PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

| OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '               |                 | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |
|--|--|-------------------|-----------------|---|--|
|  | 495358   | B. WING           |                 |   | 03/09/2018   |
| (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | 8836<br>AM<br>× | EET ADDRESS, CITY, STATE, ZIP CODE  0 VIRGINIA STREET  ELIA, VA 23002  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)   | BE COMPLETION  |
| survey was conduct 03/09/18. Correctic compliance with 42 Requirement for Lot Establishment of the CFR(s): 483.73  The [facility, except comply with all appearagency preparated facility] must establishment of the CFR(s): 483.73  The [facility, except comply with all appearagency preparated facility] must established facility must entered facility must include, but network the emergency program that meet section, utilizing and the emergency preparated facility facility and the emergency preparated facility facil | ang-Term Care Facilities. The Emergency Program (EP)  It for Transplant Center] must alicable Federal, State and local edness requirements. The olish and maintain a regency preparedness program not be limited to, the following  482.15:] The hospital must olicable Federal, State, and reparedness requirements. The oliop and maintain a regency preparedness is the requirements of this reparedness requirements. The oliop and maintain a regency preparedness is the requirements of this in all-hazards approach.  5.625:] The CAH must comply federal, State, and local edness requirements. The olion and maintain a regency preparedness an all-hazards approach.  Note that the facility document remined that the facility staff | E                 | 000             | 1. Administrator will complete Emerge Preparedness Plan that meets Federa and local emergency Preparedness rutilizing an all hazards approach.  2. To ensure 100% accuracy Kent Emergency Manageme Pete Svododa, CentralVirginia Health Coalition Medically, Vulnerable Population Coordinator, and Roger FrassistantAdministrator Heritage Hall, will reviewand check for accuracy an with all State and Federal Emergency Preparedness guidelines.  3. Inservice will be given on the Emerupon hire and to all departments and employees on 04/18/18 and annually  4. QA will review quarterly and sign og over any emergencies that came to quarter. | al, State equirements  merson, int and care  racker Blackstone d compliance  gency Plan their thereafter.  ff on it as well as |
| review it was deter  |  | i                 |                 |   |  |

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

1 dministrator

(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 sateguards 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.

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | • •                  |   | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|----------------------|---|---|-------------------------------|----------------------------|
|                          |   | 495358  | B. WING              |   |   | 03/0                          | 09/2018                    |
|                          | ROVIDER OR SUPPLIER   |   |                      | 88                                      | REET ADDRESS, CITY, STATE, ZIP CODE<br>30 VIRGINIA STREET<br>MELIA, VA 23002  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG    |   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | DBE                           | (X5)<br>COMPLETION<br>DATE |
| E 001                    | Continued From pa   | -   | E                    | 001                                     |   |                               |                            |
|                          | The facility staff fail of an emergency pr  | ed to develop a written policy eparedness plan.   |                      |   |   |                               |                            |
|                          | The findings includ   | e:  |                      | 1                                       |   |                               | Ė                          |
|                          | of the facility's eme<br>conducted with ASI<br>member) # 1, admi<br>facility's emergency<br>evidence a written<br>preparedness plan | o a.m. a review and interview rgency preparedness plan was M (administrative staff nistrator. Review of the preparedness plan failed to policy of an emergency. ASM # 1 stated that the it. We are still developing the edness plan." |                      | 300000000000000000000000000000000000000 |   |                               |                            |
|                          | (administrative stat  | oroximately 11:00 a.m. ASM<br>f member) # 1, administrator,<br>stor of nursing, were made<br>gs.  | <u>.</u>             |   |   |                               |                            |
| E 006<br>S <b>\$</b> =C  | Plan Based on All I   | ion was obtained prior to exit.<br>Hazards Risk Assessment<br>1)-(2)  | 1.                   |   | inistrator will complete Emergency P<br>at meets Federal, State, and local er   |                               |                            |
|                          | and maintain an er that must be review  | an. The [facility] must develop<br>nergency preparedness plan<br>ved, and updated at least<br>must do the following:]   | pr<br>or<br>in<br>ba | epare<br>all h<br>clude<br>ased         | edness requirements with special em<br>lazards approach and be based on a<br>d documented facility-based and cor<br>risk assessment, utilized on all-hazar<br>ch including missing residents. | phasis<br>nd<br>nmunity       |                            |
|                          | facility-based and  | nd include a documented,<br>community-based risk<br>ng an all-hazards approach.*  |                      |   |   |                               |                            |
|                          | on and include a d  | at §483.73(a)(1):] (1) Be based ocumented, facility-based and risk assessment, utilizing an   |                      |   |   |                               |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |               | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                 |
|--------------------------|---|--|---------------|--|---|
|                          |   | 495358   | B. WING       |  | 03/09/2018                                    |
| NAME OF F                | PROVIDER OR SUPPLIER  |  | 1             | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |
| AMELIA                   | NURSING CENTER  |  |               | 830 VIRGINIA STREET<br>MELIA, VA 23002   |   |
|                          | OLD MAD DV CTA  | TEMENT OF DESIGNATES   | ID            | PROVIDER'S PLAN OF CORRECTI  | ON (X5)                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | D BE COMPLETION                               |
| E 006                    | Continued From pa   | ige 2  | E 006         | 2. To ensure 100% accuracy Kent  | Emerson,                                      |
|                          | all-hazards approa  | ch, including missing residents.   |               | Coordinatorof Emergency Manager  |   |
|                          | and include a docu<br>community-based i   | 183.475(a)(1):] (1) Be based on<br>mented, facility-based and<br>risk assessment, utilizing an<br>ch, including missing clients.   |               | Pete Svododa, CentralVirginia Heal Coalation Medically, VulnerablePop Coordinator, and Roger Fracker As Administrator Heritage Hall, Blacks review Emergency Plan. They will certain it is based on and included | oulation<br>sistant<br>tone will<br>also makė |
|                          | events identified by  | ies for addressing emergency the risk assessment.  |               | facility-based and community base<br>Assessments on all hazards appro-<br>including missing residents.   | ed Risk                                       |
|                          | strategies for addre<br>identified by the ris<br>management of the<br>fallures, natural dis<br>that would affect the<br>care. | §418.113(a)(2):] (2) Include essing emergency events k assessment, including the e consequences of power easters, and other emergencies he hospice's ability to provide                  |               | 3. Inservice to staff on 04/18/18 include the documented facility community based risk assessn the all hazards approach inclumissing residents. Will have misresidents drill quarterly beginnin 03/29/2018.      | pased and<br>nents on :<br>ding<br>ssing      |
|                          | review it was deter   | erview and facility document<br>mined that the facility staff<br>mplete emergency  |               | 4. Administrator will report to QA documented facility based and obased risk assessments and the approach including missing resi   | community<br>e all hazards                    |
|                          | of the facility's risk<br>strategies and that   | lled to provide documentation<br>assessment, associated<br>the risk assessment was<br>zards approach specific to the   |               | Completion Date  | 04/23/2018                                    |
|                          | The findings include  | de:  |               |  |   |
|                          | of the facility's eme<br>conducted with AS<br>member) #1, adm<br>facility's emergence<br>evidence documen                     | 5 a.m. a review and interview ergency preparedness plan was M (administrative staff inistrator. Review of the preparedness plan failed to extend that the ciated strategies and that the |               |  |   |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | LE CONSTRUCTION  |  | E SURVEY<br>PLETED         |
|--------------------------|--|--|---------------------|--|--|----------------------------|
|                          |  | 495358   | B. WING             |  | 03/  | 09/2018                    |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |  | 8                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1830 VIRGINIA STREET<br>AMELIA, VA 23002  |  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | _D BE  | (X5)<br>COMPLETION<br>OATE |
| E 006 E 007 SS=C         | On 03/09/18 at app<br>(administrative staf<br>and ASM # 2, direct<br>aware of the finding<br>No further informat<br>EP Program Patier<br>CFR(s): 483.73(a)(<br>[(a) Emergency Pla<br>and maintain an er<br>that must be review<br>annually. The plan<br>(3) Address patient<br>but not limited to, p | as based on an all-hazards to the geographical area.  broximately 11:00 a.m. ASM f member) # 1, administrator, stor of nursing, were made gs.  ion was obtained prior to exit. at Population                                       | E 006               |  | ral, State ss updated ress but not of co                     |                            |
|                          | an emergency; and including delegation plans.**  *Note: ["Persons a hospice, PACE, HIFQHC, or ESRD fathis REQUIREMED by: Based on staff intereview it was deterfailed to have a congreparedness plant.  The facility staff fathat the written emfacility's patient po                                | d continuity of operations, ns of authority and succession trisk" does not apply to: ASC, HA, CORF, CMCH, RHC, acilities.]  NT is not met as evidenced erview and facility document mined that the facility staff mplete emergency |                     | 2. To ensure 100% accuracy Kent Coordinatorof Emergency Manage Pete Svododa, CentralVirginia Heat Coalition Medically, Vulnerable Population Coordinator, and Roge Assistant Administrator Heritage Hwill review Emergency Plan and Caccuracy and compliance with all State and Federal and Loc Preparedness guidelines. | ment and<br>althcare<br>r Fracker<br>lall, Black<br>heck for | stone                      |

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| OLIVILI                  | O I OIL WILDIO/ WIL  | & MEDIONID SERVICES   |                   |     |  | 1  |                               |  |
|--------------------------|--|---|-------------------|-----|--|--|-------------------------------|--|
|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` <i>'</i>        |     | CONSTRUCTION   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|                          |  | 495358  | B. WING           |     |  | 03/  | 09/2018                       |  |
|                          | ROVIDER OR SUPPLIER  |   |                   | 883 | REET ADDRESS, CITY, STATE, ZIP CODE<br>80 VIRGINIA STREET<br>1ELIA, VA 23002   | -  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY)  | D BE   | (X5)<br>COMPLETION<br>OATE    |  |
| E 007                    | The findings included on 03/09/18 at 9:19 of the facility's emergency evidence document emergency plan incorpopulations that we emergency event; loperations during a delegation of authorstated that the facility is emergency event; loperations during a delegation of authorstated that the facility is emergency event; loperations during a delegation of authorstated that the facility is entirely expenses. | s during an emergency and the rity and succession.  |                   |     | Cont. Paying special attention to the fact updated annually and the plan will patient/client population including, limited to, persons at risk; the type the facility has the ability to provide emergency, and continuity of operaincluding deligations of authority ar sucession plans.  3. Inservice will be given on the Er Plan upon hire and to all department their employees on 04/18/18 and atthereafter.  4. QA will review quarterly and signs well as go over any emergencicame up during the quarter.  Completion | address out not of service in an itions, id mergency ents and annually n off on it | es<br>                        |  |
|                          | (administrative state and ASM # 2, direct aware of the finding.)  No further informate Development of EFCFR(s): 483.73(b)  (b) Policies and prodevelop and imples policies and processing plan set forth in parassessment at parand the communicative this section. The previewed and updates  | proximately 11:00 a.m. ASM If member) # 1, administrator, stor of nursing, were made gs. Ition was obtained prior to exit. Policies and Procedures  Decedures. [Facilities] must ment emergency preparedness dures, based on the emergency pragraph (a) of this section, risk ragraph (a)(1) of this section, lation plan at paragraph (c) of lolicies and procedures must be lated at least annually.  Dements for PACE and ESRD | 4                 | 013 | 1. Administrator will complete Eme Prepareness Plan that meets Fede and local emergency Preparednes requirements utilizing an all hazard approach with evidence documents that the policies and procesure well developed based on the facility and community based risk assessment communication plan utilizing an all approach and evidence that the poprocedure were reviewed and updatannually.   | ral, State s ds ds ation e d s and hazards licies and                              | 1                             |  |

Facility ID: VA0002

| CENTE                    | OT ON WILDIONINE   | G WILDIONED OLIVIOLO   |                   |     |   | 10.0000 0001  |
|--------------------------|--|--|-------------------|-----|---|---|
|                          | OF OEFICIENCIES<br>F CORRECTION  | (X1) PROVIOER/SUPPLIER/CLIA<br>IOENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION  | (X3) OATE SURVEY<br>COMPLETEO   |
|                          |  | 495358   | B. WING           |     |   | 03/09/2018  |
|                          | ROVIOER OR SUPPLIER  |  |                   | 88  | TREET AOORESS, CITY, STATE, ZIP COOE<br>830 VIRGINIA STREET<br>MELIA, VA 23002  |   |
| (X4) IO<br>PREFIX<br>TAG | (EACH OEFICIENC)   | TEMENT OF OEFICIENCIES  MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)  | IO<br>PREF<br>TAG |     | PROVIOER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCEO TO THE APPROP<br>OEFICIENCY)   | BE COMPLÉTION   |
| E 013                    | procedures. The Procedures and procedures and procedures are para and the communication section. The procedures managem emergencies, inclued equipment, power, emergencies; and threaten the health staff, or the public must be reviewed at the section. The dimplement emerge procedures, based forth in paragraph assessment at parand the communication this section. The procedures inclued equipment or power emergencies, water and the communication and the communication. The procedures are and the communication and the communication and the communication and the communication. The procedures are and the communication and the communication and the communication and the communication and the communication. The procedures are and the communication a | 2.84(b):] Policies and ACE organization must ment emergency preparedness fures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must ent of medical and nonmedical ding, but not limited to: Fire; or water failure; care-related natural disasters likely to or safety of the participants, The policies and procedures and updated at least annually.  The section of this section and alysis facility must develop and not the emergency plan set (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ated at least annually. These de, but are not limited to, fire, are failures, care-related er supply interruption, and kely to occur in the facility's  NT is not met as evidenced erview and facility document mined that the facility staff mplete emergency |                   | 013 | 2. To ensure 100% accuracy Kent E Coordinatorof Emergency Managem Pete Svododa, CentralVirginia Healt Coalition Medically, Vulnerable Pop Coordinator, and Roger Fracker Ass Administrator Heritage Hall, Blackst will review Emergency Plan and chaccuracy and compliance with all S and Local Emergency Preparedness guidelines. They will make certain the documentation that the policies and were developed based on the facility communicaty based risk assessment communication plan utilizing an all happroach and evidence that the policies and procedures were reviewed and annually.  3. Inservice will be given on the Emplan upon hire and to all department employees on 04/18/18 and annually.  4. QA will review quarterly and swell as go over any emergencies up during the quarter.  Complete | nent and chcare coulation distant cone deck for tate, Federal see plan includes procedures y and at and distand cies updated ergency ts and their y thereafter. |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 | IPLE CONSTRUCTION  NG  | (X3) DATE SURVEY<br>COMPLETED                       |
|--------------------------|--|--|---------------------|--|---|
|                          |  | 495358   | B. WING_            | 1912   | 03/09/2018  |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)  | DULD BE COMPLETION                                  |
| E 013                    | that the policies an based on the facilit assessment, and call-hazards approapolicies and procedupdated annually.  The findings include On 03/09/18 at 9:1 of the facility's emergence document of acility's emergence document procedures were defacility-and-communication approach and evide procedure were reasoned and evide procedure were reasoned and evide procedures plant on 03/09/18 at apple (administrative state and ASM # 2, direct aware of the finding assessment of the finding assessment of the finding assessment on the finding assessment of the finding ass | led to provide documentation of procedures were developed y-and-community based risk ommunication plan utilizing an ch and evidence that the dure were reviewed and e:  5 a.m. a review and interview ergency preparedness plan was M (administrative staff inistrator. Review of the y preparedness plan failed to station that the policies and eveloped based on the unity based risk assessment, in plan utilizing an all-hazards ence that the policies and viewed and updated annually. At the facility did not have it. ping the emergency ."  proximately 11:00 a.m. ASM ff member) # 1, administrator, ctor of nursing, were made | E 0*                | 13   |   |
|                          | Subsistence Need<br>CFR(s): 483.73(b)<br>[(b) Policies and p<br>develop and imple<br>policies and proce  | s for Staff and Patients   | ,                   | 215 1. Administrator will complete E Prepareness Plan that meets Fe and local emergency Prepared requirements utilizing an all haz approach to include developme policies and procedures for the of pharmaceutical supplies for p and staff. | ederal, State<br>ness<br>ards<br>nt of<br>provision |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED  |
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|                          |  | 495358   | B. WING _           |   | 03/09/2018   |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | D BE COMPLETION  |
| E 015                    | assessment at para and the communication this section. The poreviewed and update minimum, the policia address the following:  (1) The provision of and patients wheth place, include, but (i) Food, water, mesupplies (ii) Alternate source following:  (A) Temperature safety and for the supplies (ii) Alternate source following:  (B) Emergency (C) Fire detection systems.  (D) Sewage and *[For Inpatient Hose Policies and proceed (6) The following and hospice-operated in the policies and proceed (6) The following:  (iii) The provision of the policies and proceed evacuate or shelter limited to the following:  (B) Alternate source (B) Alternate (B) Altern | agraph (a)(1) of this section, ation plan at paragraph (c) of plicies and procedures must be ted at least annually.] At a ites and procedures must ng:  If subsistence needs for staff er they evacuate or shelter in are not limited to the following: dical and pharmaceutical es of energy to maintain the sto protect patient health and safe and sanitary storage of ighting.  In, extinguishing, and alarm waste disposal.  Indicate at §418.113(b)(6)(iii):] dures.  Ire additional requirements for inpatient care facilities only.  Irocedures must address the of subsistence needs for sand patients, whether they in place, include, but are not | E 01                | 5 2. To ensure 100% accuracy Kent E Coordinator of Emergency Managen Pete Svododa, Central Virginia Heal Coalition Medically, Vulnerable Population Coordinator, and Roger Assistant Administrator Heritage Hal Blackstone will review Emergency P and check for accuracy and complis State, Federal and Local Emergency guidelines, also making certain to de policies and procedures for the prov pharmaceutical supplies for patients staff.  3. Inservice will be given on the Emergency Particles and to all departments are employees on 04/18/18 and annuall 4. QA will review quarterly and sign go over any emergencies that came quarter. | ment and Ithcare  Fracker II, Plan ance with all y Preparedness evelop risions of and  ergency Plan and their ly thereafter.  off on it as well as |
|                          | and safety and for   | the safe and sanitary storage  |                     |   |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | NG  | COMPLETED                       |
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|                          |  | 495358   | B. WING             |   | 03/09/2018                      |
|                          | ROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   |                                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG | PROVIDER'S PLAN OF CORRECT<br>( (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)                              | LD BE COMPLETION                |
| E 015                    | of provisions.  (2) Emergenc (3) Fire detect systems.  (C) Sewage and This REQUIREME by: Based on staff intereview it was deter failed to have a col preparedness plan The facility staff fail procedures for the supplies for patien The findings includ On 03/09/18 at 9:1 of the facility's emergency the facility's emergency the facility staff fail procedures for the supplies for patien that the facility did developing the em On 03/09/18 at ap (administrative sta and ASM # 2, dire aware of the findin | y lighting. tion, extinguishing, and alarm waste disposal. NT is not met as evidenced erview and facility document mined that the facility staff mplete emergency .  Iled to develop policies and provision of pharmaceutical ts and staff.  He:  5 a.m. a review and interview ergency preparedness plan wa IM (administrative staff inistrator. Review of the ey preparedness plan revealed ed to develop policies and provision of pharmaceutical ts and staff. ASM # 1 stated not have it. We are still ergency preparedness plan."  proximately 11:00 a.m. ASM iff member) # 1, administrator, ctor of nursing, were made ags.  ution was obtained prior to exit. |                     |   |                                 |
| E 018<br>SS=C            | 1  | acking of Staff and Patients<br>(2)  | E                   | 1. Administrator will complete Em<br>PreparenessPlan that meets Federand local emergency Preparedne<br>utilizing an all hazards approach. | eral, State<br>ess requirements |

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|--------------------------|--|---|---------------------|---|---|
|                          |  | 495358  | B. WING             | 4   | 03/09/2018  |
|                          | PROVIDER OR SUPPLIER   |   | {                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LD BE COMPLETION  |
| E 018                    | develop and imple policies and proce plan set forth in pa assessment at par and the communic this section. The previewed and update minimum, the policies the follow (2) A system to train and sheltered pation of the receiving facility] must document the [PRTF's, LTC, and after an emergency, the [PRTF's, LTC, and after an em | ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of olicies and procedures must be ated at least annually.] At a cies and procedures must ing:]  ck the location of on-duty staff ents in the [facility's] care during on-duty staff and sheltered ated during the emergency, the enterth the specific name and eiving facility or other location.  41.184(b), LTC at §483.73(b), and sheltered residents in ICF/IID or PACE] care during gency. If on-duty staff and sare relocated during the PRTF's, LTC, ICF/IID or PACE] e specific name and location of ty or other location. |                     | Will include evidence of a tracking sto document locations of patients a staff.  2. To ensure 100% accuracy Kent Coordinator of Emergency Manage Pete Svododa, Central Virginia Hec Coalition Medically, Vulnerable Population Coordinator, and Roger Assistant Administrator Heritage Helackstone will review Emergency check for accuracy and compliance State, Federal and Local Emergency guidelines. Looking for evidence of systemto document location of patistaff.  3. Inservice will be given on the Enupon hire and to all departments a employees on 04/18/18 and annual 4. QA will review quarterly and sign go over any emergencies that camquarter. | Emerson, ment and althcare Fracker all, Plan and e with all acy Preparedness a tracking ents and mergency Plan and their ally thereafter. |

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

Facility ID: VA0002

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE (<br>A. BUILDING | CDNSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                           |
|--------------------------|--|--|--------------------------------|--|-------------------------------|---------------------------|
|                          |  | 495358   | B. WING                        |  | 03/09/                        | 2018                      |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |  | 883                            | EET ADDRESS, CITY, STATE, ZIP CODE<br>O VIRGINIA STREET<br>ELIA, VA 23002                                      |                               |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | DBE CO                        | (X5)<br>DMPLETION<br>OATE |
| E 018                    | employees' on-duty hospice's care duri on-duty employees relocated during the must document the the receiving facilit *[For CMHCs at §4 procedures. (2) Sa which includes contreatment needs or responsibilities; traevacuation location means of communassistance.  *[For OPOs at § 4 procedures. (2) A documentation that donor information, potential and actuate secures and main *[For ESRD at § 4 procedures. (2) Sa procedures. | ck the location of hospice y and sheltered patients in the ing an emergency. If the sor sheltered patients are elemergency, the hospice elemergency in the cation of y or other location.  485.920(b):] Policies and fevacuees; staff ensportation; identification of in(s); and primary and alternate inication with external sources of elemergency in the cation of interest elements and elements and elements confidentiality of elements confidentiality of elements in the availability of records.  94.62(b):] Policies and elements and elements elements and element |                                |  |                               |                           |
|                          | This REQUIREME<br>by:<br>Based on staff int<br>review it was dete  | ENT is not met as evidenced serview and facility document rmined that the facility staff amplete emergency   |                                |  |                               |                           |
|                          |  | niled to develop a tracking<br>ent locations of patients and   |                                |  |                               |                           |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION  G   |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|---|--|-------------------------------|--|
|                          |  | 495358   | B. WING_            |   | 03/  | 09/2018                       |  |
|                          | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002              | ODE  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE  | (X5)<br>COMPLETION<br>OATE    |  |
| E 020                    | of the facility's emeronducted with ASI member) # 1, adm facility's emergency evidence a tracking locations of patient that the facility did developing the emotion of the facility did developing the emotion of the findin locations of the findin locations of the findin locations and ASM # 2, direct aware of the findin location | e:  5 a.m. a review and interview ergency preparedness plan was M (administrative staff inistrator. Review of the y preparedness plan failed to g system to document is and staff. ASM # 1 stated not have it. We are still ergency preparedness plan."  proximately 11:00 a.m. ASM ff member) # 1, administrator, ctor of nursing, were made gs.  tion was obtained prior to exit. and Primary/Alt. Comm.  (3)  rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency aragraph (a) of this section, risk ragraph (a)(1) of this section, cation plan at paragraph (c) of policies and procedures must be ated at least annually. At a cies and procedures must | ΕO                  |   | eets Federal, by Preparedner all egards for safe evacuation de all of the evacuation. The eds of ation location means of | ess                           |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  | 4.5  | COMPLETED           |  |  |   |
|---|--|--|---------------------|--|--|---|
|   |  | 495358   | B. WING             |  |  | 03/09/2018  |
| NAME OF PROVIDER OR SUPPLIER  AMELIA NURSING CENTER   |  |  | 8830 \              | T ADDRESS, CITY, STATE, ZIP CODE<br>/IRGINIA STREET<br>LIA, VA 23002   |  |   |
| (X4) ID<br>PREFIX<br>TAG  | (FACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG | <b>·</b>   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE COMPLETION   |
| E 020   | SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION) |  |                     | End Model Control Cont | To ensure 100% accuracy Kennerson, Coordinator of Emerger anagement and Pete Svododa, entral Virginia Healthcare polition Medically, Vulnerable opulation Coordinator, and oger Fracker Assistant Administration and compliance with all State, Fend Compliance with all State, Fend Emergency Preparedness and make certain there are policionated and coefficients and of the Consideration of care needs of accuees.  Staff responsibilities  Transportation  Identification of evacuation loce Primary and alternate means of assistance.  Completion date | crator riew ccuracy deral and guidelines es and n required  f |
|   | the facility and that  | edures for safe evacuation from at it includes all of the required |                     |  |  | 11  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ` <i>'</i>   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |   |
|--|---|--|---------------------|--|---|
|  |   | 495358   | B. WING             |  | 03/09/2018  |
|  | PROVIDER OR SUPPLIER  |  | 8                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>1830 VIRGINIA STREET<br>AMELIA, VA 23002   |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDENCY)   | DBE COMPLETION  |
| E 020  | Continued From particle elements.  The findings include   |  | E 020               |  |   |
|  | of the facility's emergence conducted with AS member) # 1, adm facility's emergence evidence documer preparedness plar procedures for saf and that it includes ASM # 1 stated the | 5 a.m. a review and interview ergency preparedness plan was M (administrative staff inistrator. Review of the py preparedness plan failed to ntation that the emergency included policies and the evacuation from the facility is all of the required elements. The facility did not have it. The pping the emergency in." |                     |  | APPEN APP IN THE COLUMN   |
|  | (administrative sta<br>and ASM # 2, dire<br>aware of the findir<br>No further informa<br>Policies/Procedure   | ation was obtained prior to exit.<br>es for Sheltering in Place  | E 02                | 2 1. Administrator will complete Emer  |   |
| SS=C   | develop and imple<br>policies and proce<br>plan set forth in pa<br>assessment at pa<br>and the communion<br>this section. The pareviewed and upd                                  | procedures. The [facilities] must ement emergency preparedness edures, based on the emergency aragraph (a) of this section, risk ragraph (a)(1) of this section, cation plan at paragraph (c) of policies and procedures must be ated at least annually. At a cies and procedures must                                     | <b>y</b>            | PreparenessPlan that meets Feder and local emergency Preparednes requirements utilizing an all hazar approach including developing policand procedure of how the facility was provide a means to shelter in place patients, staff and volunteers who rein the facility  2. To ensure 100% accuracy Kent Coordinator of Emergency Manager | s<br>rds<br>icies<br>ill<br>for<br>emain<br>Emerson,<br>ement and |
|  | address the follow  | ving:] elter in place for patients, staff,   |                     | Pete Svododa, Central Virginia Hea<br>Coalition Medically, Vulnerable<br>Population Coordinator, and Roger<br>Assistant Administrator Heritage H   | · Fracker   |

| STATEMENT                | OF DEFICIENCIES F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION<br>IG  | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|---|--|---------------------|---|---|
|                          |   | 495358   | B. WING             |   | 03/09/2018  |
|                          | PROVIDER OR SUPPLIER  | 493330   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   | 1 03/09/2010  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | DBE COMPLETION  |
| E 022                    | (2),(3),(5),(6)] A me patients, staff, and [facility].  *[For Inpatient Hos and procedures. (6) The following a hospice-operated in The policies and p following: (i) A means to shospice employee. This REQUIREMED by: Based on staff intreview it was deterfailed to have a compreparedness plant.  The facility staff far procedures of how means to shelter involunteers who read the facility's emconducted with AS member) # 1, add facility's emergence. | oremain in the [facility]. [(4) or eans to shelter in place for volunteers who remain in the spices at §418.113(b):] Policies are additional requirements for inpatient care facilities only. rocedures must address the helter in place for patients, is who remain in the hospice. ENT is not met as evidenced erview and facility document rmined that the facility staff implete emergency in.  It is develop policies and of the facility will provide a in place for patients, staff and main in the facility.  It is a.m. a review and interview ergency preparedness plan was SM (administrative staff inistrator. Review of the cy preparedness plan revealed |                     | Blackstone will review Emergency Fand check for accuracy and complia with all State, Federal and Local Em Preparedness guidelines. Making ce are policiesand procedures of how the will provide means to shelter in plar patients, staffand volunteers who re in the facility  3. Inservice will be given on the Emupon hire and to all departments are employees on 04/18/18 and annuall  4. QA will review quarterly and sign as well as go over any emergencies up during the quarter.  Completion | ergency ertain there he facility ce for emain ergency Plan hd their y thereafter. off on it |
|                          | procedures of how<br>means to shelter in<br>volunteers who re<br>stated that the face   | lled to develop policies and withe facility will provide a in place for patients, staff and main in the facility. ASM # 1 cility did not have it. We are still nergency preparedness plan."  |                     |   |   |

|                          | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|---|--|--|---|--|
|                          |   | 495358   | B. WING                                |   | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER A NURSING CENTER   |  | 8                                      | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>MELÍA, VA 23002  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LD BE COMPLET  |
| E 022                    | On 03/09/18 at app<br>(administrative star<br>and ASM # 2, direct<br>aware of the finding   | proximately 11:00 a.m. ASM  ff member) # 1, administrator, ctor of nursing, were made gs.  | E 022                                  |   |  |
|                          | [(b) Policies and procedures of CFR(s): 483.73(b)  [(b) Policies and procedures and procedures and procedures and procedures and the communication this section. The previewed and updated minimum, the policies and reserves patient confidentiality of pand maintains available. (a),(4),(6)] A system of maintains available. (b) A system of maintains available. (c) Procedures. (c) A that does the follodice of the procedures and maintains available. (d) Preserves patient confidentiality of pand maintains available. (e) Procedures and maintains available. | rocedures. The [facilities] must ament emergency preparedness dures, based on the emergency aragraph (a) of this section, risk ragraph (a)(1) of this section, cation plan at paragraph (c) of policies and procedures must be ated at least annually. At a cies and procedures must ving:]  edical documentation that information, protects patient information, and secures aliability of records. [(5) or am of medical documentation tient information, protects patient information, protects patient information, and secures patients are patients. |  | 1. Administrator will complete EmeroparenessPlan that meets Federand local emergency Preparedne requirements utilizing an all hazar approach. To also include policies procedures of how the facility prespatient information, protects confider of patient information secures and availability of records.  2. To ensure 100% accuracy Kent Coordinator of Emergency Manage Pete Svododa, Central Virginia He Coalition Medically, Vulnerable Population Coordinator, and Rogal Assistant Administrator Heritage Heritage Will review Emergency Plan and for accuracy and compliance with all State, Federal and Local Engreparedness guidelines and look and procedures how the facility propatient information, protects confideration for patient information secures and availability of records. | ral, State ss ds and serves dentialty maintains Emerson, ement and ealthcare er Fracker Hall, Blackstone check Emergency s for policies reserves dentialty |

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:   |         | E CONSTRUCTION  | (X3) OATE SURVEY<br>COMPLETEO      |
|--|--|--|---------|---|------------------------------------|
|  |  | 495358   | B. WING |   | 03/09/2018                         |
|  | (FACH OFFICIENC)   | ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)   | S<br>8  | TREET AOORESS, CITY, STATE, ZIP COOE 830 VIRGINIA STREET MELIA, VA 23002  PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPRODEFICIENCY)   | ON (X5)<br>LO BE COMPLETION        |
|  | donor information, potential and actual secures and maint.  This REQUIREME by: Based on staff intreview it was deterfailed to have a copreparedness plar.  The facility staff far procedures of how information, protect.  | system of medical t preserves potential and actual protects confidentiality of al donor information, and ains the availability of records.  ENT is not met as evidenced erview and facility document rmined that the facility staff implete emergency n.  iiled to develop policies and of the facility preserves patient cts confidentiality of patient ecures and maintains                              |         | 3. Inservice will be given on the EmPlan upon hire and to all department and their employees on 04/18/18 at annually thereafter  4. QA will review quarterly and signit as well as go over any emergency came up during the quarter.  Completion Date | nts<br>and<br>n off on<br>ies that |
|  | of the facility's emconducted with Asmember) # 1, administrative semergenthe facility's emergenthe facility staff faprocedures of how information, proteinformation, and savailability of recofacility did not have emergency preparation 03/09/18 at a (administrative st | 15 a.m. a review and interview ergency preparedness plan was SM (administrative staff ninistrator. Review of the cy preparedness plan revealed illed to develop policies and w the facility preserves patient ects confidentiality of patient secures and maintains ords. ASM # 1 stated that the redness plan."  Opproximately 11:00 a.m. ASM aff member) # 1, administrator, ector of nursing, were made |         |   |                                    |

Facility IO: VA0002

|  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |   | (X3) DATE SURVEY<br>COMPLETED  |
|--|--|--|---|--|
|  | 495358   | B. WING  |   | 03/09/2018   |
|  |  |  | 8830 VIRGINIA STREET  |  |
| (EACH DEFICIENC)   | MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOUL)  | D BE COMPLÉTION  |
| No further informate Policies/Procedure CFR(s): 483.73(b)(  [(b) Policies and procedure policies and procedures forth in particular assessment at particular and the communication this section. The procedures the following and the policies and updar minimum, the policies and updar minim | ion was obtained prior to exit. s-Volunteers and Staffing 6) cocedures. The [facilities] must ment emergency preparedness dures, based on the emergency ragraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of clicies and procedures must be ted at least annually. At a ies and procedures must ies and procedures must ng:] 7) as noted above] The use of mergency or other emergency including the process and role tate and Federally designated sionals to address surge needs acy. 403.748(b):] Policies and e use of volunteers in an mer emergency staffing less surge needs during an NT is not met as evidenced erview and facility document mined that the facility staff mplete emergency it. illed to develop policies and use of volunteers and other  | E 02   | 1. Administrator will complete Em PreparenessPlan that meets Fed State and local emergency Preparequirements utilizing an all haza approach. Also to develop policie procedures for the use of volunte other stuffing stratagies in the emplan.  2. To ensure 100% accuracy Ker Coordinator of Emergency Mana Pete Svododa, Central Virginia F Coalition Medically, Vulnerable Population Coordinator, and Rog Assistant Administrator Heritage Blackstone will review Emergency and check for accuracy and com with all State, Federal and Local Preparedness guidelines. Check policies and procedures for the divolunteers and other staffing strain the emergency plan.  3. Inservice will be given on the Plan upon hire and to all departs  | eral, aredness ards s and ers and hersecy  at Emerson, gement and lealthcare her Fracker Hall, by Plan pliance Emergency for lise of latagies  Emergency ments   |
| staffing strategies  | are in the emergency plan.   |  |   |  |
|  | Continued From particles (Fegulatory or Lead Policies (From particles) (Fegulatory or Lead Policies (From particles) (Fegulator) (Fegulato | PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  No further information was obtained prior to exit. Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)  [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]  (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency and other emergency staffing strategies to address surge needs during an emergency and other emergency staffing strategies to address surge needs during an emergency.  *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.  This REQUIREMENT is not met as evidenced | PROVIDER OR SUPPLIER  NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  No further information was obtained prior to exit. Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)  [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]  (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency and other emergency staffing strategies to address surge needs during an emergency and other emergency staffing strategies to address surge needs during an emergency and other emergency staffing strategies to address surge needs during an emergency.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.  The facility staff failed to develop policies and procedures for the use of volunteers and other | PROVIDER OR SUPPLIER  A 95358  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 8330 VIRGINA STREET AMELIA, VA 23002  PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENTY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  No further information was obtained prior to exit. Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)  (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency pilan set forth in paragraph (a) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]  (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.  *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.  *[For RNHCIs at §403.748(b):] Policies and procedures for the use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and facility document review it was determined that the facility staff failed to develop policies and procedures for the use of volunteers and other staffing strating and the procedures for the use of volunteers and other emergency preparedness plan.  The facility staff failed to develop policies and procedures for the use of volunteers and other emergency and other emergency preparedness plan. |

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | E CONSTRUCTION   | COMPLETED  |
|---|--|--|---------------------|--|--|
|   |  | 495358   | B, WING             | ·  | 03/09/2018   |
|   | ROVIDER OR SUPPLIER  | 3  | 8                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>MELIA, VA 23002   |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T  | DULD BE COMPLETION   |
| E 024   | The findings inclu On 03/09/18 at 9: of the facility's em conducted with A member) # 1, adi facility's emergen the facility staff fa procedures for th staffing strategies ASM # 1 stated ti We are still deve preparedness pla On 03/09/18 at a (administrative si  | de:  15 a.m. a review and interview hergency preparedness plan was SM (administrative staff ministrator. Review of the hergency preparedness plan revealed hilled to develop policies and her use of volunteers and other is are in the emergency plan. That the facility did not have it. Hoping the emergency an."  pproximately 11:00 a.m. ASM that member) # 1, administrator, ector of nursing, were made | E 024               | 4. QA will review quarterly and si on it as well as go over any emer that came up during the quarter.  Completion by 0   | rgencies   |
| E 025   | Arrangement with CFR(s): 483.73(  [(b) Policies and develop and impolicies and prooplan set forth in assessment at pand the commutation of the com | procedures. The [facilities] must lement emergency preparedness bedures, based on the emergency paragraph (a) of this section, risk learning paragraph (a)(1) of this section, nication plan at paragraph (c) of a policies and procedures must be least annually. At a policies and procedures must   | s<br>y<br>e         | 1. Administrator will complete El PreparenessPlan that meets Fe and local emergency Prepared utilizing an all hazards approace provide documentation or agree with other facilities to receive pathe event the facility is not able for them during an emergency.  2. To ensure 100% accuracy Ke Coordinator of Emergency Man Pete Svododa, Central Virginia Coalition Medically, Vulnerable Population Coordinator, and Ro Assistant Administrator Heritagi will review Emergency Plan and for accuracy and compliance with all State, Federal and Local Preparedness guidelines. | ederal, State   ness requirements ch. Will also ements atients in to care  ent Emerson, agement and Healthcare oger Fracker e Hall, Blackstone d check |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED  |
|---|---|--|---|---|--|
|   |   | 495358   | B. WING                                 |   | 03/09/2018   |
|   | PROVIDER OR SUPPLIER  |  |   | STREET ADDRESS, CITY, STATE, Z<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  | ZIP CODE   |
| (X4) ID<br>PREFIX<br>TAG                            | (FACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                      | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENCE  | TION SHOULD BE COMPLETION THE APPROPRIATE OATE   |
| E 025   | other [facilities] [an patients in the ever operations to main to facility patients.  *[For PACE at §46 §483.475(b), CAH §485.920(b) and E Policies and procedevelopment of ar [facilities] [or] othe in the event of limitoperations to main to facility patients.  *[For RNHCIs at § procedures. (7) The arrangements with providers to receive limitations or cess the continuity of nepatients.  This REQUIREMED by:  Based on staff intreview it was detered to have a comparedness plated to have a comprehence of the arrangement facility has with other in the event the faduring an emergent The findings inclusion.  On 03/09/18 at 9: | and other providers to receive and of limitations or cessation of tain the continuity of services  10.84(b), ICF/IIDs at at \$486.625(b), CMHCs at ESRD Facilities at \$494.62(b): adures. (7) [or (6), (8)] The rangements with other are providers to receive patients tations or cessation of a tain the continuity of services  1403.748(b): Policies and the development of a tain the event of a tain of operations to maintain the continuity of services.  1503.748(b): Policies and the development of a tain of operations to maintain the continuity of services.  1503.748(b): Policies and the development of a tail of the event of the event of a tail of the event of the event of a tail of the event of the eve | n n                                     | make certain the plan proor agreements with other patients in the event the fato care for them during and 3. Inservice will be given of Planupon hire and to all demployees on 04/18/18 and 4. QA will review quarterly well as go over any emerging the quarter. | facilities to receive acility is not able acility is not able of emergency on the Emergency departments and their and annually thereafter. |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED   |  |
|--------------------------|--|--|--|---|---|--|
|                          | æ  | 495358   | B. WING                                |   | 03/09/2018  |  |
|                          | ROVIDER OR SUPPLIER  |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | D BE COMPLETION   |  |
| E 025                    | member) # 1, adm facility's emergency evidence document and/or any agreem facilities to receive is not able to care. ASM # 1 stated that We are still develo preparedness plant.  On 03/09/18 at application of the finding aware of the finding evidence in the state of the finding facility's emergence in the state of the state o | M (administrative staff inistrator. Review of the y preparedness plan failed to station of the arrangements ents the facility has with other patients in the event the facility for them during an emergency at the facility did not have it. ping the emergency."  proximately 11:00 a.m. ASM ff member) # 1, administrator, etor of nursing, were made | E 02                                   |   |   |  |
|                          | (b) Policies and p develop and imple policies and proce plan set forth in pa assessment at pa and the communic this section. The previewed and updiminimum, the policies the follow (8) [(6), (6)(C)(iv), [facility] under a win accordance with provision of care a   | rocedures. The [facilities] must ment emergency preparedness dures, based on the emergency aragraph (a) of this section, risk ragraph (a)(1) of this section, eation plan at paragraph (c) of solicies and procedures must be ated at least annually. At a cies and procedures must  |  | <ol> <li>1. Administrator will complete Eme PreparenessPlan that meets Feder and local emergency Preparedness requirements utilizing an all hazard Must have policies and procedure that describes the facilities role in pacare and treatment at altered care 1135 waiver.</li> <li>2. To ensure 100% accuracy Kent Coordinator of Emergency Manage Pete Svododa, Central Virginia He Coalition Medically, Vulnerable Population Coordinator, and Roge Assistant Administrator Heritage H will review Emergency Plan and conformation for accuracy and compliance with all State, Federal and Local Epreparedness guidelines.</li> </ol> | ral, State ss ds approach. is the plan providing sites under an  Emerson, ement and ealthcare  r Fracker lall, Blackstone sheck |  |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

| CENTER                   | S FOR MEDICARE  | & MEDICAID SERVICES  |                     |   | MP NO. 0836-0381                               |
|--------------------------|---|--|---------------------|---|--|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED                  |
|                          |   | 495358   | B. WING             |   | 03/09/2018                                     |
| NAME OF P                | ROVIDER OR SUPPLIER   |  | DIC                 | TREET ADDRESS, CITY, STATE, ZIP CODE  |  |
| AMELIA I                 | NURSING CENTER  |  |                     | 830 VIRGINIA STREET<br>MELIA, VA 23002  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | DBE COMPLETION                                 |
| E 026                    | procedures. (8) The waiver declared by with section 1135 of at an alternative carmanagement offici. This REQUIREME by:  Based on staff intereview it was deterfailed to have a copreparedness plan. The facility staff faprocedures in the the facility's role in at altered care site. The findings include On 03/09/18 at 9:: of the facility's emergency plan the providing care and under an 1135 was facility did not have emergency prepared. | and the Secretary, in accordance of Act, in the provision of care are site identified by emergency als.  Note in the facility document and that the facility staff amplete emergency and the that the facility staff amplete emergency and the providing care and treatment as under an 1135 waiver.  The sum a review and interview ergency preparedness plan was and the facility's role in the the facilit |                     | Cont #2 Must have policies and procedure in that describes the facilities role in procare and treatment at altered care so all 35 waiver.  3. Inservice will be given on the Emplan upon hire and to all department their employees on 04/18/18 and at thereafter.  4. QA will review quarterly and sign as well as go over any emergencies up during the quarter.  Completion is | ergency its and nnually  off on it s that came |

Facility ID: VA0002

No further information was obtained prior to exit.

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT                | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  | (X3) DATE SURVEY<br>COMPLETED |   |  |
|--------------------------|--|--|-------------------------------|---|--|
|                          |  | 495358   | B. WING                       |   | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |  |                               | STREET ADDRESS, CITY, STATE, Z<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  | IP CODE  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG            |   | TION SHOULD BE COMPLETION OATE   |
| E 029                    | emergency prepar<br>that complies with<br>and must be review<br>annually.<br>This REQUIREME<br>by:<br>Based on staff interview it was deter<br>failed to have a copreparedness plar<br>The facility staff fa   | ommunication Plan ust develop and maintain an edness communication plan Federal, State and local laws wed and updated at least SNT is not met as evidenced erview and facility document mined that the facility staff mplete emergency in liled to evidence that the facility munication plan and was  | E                             | 1. Administrator will components and local emergency Presequirements utilizing an attacked and update on an an an annual basis. | ets Federal, State paredness all hazards approach. nunication plan and annual basis.  acy Kent Emerson, y Management and rginia Healthcare erable and Roger Fracker leritage Hall, nergency Plan and check nce d Local Emergency . Will also check for |
|                          | of the facility's em conducted with AS member) # 1, adn facility's emergence vidence that the communication pl annual basis. AS not have it. We a emergency preparation of the communication of the communication pl annual basis. AS not have it. We a emergency preparation of the communication pl annual basis. AS not have it. We are emergency preparation of the communication of the conduction of the conductio | 15 a.m. a review and interview ergency preparedness plan was SM (administrative staff ninistrator. Review of the cy preparedness plan failed to facility had a written and was reviewed on an M # 1 stated that the facility did re still developing the redness plan."  oproximately 11:00 a.m. ASM aff member) # 1, administrator, ector of nursing, were made |                               | go over any emergencies quarter.  | artments and their and annually thereafter.  Iy and sign off on it as well as  |

Event ID:9FTO11

No further information was obtained prior to exit.

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ' '                 | PLE CONSTRUCTION  IG  | COMPLETED  |
|--|--|--|---------------------|---|--|
|  |  | 495358   | B. WING             |   | 03/09/2018   |
|  | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP COD<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY)   | HOULD BE COMPLETION  |
| E 030<br>E 030<br>SS=C   | CFR(s): 483.73(c)( [(c) The [facility, extransplant centers, maintain an emerge communication plastate and local law updated at least ar plan must include (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Other [facilities (v) Volunteers.  *[For RNHCls at § communication plast following: (i) Staff. (ii) Entities providing: (ii) Names and confollowing: (i) Staff. (iii) Entities providing: (iv) Other RNHCls (v) Volunteers.  *[For ASCs at §41 plan must include (1) Names and confollowing: (i) Staff. (ii) Staff. | to Information 1)  cept RNHCIs, hospices, and HHAs] must develop and ency preparedness in that complies with Federal, as and must be reviewed and anually. The communication all of the following:] Intact Information for the and services under arrangement. Intact information for the and must include all of the and services under arrangement. Intact information for the Indian services under arrangement. Intact information for the | E 03                | 1. Administrator will complete E PreparenessPlan that meets Fe and local emergency Prepared utilizing an all hazards approach include evidence that all facility and contact information were in comminication plan to be review  2. To ensure 100% accuracy Ke Coordinator of Emergency Man Pete Svododa, Central Virginia Coalition Medically, Vulnerable Population Coordinator, and Re Assistant Administrator Heritag will review Emergency Plan and for accuracy and compliance with all State and Federal Eme Preparedness guidelines. Ensuthat all facility contacts and convere included in the comminication be reviewed annually.  3. Inservice will be given on the upon hire and to all department employees on 04/18/18 and an annual state of the state of | ederal, State ness requirements ch. Must contacts cluded in the ved annually.  ent Emerson, ragement and Healthcare oger Fracker e Hall, Blackstone id check regency are there is evidence tact information ation plan  e Emergency Plan its and their |

|                          | EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A, BUILDING   |   | COMPLETED           |  |                |
|--------------------------|---|---|---------------------|--|----------------|
|                          |   | 495358  | B. WING _           |  | 03/09/2018     |
|                          | F PROVIDER OR SUPPLIER<br>A NURSING CENTER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                                |                |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)        | JLD BE COMPLET |
| E 03                     | following: (1) Names and confollowing: (i) Hospice employ (ii) Entities providin (iii) Patients' physi (iv) Other hospice:  *[For OPOs at §48 plan must include (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Volunteers. (iv) Other OPOs. (v) Transplant and Donation Service This REQUIREMIN by: Based on staff in review it was determined it was determined to have a confollowing preparedness plan  The facility staff facton and confollowing included it in the communication annually.  The findings included in the facility's enconducted with A | S418.113(c):] The an must include all of the intact information for the vees. Ing services under arrangement. cians. In all of the following: Intact information for the information information information information information information information information were included in information were included in information were included in information were included in information in plan and was reviewed |                     | 4. QA will review quarterly and sign as well as go over any emergence came up during the quarter.  Completion da | cies that      |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|---|--|---------------------|---|---|
|                          |   | 495358   | B. WING             |   | 03/09/2018  |
|                          | ROVIDER OR SUPPLIEF   |  | 8                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>MELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENT   | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LD BE COMPLETION  |
| E 030                    | evidence that all finformation were plan and was revithat the facility did developing the en On 03/09/18 at ap (administrative stand ASM # 2, dire aware of the findi   | cy preparedness plan failed to acility contacts and contact included in the communication ewed annually. ASM # 1 stated in not have it. We are still nergency preparedness plan."  oproximately 11:00 a.m. ASM aff member) # 1, administrator, ector of nursing, were madeings.        | E 030               |   |   |
| E 032<br>SS=C            | Primary/Alternate CFR(s): 483.73(c)  [(c) The [facility] remergency prepart that complies with and must be reviannually.] The coall of the following (3) Primary and a communicating with the computation with the communicating with the computation with the computation with the computation with the computation with the communication with the computation with | must develop and maintain an<br>aredness communication plan<br>h Federal, State and local laws<br>ewed and updated at least<br>mmunication plan must include   | E 032               | 2 1. Administrator will complete Eme PreparenessPlan that meets Feder and local emergency Preparednes utilizing an all hazards approach. I communication plan includes prima alternate means for communicating facility, staff, federal, state tribal an emergency management agencies  2. To ensure 100% accuracy Kent Coordinator of Emergency Manage Pete Svododa, Central Virginia He | ral, State as requirements Make certain ary and g with ad local  Emerson, ement and |
|                          | *[For ICF/IIDs at alternate means ICF/IID's staff, Foliocal emergency This REQUIREM by:  Based on staff is review it was detailed.  | s, tribal, regional, and local agement agencies.  §483.475(c):] (3) Primary and for communicating with the ederal, State, tribal, regional, and management agencies.  MENT is not met as evidenced enterview and facility document termined that the facility staff complete emergency |                     | Coalition Medically, Vulnerable Population Coordinator, and Roge Assistant Administrator Heritage H will review Emergency Plan and of for accuracy and compliance with all State, Federal and Local E Preparedness guidelines. Review to make certain it includes primary alternate means for communicatin facility, staff, federal, state tribal ar emergency management agencies        | r Fracker lall, Blackstone check  mergency complaince and g with nd local           |

|               | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |         |   | (X3) DATE SURVEY<br>COMPLETED   |
|---------------|--|--|--|---------|---|---|
|               |  | 495358   | B. WING                                |         |   | 03/09/2018  |
|               | ROVIDER OR SUPPLIER  NURSING CENTER  SUMMARY STA   | NTEMENT OF DEFICIENCIES  | D                                      | 88<br>A | TREET ADDRESS, CITY, STATE, ZIP CODE  330 VIRGINIA STREET  MELIA, VA 23002  PROVIDER'S PLAN OF CORRECT  |   |
| PRÉFIX<br>TAG | (EACH DEFICIENC)<br>REGULATORY OR L  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREF<br>TAG                            |         | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | DATE  |
| E 032         | documentation that includes primary at communicating with tribal, and local emagencies by review.  The findings included the facility's emergency at the facility's emergency alternate means for staff, Federal, Staff management ager communication plantacility did not have emergency prepart.  On 03/09/18 at ap (administrative staff) | led to provide evidence of the communication plan and alternate means for he facility staff, Federal, State, pergency management ving the communication plan.  Ite:  5 a.m. a review and interview ergency preparedness plan was M (administrative staff sinistrator. Review of the ey preparedness plan failed to mentation that the en includes primary and for communicating with facility re, tribal, and local emergency increase by reviewing the en. ASM # 1 stated that the et it. We are still developing the redness plan."  proximately 11:00 a.m. ASM off member) # 1, administrator, ctor of nursing, were made |  | 032     | 3. Inservice will be given on the Eupon hire and to all departments employees on 04/18/18 and annual.  4. QA will review quarterly and signs well as go over any emergency up during the quarter.  Completion date.   | and their<br>ally thereafter.<br>on off on it<br>ies that carne                 |
| E 033<br>SS=C | Methods for Shari<br>CFR(s): 483.73(c)<br>[(c) The [facility] memergency prepart<br>that complies with   |  |  | 033     | 1. Administrator will complete Emerg<br>Prepareness Plan that meets Federa<br>and local emergency Preparedness<br>utilizing an all hazards approach. Mu<br>documentation that the comminication<br>a method for sharing information and<br>documentation for patients under the<br>as necessary, with other health prov | al, State requirements ust contain on plan includes d medical e facilitys care, |

|   | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G  | (X3) DATE SURVEY<br>COMPLETED   |
|---|--|--|---------------------|--|---|
|   |  | 495358   | B. WING             |  | 03/09/2018  |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | STREET ADDRESS, CITY, STATE, ZIP CODE  8830 VIRGINIA STREET  AMELIA, VA 23002  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF CORRECTION CORRECTI | D BE COMPLETION   |
| E 033                                   | all of the following:  (4) A method for she documentation for care, as necessary maintain the continuous forms of the continuous facility's care as property of the continuous facility's care as property for the continuous facility it was determined for the continuous facility in the care providers care, based on the made by the patients under the care providers care, based on the made by the patients under the care providers care, based on the made by the patients under the with care providers care, based on the made by the patients under the with care providers care, based on the made by the patients under the with care providers care, based on the made by the patients under the with care providers care, based on the made by the patients under the with care as providing information and local facility's care as providers care as provided to the continuous facility is care as provided to the continuous fac | namunication plan must include naring information and medical patients under the [facility's] with other health providers to nuity of care.  It event of an evacuation, to ormation as permitted under 45 (ii). [This provision is not under §484.22(c), CORFs and RHCs/FQHCs under  The same of providing information condition and location of [facility's] care as permitted with the same of the s | E 03                | the continuity of care by reviewing the comminication plan and documentate that the facility has developed policies procedure that address the means the will use to release patient information include the general conditions and to find patients by reviewing the communication of patients by reviewing the communication of Emergency Manager Pete Svododa, Central Virginia Hear Coalition Medically, Vulnerable Population Coordinator, and Roger Assistant Administrator Heritage Hawill review Emergency Plan and chefor accuracy and compliance with all State, Federal and Local Empreparedness guidelines to make on there is documentation the facility in policies and procedures that address means of facility will use to release information to include the general cand location patients by reviewing communication plan.   | ion es and ne facility n to pocation nication  merson, nent and lthcare  Fracker II, Blackstone eck  mergency ertain mass as the patient conditions |

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED     |
|--------------------------|--|---|--|--|-----------------------------------|
|                          |  | 495358  | B. WING_                               |  | 03/09/2018                        |
|                          | PROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP COD<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   | DE                                |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY)   | HOULD BE COMPLETION               |
| E 033                    | documentation that includes a method medical documentation that policies and proceed the facility will use to include the generations by reviewing The findings included the facility's emergence evidence of documentation plays and proceed the facility's emergence evidence of documentation plays and plays a | led to provide evidence of at the communication plan for sharing information and ation for patients under the ecessary, with other health ain the continuity of care by munication plan and at the facility has developed dures that address the means to release patient information eral condition and location of any the communication plan.  Ite:  5 a.m. a review and Interview ergency preparedness plan was M (administrative staff inistrator. Review of the expreparedness plan failed to mentation that the ergency as the health providers to maintain the facility's care, as the health providers to maintain are by reviewing the an and documentation that the ped policies and procedures the facility will use to commation to include the general tion of patients by reviewing the ergency plan."  proximately 11:00 a.m. ASM |  | upon hire and to all department employees on 04/18/18 and an 4. QA will review quarterly and as well as go over any emerge came up during the quarter. | nts and their inually thereafter. |
|                          | (administrative sta  | off member) # 1, administrator, ctor of nursing, were made  |  |  |                                   |

Facility ID: VA0002

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING   | COMPLETED   |
|--------------------------|--|---|--|---|
|                          |  | 495358  | B. WING  | 03/09/2018  |
|                          | PROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP CO<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  | DE  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)  | SHOULD BE COMPLETION  |
| E 034                    | Continued From pa<br>aware of the finding<br>No further informat<br>Information on Occ<br>CFR(s): 483.73(c)(                                     | gs.<br>ion was obtained prior to exit.<br>cupancy/Needs   | E 033  E 034 1. Administrator will complete Emerger  | псу   |
|                          | [(c) The [facility] memorgency prepare that complies with and must be review annually.] The compall of the following:                            | ust develop and maintain an<br>edness communication plan<br>Federal, State and local laws<br>wed and updated at least<br>imunication plan must include  | PreparenessPlan that meets Federal, and local emergency Preparedness reutilizing an all hazards approach. Will communication plan includes a means information about the facilitys needs, a ability to provide assistance to the autifursdiction the incident command center by reviewing the communication plan at that the comminication plan includes a | equirements ensure the of providing and its nority having er, or designee and documentation |
|                          | about the [facility's ability to provide as  | eans of providing information ] occupancy, needs, and its ssistance, to the authority the Incident Command ee.  | providing information about their occup  2. To ensure 100% accuracy Kent Em Coordinator of Emergency Manageme  | erson,<br>ent and   |
|                          | providing informati<br>its ability to provide  | .54(c)]: (7) A means of<br>ion about the ASC's needs, and<br>a assistance, to the authority<br>the Incident Command<br>ee.  | Pete Svododa, Central Virginia Health Coalition Medically, Vulnerable Population Coordinator, and Roger Fr. Assistant Administrator Heritage Hall, will review Emergency Plan and chec for accuracy and compliance with all State, Federal and Local Emergency   | acker<br>Blackstone<br>k  |
|                          | of providing informinpatient occupant provide assistance jurisdiction, the Incidesignee. This REQUIREME by: Based on staff intreview it was dete | spice at §418.113:] (7) A means nation about the hospice's cy, needs, and its ability to e, to the authority having cident Command Center, or ENT is not met as evidenced serview and facility document rmined that the facility staff amplete emergency n. | Preparedness guidelines and ensure comminication plan includes a means of providing information about the facilitys needs, ability to provide assistance to the aut jursdiction the incident command cent by reviewing the communication plan that the comminication plan includes a providing information about their occur.                              | and its thority having ter, or designee and documentation a means of                        |

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|--|--|---------------------|--|--|
|                          | , continuenten   |  |                     |  | 02/00/2019   |
|                          |  | 495358   | B. WING             | TREET ADDRESS, CITY, STATE, ZIP  | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |  | 8                   | REET ADDRESS, CITY, STATE, ZIP<br>830 VIRGINIA STREET<br>AMELIA, VA 23002  | CODE   |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY)   | N SHOULD BE COMPLETION DATE  |
| E 034                    | The facility staff fai documentation that includes a means the facility's needs assistance, to the incident Command reviewing the commodocumentation that includes a means their occupancy.  The findings included on 03/09/18 at 9: of the facility's emergence of documentation plant of the providing information and its ability to providing information of the mergency preparation of the mergency preparation of the providing information of the mergency preparation of the mergency preparation of the mergency preparation of the mergency preparation of 03/09/18 at at (administrative stational communication of the mergency preparation of 03/09/18 at at (administrative stational communication of the mergency preparation of 03/09/18 at at (administrative stational command communication of the mergency preparation of 03/09/18 at at (administrative stational communication of the mergency preparation of 03/09/18 at at (administrative stational communication of the mergency preparation of the mergency preparati | iled to provide evidence of it the communication plan of providing information about, and its ability to provide authority having jurisdiction, the id Center, or designee by munication plan and at the communication plan of providing information about de:  15 a.m. a review and interview ergency preparedness plan was SM (administrative staff inistrator. Review of the cy preparedness plan failed to mentation that the an includes a means of the cion about the facility's needs, rovide assistance, to the urisdiction, the incident redness plan failed to evidence at the communication plan of providing information about ASM # 1 stated that the facility's redness plan."  Deproximately 11:00 a.m. ASM aff member) # 1, administrator, ector of nursing, were made |                     | 3. Inservice will be given on upon hire and to all departremployees on 04/18/18 and 4. QA will review quarterly a go over any emergencies the quarter. | ments and their d annually thereafter. and sign off on it as well as |
|                          | No further inform  | ation was obtained prior to exit.  |                     |  |  |

Facility ID: VA0002

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

| CENTER                   | S FUR WEDICARE   | & WEDICAID SERVICES  |                   |   | LOVEN DATE SURVEY  |
|--------------------------|--|--|-------------------|---|--|
| STATEMENT<br>AND PLAN O  | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |
|                          |  | 495358   | B. WING           |   | 03/09/2018   |
| NAME OF F                | PROVIDER OR SUPPLIER   | h  |                   | STREET ADDRESS, CITY, STATE, ZIP CODE   |  |
| AMELIA                   | NURSING CENTER   |  |                   | 8830 VIRGINIA STREET<br>AMELIA, VA 23002  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |   | OULD BE COMPLETION   |
| E 035                    | CFR(s): 483.73(c)  | haring Plan with Patients<br>8)  |                   | 1. Administrator will complete En<br>PreparenessPlan that meets Fe<br>and local emergency Prepared<br>utilizing an all hazards approace<br>evidence of documentation that   | deral, State<br>ness requirements<br>n must include  |
|                          | and maintain an er<br>communication pla<br>State and local law<br>updated at least at  | ty and ICF/IID] must develop mergency preparedness on that complies with Federal, as and must be reviewed and noually.] The communication all of the following:                                      |                   | plan includes a method for shar<br>from the emergency plan, and the<br>has determined it is appropriate<br>and their families or representat<br>the plan.   | ng information<br>nat the facility<br>with resident<br>ive by reviewing                                      |
|                          | emergency plan, to<br>is appropriate, with<br>families or represe<br>This REQUIREME<br>by:<br>Based on staff intreview it was dete | erview and facility document rmined that the facility staff amplete emergency  |                   | 2. To ensure 100% accuracy Ke Coordinator of Emergency Man Pete Svododa, Central Virginia Coalition Medically, Vulnerable Population Coordinator, and Ro Assistant Administrator Heritage will review Emergency Plan an for accuracy and compliance with all State and Federal Emer Preparedness guidelines. Also evidence of documentation that plan includes a method for sha | agement and Healthcare ger Fracker e Hall, Blackstone d check gency ensure plan includes t the comminication |
|                          | documentation the includes a method the emergency pladetermined it is as   | illed to provide evidence of<br>at the communication plan<br>if for sharing information from<br>an, and that the facility has<br>opropriate with residents or<br>amilies or representatives by<br>i. |                   | from the emergency plan, and has determined it is appropriat and their families or representathe plan.  3. Inservice will be given on the upon hire and to all department employees on 04/18/18 and an arms.  | that the facility e with resident ative by receiving e Emergency Plan and their                              |
|                          | The findings inclu   |  |                   | Letter to families regarding em<br>and where they can find it.  | ergency prepardness  |
|                          | of the facility's emconducted with Atmember) # 1, addrawlers facility's emergen  | 15 a.m. a review and interview ergency preparedness plan was SM (administrative staff ninistrator. Review of the cy preparedness plan failed to mentation that the                                   | S                 | QA will review quarterly and<br>go over any emergencies that<br>quarter.  Completion  | sign off on it as well as came up during the date 04/23/18   |

communication plan includes a method for sharing information from the emergency plan,

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|---|--|---------------------|--|---|
|                          |   | 495358   | B. WING             |  | 03/09/2018  |
|                          | PROVIDER OR SUPPLIER  |  | 88                  | REET ADDRESS, CITY, STATE, ZIP CODE<br>130 VIRGINIA STREET<br>MELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | D BE COMPLETION   |
| E 035                    | appropriate with re families or represe ASM # 1 stated that We are still develo preparedness plan On 03/09/18 at apple (administrative state and ASM # 2, direct aware of the finding   | has determined it is sidents or clients and their intatives by reviewing the plan. at the facility did not have it. ping the emergency a."  proximately 11:00 a.m. ASM ff member) # 1, administrator, ctor of nursing, were made ags.  | E 035               |  |   |
| E 039<br>SS=C            | EP Testing Requir<br>CFR(s): 483.73(d)<br>(2) Testing. The [far<br>RNHCIs and OPC<br>test the emergence   | (2) acility, except for LTC facilities, bs] must conduct exercises to by plan at least annually. The RNHCIs and OPOs] must do  | E 039               | 1. Administrator will complete Emerging Prepareness Plan that meets Federa and local emergency Preparedness utilizing an all hazards approach. Pinclude evidence of documentation facilitys exercise analysis and responsible to the facility updated its emergeness program based on exercise analysis  | al, State<br>s requirements<br>lan must<br>of the<br>onse and<br>ncy    |
|                          | The LTC facility methe emergency play unannounced start procedures. The Lefollowing:]  (i) Participate in a community-based exercise is not act facility-based. If the actual natural or requires activation [facility] is exemple community-based. | s at §483.73(d):] (2) Testing. sust conduct exercises to test an at least annually, including if drills using the emergency TC facility must do all of the full-scale exercise that is for when a community-based cessible, an individual, the [facility] experiences an man-made emergency that the of the emergency plan, the the from engaging in a display of the onset of the for 1 year following the onset of | of *                | 2. To ensure 100% accuracy Kent E Coordinator of Emergency Manager Pete Svododa, Central Virginia Heat Coalition Medically, Vulnerable Population Coordinator, and Roger Assistant Administrator Heritage Hawill review Emergency Plan and chror accuracy and compliance with all State, Federal and Local En Preparedness guidelines. Check for of documentation of the facilitys exercise analysis and responders to the facility of the facility updated its emergence of the program based on exercise analysis. | ment and althcare Fracker all, Blackstone neck mergency r evidence ency |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED   |   |
|---|--|---|---------------------|---|---|
|   |  | 495358  | B. WING             |   | 03/09/2018  |
|   | PROVIDER OR SUPPLIER   |   | 88                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>330 VIRGINIA STREET<br>MELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREI<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)                                | OULD BE COMPLETION  |
| E 039   | include, but is not (A) A second fur community-based (B) A tabletop er discussion led by clinically-relevant of problem statem prepared question emergency plan. (iii) Analyze the [farmaintain document exercises, and emergency exercises and exercises and exercises and emergency plan. (ii) Conduct a paper least annually. A discussion led by clinically relevant of problem statem prepared question emergency plan. (ii) Analyze the [for exercises, and emergency exercises.  This REQUIREM by: Based on staff in review it was determined. | ditional exercise that may limited to the following: III-scale exercise that is or individual, facility-based. xercise that includes a group a facilitator, using a narrated, emergency scenario, and a set tents, directed messages, or as designed to challenge an acility's] response to and nation of all drills, tabletop nergency events, and revise the ney plan, as needed.  \$403.748 and OPOs at resting. The [RNHCI and OPO] arcises to test the emergency and OPO] must do the oper-based, tabletop exercise at rabletop exercise is a group a facilitator, using a narrated, emergency scenario, and a set nents, directed messages, or ans designed to challenge an accumentation of all tabletop mergency events, and revise the PO's] emergency plan, as  ENT is not met as evidenced anterview and facility document termined that the facility staff complete emergency | E 039               | upon hire and to all department employees on 04/18/18 and ann 4. QA will review quarterly and go over any emergencies that c quarter. | ts and their nually thereafter. sign off on it as well as |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   | TIPLE CONSTRUCTION  |           | TE SURVEY<br>MPLETED  |
|--------------------------|--|--|-------------------|---|-----------|---|
|                          |  | 495358   | B. WING           | <u> </u>  | 03        | /09/2018  |
|                          | PROVIDER OR SUPPLIER   |  |                   | STREET ADDRESS, CITY, STATE, ZIP CO<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | DDE       |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | -co offence toes to THE   | SHOULD BE | (X5)<br>COMPLETION<br>DATE  |
| E 039                    | Continued From pa  | age 34   | E                 | 039   |           |   |
|                          | documentation of tand response and   | iled to provide evidence of<br>the facility's exercise analysis<br>how the facility updated its<br>m based on the exercise   | 60                |   |           | E   |
|                          | The findings include   | de:  |                   |   |           |   |
|                          | of the facility's emerconducted with AS member) # 1, adm facility's emergence evidence of documexercise analysis facility updated its the exercise analysis. | 15 a.m. a review and interview ergency preparedness plan was in (administrative staff hinistrator. Review of the cy preparedness plan failed to mentation of the facility's and response and how the emergency program based on rsis. ASM # 1 stated that the e it. We are still developing the redness plan." |                   |   |           | H. Description of the state of |
| ls.                      | (administrative sta  | proximately 11:00 a.m. ASM aff member) # 1, administrator, ctor of nursing, were made ags.   | 1                 |   |           |   |
| F 000                    | No further informa   | ation was obtained prior to exit.<br>NTS   | F                 | 000   |           |   |
|                          | survey was condu<br>03/09/18. Correct<br>compliance with the<br>the Federal Long   | Medicare/Medicaid standard poted from 03/06/18 through tions are required for the following 42 CFR Part 483 or Term Care requirements. The purvey/report will follow.  |                   |   |           |   |
| si .                     | The census at this   | s 100 certified bed facility was<br>he survey. The survey sample   |                   |   |           | į.  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ` '                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |   | (X3) DATE SURVEY<br>COMPLETED                             |  |
|--------------------------|---|--|---------------------|--|---|---|--|
|                          |   | 495358   | B. WING _           |  | 03/   | 09/2018   |  |
|                          | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, 2<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   | IP CODE   |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENCE   | TION SHOULD BE<br>THE APPROPRIATE   | (X5)<br>COMPLETION<br>DATE                                |  |
| F 000 F 583 SS=D         | 9, 33, 61, 41, 8, 31 63,19,76,137,15,50 Residents #s (88 a Personal Privacy/C CFR(s): 483.10(h) §483.10(h) Privacy The resident has a confidentiality of hir records. §483.10(h)(l) Pers accommodations, telephone commu and meetings of fa this does not requiprivate room for ea §483.10(h)(2) The residents right to privacy in liverity to privacy in liverity to send a mail and other lett materials delivere including those de than a postal serv §483.10(h)(3) The and confidential p (i) The resident ha of personal and m provided at §483. federal or state la (ii) The facility mu Office of the State | rent residents Resident #s (56, 25, 70, 72, 6, 2,10) and two closed records, and 87). Confidentiality of Records (1)-(3)(i)(ii)  I and Confidentiality. I right to personal privacy and sor her personal and medical conal privacy includes medical treatment, written and nications, personal care, visits, amily and resident groups, but the facility to provide a fach resident.  I facility must respect the personal privacy, including the personal privacy includes the personal privacy i |                     | corrective action RN # 1 apologized to res 3/14/2018 for doing his t closing window blinds.  CNA #4 apologized to re 3/15/2018 for providing of the window blinds.  Other potential Any resident residing on residents # 25 and 15 co for receiving care or trea he window blinds.  System Changes 1. Clinical staff is being of privacy regarding closing (blinds or curtains), clos pulling privacy curtain ar between resident and ro and treatments  2. During rounds, the cli social worker, and admi validate privacy is being and treatments, with atte treatments (blinds or cur | the same unit as buld have been at ristments without closing the window treatments without closing the window treatments during the room door, round resident and commate during car inical leadership teanistrator will observe respected during cention to the window | sk<br>sing t<br>int<br>nents<br>e<br>em,<br>re to<br>care |  |

| STATEMENT                | OF DEFICIENCIES<br>F CDRRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     |     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|---------------------|-----|---|---|
|                          |  | 495358  | B. WING             | -0  |   | 03/09/2018  |
| NAME OF F                | PROVIDER OR SUPPLIER   | 493350  |                     |     | REET ADDRESS, CITY, STATE, ZIP CODE   | 00/00/2010  |
|                          | NURSING CENTER   |   |                     | 88  | 30 VIRGINIA STREET<br>MELIA, VA 23002   |   |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | x   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE)   | D BE COMPLETION   |
| F 583                    | administrative recollaw.  This REQUIREME by: Based on observainterview, facility direview, it was deterorised privacy duresidents in the suand # 25.  1. The facility staff blinds while preparent for a shower are 2. The facility staff blinds while provided blinds while provided 15.  The findings included 1. The facility staff blinds while preparent for a shower, and Resident # 25 was 11/30/2017 with denote the limited to malify with mets [metast stenosis (3).  Resident # 25's metast stenosis (3).   | NT is not met as evidenced ation, resident interview, staff ocument review, clinical record rmined the facility staff failed to ring care for two of 20 rvey sample, Residents # 15 failed to close the window ring and transferring Resident # and during wound care.  If failed to close the window ling a bed bath to Resident # and during wound care.  If failed to close the window ring and transferring Resident # and during wound care.  If failed to close the window ring and transferring Resident # and during wound care.  If sadmitted to the facility on inagnoses that included but were gnant neoplasm of prostate (1) asis] (2) to the spine and spinal most recent MDS (minimum data assessment with an ARD rence date) of 12/07/17, coded |                     | 583 | 3. 1:1 education will be provided staff persons who are observed non-compliant with closing windor during care and treatments.  4. During resident council meeting Activities Director will ask resident the window blinds or curtains are closed during care and treatment negative responses/concernsregulated the closure of window curtains for will be relayed to the Director of for intervention with staff persons.  Monitoring  1. A report of areas of non-composition be submitted to the Director of Nurse for trends. A report of areas of recommendations.  Completion Date of the provided staff of the commendations. | to be ow blinds  ags, the onts if the being ts. Any parding or care of the Nursing st.  bliance will be sing for analysis on compliance arterly QAPI on and further |
|                          | interview for mental and the control of the control | scoring a 15 on the brief tal status (BIMS) of a score of 0 gnitively intact for making daily ent # 25 was coded as requiring to being totally dependent of   |                     |     |   | Name Constitution   |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPI<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|--|-----------------------------|--|-------------------------------|
|                          |  | 495358   | B. WING                     | TREET ADDRESS, CITY, STATE, ZIP CODE   | 03/09/2018                    |
|                          | PROVIDER OR SUPPLIER   |  | 8                           |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION                 |
| F 583                    | personal hygiene at On 03/07/18 at app CNA's (certified nu Resident # 25's ro a shower chair. The room and pulled the and B-side of the room the B-side of the The window looke and had blinds. Fur evealed they were 25 was observed the back of the go 25's backside. When the bed window, the hospi Resident # 25's backside. | embers for dressing, toileting, and bathing.  proximately 11:05 a.m., three arsing assistants) entered om to transfer Resident # 25 to the CNAs closed the door to the privacy curtain dividing the A room. Resident # 25's bed was the room next to the window. It is done to the facility's parking lot urther observation of the blinds the raised and open. Resident # wearing a hospital gown with the window was assisted Resident # the CNAs assisted Resident # the CNAs assisted Resident # the CNAs assisted Resident the CNAs assisted Resident the tal gown was open exposing the tal gown was open exposing ackside to the window and to anyone that may be outside   | F 583                       |  |                               |
|                          | observation was on RN (registered nupreparations for was to up, RN # 1 and Resident #25's between was closed and the and window bed (The window blind approximately 1/3 and the yard and Resident #25's between the front of his book this hospital gown   | B a.m., a wound care conducted for Resident #25 with rse) # 1 and CNA # 4. Once wound care was completed and d CNA # 4 approached edside. The door to the room the curtain between the door bed Resident #25's bed) was pulled as were noted to be softhe way pulled up (open), parking lot was visible from ed. CNA # 4 turned the resident wound care by the nurse. The tioned onto his left side, so that dy was facing the open window was pulled up and he was bare with the resident was pulled up and he was bare was pulled up and he was bare was pulled up and he wa |                             |  |                               |

| O TALLEMENT OF DELICITIES AND ADED |   | (X2) MULTIPLE CONSTRUCTION A, BUILDING   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|------------------------------------|---|--|---------------------|---|-------------------------------|----------------------------|
|                                    |   | 495358   | B. WING             |   | 03                            | /09/2018                   |
|                                    | PROVIDER OR SUPPLIER NURSING CENTER   | 1  | 8:                  | TREET ADDRESS, CITY, STATE, ZIP COD<br>830 VIRGINIA STREET<br>MELIA, VA 23002   | Æ                             |                            |
| (X4) ID<br>PREFIX<br>TAG           | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SECTION SEC | HOULD BE                      | (X5)<br>COMPLETION<br>DATE |
| F 583                              | potentially visible to the opened windown this position from On 03/07/18 at 2:5 conducted with Chassisted with Resi 4 stated yes. Whethe wound care Chosed and the printhe bed." When a closed during would conducted with Rimanager. When a followed for province and treatment pull the privacy curesident you are pull the privacy curesident you are provinced to the observation of during the wound | o anyone that may be outside w. The resident remained in 11:37 a.m., to 12:22 p.m.  69 p.m., an interview was IA # 4. When asked if she dent # 25's wound care CNA # en asked about privacy during NA # 4 stated, "The door was vacy curtain was pulled around sked if the window blinds were nd care, CNA # 4 stated, "No."  43 p.m., an interview was N (registered nurse) # 1, unit sked to describe the process ling privacy during personal ats, RN # 1 stated, "You need to reviding care to and shut the mate in present at the time of the roommate does not invade is privacy. When informed of the window blinds being open care and transfer care provided RN #1 stated, "Blinds should | F 583               |   |                               |                            |
|                                    | Resident # 25 rev<br>neat lying in bed.<br>blinds being open<br>care on 03/07/18,<br>Observation of Re<br>window blind lowed<br>closed. When as   | 20 a.m., an observation of realed he appeared clean and When asked about the window during his transfer and wound Resident# 25, "I don't know." resident # 25's room revealed the red, covering the window and ked if he preferred to have the en or closed Resident # 25 did canswer.   |                     |   |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULT<br>A. BUILDIN   | IPLE CONSTRUCTION  NG | (X3) DATE SURVEY<br>COMPLETED  |                      |
|--|---|---|-----------------------|--|----------------------|
|  |   | 495358  | B. WING_              |  | 03/09/2018           |
|  | PROVIDER OR SUPPLIER  |   |                       | STREET ADDRESS, CITY, STATE, ZIP CO<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002      | ODE                  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE COMPLETION |
| F 583  | interview with was practical nurse) # 1 of Resident # 25. always oriented. Honoral oriented with CN describe how privatesident's care or the bath or shower, Cl closed and the private asked if she assistichair with two other When asked if Reshospital gown and open, CNA # 2 starecalled the positic transfer, CNA # 2 all checked the wire were closed. It did | age 39 broximately 9:30 a.m., an conducted with LPN (licensed I regarding the cognitive ability LPN # 1 stated, "He is not the has periods of confusion."  33 a.m., an interview was IA#2. When asked to acy is provided during a stransfer for preparation for a NA#2 stated, "Doors are vacy curtain is pulled." When ted Resident # 25 into a shower or CNAs, CNA#2 stated, "Yes." sident # 25 was wearing a if the back of the gown was ted, "Yes". When asked if she on of the blinds at the time of stated, "No. We should have andow to make sure the blinds dn't even cross my mind to look cused on helping with the | T                     | 83   |                      |
|  | conducted with CN asked to describe a resident's care of bath or shower, C and closed the do window blinds. W window blinds in F transfer in his root 25) has told me in his blinds closed." preference for not documented some just word of mouth  | :03 a.m., an interview was NA #1 regarding privacy. When how privacy is provided during or transfer for preparation for a NA # 1 stated, "Pull the curtain, or to the room and close the hen asked about closing the Resident # 25's room during his m, CNA # 1 stated, "(Resident # 1 the past that he doesn't want when asked if Resident # 25't having the blinds closed was ewhere, CNA # 1 state, "No it is n." When informed of the norning of Resident # 25's  | £ S                   |  |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | 1 ` '   | IPLE CONSTRUCTION   | COMPLETED   |                   |
|--|--|---|---------------------|---|-------------------|
|  |  | 495358  | B. WING_            |   | 03/09/2018        |
|  | PROVIDER OR SUPPLIER   | ₹   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                     |                   |
| (X4) ID<br>PREFIX<br>TAG   | (FACH DEFICIENT  | TATEMENT OF DEFICIENCIES<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIOR DEFICIENCY) | JLD BE COMPLETION |
| F 583  | window blinds bei<br>expressed by the<br>window blinds, Cl<br>The facility's polic<br>documented, "4.<br>when care or med<br>provided." On 03/08/18 at a<br>(administrative st | Ing closed and no concerns Resident #25 regarding his NA# 1 stated, "I don't know."  BY "Resident's Rights" Privacy. C. To have privacy dical treatment is being  Deproximately 5:00 p.m. ASM aff member) # 1, the I ASM # 2, director of nursing               | F 5                 | 83  |                   |
|  | ,  | ation was provided prior to exit.   |                     |   |                   |
|  | prostate gland. T<br>walnut-shaped st<br>man's reproducti<br>urethra, the tube<br>body. This inform<br>website:<br>https://medlineple  | per is cancer that starts in the the prostate is a small, tructure that makes up part of a ve system. It wraps around the that carries urine out of the nation was obtained from the us.gov/ency/article/000380.htm   |                     |   |                   |
|  | the blood or lymp<br>surfaces. This in<br>website:<br>http://www.diction<br>(3) A narrowing of<br>pressure on the<br>openings (called<br>nerves leave the<br>was obtained fro  | other parts of the body by way on the body by way of the body by way of the spinal column that causes spinal cord, or narrowing of the neural foramina) where spinal column. This information the website:  Justice 1 (1997) 1997 1997 1997 1997 1997 1997 1997 | s l                 |   |                   |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|--|--|-------------------------------|--|
|                          |  | 495358  | B. WING                                |  | 03/09/   | 2018                          |  |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                    |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | TOTAL TOTAL CONTROL OF THE PARTY OF THE PART | (X5)<br>OMPLETION<br>OATE     |  |
| F 583                    | Continued From pa  | age 41  | F 5                                    | 83   |  |                               |  |
|                          | The facility staff blinds while providing.   | failed to close the window ng a bed bath to Resident#   |  |  |  |                               |  |
|                          | 03/13/2014 with a diagnoses that includerebral infarction  | admitted to the facility on readmission of 03/01/2017 with uded but were not limited to (1), chronic kidney disease (2), sphagia (4) and heart disease.   |  |  | Y  |                               |  |
|                          | set), an annual ass<br>(assessment refer<br>Resident # 15 as s<br>interview for mental<br>(zero) - 15, 3 (three<br>cognition for making<br>15 was coded as b   | set recent MDS (minimum data sessment with an ARD ence date) of 12/13/17, coded scoring a 3 (three) on the brief at status (BIMS) of a score of 0 e) being severely impaired of a daily decisions. Resident # being totally dependent of one ers for activities of daily living.  |  |  |  |                               |  |
|                          | was conducted on Resident # 15 resident # 15 resident # 15 resident # 15's room Resident # 15's room Resident # 15. Resident # 15's with e A and B-sides Resident # 15's with were left open durn Resident # 15's with a facility's parking loom facility. At approximanager RN (regimanager entered | Resident # 15's personal care 03/07/18 at 10:34 a.m. ded on B-side of the room with utside next to his bed. CNA assistant) # 4 was present in om providing a bed bath to esident # 15's door was closed as pulled closed, to separate of the room. The blinds on indow on the B-side of the rooming Resident # 15's bed bath. Indow looked out onto the and front entrance to the imately 10:53 a.m. the unit stered nurse) #9, the unit Resident # 15's room, went to oom and asked CNA # 4 if she |  |  |  |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE (<br>A. BUILDING   | (X3) DATE SURVEY<br>COMPLETED |  |                |
|--|---|--|-------------------------------|--|----------------|
|  |   | 495358   | B. WING                       |  | 03/09/2018     |
|  | PROVIDER OR SUPPLIER  |  | 883                           | EET ADDRESS, CITY, STATE, ZIP CODE<br>0 VIRGINIA STREET<br>ELIA, VA 23002                                    |                |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLÉTIC |
| F 583  | Resident # 15 was On 03/07/18 at 2:5 conducted with CN care provided to R she provided a cor and changed Resid dressed him. Whe process of providir CNA # 4 stated, "K tell them what I'm curtain, and close ADL (activities of c if privacy was prov his personal care, informed of the ob being open during Resident # 15, CN blinds. They shou On 03/07/18 at 1:4 (registered nurse) asked to describe privacy during personeed to pull the pr the resident you at the door. If the roo of care make sure invade the other re informed of the ob being open during to Resident # 15, have been closed to check the windo | s, she then left the room while still being dressed.  9 p.m., an interview was IA # 4 regarding the personal esident # 15. CNA # 4 stated inplete bed bath, mouth care dent # 15's clothes and en asked to describe the ing privacy during personal care, finock on the resident's door, going to do, pulled the privacy the door. Then proceed with daily living) care." When asked ided for Resident # 15 during CNA #4 stated, "Yes." When servation of the window blinds the care she provided to IA # 4 stated, "I forgot about the Id be closed during care."  43 p.m. an interview with RN # 1, unit manager. When the process for providing sonal care, RN # 1 stated, "You ivacy curtain around the bed of re providing care to and shut ommate in present at the time of the window blinds the care provided by CNA # 4 RN #1 stated, "Blinds should. It didn't even cross my mind |                               |  |                |
|  | administrative sta  | ASM # 2, director of nursing   | i                             |  | i i            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |  |
|--|---|--|---------------------|--|--|
|  |   | 495358   | B. WING             | 115 s =  | 03/09/2018   |
|  | PROVIDER OR SUPPLIER  |  | 88                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>330 VIRGINIA STREET<br>MELIA, VA 23002   |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)   | ULD BE COMPLETION  |
| F 583  | Continued From pa   |  | F 583               |  |  |
|  | Transfer and Disch CFR(s): 483.15(c)( §483.15(c)(1) Faci (i) The facility must remain in the facility discharge the reside (A) The transfer or resident's welfare cannot be met in the facility of the transfer or because the reside sufficiently so the reside sufficiently so the reside (C) The safety of it endangered due to status of the reside | arge Requirements 1)(i)(ii)(2)(i)-(iii)  er and discharge- lity requirements- t permit each resident to ty, and not transfer or dent from the facility unless- discharge is necessary for the and the resident's needs the facility; discharge is appropriate ent's health has improved resident no longer needs the by the facility; andividuals in the facility is to the clinical or behavioral | F 622               | 1.corrective action  Resident #63 was transferred to he 1/18/2018 per physician order dust change in the resident's condition required extensive hospitalization treatment that could not be provided nursing facility. Resident did not negative outcome related to the physician documentation justifying hospital transfer.  Resident #56 was transferred to ER on 12/30/17 per physician ordered in the resident's condition experienced no negative outcom lack of physician documentation hospital transfer. | e to a n and n and ded by the experience lack of g the the hospital der due to a on. Resident e related to |
|  | otherwise be enda (E) The resident h appropriate notice under Medicare or Nonpayment appli submit the necess payment or after t Medicare or Medic resident refuses to resident who become admission to a fact resident only allow or (F) The facility cea   | angered; as failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. es if the resident does not eary paperwork for third party he third party, including caid, denies the claim and the pay for his or her stay. For a smes eligible for Medicaid after stay, the facility may charge a wable charges under Medicaid;   |                     | 2.other potential  Any resident residing in facility, where transferred to hospital ER for evaluation or admission could haffected by the lack of document justifying the transfer to acute can a systemic Changes  • Physician and non-physician practitioners will be educated or importance of documenting reast transfer to the acute care setting medical record and/or including or transfer in their orders.  | for ave been intation are setting.  In the son for g in the  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  | E SURVEY<br>PLETED         |
|--------------------------|--|--|---------------------|---|--|----------------------------|
|                          |  | 495358   | B. WING _           |   | 03/  | 09/2018                    |
| ,                        | PROVIDER OR SUPPLIER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   | DDE  |                            |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENCY   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE  | (X5)<br>COMPLETION<br>DATE |
| F 622                    | § 431.230 of this of exercises his or he discharge notice for 431.220(a)(3) of the discharge or transfor safety of the restacility. The facility that failure to transfor safety of the restacility. The facility that failure to transform the facility to tresident under any In paragraphs (c)(1) section, the facility or discharge is downedical record and communicated to the institution or provide (i) Documentation must include:  (A) The basis for the case of section, the specific be met, facility attended, and the sefacility to meet the (ii) The document (2)(i) of this section.  (A) The resident's discharge is necessary under part of the section.  (iii) Information promust include a mineral include a mineral section. | hapter, when a resident r right to appeal a transfer or om the facility pursuant to § is chapter, unless the failure to fer would endanger the health ident or other individuals in the must document the danger fer or discharge would pose.  Jumentation.  ansfers or discharges a of the circumstances specified (i)(i)(A) through (F) of this must ensure that the transfer cumented in the resident's dappropriate information is the receiving health care for.  In the resident's medical record the transfer per paragraph (c)(1) paragraph (c)(1)(i)(A) of this ic resident need(s) that cannot empts to meet the resident rvice available at the receiving need(s).  ation required by paragraph (c) must be made byphysician when transfer or sarry under paragraph (c) (1) ection; and the transfer or discharge is paragraph (c)(1)(i)(C) or (D) of covided to the receiving provider nimum of the following: |                     | 22 Licensed nurses will be educted documentation of assessment condition and communication. If a verbal order is obtained to resident to an acute care setting absence of the physician being the nursing facility, the physician include the reason for transfectore setting.  4. Monitoring  • DON or designee will audite records of residents who transhospital to validate document assessment supporting the retransfer as well as presence order or documentation station resident transfer to acute car.  • DON or designee will submareas of non-compliance in the QAPI committee meeting for further recommendations. | t of resident to the provider to transfer the ing in the ing on-site at itan order will r to the acute  clinical sferred to tation of eason for of a physician ing reason for e setting.  it a report of the quarterly |                            |
|                          | (A) Contact inform   | nation of the practitioner   |                     |   |  |                            |

|                          | OF DEFICIENCIES<br>CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING _       | CONSTRUCTION  | COMPLETED       |  |
|--------------------------|---|---|---------------------|---|-----------------|--|
|                          |   | 495358  | B. WING             |   | 03/09/2018      |  |
|                          | ROVIDER OR SUPPLIER   |   | 88                  | REET ADDRESS, CITY, STATE, ZIP CODE<br>30 VIRGINIA STREET<br>MELIA, VA 23002                                  |                 |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PERICIENCY) | D BE COMPLETION |  |
| F 622                    | (B) Resident repre contact information (C) Advance Direct (D) All special instruction ongoing care, as a (E) Comprehensiv (F) All other necest copy of the resider consistent with §44 any other docume a safe and effective This REQUIREMED by:  Based on staff intrand clinical record the facility staff fair the physician in the two of 20 residents Residents #63 and hospital. | care of the resident. sentative information including tive information ructions or precautions for ppropriate.  |                     |   |                 |  |
|                          | the hospital on 1/1<br>notes documented<br>the reason the fac   | 8/18. There were no physician<br>in the clinical record justifying<br>illity was not able to manage the<br>n, and why Resident #63  |                     |   | £:              |  |
|                          | documentation from specific needs the efforts to meet the needs the receiving the needs of Resi   | ff failed to provide written om the physician evidencing the facility could not meet, facility's those needs and the specific ng facility could provide to mee dent # 56 for a facility initiated spital on 12/30/2017. | <b>S</b>            |   |                 |  |
|                          | The findings inclu  |   |                     |   |                 |  |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|--|-------------|-------------------------------|--|
|                          |  | 495358  | B. WING                                |  | 03          | /09/2018                      |  |
|                          | PROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | ODE         |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     |  | N SHOULD BE | (X5)<br>COMPLETION<br>OATE    |  |
| F 622                    | the hospital on 1/1 notes documented the reason the faci resident's condition required transfer to Resident #63 was 6/9/08 and readmid diagnoses of but in hemorrhage, renal diabetes, benign p dysphagia, hemipl hepatitis C, obesity and high blood pre (Minimum Data Se assessment with a Reference Date) of coded as being se ability to make dai requiring total care daily living.  A review of the climated the clinical record 1/18/18 Resident a hospital. The follow the clinical record 1/18/18 at 12:21 A warm to the touch and flushed. VS'S 97 (pulse) 18 (respressure) o2 sats the blood) 96% or (administered) Tyl 0015 (12:15 AM). (temperature) in 3 | as transferred and admitted to 8/18. There were no physician in the clinical record justifying lity was not able to manage the n, and why Resident #63 the hospital.  admitted to the facility on ted on 2/7/18, with the ot limited to traumatic brain dialysis, genitourinary surgery, rostatic hyperplasia, egia, cerebrovascular disease, y, postconcussional syndrome, essure. The most recent MDS et) was a readmission 5-day an ARD (Assessment f 2/28/18. The resident was verely cognitively impaired in ly life decisions and as e for all areas of activities of | F                                      |  |             |                               |  |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |  |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|-------------------|--|--------------------------------|-------------------------------|--|
|                          |  | 495358   | B. WING           |  |                                | 3/09/2018                     |  |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |  |                   | STREET ADDRESS, CITY, STATE, ZIP<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | CODE                           |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |  | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 622                    | arms and forehead  1/18/18 4:26 AM, "  0410 (4:10 AM). For forehead with cold adm. (administered audible wheezing in the street audible wheezing in the str | Resident's temp rechecked at Resident continues with a fever ne was packed under arms and compresses. Tylenol 650 mg d) Resident lungs sounds with mainly in right lobe."  "10:35 am: Discharge note: charged) to (hospital) and was not being held. Will follow up ding return."  "Resident sent to (hospital) viand symptoms) continuous (02, SOB (Shortness of Breath bilateral wheezing noted. RP) notified. Will contact hospital | a<br>),           | 622  |                                |                               |  |
|                          | documented, "Ser eval (evaluation). breathing / Abnorr A review of the ph dated 1/10/18, as hospitalization on days after readmin anything relating to   | ysician's notes revealed one<br>the most recent prior to the<br>1/18/18, and one on 2/9/18, 2<br>ssion, which did not document<br>to the resident's hospitalization  |                   |  |                                |                               |  |
|                          | #3 (Administrative she stated the protection the hospital is, if it  | p.m., in an interview with ASM e Staff Member, the physician), occass for sending a resident to t is during the day and she in ir valuates the resident. If it is  | 4                 |  |                                |                               |  |

| FREEX TAG REGULATORY OR LSC IDENTIFYMS INFORMATION)  F 622  Continued From page 48 after hours, the facility calls the on-call physician, the nurse will describe the signs and symptoms and the physician will make a determination. When asked about the physician documenting the rationale for sending the resident to the hospital, she stated if they are seen by the physician does not usually document anything; the nurses documents about the resident going to the hospital.  A review of the facility policy, "Emergency Transfer to Acute Care Hospital" did not document the requirement that they physician specifically needs to document in the clinical record the rationale for transfer and why the facility was not able to manage the resident's condition.  On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey.  [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.h tml  [11] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.h tml |        |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MUL <sup>*</sup><br>A. BUILDI | TIPLE CONSTRUCTION                                  | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|--|--------|--|--|------------------------------------|---|-------------------------------|----------------------------|--|
| AMELIA NURSING CENTER    XIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL FREEK TAG   |        |  | 495358   | B, WING                            |   |                               | /09/2018                   |  |
| F 622  Continued From page 48 after hours, the facility calls the on-call physician, the nurse will describe the signs and symptoms and the physician will make a determination. When asked about the physician documenting the rationale for sending the resident to the hospital, she stated if they are seen by the physician does not usually document anything; the nurses documents about the resident going to the hospital.  A review of the facility policy, "Emergency Transfer to Acute Care Hospital" did not document that they physician specifically needs to document in the clinical record the rationale for transfer and why the facility was not able to manage the resident's condition.  On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey.  [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.h tml  [11] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.h tml  |        |  |  | 8830 VIRGINIA STREET               |   |                               |                            |  |
| after hours, the facility calls the on-call physician, the nurse will describe the signs and symptoms and the physician will make a determination.  When asked about the physician documenting the rationale for sending the resident to the hospital, she stated if they are seen by the physician, they will document it. Otherwise, the physician does not usually document anything; the nurses documents about the resident going to the hospital.  A review of the facility policy, "Emergency Transfer to Acute Care Hospital" did not document the requirement that they physician specifically needs to document in the clinical record the rationale for transfer and why the facility was not able to manage the resident's condition.  On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey.  [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html  [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html                                     | PREFIX | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL   | PREFI                              | X (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THI | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETION<br>DATE |  |
| [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html   | F 622  | after hours, the fact the nurse will descrand the physician. When asked about the rationale for se hospital, she state physician, they will physician does not the nurses document the hospital.  A review of the fact Transfer to Acute document the requisional process of the rational facility was not abcondition.  On 3/8/18 at 5:09 [administrative state Nursing, ASM #2, findings. No furth the end of the sure painand to redulation obtain https://medlineplus. | cility calls the on-call physician, with the signs and symptoms will make a determination. It the physician documenting ending the resident to the difference of the differenc |                                    | 522   |                               |                            |  |
| (1) A stroke. When blood flow to a part of the   |        | [1] Tylenol is used painand to redu Information obtain https://medlineplutml   | uce fever<br>ned from<br>is.gov/druginfo/meds/a681004.h  |                                    |   |                               |                            |  |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  |   |                   | TIPLE CONSTRUCTION   |                                | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|-------------------|--|--------------------------------|-------------------------------|--|
|   |  | 495358  | B. WING           |  | 03                             | /09/2018                      |  |
| •   | PROVIDER OR SUPPLIER   |   |                   | STREET ADDRESS, CITY, STATE, ZIF<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | CODE                           |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG | A THE STREET OF THE TOTAL TO THE   | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETION<br>DATE    |  |
| F 622   | attack." If blood flot few seconds, the boxygen. Brain cells damage. This inforwebsite: https://medlineplus.  (2) Kidneys are dathey should. This in the website: https://medlineplus.  (3) High blood presobtained from the https://www.nlm.niessure.html.  (4) A swallowing cobtained from the https://www.nlm.niessure.html.  2. The facility staff documentation from specific needs the efforts to meet the needs the receiving the needs of Resident # 56 was 11/05/2011 and a diagnoses that incomparison of the second in the needs of the needs o | ke is sometimes called a "brain ow is cut off for longer than a brain cannot get nutrients and a can die, causing lasting rmation was obtained from the s.gov/ency/article/000726.htm.  maged and can't filter blood as information was obtained from s.gov/chronickidneydisease.htm  ssure. This information was website: ih.gov/medlineplus/highbloodpr  disorder. This information was |                   | 622  |                                |                               |  |
|   | Resident # 56's m  | nost recent MDS (minimum data   | a                 |  |                                |                               |  |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |             | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---|--|-------------|-------------------------------|--|
|                          |  | 495358   | B. WING                                 | - U  | 03          | /09/2018                      |  |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |  |   | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | ;ODE        |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                      |  | N SHOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 622                    | (assessment refered Resident # 56 as so interview for mental (zero) - 15, 10 being for making daily decoded as requiring assistance of one stables (activities of the nurse's "Progration of Resident # 56 of Resident was noted (temperature), Tyle effect, c/o (complasupervisor notified (medical doctor) in (Name of Hospital Review of the physical 12/01/17 through of documentation of could not meet, far needs and the specould provide to medical provid | sessment with an ARD ence date) of 02/09/18, coded coring a 10 on the brief all status (BIMS) of a score of 0 ag mildly impaired of cognition ecisions. Resident # 56 was limited assistance to extensive staff member for activities for daily living).  The sess Notes," dated 12/30/2017 documented, "9:54 p.m. d to have low grade temperator was administered with no int of) abdominal pain, and further assessed, MD obtified and resident sent to 0 to evaluate."  Sician's progress notes dated 01/24/18 failed to evidence the specific needs the facility cility's efforts to meet the those ecific needs the receiving facility neet the needs of Resident # |   | 522  |             |                               |  |
|                          | with ASM (Administ physician she state resident to the host and she in in the fresident. If it is after on-call physician, and symptoms and determination. With documenting the resident to the host   | p.m., in a telephone interview strative Staff Member) #3, the ed the process for sending a spital is, if it is during the day acility, she evaluates the ter hours, the facility calls the the nurse will describe the signs of the physician will make a hen asked about the physician rationale for sending the spital, she stated if they were cian, they would document it.  |   |  |             |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |          |  | E SURVEY<br>PLETED         |                            |
|--------------------------|---|---|---|----------|--|----------------------------|----------------------------|
|                          |   | 495358  | B. WING                                 |          |  |                            | 09/2018                    |
|                          | ROVIDER OR SUPPLIER   |   |   | 8830 VIR | ADDRESS, CITY, STATE, ZIP CODE<br>RGINIA STREET<br>A, VA 23002                                       |                            |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREP<br>TAG                       |          | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SH<br>PROSS-REFERENCED TO THE APP<br>DEFICIENCY) | IOULD BE                   | (X5)<br>COMPLETION<br>OATE |
| F 622                    | document anything about the resident  On 03/08/18 at app (administrative state administrator and were made aware)  No further information in the physical finding occur after an episactivity in the brain obtained from the https://medlineplus/regulate the amount information was on https://www.nlm.n.001214.htm. | sician does not usually g; that the nurses documents going to the hospital.  proximately 5:00 p.m. ASM ff member) # 1, the ASM # 2, director of nursing of the findings.  tion was provided prior to exit.  ure" is often used ith "convulsion." A seizure is gs or changes in behavior that sode of abnormal electrical in. This Information was |   | 622      |  |                            |                            |
| F 623<br>SS=0            | right after eating. or pain in the area lower part of the b that comes on so the meal is over. from the website: https://medlineplus Notice Requirement   | It may feel like: Heat, burning, a between the navel and the breastbone; Unpleasant fullness on after a meal begins or when This information was obtained as.gov/ency/article/003260.htm. ents Before Transfer/Discharge  |   | on t     | facility social workers will b<br>the requirements for written<br>ransfers and discharges.           | e educated<br>notification |                            |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|--|---|---------------------|---|--|
|                          |  | 495358  | B. WING _           |   | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  | CODE   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO TH<br>DEFICIENCY)  | N SHOULD BE COMPLETION DATE  |
| F 623                    | resident, the facility (i) Notify the resider representative(s) of the reasons for the language and man facility must send a representative of the Long-Term Care Cong-Term | ce before transfer. Insfers or discharges a I must- Int and the resident's If the transfer or discharge and I move in writing and in a Inner they understand. The I copy of the notice to a Ine Office of the State I mbudsman. I sons for the transfer or I sident's medical record in I aragraph (c)(2) of this section; Inotice the items described in I f this section. I ing of the notice. I iffied in paragraphs (c)(4)(ii) and I on, the notice of transfer or I under this section must be I y at least 30 days before the I made as soon as practicable |                     | The facility Social Worker w resident representative for mapologize for not sending a of the transfer to hospital with a neutropenic fever and diagnosed as sepsis requiring reatment with dialysis. Socwith resident representative or not sending the transfer to the ER/hospital may be at rist notification not being sent to the representative.  System Changes  1. Social Workers will be edual requirements to send a writter regarding the resident transfer epresentative.  2. Social Worker will send the of trasfer to resident representative.  2. Social Worker will send the of trasfer to resident representative.  3. Social Worker will document a Friday or through the withe letter will be sent on the form the letter is sent representative. | esident #56 and written notification in 12/30/17.  will contact the resident #63 on gnosed at hospital and eventually ing short term t ial worker will talk be and apologize f letter.  been transferred to sk for written the resident  cated on the en notification er to the resident r  written notification er to the day after ine transfer. ed to the hospital eekend, following Monday.  ent in progress |

| STATEMENT                | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | (                   |   |                                 | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|---|---------------------------------|-------------------------------|--|
| AND PLAN 0               | F CORRECTION   | IDENTIFICATION NUMBER:  | A. BUILDING         |   | OCIVII LETES                    |                               |  |
|                          |  | 495358  | B. WING             |   | 03/0                            | 9/2018                        |  |
|                          | PROVIDER OR SUPPLIER   |   | 8                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>MELIA, VA 23002  |                                 |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | OBE                             | (X5)<br>COMPLET(OI<br>DATE    |  |
| F 623                    | notice specified in must include the formust including the name and telephone number to obtain an appear completing the formust including the formust including the name and telephone number to obtain an appear completing the formust including the formust include the formust include the formust include the formust include the formust including the formust including the formust include the for | tents of the notice. The written paragraph (c)(3) of this section ollowing: transfer or discharge; ate of transfer or discharge; which the resident is harged; the resident's appeal rights, e, address (mailing and email), niber of the entity which uests; and information on how all form and assistance in m and submitting the appeal dress (mailing and email) and of the Office of the State ombudsman; cility residents with intellectual all disabilities or related alling and email address and of the agency responsible for advocacy of individuals with abilities established under Part act of 2000 (Pub. L. 106-402, .C. 15001 et seq.); and disabilities, the mailing and disabilities, and mental disorder the Protection and Advocacy ividuals Act. | F 623               | Monitoring 1. QA Director will complete audit earmonth to validate letters were sent to representative of each resident who to the hospital. A report of areas of non-compliance will be discussed in quarterly QAPI committee meeting for discussion and further recommendate.  Completion date 4. | was sent<br>the<br>or<br>tions. |                               |  |
|                          |  | anges to the notice.  In the notice changes prior to  |                     | <u>+</u>  |                                 | 1                             |  |

| STATEMENT OF BELLDIENGES |  | 1 ` ′   | PLE CONSTRUCTION  G |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|---|---------------------|---|-------------------------------|----------------------------|
|                          |  | 495358  | B. WING             |   | 03/                           | 09/2018                    |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                 | IDE                           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETION<br>OATE |
| F 623                    | effecting the transfirmust update the reas practicable once becomes available §483.15(c)(8) Notice In the case of facility the administrator of written notification to the State Survey State Long-Term Of the facility, and the well as the plan for relocation of the reasonable of the | er or discharge, the facility recipients of the notice as soon at the updated information.  The in advance of facility closure try closure, the individual who is if the facility must provide prior to the impending closure of Agency, the Office of the Care Ombudsman, residents of the transfer and adequate esidents, as required at §  ENT is not met as evidenced erview, clinical record review, ent review, it was determined itled to provide the required to the resident representative itiated transfer to the hospital, ents in the survey sample, difficulty didencing the resident R) was notified in writing, when transferred to the hospital on the failed to provide written idencing Resident # 56's RP) was notified in writing when is transferred to the hospital on the control of the hospital on the control of the hospital on the hospital on the control of | F 62                |   |                               |                            |
|                          | The findings inclu   | de:   | i                   |   |                               |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                   | TIPLE CONSTRUCTION   |                                   | TE SURVEY<br>MPLETED                   |
|--------------------------|---|--|-------------------|--|-----------------------------------|--|
|                          |   | 495358   | B. WING           |  | 03                                | /09/2018                               |
|                          | NAME OF PROVIDER OR SUPPLIER  AMELIA NURSING CENTER   |  |                   | STREET ADDRESS, CITY, STATE, Z<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | IP CODE                           |  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |  | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>OATE             |
| F 623                    | documentation evirepresentative (RF Resident #63 was 1/18/18.  Resident #63 was 6/9/08 and readmidiagnoses of but rhemorrhage, renadiabetes, benign playsphagia, hemiphepatitis C, obesit and high blood professional management with a Reference Date) coded as being seability to make da | age 55 If failed to provide written idencing the resident R) was notified in writing, when transferred to the hospital on admitted to the facility on itted on 2/7/18, with the not limited to traumatic brain I dialysis, genitourinary surgery, prostatic hyperplasia, legia, cerebrovascular disease, y, postconcussioanl syndrome, essure. The most recent MDS et) was a readmission 5-day an ARD (Assessment of 2/28/18. The resident was everely cognitively impaired in illy life decisions and as e for all areas of activities of | F                 | 623  |                                   |  |
|                          | 1/18/18 Resident hospital. The following the clinical record 1/18/18 at 12:21A warm to the touch and flushed. VS' 97 (pulse) 18 (respressure) o2 sats the blood) 96% o  | M, "Resident noted to be very<br>n, his cheeks are noted to be red<br>S (vital signs) 101 (temperature)<br>spirations) 135/82 (blood<br>s (saturation) (level of oxygen in<br>n room air. Resident was adm.  |                   |  |                                   |  |
|                          | 0015 (12:15 AM)<br>(temperature) in 3   | Menol [1] 360mg (milligrams) at Will re-check temp. 30 mins (minutes)."  "Resident temp (temperature) orally. Cold compresses under  |                   | *  |                                   | 11 11 11 11 11 11 11 11 11 11 11 11 11 |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPL<br>A. BUILDING | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|---|---|--|-----------------------------|--|-------------------------------|----------------------------|--|
|   |   | 495358   | B. WING                     |  | 03                            | /09/2018                   |  |
|   | PROVIDER OR SUPPLIER NURSING CENTER   |  | 8                           | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>AMELIA, VA 23002  |                               | -                          |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM (EACH CORRECTION CO | ULD BE                        | (X5)<br>COMPLETION<br>OATE |  |
| F 623   | arms and forehead  1/18/18 4:26 AM, "I 0410 (4:10 AM). R of 102 agein [sic] h forehead with cold adm. (administered audible wheezing r  1/18/18 10:35 AM, Resident D/C (disc admitted. Bed is n with hospital regard  1/18/18 10:35 AM, EMS. S/S (signs a | Resident's temp rechecked at desident continues with a fever se was packed under arms and compresses. Tylenol 650 mg d) Resident lungs sounds with mainly in right lobe."  "10:35 am: Discharge note: tharged) to (hospital) and was ot being held. Will follow up |                             |  |                               |                            |  |
|   | (responsible party)<br>for follow up inform  A physician's order<br>documented, "Sen  | dated 1/18/18 at 9:1.,<br>d resident to (hospital) ER for<br>RE: Increased temp / Labored  |                             |  |                               | * 10.000mm                 |  |
|   | #6 (Other Staff Me<br>Services staff men<br>requirement for wr<br>representative of a<br>and why the reside   | o.m., in an interview with OSM imber, the Admissions/Social nber), regarding the litten notification to the resident a resident being hospitalized ant was hospitalized, she ou now, I don't have that."   |                             |  |                               |                            |  |
|   | Transfer to Acute (   | ility policy, "Emergency Care Hospital" did not uirement that the facility must ification to the responsible spitalization.  |                             |  |                               |                            |  |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                               |  | 1, ,   |  | (X3) DATE SURVEY<br>COMPLETED   |
|--|--|--|--|---|
|  | 495358   | B. WING  |  | 03/09/2018  |
| PROVIDER OR SUPPLIER  NURSING CENTER   |  |  | STREET ADDRESS, CITY, STATE, ZIP COL<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   | DE  |
| (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)   | HOULD BE COMPLETION   |
|  |  | F 6  | 23   |   |
| [administrative staf<br>Nursing, ASM #2, v<br>findings. No further   | f member] #1) and Director of<br>was made aware of the<br>er information was provided by   | 1  |  |   |
| painand to reduce Information obtains  | ce fever<br>ed from  | h  |  |   |
| painand to reduce Information obtains  | ce fever<br>ed from  | h  |  |   |
| documentation evi  | dencing Resident # 56's RP ) was notified in writing when  | ***************************************  |  |   |
| 11/05/2011 and a l<br>12/30/17 with diag<br>not limited to conv  | readmitted to the facility on<br>moses that included but were<br>rulsions (1), diabetes mellitus   |  |  | And (i)   |
| set), an annual as<br>(assessment refer<br>Resident # 56 as s<br>interview for ment<br>(zero) - 15, 10 bei | sessment with an ARD rence date) of 02/09/18, coded scoring a 10 on the brief al status (BIMS) of a score of ng mildly impaired of cognition   | 0  |  |   |
|  | PROVIDER OR SUPPLIER  NURSING CENTER  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa  On 3/8/18 at 5:09 p [administrative staft Nursing, ASM #2, v findings. No further the end of the surv  [1] Tylenol is used painand to reduce the length of the surve  [1] Tylenol is used painand to reduce the length of the surve  [1] Tylenol is used painand to reduce the length of the surve  [1] Tylenol is used painand to reduce the length of the surve the length of the surve the length of the surve the length of the length o | PROVIDER OR SUPPLIER  NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 57  On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey.  [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.tml  [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.tml  2. The facility staff failed to provide written documentation evidencing Resident # 56's RP (responsible party) was notified in writing when Resident # 56 was transferred to the hospital on 12/30/17.  Resident # 56 was admitted to the facility on 11/05/2011 and a readmitted to the facility on 12/30/17 with diagnoses that included but were not limited to convulsions (1), diabetes mellitus (2) and dyspepsia (3).  Resident # 56's most recent MDS (minimum da set), an annual assessment with an ARD (assessment reference date) of 02/09/18, coded Resident # 56 as scoring a 10 on the brief interview for mental status (BIMS) of a score of (zero) - 15, 10 being mildly impaired of cognition for making daily decisions. Resident # 56 was | PROVIDER OR SUPPLIER  NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 57  F 60  Continued From page 57  Continued From page 57  F 60  Continued From page 57  F 60  Continued From page 57  F 60  Continued From page 57  Continued From page 57  F 60  Indicate the findings of the | DENTIFICATION NUMBER:  495358  BROVIDER OR SUPPLIER  NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFIYING INFORMATION)  Continued From page 57  Continued From page 57  On 3/8/18 at 5:09 p.m., the Administrator (ASM [administrative staff member] #1) and Director of Nursing, ASM #2, was made aware of the findings. No further information was provided by the end of the survey.  [1] Tylenol is used to relieve mild to moderate painand to reduce fever Information obtained from https://medlineplus.gov/druginfo/meds/a681004.h tml  2. The facility staff failed to provide written documentation evidencing Resident # 56's RP (responsible party) was notified in writing when Resident # 56 was transferred to the hospital on 12/30/17.  Resident # 56 was admitted to the facility on 11/06/2011 and a readmitted to the facility on 11/2/30/17 with diagnoses that included but were not limited to convulsions (1), diabetes mellitus (2) and dyspepsia (3).  Resident # 56 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 10 being mildly impaired of cognition for making daily decisions. Resident # 56 was sporing a 10 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 10 being mildly impaired of cognition for making daily decisions. Resident # 56 was s |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |
|--------------------------|--|---|--|--|-------------------------------|
|                          |  | 495358  | B. WING_                               |  | 03/09/2018                    |
| ,                        | PROVIDER OR SUPPLIER NURSING CENTER  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION SHOTO CROSS-REFERENCED TO THE APPLICATION SHOTO CROSS-REFERENCED TO THE APPLICATION OF THE APPLIC | OULD BE COMPLETION            |
| F 623                    | assistance of one stands and the nurse's "Progrator Resident # 56 of Resident was note (temperature), Tyle effect, c/o (complassive supervisor notified (medical doctor) notif | staff member for activities for daily living).  The sess Notes," dated 12/30/2017 documented, "9:54 p.m. do to have low grade temperol was administered with no int of) abdominal pain, and further assessed, MD obtified and resident sent to be to evaluate."  The second for Resident # 56 written notification to Resident of (responsible party) of the ensign to the hospital on the p.m., in an interview with OSM ember, the Admissions/Social enber), regarding the itten notification to the resident a resident being hospitalized ent was hospitalized, she |  | 3  |                               |
|                          | On 3/8/18 at 5:00<br>[administrative sta<br>Nursing, ASM #2,   | p.m., the Administrator (ASM ff member] #1) and Director of was made aware of the er information was provided by vey.   |  |  |                               |
|                          | painand to redu  |   | 1                                      |  |                               |
|                          | No further informa   | ation was provided prior to exit.   |  |  | (B)                           |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|--|---|--|---|--|
|                          |  | 495358  | B. WING                                |   | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER   |   | 88                                     | REET ADDRESS, CITY, STATE, ZIP CODE<br>30 VIRGINIA STREET<br>MELIA, VA 23002  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | ILD BE COMPLETION  |
| F 623                    | Continued From pa  | age 59  | F 623                                  | )   | ii<br>a  |
| F 625<br><b>SS</b> =D    | the physical finding occur after an epis activity in the brain obtained from the https://medlineplus  (2) A chronic disearegulate the amou information was obhttps://www.nlm.ni 001214.htm.  (3) Indigestion (dynthe upper belly or right after eating. I or pain in the area lower part of the bhat comes on soot the meal is over. from the website: https://medlineplus.Notice of Bed Hold CFR(s): 483.15(d)  §483.15(d) Notice  §483.15(d)(1) Notinursing facility trait the resident goes nursing facility muther resident or respecifies-  (i) The duration of | th "convulsion." A seizure is as or changes in behavior that ode of abnormal electrical. This information was website: a.gov/ency/article/003200.htm.  se in which the body cannot not of sugar in the blood. This obtained from the website: h.gov/medlineplus/ency/article/ spepsia) is a mild discomfort in abdomen. It occurs during or to may feel like: Heat, burning, between the navel and the reastbone; Unpleasant fullness on after a meal begins or when This information was obtained s.gov/ency/article/003260.htm. |  | Corrective Action Resident #63 did not hold his bed who went to hospital on 1/18/18. When he from hospital on 02/07/18, he was rest to the same bed in which he previous Resident # 56 was transferred to the room on 12/30/17. Resident did return facility without being admitted to the Resident experienced no negative or related to resident and resident represent receiving a copy of the bed hold the time of resident transfer to the erroom; | e returned admitted ly resided. emergency rn to nospital. butcome esentative policy at |

| STATEMENT | MENT OF DEFICIENCIES LAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   (X2) MULTIPLE CONSTRUCTION   A. BUILDING  |  |              | (X3) DATE SURVEY<br>COMPLETED  |  |
|-----------|--|--|--------------|--|--|
|           |  | 495358   | B. WING      |  | 03/09/2018   |
|           | (FACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL  | ID<br>PREFIX | TREET ADDRESS, CITY, STATE, ZIP CODE  830 VIRGINIA STREET  AMELIA, VA 23002  PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES  (EACH COPPROPRIES PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES  RESTATEMENT OF THE APPROPRIES PROPRIES PRO | LD BE COMPLETION   |
| TAG       | Continued From pa  |  | F 625        | Other Potential Any resident transferred to hospita  |  |
|           | facility; (ii) The reserve be plan, under § 447. (iii) The nursing far bed-hold periods, paragraph (e)(1) or resident to return; (iv) The informatio of this section. §483.15(d)(2) Bed the time of transfe hospitalization or transfer hospitalization or tra | n specified in paragraph (e)(1) -hold notice upon transfer. At   |              | of not receiving the bed hold policy time of transfer.  System Changes  1. The Notice of Bed Hold Policy/F reviewed and revised on 3/22/18.  2. When a resident is being sent to emergency room/hospital, the nurse the resident of the bed hold policy a copy of the form is being sent to emergency room with him/her.  3. At the time the resident represe is notified of the transfer by the nurse will notify him/her of the bed being sent to emergency room with the transfer is during regular but the social worker will notify the rehe resident representative of the known/policy.   | orm was  the se will inform and that the  ntative arse, the I hold policy h resident. siness hours, sident and t |
|           | that the facility state hold policy/notificate resident represent transfer to the host the survey sample.  The facility staff fathold policy/notificate resident represent transfer and admit The findings inclusively for the findings in findings in the f | iff failed to provide a written bed ation to the resident and/or tative, within 24 hours of a spital for one of 20 residents in a Resident #63.  alled to provide a written bed ation to Resident #63 and/or tative, within 24 hours of a ssion to the hospital on 1/18/18 |              | 4. Nurses will be educated on the be policy and their role in sending the for notification and documentation.  5. Social Worker/admission staff will printed copy of the bed hold agreemed representative along with the written transfer.  Monitoring The ADON/QA nurse will audit reconscidents sent to ER to validate the of notification of bed hold and policy, sent with resident to the hospital. The DON will be notified of areas of for follow up and 1:1 education with nurse(s).   | rm, send a ent to resident inotice of  ds of documentation form being non-compliance                             |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |   | E SURVEY<br>MPLETED        |
|--------------------------|---|--|--|--|---|----------------------------|
|                          |   | 495358   | B. WING                                |  | 03/   | /09/2018                   |
|                          | PROVIDER OR SUPPLIER NURSING CENTER   |  |  | STREET ADDRESS, CITY, STATE, ZII<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   | PCODE                                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO TI<br>DEFICIENCY  | ION SHOULD BE<br>HE APPROPRIATE             | (X5)<br>COMPLETION<br>DATE |
| F 625                    | diabetes, benign prodysphagia, hemiple hepatitis C, obesity and high blood pre (Minimum Data Seassessment with a Reference Date) of coded as being seability to make dail requiring total care daily living.  A review of the clir 1/18/18 Resident hospital. The follothe clinical record 1/18/18 at 12:21 A warm to the touch and flushed. VS'S 97 (pulse) 18 (respressure) of 2 sats the blood) 96% of (administered) Tyl 0015 (12:15 AM). (temperature) in 3 1/18/18 1:16 AM, noted to be 102 of arms and forehead 1/18/18 4:26 AM, 0410 (4:10 AM). of 102 agein [sic] forehead with cold | dialysis, genitourinary surgery, rostatic hyperplasia, egia, cerebrovascular disease, postconcussioanl syndrome, ssure. The most recent MDS at was a readmission 5-day in ARD (Assessment f. 2/28/18. The resident was verely cognitively impaired in y life decisions and as a for all areas of activities of a mical record revealed that on the form of the for |  | The ADON/QA director will compliance report to the question committee for discussion a recommendations in the present the pres | l present a<br>uarterly QAPI<br>and further |                            |
|                          | adm. (administere   | ed) Resident lungs sounds with<br>mainly in right lobe."   | ĺ                                      |  |   |                            |

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|--|--|-------------------------------|--|
|                          |   | 495358  | B. WING                                | <del></del>  | 03/09/2018                    |  |
|                          | PROVIDER OR SUPPLIER  |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                          |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETION              |  |
| F 625                    | 1/18/18 10:35 AM, Resident D/C (disc admitted. Bed is rwith hospital regarment of the second of the | "10:35 am: Discharge note: charged) to (hospital) and was not being held. Will follow up ding return."  "Resident sent to (hospital) via and symptoms) continuous 102, SOB (Shortness of Breath), bilateral wheezing noted. RP) notified. Will contact hospital mation."  In dated 1/18/18 at 9:16 a.m., and resident to (hospital) ER for RE: Increased temp / Labored |  |  |                               |  |
|                          | Policy" document hospital today. If you are admitted does not pay to h payment source, to reserve the bette nursing home  | cility policy, "Notice of Bed Hold ed, "You are being sent to the you are a Medicaid resident and to the hospital, Virginia Medicaid old your bed. Whatever your unless the nursing home is paid while you are in the hospital, a may move someone else into ever, even if the nursing home is  | d'                                     |  |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A, BUILDING |   | (X3) DATE SURVEY<br>COMPLETED                  |
|--------------------------|---|---|--|---|--|
|                          |   | 495358  | B. WING                                |   | 03/09/2018                                     |
|                          | ROVIDER OR SUPPLIER   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY)   | BE COMPLETION                                  |
| F 656<br>SS=D            | to return as soon a semi-private room as your [sic] still net this nursing home you are eligible for services"  On 3/8/18 at 5:09 [administrative stat Nursing, ASM #2, findings. No furthe the end of the surve [1] Tylenol is used painand to redu Information obtain https://medlineplustml  Develop/Implement CFR(s): 483.21(b)  §483.21(b) Compressident rights set §483.21(b)(1) The implement a compcare plan for each resident rights set §483.10(c)(3), that objectives and tim medical, nursing, needs that are ideassessment. The describe the follow (i) The services the or maintain the rephysical, mental, required under §4 | ur bed, you may have the right is a bed is available in a in this nursing home as long and the services provided by (and, if you are on Medicaid, Medicaid nursing home  o.m., the Administrator (ASM if member] #1) and Director of was made aware of the er information was provided by ey.  to relieve mild to moderate be fever and from a.gov/druginfo/meds/a681004.h  at Comprehensive Care Plan (1)  rehensive Care Plans facility must develop and orehensive person-centered resident, consistent with the forth at §483.10(c)(2) and the includes measurable eframes to meet a resident's and mental and psychosocial ntified in the comprehensive comprehensive care plan must |  | Ftag 656 Corrective Action The care plan for resident #72 is bei reviewed and revised as needed. The DON met with the physician on to discuss resident diagnosis of demand the psychology note that recom tapering off of Aricept as cognition i Physician reassessed for diagnosis dementia and cognition. The care p be updated following the completion that assessment.  The fall mats have been in place for #56 as indicated on the fall preventicare plan. | 3/23/18 nentia mended s intact. of lan will of |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '           | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|---------------|--|---|---|
|                          |  | 495358   | B. WING       |  |   | 03/09/2018  |
| AMELIA<br>(X4) ID        | PROVIDER OR SUPPLIER  NURSING CENTER  SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID PREFU      | 88<br>Al                               | REET ADDRESS, CITY, STATE, ZIP CODE  330 VIRGINIA STREET  MELIA, VA 23002  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) | D BE COMPLETION   |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From payinder §483.24, §48 provided due to the under §483.10, incept treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's represer (A) The resident's represer (A) The resident's future discharge. For the resident's future discharge. For the resident's future discharge plan plan, as appropriate requirements set for this pure (C) Discharge plan plan, as appropriate requirements set for the resident of th | age 64 33.25 or §483.40 but are not e resident's exercise of rights luding the right to refuse 183.10(c)(6). If services or specialized 29 services 20 services | PREFITAGE F 6 | ×                                      | PROVIDER'S PLAN OF CORRECTION   | all mat , ents er ed. ementia apprehensive completed iagnosis are plan ized the d on the ividualized nosis ventions on fall mats. |
|                          | prevention compre  | ff failed to implement the fall<br>ehensive care plan for Residen  | t             |  |   |   |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 03/20/2018 FORM APPROVED

|                          | S EOD MEDICARE  | & MEDICAID SERVICES   |  |     | 0  | MB NO. 0938-0391  |
|--------------------------|---|---|--|-----|--|---|
| STATEMENT                | OF DEFICIENCIES<br>F CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |  | (X3) DATE SURVEY<br>COMPLETED   |
|                          |   | 495358  | B. WING                                |     |  | 03/09/2018  |
| NAME OF F                | ROVIDER OR SUPPLIER   |   |  |     | TREET ADDRESS, CITY, STATE, ZIP CODE   |   |
| ADAI: LA I               | MIDSING CENTED  |   |  | 1   | 330 VIRGINIA STREET  |   |
| AMELIA                   | NURSING CENTER  |   |  | Α   | MELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | DBE COMPLETION  |
| F 656                    | #72's dementia.  Resident #72 was 1/12/18. Resident were not limited to depressive disorder #72's most recent day Medicare asses (assessment refer the resident as cog documented an act Non-Alzheimer's desident received order during Januar March 2018. A ph documented, "3. desident #72's con 1/24/18 document resident's behavior information (including arding demention) on 3/8/18 at 11:38 conducted with Riversident was sometiments. | failed to develop a re plan to address Resident admitted to the facility on #72's diagnoses included but heart disease, major rand dementia (1). Resident MDS (minimum data set), a 30 research with an ARD rence date) of 2/20/18, coded gnitively intact. Section I record revealed red Aricept (2) per physician's rary 2018, February 2018 and ysician's note dated 2/5/18 rementia w/ (with) behaviors- on mprehensive care plan dated red information regarding the rs but failed to document ling treatment and services) a. |  | 656 | 5. Fall mats will be added to an obs book which is maintained at the nu Nursing staff will be expected to sig the presence of fall mats each shift 6. Nurses will also document the us /presence of fall mats on the TAR elementary of the presence of fall mats on the TAR elementary of the presence of fall mats on the TAR elementary of the presence of fall mats on the TAR elementary of the presence of fall mats and individuality of the presence of fall mats and individuality of the presence of the residents with diagnosis of dementary of the presence of the residents with diagnosis of dementary of the present as per ord the unit staff.  Monitoring:  During rounds, the clinical leaders with the unit staff.  Monitoring:  During rounds, the clinical leaders with the use of fall mats as identified on the title ducation will be provided to nursiff fall mats are not present as per ord QA Director will review the care plantary of the present as per ord present as per ord the present as | rse station. n off on  ee ach shift. e of dicated ementia zed lans e individual tia residing  aff the re plans re plan li monitor he care plan. sing assistant er/care plan. of new |
|                          | stated Resident #   | 72 "Comes off cognitively intact  | .00                                    |     | residents with dementia diagnosis to a care plan has been initiated with in  | validate  |

but is fairly unstable."

On 3/8/18 at 1:58 p.m., an interview was conducted with CNA (certified nursing

approaches.

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|---|--|--|--|--|
|                          |   | 495358   | B. WING                                |  | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER  |  | 1                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF CROSS-REFERENCED TO THE APPROPRIES OF CORRECT OF | JLD BE COMPLETION  |
| F 656                    | assessment) #5 (a Resident #72 and resident until one in #5 was asked if Re CNA #5 stated, "Not told to us. I know sight got better then she tapered off."  On 3/8/18 at 3:09 conducted with AS member) #2 (the conducted with AS member) #2 (the conducted with as a sked to design guidelines and prowe normally do, the have that set aside centered care, der to the resident's casked if information be documented or resident has a diagstated, "Yes. Their Conducted with AS physician). ASM # #72 was diagnose When asked to deability, ASM #3 stand out as far as a conversation behavior."  On 3/8/18 at 4:58 administrator) and the above findings.  The facility policy | CNA who was familiar with routinely worked with the month before the survey). CNA esident #72 had dementia. It that I know of. It hasn't been she's been emotional before. It got emotional again and it's p.m., an interview was M (administrative staff lirector of nursing). ASM #2 with the facility dementia care tocols. ASM #2 stated, "What e comprehensive care plan, we and centered toward resident mentia, or anxiety. It's centered are specifically." ASM #2 was on regarding dementia should a resident's care plan if the gnosis of dementia. ASM #2 re should be."  p.m., an interview was SM #3 (Resident #72's capitive at with dementia in the hospital. As with dementia in the hospital. As with dementia in the hospital. As with dementia in the hospital and with dementia in the hospital. As with dementia in the hospital and change some of her |  | QA Director will do a weekly audit residents who were discussed in care plan to validate there is an implan of care for residents with der This will be done weekly for 3 more compliance with care planning for maintained, then a quarterly audit conducted for 3 quarters.  A report of areas of non-compliant submitted to the quarterly QAPI of for discussion and further recomm Completion date Complet | uarterly dividualized nentia. Iths. If dementia is will be ce will be ommittee nendations. |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |         | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|---|---------|-------------------------------|--|
|  | 495358   | B. WING                                |   | 03      | /09/2018                      |  |
| NAME OF PROVIDER OR SUPPLIER  AMELIA NURSING CENTER  |  | 88                                     | REET ADDRESS, CITY, STATE, ZIP CODE<br>30 VIRGINIA STREET<br>MELIA, VA 23002                          |         |                               |  |
| PREFIX (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRE<br>(EACH CORRECTIVE ACTION SHI<br>CROSS-REFERENCED TO THE APF<br>DEFICIENCY) | DULD BE | (X5)<br>COMPLETION<br>OATE    |  |
| individualized need care plan a resider Interdisciplinary Te develop the care p specific diagnosis status, renal (dialyse conditions; impaire (cognitive impairm psychosocial need No further informa  (1) "Dementia is the symptoms caused brain. It is not a sydementia may not do normal activitie eating. They may problems or contropersonalities may agitated or see this information was of https://vsearch.nlmmeta?v%3Aproject medlineplus-bundl | re plan addresses the ds of the resident, making the nt centered document. 4. The sam will work collaboratively to lan that addresses the resident related needs: such as cardiac sis) conditions; end of life ed skin integrity; dementia ent, delirium, confusion, |  |   |         |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | . ,                | TIPLE CONSTRUCTION  NG   |             | TE SURVEY<br>MPLETED |
|--------------------------|--|---|--------------------|--|-------------|----------------------|
|                          |  | 495358  | B. WING            |  | 03          | 3/09/2018            |
|                          | PROVIDER OR SUPPLIER   |   |                    | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | :ODE        |                      |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | N SHOULD BE | COMPLETION<br>DATE   |
| F 656                    | 12/30/17 with diagrant limited to convice (2) and dyspepsia.  Resident # 56's makes, an annual assessment references (assessment references) - 15, 10 being for making daily decoded as requiring assistance of one ADLs (activities of ADLs (activiti | noses that included but were ulsions (1), diabetes mellitus (3).  Ost recent MDS (minimum data sessment with an ARD ence date) of 02/09/18, coded coring a 10 on the brief al status (BIMS) of a score of 0 ng mildly impaired of cognition ecisions. Resident # 56 was a limited assistance to extensive staff member for activities for |                    | 556  |             |                      |

| _ ,                      | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                   |     | CONSTRUCTION  |      | E SURVEY<br>MPLETED        |
|--------------------------|--|--|-------------------|-----|---|------|----------------------------|
|                          |  | 495358   | B. WING           |     |   | 03   | /09/2018                   |
|                          | PROVIDER OR SUPPLIER   | 1  |                   | 883 | REET ADDRESS, CITY, STATE, ZIP CODE<br>BO VIRGINIA STREET<br>MELIA, VA 23002                                    |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE | (X5)<br>COMPLETION<br>DATE |
| F 656                    | positioned low to flifloor next to left sid mat was observed. The current signed 12/08/17 - 01/08/18 on 01/24/18 docum. Floor mats bedside Day shift, Evening. The comprehensive for Resident # 56 of Category: Falls. He transfer without as lincreased agitation psychotropic meds low bed with mats; Under "Approach" mats beside. App. On 03/08/18 at ap interview and observom was conduct nurse) # 1. Upon LPN # 1 verbally a was on floor next to other fall mat was asked if Resident the right and left s 56 was in bed, LP the orders." After orders for Resider health record), LP mat on both sides proceeded to Resider | and clean, the bed was our and one fall mat was on the of the bed. The other fall leaning against the wall.  I physician's orders dated 8 and signed by the physician mented, "BL (bilateral) [two] a bed while in bed. Every shift; shift, Night shift. 02/22/2017."  We care plan dated 02/16/2018 documented, "Problem. listory of falls. Will attempt to sking for assist (assistance). In with behavior issues receives a (medication) daily; Fall alarm, No recent falls this review."  It documented, "Low bed with roach Start Date: 02/16/2018."  Proximately 2:40 p.m. an ervation of Resident # 56's ted with LPN (licensed practical entering Resident # 56's room, acknowledged that a fall mat to left side of the bed and the leaning against the wall. When # 56 was to have a fall mat on ide of the bed when Resident # N # 1 stated, "I need to check reviewing the physician's and the bed." LPN # 1 then ident # 56's room and placed on the floor to the right side of |                   | 656 |   |      |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|--|--|-------------------------------|--|
|                          |  | 495358  | B. WING                                |  | 45.  | 03/09/2018                    |  |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  | ,   |  | STREET ADDRESS, CITY, STAT<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | E, ZIP CODE  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     | (EACH CORRECTIVE CROSS-REFERENCED                                      | N OF CORRECTION<br>EACTION SHOULD BE<br>TO THE APPROPRIATI<br>HENCY) | (X5)<br>COMPLETION<br>E DATE  |  |
| F 656                    | conducted with RN manager. When a of the care plan RN guideline for us (st resident." RN #1 v observations of Reput in place. Resided 12/08/17 - 0 Resident # 56 were was then asked if implemented for remarked in the remark | 0 a.m., an interview was a (registered nurse) # 1, unit sked to describe the purpose N # 1 stated, "To serve as a aff) for the care of the was informed of the above sident # 56's fall mat not being ent #56's physician's orders 1/08/18 and the care plan for e reviewed with RN #1. RN # 1 the fall care was being esident # 56. RN # 1 stated, as a.m., an interview was M (administrative staff ctor of nursing. When asked to be of the care plan, ASM # 2 e needs of the resident and to do for the resident." After the above observations of II mat not being put in place, ician's orders dated 12/08/17 - Jent # 56 and the care plan for M #2 was asked if the fall care ented for resident # 56. ASM # proximately 5:00 p.m. ASM aff member) # 1, the ASM # 2, director of nursing of the findings. |  | 656  |  |                               |  |

| STATEMENT<br>AND PLAN O  | OF DEFICIENCIES<br>F CORRECTIDN  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|--|---|---|
|                          |  | 495358  | B. WING                                |   | 03/09/2018  |
|                          | ROVIDER OR SUPPLIER  |   | 8                                      | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>AMELIA, VA 23002   |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | LD BE COMPLETION  |
| F 689<br>SS=D            | activity in the brain obtained from the whites://medlineplus (2) A chronic disearegulate the amount information was obtites://www.nlm.nii 001214.htm.  (3) Indigestion (dysthe upper belly or a right after eating. If or pain in the area lower part of the bith that comes on soot the meal is over. from the website: https://medlineplus.Free of Accident FCFR(s): 483.25(d) Accide The facility must e §483.25(d)(1) The as free of accidents. This REQUIREME by:  Based on observing record, it was determined to the standard of the st | ode of abnormal electrical. This information was website:gov/ency/article/003200.htm. se in which the body cannot not of sugar in the blood. This stained from the website: h.gov/medlineplus/ency/article/ spepsia) is a mild discomfort in abdomen. It occurs during or the may feel like: Heat, burning, between the navel and the reastbone; Unpleasant fullness on after a meal begins or when This information was obtained as gov/ency/article/003260.htm. lazards/Supervision/Devices (1)(2) ents. Insure that - I resident environment remains thazards as is possible; and in resident receives adequate esistance devices to prevent entire that the facility staff interview and clinical ermined that the facility staff interview and clinical ermined that the facility staff interview one of 20 residents in the | F 689                                  | Corrective Action Upon notification, the fall mats we at the bedside for resident #56. T assistants on that unit have been on the fall prevention approach of mats. Fall mats have been observable as ordered since then.  Other Potential Any resident with orders or care p approaches for the use of fall mats could have been at risk for them in place. Five other residents with fabeen observed with the mats in plordered/care planned. | The nursing re-educated use of fall   wed to be in lan sat bedside not being in lan sat base hat have |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |   | (X3) DATE SURVEY<br>COMPLETED   |
|---|---|--|---|---|---|
|   |   | 495358   | B. WING                                 |   | 03/09/2018  |
|   | PROVIDER OR SUPPLIER  |  | 8                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1830 VIRGINIA STREET<br>AMELIA, VA 23002   |   |
| (X4) ID<br>PREFIX<br>TAG                            | (FACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)  | D BE COMPLETION   |
| F 689   | The findings included Resident # 56 was 11/05/2011 and real 12/30/17 with diagnot limited to convious (2) and dyspepsia. Resident # 56's miset), an annual as (assessment refered Resident # 56 as sinterview for ment (zero) - 15, 10 bein for making daily discorded as requiring assistance of one ADLs (activities of An observation was 03/06/18 at 3:06 pix bed asleep. The mat was on floor other fall mat was alarm observed at the resident had a Nurses entered the tested the bed alarthe fall mat observed. | illed to place bilateral (two) fall next to bed for Resident # 56.  de:  admitted to the facility on admitted to the facility on noses that included but were ulsions (1), diabetes mellitus (3).  ost recent MDS (minimum data sessment with an ARD rence date) of 02/09/18, coded scoring a 10 on the brief al status (BIMS) of a score of 0 ng mildly impaired of cognition ecisions. Resident # 56 was a limited assistance to extensive staff member for activities for |   | System Changes  1. Nursing Assistants have been reon the use of fall mats as fall approach.  2. The clinical leadership team. Adm Social Services will observe the plate of fall mats during daily rounds. Observing fall mats will result in immaction to replace the mat as bedsided.  3. A review will be conducted of car and orders to ensure all residents we care plan approach for fall mats will them in place per care plan/ orders.  4. An updated listing of residents we mats will be maintained in a binder nurse station.  5. Nursing Assistants will be initial tof fall mats in the observation book licensed nurses will document the updated falls mats on the TAR each shift. | ninistrator, acement servations nediate e as ordered. e plans with have lith fall at the he use and |
|   | An observation w<br>03/07/18 at 1:19 pup in bed dressed   | as made of Resident # 56 on<br>p.m. Resident # 56 was sitting<br>d neat and clean. A CNA<br>assistant) was present assisting   | 3                                       |   |   |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |     |   | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|--|-----|---|---|
|                          |  | 495358   | B. WING                                |     | ***   | 03/09/2018  |
|                          | PROVIDER OR SUPPLIER   |  |  | 88  | REET ADDRESS, CITY, STATE, ZIP CODE<br>30 VIRGINIA STREET<br>MELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG                     | ×   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE COMPLETION   |
| F 689                    | Resident # 56 with assistance. Observation was conduct nurse) # 1. Upon eLPN # 1 verbally a was on floor next to ther fall a to ther fall a to the register and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # to the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides a saked if Resident # the right and left sides # the rig | ge 73 his lunch. He required total vation of the room revealed a next to the left side of the mat was observed leaning  s made of Resident # 56 on m. Resident # 56 was lying in and clean, the bed was por and one fall mat was on e of the bed. The other fall leaning against the wall.  physician's orders dated and signed by the physician ented, "BL (bilateral) [two] bed while in bed. Every shift; shift, Night shift. 02/22/2017."  e care plan dated 02/16/2018 locumented, "Problem. istory of falls. Will attempt to king for assist (assistance). with behavior issues receives (medication) daily; Fall alarm, No recent falls this review." it documented, "Low bed with roach Start Date: 02/16/2018."  proximately 2:40 p.m. an envation of Resident # 56's room, cknowledged that a fall mat on the leaning against the wall. When # 56 was to have a fall mat on de of the bed when Resident # N # 1 stated, "I need to check |  | 689 | MONITORING:  The placement of fall mats will be oby clinical leadership daily during rote.  Charge nurses and supervisors will placement of fall mats on evening an and submit an audit form to the DO validating the placement of devices.  DON will review the observation be to determine if the nursing assistant compliant with the placement and simust placement.  A report of areas of non-compliant prepared and submitted to the quart QAPI committee for discussion and recommendations.  Completion of the placement of | ounds.  I observe and night shifts N each day ook weekly ts are gning of fall terly |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  |                     |              |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--|--|---------------------|--------------|---|-------------------------------|----------------------------|
|  |  | 495358   | B. WING             |              | A   | 03/                           | 09/2018                    |
|  | PROVIDER OR SUPPLIER   |  |                     | <b>883</b> 0 | ET ADDRESS, CITY, STATE, ZIP CODE<br>VIRGINIA STREET<br>ELIA, VA 23002  |                               |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | <b>,</b> !   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | DBE                           | (X5)<br>COMPLETION<br>DATE |
| F 689  | the orders." After rorders for Residen health record), LPN mat on both sides proceeded to Resident with eather fall mat or Resident # 56's be On 03/09/18 at 8:3 conducted with RN manager. After be observations of Reput in place, review dated 12/08/17 - 0 the care plan for Rasked if the fall marked if the fall marked with AS member) # 2, directinformed of the ab 56's fall mat not be physician's orders Resident # 56 and 56, ASM # 2 was a being implemented stated, "No."  On 03/08/18 at ap (administrative stated administrator and were made aware No further informal References: (1) The term "seiz | reviewing the physician's  If # 56 on the EHR (electronic  If # 1 stated, "The orders say a  of the bed." LPN # 1 then  dent # 56's room and placed  If the floor to the right side of  If the floor the floor the side of  If the floor the floor the floor the care plan for Resident #  If the floor the f | F 6                 | 89           |   |                               |                            |

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

|                          | F DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ` '                 | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|--|---|---------------------|---|---|
| 7410   2711 01           |  |   |                     | - 1904  |   |
|                          |  | 495358  | B. WING             | TIP CORE  | 03/09/2018  |
|                          | OVIDER OR SUPPLIER  JRSING CENTER  |   | 88                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>330 VIRGINIA STREET<br>MELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | D BE COMPLETION   |
| F 744<br>SS=D            | activity in the brain obtained from the voltage of the amount of the segulate the segu | is or changes in behavior that ode of abnormal electrical. This information was website:gov/ency/article/003200.htm.  se in which the body cannot of sugar in the blood. This otained from the website: h.gov/medlineplus/ency/article/spepsia) is a mild discomfort in abdomen. It occurs during or the may feel like: Heat, burning, between the navel and the reastbone; Unpleasant fullness on after a meal begins or when This information was obtained in percentage. |                     | Corrective Action Recent evaluation in facility by psy indicates resident is cognitively in recommended discontinue of Arice A comprehensive MDS was compresident on 01/19/2018 with a BIN 15. Resident's order for Xanax was discontinued on 3/19/18 and phys to discontinue Aricept on 3/26/18, recommended by the psychologis to no signs of cognitive impairmed The resident's plan of care will be and updated. The resident's activist will be revised. | tact and ept.  leted on the MS score of as ician plans , as t, related nt. reviewed |

Facility ID: VA0002

| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   |                     | IPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|---|---|---------------------|--|--|
| AND PLAN O               | F CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDI           | NG   |  |
|                          |   | 495358  | B. WING_            |  | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CO<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  | DE   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)  | SHOULD BE COMPLETION   |
| F 744                    | dementia related n care to provide trearesident's dementia. The findings include The facility staff faidementia related n care to provide trearesident's dementia. Resident #72 was 1/12/18. Resident were not limited to depressive disorder #72's most recent day Medicare asses (assessment refer the resident as condocumented an act Non-Alzheimer's demential tracept"  A speech therapy documented, "3. demented, "3. dement | eeds and develop a plan of atment and services for the atment disease, major are and dementia (1). Resident MDS (minimum data set), a 30 assment with an ARD ence date) of 2/20/18, coded gnitively intact. Section I attive diagnosis of the atmentia.  In #72's clinical record revealed are developed Aricept (2) per physician's ary 2018, February 2018 and and anysician's note dated 2/5/18 the atmentia w/ (with) behaviors- on the first step to determining pt's order to allow her to |                     | The MDS/Care plan nurses waudit of care plans of all residuagnosis of dementia to valid a comprehensive individualized dementia as related to the redementia needs.  System Changes  1. Facility staff will be re-educed of the dementia residents, us Hand Dementia Training.  2. Care plans of each resident diagnosis of dementia will be updated as indicated to ensuis addressing the diagnosis of has individualized approache resident diagnosis, behavior cognition.  3. Staff assigned to the care with dementia will be educated and needs of the individual resident diagnosis of specific resident diagnosis of specific resident diagnosis of specific resident diagnosis of specific resident diagnosis of dementia. Interpretation of the sum of the second of the s | ents with ate each has ad care plan for sident's ated on care ing the Hand in t with reviewed and re the care plan f dementia and s specific to the s, and level of of resident's ad on the care esident.  Scusses the dent diagnosis, d as indicated.  Information is for residents formation will be abmitted to iscussion and ding the care |
|                          | Clinical Impressio  | ns: Pt able to follow 2-3 step  |                     |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING |  |                                       | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|--|--|---------------------------------------|-------------------------------|--|
|   |   | 495358   | B. WING                                |  | 03/0                                  | 9/2018                        |  |
|   | PROVIDER OR SUPPLIER  |  | 8                                      | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>AMELIA, VA 23002  |                                       |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION (CORRECTION CORRECTION | DBE                                   | (X5)<br>COMPLETION<br>DATE    |  |
| F 744   | Further review of Railed to reveal an adementia related in comprehensive cardocumented inform behaviors but failed (including treatmer dementia care.  On 3/8/18 at 11:38 conducted with RN stated Resident #7 but is fairly unstabled describe the facility protocols. RN #2 sindividualized for eknow how you couknow if we have prindividualized for each resident is gRN #2 was asked dementia care proincluding the assedementia related in Cn 3/8/18 at 1:58 conducted with Cn assessment) #5 (a Resident #72 and resident until one #5 was asked if R CNA #5 stated, "N told to us. I know got better then she quidelines or proto | age 77 good verbal reasoning skills"  tesident #72's clinical record assessment of the resident's eeds. Resident #72's re plan dated 1/24/18 nation regarding the resident's d to document information in and services) regarding  a.m., an interview was I (registered nurse) #2. RN #2 (2 "Comes off cognitively intact le." RN #2 was asked to y dementia care guidelines and tated, "I think that's each specific resident. I don't lid broad spectrum that. I don't rotocols. I'think that is more each resident with dementia. Sing to progress differently." to provide evidence of the vided to Resident #72, ssment of the resident #72, ssment of the resident's needs and care planning.  p.m., an interview was NA (certified nursing a CNA who was familiar with routinely worked with the month before the survey). CNA esident #72 had dementia. To that I know of. It hasn't been she's been emotional before. It is got emotional again and it's en asked if the facility had be cols for dementia care, CNA #6 on asked if the facility had be cols for dementia care, CNA #6 on asked if the facility had be cols for dementia care, CNA #6 on asked if the facility had be cols for dementia care, CNA #6 on asked if the facility had be cols for dementia care, CNA #6 on asked if the facility had be cols for dementia care, CNA #6 on asked if the facility had be the answer to that question. |  | The care plans for residents with dia of dementia will be reviewed during quarterly care plan meetings to valid care plans are updated with individual approaches as the resident dement change  Completion Date 04  | the<br>date the<br>ualize<br>ia needs |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | TIPLE CONSTRUCTION<br>DING | (X3) DAT<br>COM  | (X3) DATE SURVEY<br>COMPLETED     |                            |
|---|--|---|----------------------------|--|-----------------------------------|----------------------------|
|   |  | 495358  | B. WING                    | 4  | 03/                               | 09/2018                    |
|   | PROVIDER OR SUPPLIER   |   |                            | STREET ADDRESS, CITY, STATE, 2<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | ZIP CODE                          |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG          | A TARREST TO TO TO   | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>OATE |
| F 744   | When asked if she training at the facilithis time, CNA #5 had a diagnosis of she was not aware and had not receive how to care for the stated, "No I didn't but I have never his conducted with AS member) #2 (the conducted with AS asked if information be documented or resident has a diastated, "Yes. The asked if any demecompleted for resistated the facility dementia the residents asked if any demecompleted for resistated the facility dementia the residents asked if any demecompleted for resistated the facility dementia related residents, ASM #2 secure environments from the hospital, ASM #2 was made for Resident #72 ensures the best provided to Resident Resident Resident #72 ensures the best provided to Resident Resid | age 78 ence prior to coming here." was provided dementia ity, CNA #5 stated, "Yes." At was made aware Resident #72 dementia. CNA #5 confirmed the resident had dementia ed specialized instructions on resident's dementia. CNA #5 even know she had dementia ad troubles with her."  p.m., an interview was im (administrative staff director of nursing). ASM #2 cribe the facility dementia care tocols. ASM #2 stated, "What e comprehensive care plan, we e and centered toward resident mentia, or anxiety. It's centered are specifically." ASM #2 was on regarding dementia should in a resident's care plan if the gnosis of dementia. ASM #2 re should be." ASM #2 was entia related assessments were dents with dementia. ASM #2 staff looks at the type of dent is diagnosed with, and ther uates the resident and ation. When asked to describe care that is provided to 2 stated, "To provide a safe and ent. Orient, reorient, referrals home, talk with the family." e aware of the above findings and asked how the facility staff dementia care and services are ent #72. ASM #2 stated, "Let at. The main thing is providing |                            | 744  |                                   |                            |

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

|                          | NT OF DEFICIENCIES I OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING  |  |                     | (X3) DATE SURVEY<br>COMPLETED  |      |                            |
|--------------------------|---|--|---------------------|--|------|----------------------------|
|                          |   | 495358   | B. WING             |  | 03/0 | 9/2018                     |
|                          | PROVIDER OR SUPPLIER  |  | 88                  | REET ADDRESS, CITY, STATE, ZIP CODE<br>30 VIRGINIA STREET<br>MELIA, VA 23002                         |      |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | DBE  | (X5)<br>COMPLETION<br>OATE |
| F 744                    | a safe and secure to one and providi stage of dementia asked to provide a dementia care and facility did not hav  On 3/8/18 at 4:01 conducted with AS physician). ASM # #72 was diagnose When asked to deability, ASM #3 stand out as far as on a conversation behavior." ASM # behavior had improsychotherapy.  On 3/8/18 at 4:58 administrator) and the above finding. Review of facility training on demential may not do normal activities ating. They may problems or contpersonalities may agitated or see the information was desired. | environment, re-orienting, one ng calendars depending on the ." At this time, ASM #2 was any facility policies regarding diservices. ASM #2 stated the eithe requested policies.  p.m., an interview was SM #3 (Resident #72's 3 stated she thought Resident ad with dementia in the hospital. escribe Resident #72's cognitive ated, "Cognitively she goes in memory but she's able to carry and change some of her 3 stated Resident #72's roved since the initiation of p.m. ASM #1 (the di ASM #2 were made aware of stated documentation revealed staff |                     |  |      |                            |

Event ID: 9FT011

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY<br>COMPLETED  |  |
|---|--|--|-----------------------|--|--|
|   | 10   | 495358   | B. WING               |  | 03/09/2018   |
| ,   | PROVIDER OR SUPPLIER   |  |                       | STREET ADDRESS, CITY, STATE, ZIP<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   | CODE   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)   | ON SHOULD BE COMPLETION DATE  COMPLETION DATE  |
| F 744   | medlineplus-bundle<br>29535.891036110.<br>942321<br>(2) Aricept is used<br>information was ob  | ge 80 =medlineplus&v%3Asources= e&query=dementia&_ga=2.161 1520856028-139120270.1477  to treat dementia. This tained from the website: .gov/druginfo/meds/a697032.h  | F 7                   | 44   |  |
|   | CFR(s): 483.45(c)(<br>§483.45(c) Drug R<br>§483.45(c)(1) The   | egimen Review.<br>drug regimen of each resident<br>at least once a month by a  | F 7                   | 756 Ftag 756<br>Corrective Action<br>Resident #6 experienced<br>outcome related to the fac<br>Regimen Review Policy I<br>time frame for the manag<br>pharmacy recommendation   | cility Medication<br>naving no identified<br>pement of the<br>ons.   |
|   | §483.45(c)(4) The irregularities to the facility's medical d and these reports (i) Irregularities induced that the facility's medical d and these reports (ii) Irregularities induced that meets the diagram of this section of the facility of this section of the facility o | review must include a review edical chart.  pharmacist must report any attending physician and the rector and director of nursing, must be acted upon. Clude, but are not limited to, any e criteria set forth in paragraph for an unnecessary drug. Es noted by the pharmacist must be documented on a seport that is sent to the n and the facility's medical or of nursing and lists, at a dent's name, the relevant drug, of the pharmacist identified. Physician must document in the record that the identified en reviewed and what, if any, aken to address it. If there is to |                       | Resident #70 experienced outcome related to the fact Regimen Review Policy has time frame for the manager pharmacy recommendation.  Resident #72 experienced outcome related to the fact Regimen Review Policy time frame for management recommendations.  Resident #19 experienced outcome related to the fact Regimen Review Policy time frame for the management for the management outcome related to the fact Regimen Review Policy time frame for the management for the manage | cility Medication raving no identified rement of the rons.  d no negative cility Medication rement of the pharmacy red no negative racility Medication rement of the |

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|                          |  |   |                     | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |  |                            |
|--------------------------|--|---|---------------------|--|--|----------------------------|
|                          |  | 495358  | B. WING             | ( V=100 1000   | 03/0   | 09/2018                    |
|                          | PROVIDER OR SUPPLIER   |   | 8                   | TREET ADDRESS, CITY, STATE, ZIP CO<br>830 VIRGINIA STREET<br>MELIA, VA 23002   | DDE  |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY)   | SHOULD BE  | (X5)<br>COMPLETION<br>OATE |
| F 756                    | physician should dithe resident's med  §483.45(c)(5) The maintain policies a drug regimen revieilimited to, time frait the process and stock when he or she iderequires urgent at This REQUIREME by:  Based on staff intreview, and clinical determined the fact monthly pharmacy policy included all five of 20 resident Resident #6, #70,  1. The facility stati implement policies frames for the steregimen review to acting on gradual recommendations #6.  2. The facility stati implement policies frames for the steregimen review to acting on gradual recommendations #70. | e medication, the attending ocument his or her rationale in ical record.  facility must develop and and procedures for the monthly ew that include, but are not mes for the different steps in eps the pharmacist must take entifies an irregularity that tion to protect the resident. ENT is not met as evidenced erview, facility document if record review, it was cility staff failed to ensure the medication regimen review the required components for in the survey sample; #72, #19, and #50.  If failed to develop and is that addressed the time ps of the monthly medication guide staff on the process for dose reduction. If failed to develop and is that addressed the time ps of the monthly medication guide staff on the process for |                     | Other Potential Other residents residing in fact the potential to be affected by Regimen Review Policy not ide frame in which the pharmacy in must be managed. There have known negative outcomes related recommendations and the lack written into the policy.  System Changes 1. The policy for Medication R Review will be reviewed and in a time frame for the recommendations and physical policy for management recommendations.  3. Physicians will be notified to amended policy which will inditime frame for management of the pharmacy in compliance with the revised Monitoring 1. Upon physician review with decline of a pharmacy recommendation of a pharmacy r | the Medication entifying a time recommendation to the k of a time fram revised to indicated on the revised to indicated on the retorn to face on the retor | ne<br>ate                  |

implement policies that addressed the time

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |   | PLE CONSTRUCTION    | (X3) DATE<br>COMP   | SURVEY<br>LETED  |                            |
|---|--|---|---------------------|---|--|----------------------------|
|   |  | 405250  | B. WING             | - <del> </del>  | 02/0   | 9/2018                     |
|   |  | 495358  | B. WING             | STREET ADDRESS, CITY, STATE, ZIP C  |  | 19/2016                    |
|   | PROVIDER OR SUPPLIER  NURSING CENTER   |   |                     | 8830 VIRGINIA STREET<br>AMELIA, VA 23002  |  |                            |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | NTEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY)  | N SHOULD BE  | (X5)<br>COMPLETION<br>OATE |
| F 756   | frames for the step regimen review to acting on gradual or recommendations #72.  4. The facility staff implement policies frames for the step regimen review to acting on gradual or recommendations #19.  5. The facility staff implement policies frames for the step regimen review to acting on gradual recommendations #50.  The findings included the frames for the step regimen review to acting on gradual recommendations #50. | s of the monthly medication guide staff on the process for lose reduction by the pharmacist for Resident failed to develop and that addressed the time os of the monthly medication guide staff on the process for dose reduction by the pharmacist for Resident failed to develop and that addressed the time os of the monthly medication guide staff on the process for dose reduction by the pharmacist for Resident described to develop and the pharmacist for Resident described to develop and that addressed the time of the monthly medication guide staff on the process for |                     | forms to validate they were in the time frame as specified be policy.  3. DON will submit a report of non-compliance to the quartic committee for discussion and recommendations.  4. Medical Director will assist addressing other attending pare non-compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will become compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and will be compliant with the pand ensure those physician and the pand ensure those physician and the pand ensure | of areas of early QAPI d further the DON in only sicians who colicy to discuss sunderstand | Î                          |
| -   | 3/19/12 and readr<br>diagnoses of but the<br>hemiplegia, stroke<br>depression, anxie   | admitted to the facility on<br>nitted on 6/6/17, with the<br>not limited to diabetes, spastic<br>e, mood disorder, dementia,<br>ty, insomnia, and high blood<br>ost recent MDS (Minimum Data  |                     |   |  |                            |

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | ' 'DELETICIONETONINADED  |                     | TIPLE CONSTRUCTION NG   |           | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|--|---------------------|---|-----------|-------------------------------|--|
|   |  | 495358   | B. WING             | - N°  | 03        | /09/2018                      |  |
|   | PROVIDER OR SUPPLIER NURSING CENTER  | <u> </u>   |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002              |           |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFII<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>OATE    |  |
| F 756   | Set) was a quarter (Assessment Referesident was code impaired in ability to the monosheet dated 2/8/18 that Resident #6 with medications that mose Reduction):  Lexapro [1] 20 mg Seroquel [2] 50 mg Seroqu | ly assessment with an ARD rence Date) of 12/5/17. The das being mildly cognitively o make daily life decisions.  It recent Physician's Order in the clinical record revealed as on the following hay require a GDR (Gradual daily, order dated 9/6/17 g daily, order dated 1/5/18 is of the orders, a GDR was not a above medications. However, illity policy "Medication Regimented," 7. Facility should ian/Prescriber or other es reviewing the MRR and the |                     | 56  |           |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--|---|---|---------------------|---|-------------------------------|--|--|
|  |   | 495358  | B. WING             |   | 03/09/2018                    |  |  |
|  | PROVIDER OR SUPPLIER  | L   | 8                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>AMELIA, VA 23002                                 |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | DBE COMPLETION                |  |  |
| F 756  | Manager to review if there are any ch off the orders and When asked if the which the doctor in #2 stated she did thought that it sho  On 3/8/18 at 4:33 not locate any poliframe for the step  On 3/8/18 at 5:09 Director of Nursing findings. No furth the end of the sur [1] Lexapro is use generalized anxiet Information obtain https://medlineplutml  [2] Seroquel can be medications to tree Information obtain https://medlineplutml | and sends them to the Unit with the doctor. ASM #2 stated anges, the unit manager takes the care plan is updated. The is a specific time frame in the second active the care plan is updated. The is a specific time frame in the second active the second active the second active that addressed the time is of GDR's.  p.m., the Administrator and great made aware of the er information was provided by the second active the second |                     |   |                               |  |  |
|  | implement policie<br>frames for the ste<br>regimen review to<br>acting on gradual   | es that addressed the time<br>eps of the monthly medication<br>orguide staff on the process for   |                     |   | i                             |  |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | FIPLE CONSTRUCTION  NG | (X3) DATE<br>COMF  | SURVEY   |                            |
|--|--|--|------------------------|--|----------|----------------------------|
|  |  | 495358   | B, WING                |  |          | 9/2018                     |
|  | PROVIDER OR SUPPLIER   |  |                        | STREET ADDRESS, CITY, STATE, ZIP COI<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | DE       |                            |
| (X4) ID<br>PREFIX<br>TAG   | (FACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG     |  | HOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 756  | Continued From pa  | age 85   | F7                     | 756  |          |                            |
|  | diagnoses of but nurinary retention, reosteoporosis, glaurand hypothyroidism (Minimum Data Sewith an ARD (Assez/16/18. The resides ignificantly cognit daily life decisions.  A review of the most sheet dated 2/8/18 that Resident #6 we medications that in Dose Reduction):  Lexapro 10 [1] mg Seroquel 25 [2] mg Seroquel | est recent Physician's Order B in the clinical record revealed was on the following may require a GDR (Gradual daily, order dated 12/14/17 g daily, order dated 1/9/18 es of the orders, a GDR was not e above medications. However, cility policy "Medication Regimer ated, "7. Facility should cian/Prescriber or other es reviewing the MRR and the |                        |  |          |                            |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |          |   |         | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|----------|---|---------|-------------------------------|--|
|   |  | 495358  | B. WING                                |          |   | 03      | /09/2018                      |  |
|   | PROVIDER OR SUPPLIER   |   |  | 8830 VIR | ADDRESS, CITY, STATE, ZIP CODE<br>RGINIA STREET<br>A, VA 23002  |         |                               |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG                      | x c      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>ROSS-REFERENCED TO THE APP<br>DEFICIENCY) | DULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 756   | GDR recommenda On 3/8/18 at 3:10 p #2 (Administrative Nursing), she state medication review recommendations, recommendations, recommendations Manager to review if there are any character of the orders and When asked if there which the doctor m #2 stated she did not be the doctor of the doctor m #2 stated she did not be the doctor of the steps On 3/8/18 at 4:33 p not locate any polic frame for the steps On 3/8/18 at 5:09 p Director of Nursing findings. No further the end of the surv [1] Lexapro is used generalized anxiety Information obtains that ps://medlineplustml [2] Seroquel can b medications to treat Information obtains that ps://medlineplustml 3. The facility staff | tions the pharmacy may make, b.m., in an interview with ASM Staff Member, the Director of d that for the monthly process, the pharmacy makes then she reviews the and sends them to the Unit with the doctor. ASM #2 stated anges, the unit manager takes the care plan is updated. The is a specific time frame in the frame in the frame but and be within the month.  To.m., ASM #2 stated she could be within the month.  To.m., ASM #2 stated she could be within the month.  To.m., the Administrator and the printer and the provided by the stated depression and the graph of the ser information was provided by the stated along with other at depression. |  | 756      |   |         |                               |  |
|   | frames for the step  | os of the monthly medication  |  |          |   |         |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |  |   | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|---|--|---|---|-------------------------------|----------------------------|
|                          |  | 495358  | B. WING                                |   |   | 03/                           | 09/2018                    |
|                          | PROVIDER OR SUPPLIER   |   |  | 8830                                    | EET ADDRESS, CITY, STATE, ZIP CODE<br>D VIRGINIA STREET<br>ELIA, VA 23002                                       |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG                     | ×                                       | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE                            | (X5)<br>CDMPLETION<br>DATE |
| F 756                    | acting on gradual d<br>recommendations<br>#72.   | guide staff on the process for ose reduction by the pharmacist for Resident   | Fi                                     | 756                                     |   |                               |                            |
|                          | 1/12/18. Resident<br>were not limited to<br>depressive disorde<br>#72's most recent<br>day Medicare asse   | admitted to the facility on #72's diagnoses included but heart disease, major r and dementia (1). Resident MDS (minimum data set), a 30 ssment with an ARD ence date) of 2/20/18, coded initively intact.                         | 10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |   |   |                               |                            |
|                          | a pharmacy recom documented, "(Nar PRN (as needed) of medication), which than 14 days withon Recommendation: discontinued at this require that the presindication for use, "therapy, and the raperiod" The phyrecommendation of documented besid | n 2/21/18 and a check was   |  | 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - |   |                               |                            |
|                          | regimen reviews a recommendations documentation reg pharmacy recommended to the physician. Although  | ility policy regarding medication<br>nd pharmacy<br>failed to include any<br>larding the time frames that a<br>endation is required to be<br>sician and acted upon by the<br>the above pharmacy<br>was acted upon, the policy did |  |   |   |                               |                            |

|                          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|---|---|---|--|---|-------------------------------|----------------------------|
|                          |   | 495358  | B. WING                                 |  |   | 03                            | /09/2018                   |
|                          | PROVIDER OR SUPPLIER  |   |   | <b>88</b> 3 <b>0</b>   | EET ADDRESS, CITY, STATE, ZIP CODE<br>VIRGINIA STREET<br>ELIA, VA 23002   |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | <  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETION<br>DATE |
| F 756                    |   | nge 88<br>requirements of specifying  | F7                                      | 56   |   |                               |                            |
|                          | conducted with ASI member) #2 (the di was asked about tr pharmacy recommerceives the recompharmacy, reviews then gives the reco ASM #2 stated if a is required due to the care plans. With for acting upon phacontains any time f sure we do. It show When asked if the | M., an interview was M (administrative staff irector of nursing). ASM #2 he facility policy for acting upon endations. ASM #2 stated she mendations from the the recommendations and emmendations to the physician. change in a physician's order he recommendation then the ender change and update hen asked if the facility process armacy recommendations frames, ASM #2 stated, "I'm buld be within the month." time frames were documented, ASM #2 stated she would |   | The first the second of the se |   |                               |                            |
|                          | facility policy for me  | o.m., ASM #2 confirmed the edication regimen reviews and endations did not contain any  |   | , tr   |   |                               |                            |
|                          | On 3/8/18 at 4:58 padministrator) and the above findings.   | ASM #2 were made aware of   |   |  |   |                               |                            |
|                          | No further informat   | tion was presented prior to exit.   |   | 3  |   |                               | 1                          |
|                          | symptoms caused<br>brain. It is not a sp<br>dementia may not<br>do normal activities  | e name for a group of<br>by disorders that affect the<br>pecific disease. People with<br>be able to think well enough to<br>s, such as getting dressed or<br>lose their ability to solve  |   |  |   |                               | ii                         |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING |  |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---|--|------|-------------------------------|--|
|                          |  | 495358   | B. WING                                 |  | 03/  | 09/2018                       |  |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |  | 8                                       | TREET ADDRESS, CITY, STATE, ZIP CODE<br>830 VIRGINIA STREET<br>MELIA, VA 23002                         |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 756                    | problems or contropersonalities may of agitated or see thin information was obhttps://vsearch.nlmmeta?v%3Aprojectmedlineplus-bundle 29535.891036110.942321  (2) "Alprazolam is used and panic disorder of extreme fear and This information was https://medlineplustml  4. The facility staff implement policies frames for the step regimen review to gacting on gradual of recommendations #19.  Resident #19 was a 8/29/13. Resident were not limited to pressure and anxiemost recent MDS (significant change ARD (assessment) | I their emotions. Their change. They may become gs that are not there." This tained from the website: .nih.gov/vivisimo/cgi-bin/query=medlineplus&v%3Asources=e&query=dementia&_ga=2.1611520856028-139120270.1477  used to treat anxiety disorders (sudden, unexpected attacks d worry about these attacks)." as obtained from the website: .gov/druginfo/meds/a684001.h  failed to develop and that addressed the time s of the monthly medication guide staff on the process for | F 756                                   |  |      |                               |  |
|                          | a pharmacy recom documented, "(Nar   | t #19's clinical record revealed<br>mendation dated 12/8/17 that<br>me of Resident #19) has a<br>order for an anxiolytic (anxiety  | i                                       |  |      |                               |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | (X2) MULTI<br>A. BUILDIN | PLE CONSTRUCTION  G   | (X3) DATE SURVEY<br>COMPLETED |
|---|--|---|--------------------------|---|-------------------------------|
|   |  | 495358  | B. WING _                | 1140.4  | 03/09/2018                    |
| -   | PROVIDER OR SUPPLIER   |   |                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                       |                               |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE COMPLÉTION             |
| F 756   | medication), which than 14 days witho 0.5 mg (milligrams). Recommendation: discontinued at this require that the preindication for use, therapy, and the raperiod." The physical recommendation on "D/C (Discontinue). A review of the fact regimen reviews at recommendations documentation regimen reviews at recommendations documentation regimen reviews at recommendations documentation regimen reviews at recommendation who the fact regulators that the phyphysician. Although recommendation who the time frames. On 3/8/18 at 3:09 conducted with AS member) #2 (the dwas asked the fact pharmacy reviews then gives the recompharmacy, reviews then gives the recompharmacy, reviews then gives the recompharmacy as the recompharmacy and the care plans. We for acting upon phyphysicians any time sure we do. It should be at the contains any time sure we do. It should be at the care plans and the care plans and the care plans any time sure we do. It should be at the care plans and the care plans any time sure we do. It should be at the care plans and the care plans are the care plans | has been in place for greater ut a stop date: Lorazepam (1) twice daily prn.  If the medication cannot be time, NEW regulations escriber document the the intended duration of tionale for the extended time cian signed the n 12/11/17 and documented, Lorazepam."  It is policy regarding medication and pharmacy failed to include any larding the time frames that a rendation is required to be sician and acted upon by the in the above pharmacy was acted upon, the policy did y requirements of specifying |                          | 66  |                               |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | TIPLE CONSTRUCTION |  | TE SURVEY<br>MPLETED |                            |
|--|--|--|--------------------|--|----------------------|----------------------------|
|  |  | 495358   | B, WING            |  | 03                   | 3/09/2018                  |
|  | PROVIDER OR SUPPLIER   |  |                    | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002 | ODE                  |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |  | I SHOULD BE          | (X5)<br>COMPLETION<br>OATE |
| F 756  | look.  On 3/8/18 at 4:33 pfacility policy for me pharmacy recomm time frames.  On 3/8/18 at 4:58 pfadministrator) and the above findings.  No further information was observed in the second se | ASM #2 stated she would<br>o.m., ASM #2 confirmed the<br>edication regimen reviews and<br>endations did not contain any<br>o.m. ASM #1 (the<br>ASM #2 were made aware of   |                    | 756  |                      |                            |
|  | implement policies frames for the step regimen review to acting on gradual of recommendations #50.  Resident #50 was 9/1/15. Resident # were not limited to constipation and a most recent MDS assessment with a date) of 2/7/18, co severely impaired.  | failed to develop and that addressed the time is of the monthly medication guide staff on the process for dose reduction by the pharmacist for Resident admitted to the facility on 450's diagnoses included but urinary tract infection, exiety disorder. Resident #50's (minimum data set), a quarterly in ARD (assessment reference ded the resident's cognition as at #50's clinical record revealed |                    |  |                      |                            |

| AMELIA NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  SUMING  STREET ADDRESS, CITY, STATE, ZIP CODE  8830 VIRGINIA STREET  AMELIA, VA 23002  (X5) PROVIDER'S PLAN OF CORRECTION  (X5) PROVIDER'S PLAN OF CORRECTION  (X5) CONTROL OF CORRECTION  (X6) CONTROL OF CORRECTION  ( |        | FOF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULT<br>A. BUILDIN | IPLE CONSTRUCTION  NG                                       | (X3) DATE SURVEY<br>COMPLETED |                            |
|--|--------|--|--|-------------------------|---|-------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  AMELIA NURSING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  8830 VIRGINIA STREET  AMELIA, VA 23002  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  |        |  | 495358   | B. WING _               |   | 03/                           | 09/2018                    |
|  |        |  |  |                         | 8830 VIRGINIA STREET  | 11761                         |                            |
| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  | PREFIX | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | PREFIX                  | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE                          | (X5)<br>COMPLETION<br>DATE |
| F 756 Continued From page 92 a pharmacy recommendation dated 2/15/18 that documented, "(Name of Resident #50's) PRN (as needed) order(s) below have not been used within the previous 60 day.  1. Senna (1) 2. Bisacodyl (2) 3. Triamicinolone (3) Please consider discontinuing due to lack of use." The physician signed the recommendation on 2/28/18 and documented a check beside, "I accept the recommendation(s) above, please implement as written."  A review of the facility policy regarding medication regimen reviews and pharmacy recommendations falled to include any documentation regarding the time frames that a pharmacy recommendations falled to include any documentation regarding the time frames that a pharmacy recommendation is required to be provided to the physician and acted upon by the physician. Although the above pharmacy recommendation was acted upon, the policy did not meet regulatory requirements of specifying those time frames.  On 3/8/18 at 3:09 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 was a sked the facility policy for acting upon pharmacy recommendations from the pharmacy, reviews the recommendations from the pharmacy, reviews the recommendations from the pharmacy, reviews the recommendations of the the unit managers note the order change and update the care plans. When asked if the facility process for acting upon pharmacy recommendations contains any time frames, ASM #2 stated, "I'm   | F 756  | a pharmacy recommended ocumented, "(Nameded) order(s) be within the previous 1. Senna (1) 2. Bisacodyl (2) 3. Triamicinolone (3) Please consider dis The physician signe 2/28/18 and documented as writted accept the recommendations of the facility of the f | mendation dated 2/15/18 that the of Resident #50's) PRN (as allow have not been used 60 day.  B) continuing due to lack of use."  Be the recommendation on ented a check beside, "I endation(s) above, please en."  Bity policy regarding medication and pharmacy failed to include any arding the time frames that a endation is required to be sician and acted upon by the in the above pharmacy as acted upon, the policy did a requirements of specifying endations. ASM #2 stated she mendations from the the recommendations and mmendations to the physician. Change in a physician's order the recommendation then the the order change and update then asked if the facility process irmacy recommendations. |                         | 56  |                               |                            |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |  | PLE CONSTRUCTION    | (X3) DATE SURVEY<br>COMPLETED   |         |                            |
|--|--|--|---------------------|---|---------|----------------------------|
|  |  | 495358   | B. WING_            |   | 03/0    | 9/2018                     |
|  | PROVIDER OR SUPPLIER NURSING CENTER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002   |         |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY)   | DBE     | (X5)<br>COMPLETION<br>DATE |
|  | in the facility policy look.  On 3/8/18 at 4:33 pfacility policy for me pharmacy recomm time frames.  On 3/8/18 at 4:58 padministrator) and the above findings.  No further informating information was obtained information was obtained. | time frames were documented, ASM #2 stated she would o.m., ASM #2 confirmed the edication regimen reviews and endations did not contain any o.m. ASM #1 (the ASM #2 were made aware of | F 75                | 56  |         |                            |
|  | information was obhttps://medlineplusml  (3) Triamcinolone i This information whitps://medlineplusml Free from Unnec F CFR(s): 483.45(c)(3) §483.45(c)(3) A ps affects brain activit processes and beh                                     |  | F 7                 | Corrective Action Res. # 72 has order in place for Alp po be given once a day a needed. order for Xanax was discontinued of 3/19/18 with resident being in agree. with that plan. | The PRN |                            |

|       | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |
|-------|--|--|--------------------|---|--|
|       |  | 495358   | B. WING            |   | 03/09/2018   |
|       | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFI<br>TAG |   | RRECTION (X5) N SHOULD BE COMPLETION   |
| F 758 | (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic  Based on a compreresident, the facility §483.45(e)(1) Resipsychotropic drugs unless the medical specific condition a in the clinical recor §483.45(e)(2) Residugs receive grad behavioral interver contraindicated, in drugs; §483.45(e)(3) Respsychotropic drugs unless that medical diagnosed specific in the clinical recor §483.45(e)(4) PRN are limited to 14 da §483.45(e)(5), if the prescribing practiti appropriate for the beyond 14 days, hrationale in the resindicate the duratic §483.45(e)(5) PRN drugs are limited to | chensive assessment of a must ensure that dents who have not used are not given these drugs ion is necessary to treat a is diagnosed and documented d; dents who use psychotropic ual dose reductions, and ations, unless clinically an effort to discontinue these idents do not receive pursuant to a PRN order ation is necessary to treat a condition that is documented |                    | Other Potential An audit will be completed of active resident in facility to ide residents who may have proper medication. Clarification order for any resident having such containing no time limit.  System Change  1. Licensed nurses will be ed requirements for use of psychmedications  2. The Director of Nursing will the attending physician/medic discuss the regulation for the addition to the notes she is enthe records.  3. New orders for PRN psychmedications will be identified hour report.  4. Unit managers will review to validate the appropriatenes and the inclusion of time framinto the order.  5. the facility policy for use of psychotropic medications will and revised if indicated. Lice will be re-educated on policy | entify other psychotropic ers will be obtained orders but  fucated on the hotropic  If meet with cal director to corders in entering into  notropic on the 24  those records ess of the orders nes being written  If PRN If be reviewed ensed nurses |

PRINTED: 03/20/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT                | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                   |     | E CONSTRUCTION   |                | E SURVEY<br>PLETED         |
|--------------------------|---|---|-------------------|-----|--|----------------|----------------------------|
|                          |   | 40.555  |                   | -   |  |                |                            |
| NAME OF I                | PROVIDER OR SUPPLIER  | 495358  | B, WING           | S   | TREET ADDRESS, CITY, STATE, ZIP CODE   | 03/            | 09/2018                    |
| AMELIA                   | NURSING CENTER  |   |                   |     | B30 VIRGINIA STREET<br>MELIA, VA 23002   |                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREF<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | D BE           | (X5)<br>COMPLETION<br>DATE |
| F 758                    | the appropriatenes This REQUIREME by: Based on staff inte and clinical record the facility staff faile residents in the sur was free of unnece The facility staff fail physician addresse needed anxiety me and failed to ensur the duration for the The findings Includ Resident #72 was 1/12/18. Resident were not limited to depressive disorde #72's most recent day Medicare asse (assessment refere the resident as cog document Resider medication two day back period.  Review of Resider a physician's order (2) 0.25 mg (millig) No stop date was Review of Resider | oner evaluates the resident for s of that medication.  NT is not met as evidenced erview, facility document review review, it was determined that ed to ensure one of 20 rvey sample, Resident #72, essary medication.  Illed to ensure Resident #72's ed the continued need for as edication within a 14 day period the physician documented emedication order.  Ite:  admitted to the facility on #72's diagnoses included but heart disease, major er and dementia (1). Resident MDS (minimum data set), a 30 essment with an ARD ence date) of 2/20/18, coded gnitively intact. Section N at #72 received anxiety ys during the seven-day look  on #72's clinical record revealed of dated 1/26/18 for alprazolam rams) once a day as needed.  ont #72's January 2018 and | F                 | 758 | Monitoring:  1. Unit managers will submit audits PRN psychotropic medications to the Director of Nursing.  2. Any nurse who is non-compliant protocol will receive 1:1 counselling  3. DON will analyze and trend audit and will submit a report of areas of non-compliance in the quarterly QA committee meeting.  Completion Date 04 | with . results |                            |
|                          |   | ARs (electronic medication ords) revealed the resident  |                   |     |  |                |                            |

received as needed alprazolam on 1/23/18,

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | ' '               | TIPLE CONSTRU |   |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|-------------------|---------------|---|------|-------------------------------|--|
|                          |  | 495358  | B. WING           |               |   | 03/  | /09/2018                      |  |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |   |                   |               | ORESS, CITY, STATE, ZIP CODE<br>NIA STREET<br>VA 23002  |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREF<br>TAG | X (EA         | PROVIDER'S PLAN OF CORRECTION<br>ACH CORRECTIVE ACTION SHOULD<br>SS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 758                    | Resident #72's con 1/24/18 documents meds (medications to) increase in anxibehaviors such as food" The care preview of alprazola documentation of the document of the document of the therapeutic interversional continued need. It therapeutic interversional to self and others continued need for the duration for the was not document. Further review of Frevealed the physic continued need for (16 days from 2/5/dated Wednesday, "Reviewed Xanax from the continues to be a wher. This medication help prevent har physician did not a alprazolam within as needed medical documented. | ded, "Psychotropics and anxiety") added on admission d/t (due ety and inappropriate cussing staff and throwing plan failed to address physician mevery 14 days or physician the duration of the medication.  The physician on 2/5/18 throwing the duration of the medication of the medication.  This medication of the medication of the rational for the alprazolam was documented, as needed medication order ed.  The physician's note alprazolam again until 2/21/18 through the rational for the alprazolam was documented, as needed medication order ed.  The physician's note alprazolam again until 2/21/18 through the record cian did not address the alprazolam again until 2/21/18 through the record on continued need. It wall the the alprazolam to be necessary medication to the total through the duration for the dress the continued need for 14 days and the duration for the tion, order was not the communication. |                   | 758           |   |      |                               |  |
|                          | conducted with AS member) #2 (the d  | M (administrative staff irector of nursing). ASM #2   |                   |               |   |      |                               |  |

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | · ·                 | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |          | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|---------------------|--|----------|-------------------------------|--|
|                          |  | <b>49535</b> 8  | B. WING             | ·  | 03/      | 09/2018                       |  |
|                          | PROVIDER OR SUPPLIER   | <del>*************************************</del>  |                     | STREET ADDRESS, CITY, STATE, ZIP COI<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002           |          |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5)<br>COMPLETION<br>DATE    |  |
| F 758                    | needed anxlety me ASM #2 stated, "I v On 3/8/18 at 4:01 p conducted with ASI physician) regarding anxiety medication other interventions anxiety medication are aggressive and patients, so sometimedication. When evaluating the contanxiety medication all medications durrecertification perior regulations, she had need for as needed weeks. When ask duration for the contanxiety medication document the duration the continued need weeks. At this time the continued need was not evaluated ASM #3 stated the | dication should be reviewed. yould say within two weeks."  J.m. an interview was M #3 (Resident #72's g the prescribing of as needed ASM #3 stated she attempts before prescribing as needed but of course, some patients can harm staff or other mes she has to prescribe asked her process for inued need for as needed ASM #3 stated she evaluates ing residents' 60-day ds, but now with the new is to evaluate the continued d anxiety medication every two ed if she documents the ntinued use of as needed ASM #3 stated she does not tion because she will evaluate for the medication in two e, ASM #3 was made aware for Resident #72's alprazolam from 2/5/18 until 2/21/18.  14th day may have occurred he may have followed up the | F 7                 | 58   |          |                               |  |
|                          |  | o.m. ASM #1 (the<br>ASM #2 (the director of<br>e aware of the above findings.   |                     |  |          |                               |  |
|                          | documented, "3. The monitors the use of recommends grade   | tropic medication protocol<br>ne Consultant pharmacist<br>f psychotropic medications and<br>ual dosage reduction<br>Primary Care Physician will   |                     |  |          |                               |  |

| AND PLANCE CORRECTION DENTIFICATION NUMBER: |  | (X2) MULTIP<br>A. BUILDING  | LE CONSTRUCTION     | (X3) DATE SURVEY<br>COMPLETED   |                |
|---|--|---|---------------------|---|----------------|
|   |  | 495358  | B. WING             |   | 03/09/2018     |
|   | PROVIDER OR SUPPLIER   |   | 1                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1830 VIRGINIA STREET<br>AMELIA, VA 23002                               | 1 33/33/2313   |
| (X4) ID<br>PREFIX<br>TAG                    | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | DBE COMPLÉTION |
| F 758                                       | Continued From pa  | ge 98   | F 758               |   |                |
|   | psychotropic medicagree with the GDF and write orders reprotocol failed to do the above concern.  No further informat  (1) "Dementia is the symptoms caused brain. It is not a specified may not be do normal activities eating. They may I problems or contropersonalities may agitated or see thin information was obhttps://vsearch.nlmmeta?v%3Aprojectmedlineplus-bundle | for continuation of sation at the same dosage or R (Gradual Dose Reduction) ducing the medication" The ocument information regarding ion was presented prior to exit. It is name for a group of by disorders that affect the ecific disease. People with the able to think well enough to be able to think well enough to b |                     |   |                |
|   | and panic disorder<br>of extreme fear and<br>This information wa<br>https://medlineplus<br>tml   | used to treat anxiety disorders (sudden, unexpected attacks di worry about these attacks)." as obtained from the website: .gov/druginfo/meds/a684001.h  |                     |   |                |
|   | CFR(s): 483.60(i)(1  |   | F 812               | Corrective Action: Nursing Assistant #1, who touched using her bare hands, was counsell                         |                |
|   | §483.60(i) Food sa<br>The facility must -  | fety requirements.  |                     | DON on 03/08/18 regarding the proper use of gloves to handle resid  | lents food.    |
|   | §483.60(i)(1) - Prod   | cure food from sources  |                     |   |                |

|   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | , ,   |  | (X3) DATE SURVEY<br>COMPLETED   |
|---|--|---|--|---|
|   | 495358   | B. WING   |  | 03/09/2018  |
|   |  | 88  | 330 VIRGINIA STREET  |   |
| (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | DBE COMPLÉTION  |
| approved or considing state or local autho (i) This may include from local producer and local laws or region (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for from consuming for serve food in according standards for food This REQUIREMED by:  Based on observation of the facility staff fail preparing toast for room during breakt The findings included On 03/07/18 at appropriate of the resion of the | lered satisfactory by federal, rities. In food items obtained directly responding to applicable State equilations. In oes not prohibit or prevent goroduce grown in facility of compliance with applicable produce grown in facility. In oes not preclude residents of the facility. In oes not preclude residents of the facility of the facility. In oes not procured by the facility. In o |   | Other potential Other residents who were assisted water breakfast meal in the dining room combeen at risk for that same employed their food without gloves. There have no concerns expressed by residents resident has displayed a negative of related to food possibly being touched bare hands.  System Changes:  1. Nursing Assistants will be re-educed on feeding technique, with emphasis handling of resident food and glove.  2. An Administrative nurse will be asted to observe the dining room through one meal each day to validate staff proper technique (wearing gloves) handling resident food.  3. A weekly report will be submitted DON on the dining observations.  4. Facility policy for assisting reside food will be reviewed and revised as indicated.  Monitoring The DON will analyze the weekly redining observations and will submit of areas of non-compliance to the completion Daries of the properties of the pr | ould have e handling we been and no utcome ed by  cated s on use ssigned at least using in  to the  https://www.assigned.com/assigned/at least using in  to the cated s on use segment with s seports of a report quarterly gresident liately e   |
| the side of the resi  | dent's toast to hold it in place   |   |  |   |
|   | Continued From parapproved or considistate or local author (i) This may include from local producer and local laws or refusion discilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for serve food in according the same and ards for food This REQUIREMED by:  Based on observation determined that the food in a sanitary management of the findings included the findings included the side of the resident of the side of the side of the resident of the side of th | A95358  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced | ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99  approved or considered satisfactory by federal, state or local authorities.  (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.  (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (iii) This provision does not preclude residents from consuming foods not procured by the facility.  §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.  This REQUIREMENT is not met as evidenced by:  Based on observation and staff interview, it was determined that the facility staff failed to serve food in a sanitary manner.  The facility staff failed to wear gloves while preparing toast for three residents in the dining room during breakfast.  The findings include:  On 03/07/18 at approximately 8:30 a.m., the following observations of the dining room were conducted during the breakfast meal:  On 03/07/18 at approximately 8:50 a.m., a staff member was observed with their finger against the side of the resident's toast to hold it in place while she buttered it.  On 03/07/18 at approximately 8:55 a.m., a staff member was observed with their finger against  | ROVIDER OR SUPPLIER  A BUILDING  SUMMARY STATEMENT OF DEFICIENCIES  (EACH GERICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 99  approved or considered satisfactory by federal, state or local authorities.  (I) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.  (II) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (III) This provision does not proclude residents from consuming foods not procured by the facility. \$483.60(I)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.  This REQUIREMENT is not met as evidenced by:  Based on observation and staff interview, it was determined that the facility staff failed to serve food in a sanitary manner.  The facility staff failed to wear gloves while preparing toast for three residents in the dining room during breakfast.  The findings include:  On 03/07/18 at approximately 8:50 a.m., a staff member was observed with their finger against the side of the resident's toast to hold it in place while she buttered it.  On 03/07/18 at approximately 8:55 a.m., a staff member was observed with their finger against the side of the resident's toast to hold it in place while she buttered it.  On 03/07/18 at approximately 8:55 a.m., a staff member was observed with their finger against |

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION  |           | OATE SURVEY<br>OMPLETED    |
|--------------------------|--|---|---------------------|---|-----------|----------------------------|
|                          |  | 495358  | B. WING             |   | ,         | 3/09/2018                  |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |   |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002    |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 812                    | while she buttered On 03/07/18 at apprinterview was condimember) # 1, food to describe the profor handling a resid "They should wear On 03/07/18 at 10: conducted with CN 1. When asked if smorning serving br "Yes." When ask t followed when han 1 stated, "You don' wear gloves." Who observations of hoplace with her bare toast, CNA # 1 stated toast."  The facility's policy and Use of Plastic use clean barriers tongs, deli paper a borne illness."  According to the Fwhen washing fruit under §3-302.15 of this section, FOOD contact exposed, Fitheir bare hands a UTENSILS such a single-use gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed, Fitheir bare gloves, On 03/08/18 at apprint the contact exposed gloves, On 03/08/18 at apprint | oroximately 9:30 a.m., an lucted with OSM (other staff service director. When asked cedure to be followed by staff lent's food, OSM # 1 stated, |                     |   |           |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIP<br>A. BUILDING | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED   |
|--------------------------|--|--|----------------------------|--|---|
|                          |  | 495358   | B. WING                    |  | 03/09/2018  |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |  | 1 :                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)  | DBE COMPLÉTION  |
|                          | administrator and A<br>were made aware o   | SM # 2, director of nursing of the findings.  on was provided prior to exit.   | F 812                      | 1. No resident's were identified to ha   |   |
| SS=C                     | §483.70(e) Facility The facility must co facility-wide assess resources are nece competently during and emergencies. update that assess least annually. The update this assess facility plans for, an substantial modifica assessment. The fa address or include: §483.70(e)(1) The including, but not lii (i) Both the number resident capacity; (ii) The care require considering the typ physical and cognit and other pertinent that population; (iii) The staff compe provide the level ar resident population (iv) The physical er services, and other that are necessary (v) Any ethnic, cultu- | assessment.  Induct and document a ment to determine what issary to care for its residents both day-to-day operations. The facility must review and ment, as necessary, and at facility must also review and ment whenever there is, or the y change that would require a action to any part of this acility assessment must  facility's resident population, mited to, of residents and the facility's ed by the resident population es of diseases, conditions, ive disabilities, overall acuity, facts that are present within estencies that are necessary to and types of care needed for the |                            | been impacted by the incomplete Fa Assessment  2. All residents had the potential to affected by the incomplete Facility / The organization will complete the Fassessment.  3. Additional information has been of and will be compiled into a complete Assessment with input from the Me Director and key facility leadership, The Facility Assessment will address required components including: a fabased and community based all-haz risk assessment, health information technology resources and electronic sharing information with other organ Where needed, appropriate polcies / protocols will be refined and/or devand scheduled for implementation to the processes addressed in the Fact Assessment.  4. The completed Facility Assessment will be reviewed and revised annual Completion date. | be Assessment. Facility  Obtained e Facility dical s all acility zard  cally nizations. / procedures veloped o support cility ent |

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING |   |       | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|---|-------|-------------------------------|--|
|                          |  | 495358  | B. WING                                |   | 03    | /09/2018                      |  |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |   | 883                                    | REET ADDRESS, CITY, STATE, ZIP CODE<br>80 VIRGINIA STREET<br>MELIA, VA 23002                                |       |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETION<br>OATE    |  |
| F 838                    | food and nutrition s §483.70(e)(2) The but not limited to, (i) All buildings and and vehicles; (ii) Equipment (med (iii) Services provid pharmacy, and spe (iv) All personnel, in employees and tho contract), and volun education and/or tr related to resident (v) Contracts, mem or other agreement services or equipm normal operations (vi) Health informat such as systems for | ut not limited to, activities and ervices.  facility's resources, including for other physical structures dical and non-medical); ed, such as physical therapy, cific rehabilitation therapies; including managers, staff (both se who provide services under nteers, as well as their aining and any competencies care; orandums of understanding, its with third parties to provide ent to the facility during both and emergencies; and ion technology resources, or electronically managing telectronically sharing | F 838                                  |   |       |                               |  |
|                          | all-hazards approach This REQUIREMED by: Based on staff interreview, it was determined to develop a The facility-based and cassessment, utilizing and failed to address technology resource.   | isk assessment, utilizing an  |  |   |       |                               |  |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | TIPLE CONSTR<br>ING |   |        | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|--------------------|---------------------|---|--------|-------------------------------|--|
|                          |  | 495358   | B. WING            |                     |   | 03     | 3/09/2018                     |  |
|                          | PROVIDER OR SUPPLIER   |  |                    |                     | DRESS, CITY, STATE, ZIP CODE<br>INIA STREET<br>VA 23002   |        |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | JD<br>PREFI<br>TAG | X (E                | PROVIDER'S PLAN OF CORREC<br>ACH CORRECTIVE ACTION SHO<br>OSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE | (X5)<br>COMPLETION<br>OATE    |  |
| F 838                    | responsible to the facility or all-hazards approach information technol systems for electrorecords and elect | e:  ty assessment failed to reveal y-based and isk assessment, utilizing an ch and failed to address health ogy resources, such as nically managing patient enically sharing information | F                  | 338                 |   |        |                               |  |
|                          | member) #4 (the be provide that docume On 3/9/18 at 8:22 at business associate at section 3.b. Secured Transfer Secured Secure | usiness office manager) could  |                    |                     |   |        |                               |  |

|                          | TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING   |  |                     | (X3) DATE SURVEY<br>COMPLETED  |           |                            |
|--------------------------|--|--|---------------------|--|-----------|----------------------------|
|                          |  | 495358   | B. WING             |  | 03        | /09/2018                   |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP C<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                             |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFII<br>TAG |  | SHOULD BE | (X5)<br>COMPLETION<br>OATE |
| F 838                    | Agreement, as ame required by law. WBUSINESS ASSOC administrative, physical that reasonably and confidentiality, integelectronic PHI. BU warrants that it will any manner that will any manner that will any manner that will regulations if (namengaged in such act to address the facility technology resource aware this surveyo emergency risk assistied to "type some asked if she had expeditional to the solution of the surveyorement | than as provided by the Prior ended by this Agreement, or as lithout limiting the foregoing, CIATE agrees to implement sical and technical safeguards appropriately protect the grity and availability of ISINESS ASSOCIATE further not use or disclose any PHI in II violate HIPAA (Health ty and Accountability Act) ne of Facility Company) ctivity." The agreement failed ity's health information | F8                  | 338  |           |                            |
|                          |  | a.m., ASM #1 stated the a policy regarding the facility  | i                   | ii<br>a  |           |                            |
| F 880<br>SS=F            | Infection Preventio<br>CFR(s): 483.80(a)(<br>§483.80 Infection C<br>The facility must es   | 1)(2)(4)(e)(f)   |                     | corrective Action  1. The facility adopted a policy Management Program to Pre Legionnaires Disease on 3/7/ | vent      |                            |

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIF<br>A, BUILDING | PLE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED  |
|--------------------------|--|---|----------------------------|--|--|
|                          |  | 495358  | B. WING_                   |  | 03/09/2018   |
|                          | PROVIDER OR SUPPLIER NURSING CENTER  |   |                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | D BE COMPLETION  |
| F 880                    | designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control program a minimum, the following services to arrangement based conducted accordinaccepted national services of the but are not limited to the followed to provide to be followed to providing Standard and tr to be followed to providing upon the involved, and | e a safe, sanitary and ment and to help prevent the cansmission of communicable cions.  In prevention and control  tablish an infection prevention in (IPCP) that must include, at owing elements:  Stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual in upon the facility assessmenting to §483.70(e) and following standards;  en standards, policies, and program, which must include, or eillance designed to identify table diseases or ey can spread to other ity;  som possible incidents of ease or infections should be ansmission-based precautions event spread of infections; isolation should be used for a | F 884                      | 2. There have been no negative outrelated to the facility not having previmplemented the policy.  Other Potential No resident was identified in this citathere could have been potential for a resident to be impacted in the even contaminated water causing illness.  3. System Changes  1. Legionella policy was adopted by facility on 3/7/18.  2. Facility staff will be educated on the standard symptom of the sympt | ation, but any t of the he policy oms.  Inples slia will oles.  control incerns.  Legionnaires updated and discuss |

|                          |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING   |                     |   | (X3) DATE SURVEY<br>COMPLETED |                            |
|--------------------------|--|--|---------------------|---|-------------------------------|----------------------------|
|                          |  | 495358   | B. WING _           |   | 03                            | 3/09/2018                  |
|                          | PROVIDER OR SUPPLIER  NURSING CENTER   |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>8830 VIRGINIA STREET<br>AMELIA, VA 23002                         |                               |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC'<br>(EACH CORRECTIVE ACTION SHO'<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | ULD BE                        | (X5)<br>COMPLETION<br>DATE |
| F 880                    | circumstances. (v) The circumstance must prohibit employed disease or infected contact with resider contact will transmit (vi) The hand hygies by staff involved in §483.80(a)(4) A systidentified under the corrective actions to §483.80(e) Linens. Personnel must hat transport linens so infection. §483.80(f) Annual The facility will consider in the program of the program.  The facility staff fair address legionella.  The findings included the conference on festaff member) # 1, | ces under which the facility by ees with a communicable skin lesions from direct has or their food, if direct to the disease; and he procedures to be followed direct resident contact.  Stem for recording incidents of facility's IPCP and the aken by the facility.  Indle, store, process, and has to prevent the spread of the review.  Induct an annual review of its heir program, as necessary.  In is not met as evidenced berview and facility document remined that the facility staff complete infection control led to develop a protocol to (1). |                     | 30  |                               |                            |

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | CONSTRUCTION  |     | SURVEY<br>PLETED           |
|--------------------------|---|---|--------------------|-----|---|-----|----------------------------|
|                          |   | 495358  | B. WING            |     |   | 03/ | 09/2018                    |
|                          | PROVIDER OR SUPPLIER NURSING CENTER   |   |                    | 88  | REET ADDRESS, CITY, STATE, ZIP CODE<br>30 VIRGINIA STREET<br>/IELIA, VA 23002                                     |     |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE  | (X5)<br>COMPLETION<br>OATE |
| F 880                    | provided this survey "Water Management Legionnaire's Diseat policy documented, medical director. On 03/07/18 at appinterview was conditated, "It was done No further information. Whe regarding legionella stated, "It was done No further information. Whe regarding legionella stated, "It was done No further information. References:  (1) Is a respiratory bacteria. Sometime type of pneumonia Legionnaires' diseat cause a less serious that has symptoms flu. It is found natue environments, like I become a health cospreads in humanishowers and fauce (air-conditioning un tubs that aren't draif fountains and water heaters, and large information was ob | roximately 1:55 p.m. ASM # 1 yor with a document entitled int Program to Prevent ase." Further review of the "Approved by: (ASM # 3), original Date: 3/7/18, (ASM # riginal Date: 3/7/18."  proximately 1:55 p.m. an ucted with ASM # 1, en asked when the policy a was developed, ASM # 1 e today."  ion was provided prior to exit.  disease caused by Legionella es the bacteria cause a serious (lung infection) called ase. The bacteria can also as infection called Pontiac fever similar to a mild case of the rally in freshwater lakes and streams. It can oncern when it grows and made water systems like |                    | 380 |   |     |                            |
|                          |   |   | ,                  |     |   |     |                            |

PRINTED: 03/20/2018 FORM APPROVED

State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING 495358 B. WING 03/09/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **AMELIA NURSING CENTER** 8830 VIRGINIA STREET AMELIA, VA 23002 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 000 **Initial Comments** F 000 An unannounced biennial State Licensure Inspection was conducted 03/06/18 through 03/09/18. Corrections are required for compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census at this 100 certified bed facility was 85 at the time of the survey. The survey sample consisted of 18 current residents Resident #s (56, 9, 33, 61, 41, 8, 31, 25, 70, 72, 6, 63,19,76,137,15,50,10) and two closed records, Residents #s (88 and 87). F 001 Non Compliance F 001 Please reference plan of correction for FTag 656 for correction plan. The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-250, Resident Assessment and Care Planning cross reference to F656.

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

TITLE

(X6) DATE

STATE FORM

02119

101F11

dministrator

If continuation sheet 1 of 1