on 11/30/16 by Director. There were no		
	The findings include	d:			identified of the alleged		
	4. F. (Decident #7. t	he facility stoff failed to			identified of the alleged	ucricic	nt proctice.
		he facility staff failed to umentation of bowel			3. The Director of Nursin	g in-se	rviced nursing
	ensure accurate doc movements.	Untertiation of bower			staff 11/28/16 regarding		
	movements.				documentation of the Bo	wel Pr	otocol.
	Resident #7 was adr	mitted to the facility on			The Administrator in-ser	viced t	ha Madical
ĺ	09/17/13 and readmi	itted on 07/15/15. Diagnoses			Records Director 11/28/		
i	included but not limit	ed to hypertension, anxiety,			notes in the clinical reco		riamb brogress
(depression, post-trau	imatic stress disorder,					
i	nsomnia, gastroesor	phageal reflux disease,			The Director of Nursing/		
		disorder, and schizoid			Bowel Movernent Repor		
(disorder.				week x 4 weeks, and the	n 1 x w	reek x 4 weeks.
-	The most recent MO	S (minimum data set) with			The Medical Records Dir	ector/r	designee will audit
_	n ARD (assessment	t reference date) of 09/27/16			5 residents x 4 week, 3 re		
·	noded the Resident a	s 15 of 15 in section C,			the 1 resident x 4 weeks		·
(cognitive patterns. Th	nis is a quarterly MDS.			**** # * - #** # ****		
		record was reviewed on La signed POS (physician's					·

ORM CMS-2567(02-99) Previous Versions Obsolele

If continuation sheet Page 65 of 70

		AND HUMAN SERVICES		·	FORM APPROVED		
CENTE	RS FOR MEDICARE	& MEDIC/ `SERVICES	,		OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVID SUPPLIER/CLIA IOENTIFICATION NUMBER:		LTIPLE CONSTRUCTIÓ	(X3) DATE SURVEY COMPLETED		
		495338	B. WING		C 11/10/2016		
NAME OF	PROVIDER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP CO	ODE		
				600 WALDEN ROAD			
GRACE HEALTHCARE OF ABINGDON			ABINGDON, VA 24210				
(X4 ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	*** ** * *****************************	SHOULD BE COMPLETION APPROPRIATE OATE		
		or.		-4.4	12/09/16		
F 514	514 Continued From page 65		F 5		a Idorianoo will report		
		ich read in part "K59.00		 The Director of Nursing audit findings to the mo 	ng/designee will report		
	Constipation, unspe	cified COLACE 100 MG		audit findings to the mo	noment Committee x 3		
	CAPSULE TAKE 2	CAPS (200 MG) BY MOUTH		and Performance Improvement Committee x 3 months or until substantial compliance is			
	EVERY DAY" and	K59.00 Constipation, LAX POWDER GIVE 17 GM		achieved. The QAPI Com	amittee includes but is		
		IQUID BY MOUTH EVERY		not limited to the Medic			
	- DAT AS NEEDED T				ties Director,		
	Resident #7's clinica	al record also contained "BM		Maintenance Director,			
		Record Roster" for the months		Admissions/Marketing I			
	of August, September	er, October and November		Director, HR Director, a			
	2106. For the month	of August, the BM record		Manager.			
	indicated a period of	f 5 days (08/25-08/29/16) with					
	no recorded BM's for Resident #7. For the month			The Medical Records Director/designee will			
of September, the BM record indicated a period			report audit findings to the monthly Quality Assurance and Performance Improvement				
of 8 days (09/10-09/17/16) and a period of 7 days			Assurance and Performance Improvement Committee x 3 months or until substantial				
(09/25-10/01/16) with no recorded BM's. For the			compliance is achieved. The QAPI Committee				
month of October, the BM record indicated two			includes but is not limited to the Medical				
periods of 5 days each (10/08-10/12/16 and 10/21-10/25/16) with no recorded BM's.				Director, Administrator, Director of Nursing,			
	10/21" 10/25/ 10 J Will	The recorded Sittle.		Social Services Director			
	Resident #7's MAR's	(medication administration		Maintenance Director,			
	record) for the month	ns of August, September,		Admissions/Marketing	Director, Dietary		
		ber were reviewed. The	·	Director, HR Director, a			
		ries which read in part		Manager.	·		
	"Constipation, unspe	cified COLACE 100 MG		ū			
	CAPSULE TAKE 2 C	APS (200 MG) BY MOUTH					
		GLYCOLAX POWDER GIVE			į		
		S OF LIQUID BY MOUTH					
	EVERY DAY AS NEE						
	CONSTIPATION . II	ne entry for Colace had been en administered as ordered.					
	Signed as having bee	olay had not been signed at		RECEIVED			
	The entry for the glycolax had not been signed at any time to indicate that it had been administered			1 1	ļ		
	as needed.			DEC 0 5 2016			
(The Resident's clinical record also contained copy of the facility "Bowel Protocol" which read in part "No BM x 2 days-Please administer 30ml			VDH/OLC			

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC J SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495338 B. WING 11/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 12/09/16 F 514 Continued From page 66 F 514 Milk of Magnesia q.h.s. x 1 at bedtime. No BM x 3 days- Please administer Dulcolax suppository x 1 at bedtime. No BM x 4 days-Please administer Fleets enema x 1 at bedtime. Bowel movement documentation will be reviewed by the 2-11 charge nurses for each unit and medication administered per review of the BM record for each Resident. All laxatives will require documentation on MAR fro (sic) that Resident." The surveyor could not locate any supporting documentation to indicate that the bowel protocol had been instituted for Resident #7. Surveyor spoke with LPN #1 on 11/09/16 at approximately 1130 regarding Resident #7. LPN #1 stated that the MAR indicated the last time Resident had received glycolax was 06/22/16. LPN #1 also stated that she had not administered glycolax to Resident over the last month. Surveyor spoke with Resident #7 on 11/09/16 at approximately 1145 regarding constipation. Resident stated "I don't generally have a problem with constipation because I take Colace regularly and if I go more than 2 days without a BM, I tell the nurse and she gives me milk of

The concern of the inaccurate documentation of BM's was discussed with the administrative team during meeting on 11/09/16 at approximately 1410.

magnesia". Surveyor asked Resident if she ever got glycolax and Resident stated "I don't like that stuff, I would rather have the milk of mag, so that

No further information was provided prior to exit.

2. The facility staff failed to maintain progress

DEC 0 5 2016

VDH/OLC

s what I ask for".

PRINTED: 11/22/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDIC OMB NO. 0938-0391 **SERVICES** STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING . 495338 B. WING 11/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON AB)NGDON, VA 24210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 12/09/16 F 514 Continued From page 67 F 514 notes in the clinical record of Resident #1. Resident #1 was originally admitted to the facility on 6/12/13 but has a readmission date back to the facility on 10/26/16. On the quarterly MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 9/27/16, Resident #1 was coded as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 5 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members for personal hygiene and being totally dependent on 2 staff members for bathing. A clinical record review was performed by the surveyor on 11/8 and 11/9/16. The surveyor noted that there were progress notes in the paper clinical record dated for 10/20/15 then the next one was dated for 2/26/16. The surveyor also reviewed the electronic clinical record and could not find any further progress notes for Resident #1. The QA (Quality Assurance) nurse #1 was notified of the above documented findings on 11/9/16 at 11 am. The QA nurse #1 stated "Let me go see if we have a copy of another physician progress note during that time frame and I will also call the physician to ask to see if he might have it with him. I will let you know what I find out."

At approximately 3 pm in the conference room on 11/9/16, the administrative staff was notified of the above documented findings.

On 11/10/16 at 8:55 am in the conference room, the Q nurse #1 provided a copy of a progress note dated for 1/15 16 for Resident #1. The

DEC 0.5 2016 VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORMACING CONTERS FOR MEDICARE & MEDICALD SERVICES OMB NO. 0938-0391								
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDE JPPLIER/CLIA				TIPLE CONSTRUCTIO	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	1	ING	COMPLETED			
					С			
		495338	B. WING		11/10/2016			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
GRACE	HEALTHCARE OF ABI	NGDON	600 WALDEN ROAD					
				ABINGDON, VA 24210				
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION			
					12/09/16			
F 514	4 Continued From page 68		F 5	14				
	note was found and	nurse #1 were this progress she stated "This was on the But this was not in the find."						
		on was provided to the						
		exit conference on 11/10/16.						
	483.75(o)(1) QAA		F.5.	20 1. No residents were cit-	ed for this alleged			
SS=E	COMMITTEE-MEMI QUARTERLY/PLAN			deficient practice.				
	QUARTERLITELAN	3		2. All residents have the	notential to be			
				affected by the alleged	deficient practice.			
	A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.							
				3. The Administrator an	d Director of Nursing			
				in-serviced the Medical regarding requirements	of the Medical			
				regarding requirements Director's attendance to	o the QA Committee.			
	lacinty o otali.	. e -						
	The quality assessm	ent and assurance		The Administrator/desi	gnee will audit the			
	committee meets at least quarterly to identify				al Directors attendance for the next 3			
		o which quality assessment ties are necessary; and		quarters of QA meeting				
		nents appropriate plans of		4. The Administrator/d-	esignee will report audit			
		itified quality deficiencies.		findings to the monthly	Quality Assurance and			
		, ,		Performance Improven	nent Committee x 3			
	A State or the Secre			months or until substar	ntial compliance is mmittee includes but is			
		ords of such committee		achieved. The QAPI Col not limited to the Med				
		th disclosure is related to the		Administrator, Director	r of Nursing, Social			
	compliance of such crequirements of this s			Services Director, Activ	rities Director,			
•	requirements or mis s	SCENOTI.		Maintenance Director,	MDS Coordinator,			
,	Good faith attempts b	by the committee to identify		Admissions/Marketing	Director, Dietary			
	and correct quality de	eficiencies will not be used as		Director, HR Director,	and Business Office			
i	a basis for sanctions.			Manager.				
	This REQUIREMENT by:	is not met as evidenced						
		saloto Europi ID: T58V/11		If c	ontinuation sheet Page 69 of 70			

DEPARTMENT OF HEALTH AND HUMAN SERVICES			6	PRINTED: 11/22/2010	
CENTERS FOR MEDICARE & MEDI D SERVICES				FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495338	B. WING		C 44/40/2040	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/10/2016	
GRACE HEALTHCARE OF ABINGDON			600 WALDEN ROAD		
			ABINGDON, VA 24210		
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX IAG_	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION	
F 520 Continued From				12/09/16	
F 520 Continued From pa	ge 69 rview, and facility document	F 52	20	12/09/16	
review, the facility s	taff failed to maintain a quality				
assessment and as	surance (QA) program which				
met regulatory requ	irements.				
A facility must maint	ain a quality assessment and				
assurance committe	e consisting of the director of				
facility, and at least	ohysician designated by the 3 other members of the				
facility's staff and wh	nich meets at least quarterly.				
11/10/16 to review the administrator was neadministrator was neadministrator was neadministrator was neadministrator was neadministrator was neadministrator one QA meetings in a QA meetings held in did attend the Januar QA meeting attendant physician had only attin 2016. The surveyor concludation that the full committees	th the administrator on the QA program. The ew and had only been at the man a month. While with her new position, she cal director had attended only 2016. The administrator, documentation, for monthly 2016. The Medical Director by QA meeting. Review of the ce record confirmed the tended the January meeting the ded there was no evidence expected including the physician parterly to address QA issues				
identified by facility sta	aff.				
Prior to exit no further information was provided to the surveyor related to the QA meetings.			RECEIVED		
			DEC 0 5 2016		
			VDH/OLC		