PRINTED: 05/19/2017 FORM APPROVED OMB NO. 0938-0391

CIENCIES CTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '			(X3) OATE SURVEY COMPLETEO	
	495336	B. WING			1	C 09/2017
OR SUPPLIER	B CENTER		83	CROSSROADS LANE	, , ,	
CH DEFICIENCY	/ MUST BE PRECEOED BY FULL	:		(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION OATE
announced Mass conduct 2017. An ext 2017 through ions are requested the following iate Jeopard Comprehering on 05/04/2 ed the immediate removal everity was located of Quality	Medicare/Medicaid standard ted 05/02/2017 through tended survey was conducted 05/09/2017. Significant uired for compliance with 42 eral Long Term Care Life Safety Code Illow. Five complaints were the survey. Ity (IJ) was identified in the esive Person-Centered Care 2017 at 1:55 p.m. The facility diacy on 05/04/2017 at 8:55 of the immediacy the Scope ewered to a Level III, isolated. Ity of Care (SQC) was identified the form of the conduction of the conducti	FC	000	does not constitute admission or agreement by the provider of the tr the facts alleged or conclusions set on the statement of deficiencies. T plan of correction is prepared and/ executed solely because it is require	ruth of t forth This or red by	
Notification	/ROOM, ETC) of Changes.	F 1	157	affects and did not require transfe	r to a	06/23/17
	SUMMARY STACH DEFICIENCY SULLATORY OR L COMMENT COMMEN	CTION IDENTIFICATION NUMBER:	A BUILD 495336 B. WING COR SUPPLIER ING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEOED BY FULL BUILATORY OR LSC IDENTIFYING INFORMATION) COMMENTS F (COMMENTS) COMMENTS COMMENTS F (COMMENTS) COMMENTS COMMENTS F (COMMENTS) F (COMMENTS) COMMENTS F (COMMENTS) F (COMMENTS) F (COMMENTS) F (COMMENTS) COMMENTS F (COMMENTS) F (COMME	A BUILOING	A BUILOING 495336 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 32 CROSSROADS LANE FISHERSVILLE, VA 22939 SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) COMMENTS FOOD Preparation and/or execution of the does not constitute admission or agreement by the provider of the the facts alleged or conclusions set on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required the provisions of federal and state executed solely because it is required to the immediacy on 05/04/2017 at 1:55 p.m. The facility de the immediacy on 05/04/2017 at 3:55 fifter removal of the immediacy the Scope everity was lowered to a Level III, isolated. COMMENTS COMMENTS FOOD Preparation and/or execution of the does not constitute admission or agreement by the provider of the the facts alleged or conclusions set on the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required the provisions of federal and state executed solely because it is required to provisions of federal and state executed solely because it is required to provisions of federal and state executed solely because it is required to provisions of federal and state executed solely because it is required to provisions of federal and state executed solely because it is required to provisions of fe	A BUILOING 495336 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEOED BY FULL LIATORY OR LSC IDENTIFYING INFORMATION) COMMENTS FOOD Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. COMMENTS COMMENTS COMMENTS FOOD Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. COMMENTS COMMENTS FOOD Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. COMMENTS COMMENTS FOOD PREFIX TAG Preparation and/or execution of this plan does not constitute admission or agreement by the provisions of federal and state law. FOOD COMMENTS COMMENTS FOOD PREFIX TAG Preparation and/or execution of the ruth of the facts alleged or conclusions set forth on the statement of deficiencies. This

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

TITLE

(X6) DATE

Executive Director

05/29/2017

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

CENTE	43 FUR MEDICARE	& MEDICAID SERVICES	,			<u> </u>	<u>. 0936-039 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO		LE CONSTRUCTION	COV	TE SURVEY MPLETEO
		495336	B. WING	·			C / 09/2017
NAME OF I	PROVIDER OR SUPPLIER			s	STREET AODRESS, CITY, STATE, ZIP CODE		
ALIGUET	A MUDONO & DELLA	- AFNTED		8	3 CROSSROADS LANE		
AUGUST	A NURSING & REHA	BCENTER		F	FISHERSVILLE, VA 22939		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION OATE
F 157	(A) An accident inversults in injury and physician intervention. (B) A significant characteristic in injury and physician intervention. (B) A significant characteristic intervention in heat status in either life-clinical complication. (C) A need to alter a need to discontinus treatment due to accommence a new for the fast of	olving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or hs); treatment significantly (that is, we an existing form of liverse consequences, or to orm of treatment); or ansfer or discharge the hcility as specified in otification under paragraph (g) n, the facility must ensure that ation specified in §483.15(c)(2) vided upon request to the sident representative, if any, and or roommate assignment 3.10(e)(6); or ident rights under Federal or ions as specified in paragraph	F	157	Resident #10's physician notified of 05/03/17 of blood sugar of 25. Reshas not had blood sugar requiring physician notification since 05/03/2. A Quality review of current rewith physician orders for sliding so insulin and/or Insulin dependent we completed to verify finger stick blosugar (FSBS) checks are in place whigh/low parameters, hypo/hyperg protocols and when to contact physician notification r/t residents low FSBS per order and/or admini of oral glucose or IM glucagon is pin the medical record. 3. Licensed nurses re-educate the DCS/Designee regarding obtain orders for FSBS containing high/loparameters, hypo/hyperglycemic Pphysician orders and when to contaphysician with documentation in the medical record. Licensed nurses reeducated by the DCS/Designee r/t physician notification of residents low FSBS per order and/or admini of oral glucose and/or IM glucagon present in the medical record. Licenser nurses re-educated by the DCS/Deregarding location of physician coninformation along with hypoglycen management process.	17. sidents cale as cod with lycemic sician. with stration oresent ed by ning ow PRN act ne stration is signee ntact	
		(mailing and email) and					

CENTE	<u>RS FOR MEDICARE</u>	<u> & MEDICAID SERVICES</u>				<u>OMB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION) COM	E SURVEY MPLETED
		495336	B. WING				C /09/2017
NAME OF I	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	103/2017
					3 CROSSROADS LANE		
AUGUST	A NURSING & REHA	B CENTER			ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
E 157	Continued From pa	ogo 2	r.,	, 157	4 DCG/D : 1 : :		
F 137		_	F	157	4. DCS/Designee during mornin		
		ne resident representative(s).			clinical meeting to conduct qualit	•	
		NT is not met as evidenced			monitoring of physician orders for		
	by:	rview, and clinical record			admissions related to FSBS, high	'low	
		failed to notify the physician of			parameters, when to contact phys	ician,	
		on for one of 25 residents in			and hypo/hyperglycemic protoco	s daily x	
	the survey sample,				4, weekly x 4 then monthly, PRN	and as	
					indicated. DCS/Designee to cond	luct	
		o notify the physician of a			quality monitoring related to phy	sician	
	blood sugar reading	g of 25 for Resident #10.			notification of residents who requ	ire	
					administration of hypoglycemic p		
	Findings included:				per physician with documentation		
	on 11/19/2011 and diagnoses including Paraplegia, Aspirat (Chronic Obstructiv Depression, Anxiet	originally admitted to the facility readmitted on 04/03/2017 with g, but not limited to: ion Pneumonitis, COPD re Pulmonary Disease), y, Diabetes, Hypertension, r, and Chronic UTI (Urinary			medical record as indicated. Find be reported to QAPI committee n and updated as indicated. Quality monitoring schedule modified ba findings.	ings to nonthly	
	The most recent Mi	DS (minimum data set) was a	:				
	quarterly assessme	ent with an ARD (assessment					
		04/10/2017. Resident #10 was	:				
		rately impaired in her cognitive					
	status with a total c	ognitive score of 10 out of 15.					
	During review of Re	esident #10's medical record					
	on 05/03/17 at appr	oximately 10:00 a.m. the	i ! !				
		ation was located in the					
		erdisciplinary Progress Note"					!
		[5:00 a.m.] I checked the					:
		d sugar] and it was 25. I gave	: : !				1
		ose tab [tablet] and pudding ew the tab. I then gave her the					
		ise her BS. The final number	• :				
		r RP [responsible party] and					1
	will notify the MD [p						1 •

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495336	B. WING				C / 09/2017
•	PROVIDER OR SUPPLIER A NURSING & REHAL			STR	EET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE HERSVILLE, VA 22939	<u> U3</u>	/U9/2U1/
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	Continued From pa		F 1	57			
	interviewed at 10:5 stated, "There are r	5 a.m. on 05/03/17. LPN #2 no standing orders for hat when I got here."					
	05/03/17. LPN #3 : low blood sugar this (physician assistan	ewed at 11:10 a.m. on stated, "Received in report of s morning. (Name) PA t) knows. I rechecked; it was the on-call doctor was					
	PA stated, "I was no when I came in. I c was notified or not. was on-call last nig	at 11:15 a.m. on 05/03/17. otified this morning at 9:08 Ion't know if the on-call doctor I am going to find out who ht and ask them myself. I will also didn't get her bedtime	:				
	entered the confere surveyor the following Whom It May Cond Resident #10], I wanthat her accuchek [gave her a glucose was administered a about any input from knew. I called over call made to the on orders. This incide today. An accuche	00 p.m. on 05/03/17 the PA ence room and handed this ing note: "5-3-17 Noon To ern: In regard to [(Name) s notified at 0908 (9:08 a.m.) blood sugar] was 25. Nursing tab and pudding. She then a Glucagon injection. I inquired in the on call doctor but no one office (sic) and there was no call physician to direct these int occurred about 5:30 a.m. k at time of exam was 136"					
	were notified of the meeting with the su	and DON (director of nursing) above findings during a rvey team on 05/03/2017 at p.m. No further information					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495336	B. WING			C 05/09/2017
NAME OF F	PROVIDER OR SUPPLIER	10000	1		REET ADDRESS, CITY, STATE, ZIP CODE	03/09/2017
TAMINE OF 1	MOVIDER OR SOLI ELEK				CROSSROADS LANE	
AUGUST	A NURSING & REHA	3 CENTER			SHERSVILLE, VA 22939	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 15 7	Continued From pa	-	F 1	57		
	conference on 05/0				7207 37 4 67 1 17 11	06/02/17
F 205 SS=D	483.15(d)(1)(i)-(iv)(i POLICY BEFORE/U	2) NOTICE OF BED-HOLD UPON TRANSFR	F 2	<u>205</u>	F 205: Notice of Bed-Hold Policy Before/Upon Transfer	06/23/17 r
	(d) Notice of bed-ho	old policy and return-			1. Resident #21 no longer resides in the facility.	
		ansfer. Before a nursing facility			2. Quality review of hospita	₅ 1
		t to a hospital or the resident				
		c leave, the nursing facility			re-admissions for previous 3	U
	•	n information to the resident or			days 4/10-5/10 for room	
	resident representa	·			changes to ensure documentation is present in t	the
		he state bed-hold policy, if			medical record if indicated.	
		he resident is permitted to residence in the nursing			3. Social Services, Licensed	1
	facility;	residence in the nursing			Nurses, Admissions, DCS and ED re-educated by the Division	
		l payment policy in the state l0 of this chapter, if any;			Education Specialist/Designoregarding notification of Bed	
		,	İ		Hold policy prior to hospital	
I		ility's policies regarding			discharge and notification of	
ı		which must be consistent with			room change before returnin	
ı	paragraph (c)(5) of resident to return; a	this section, permitting a			to the facility.	g
	(iv) The information	specified in paragraph (c)(5)				
ı	of this section.	•				
l		upon transfer. At the time of				:
ı		nt for hospitalization or	ļ			
I		nursing facility must provide	İ			•
İ		the resident representative				
		specifies the duration of the	! ! !			
	this section.	cribed in paragraph (e)(1) of	!			
		NT is not met as evidenced				
	•					

CLIVIL	13 I OK MEDICAKE	A MEDICAID SERVICES	,			AND INC.	. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	СОМ	E SURVEY IPLETED
		495336	B. WING	i			C 09/2017 :
NAME OF I	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	03/2011
				l	3 CROSSROADS LANE		
AUGUST	A NURSING & REHA	B CENTER		l	FISHERSVILLE, VA 22939		
()(1)(5)	SI MAMA DV STA	ATEMENT OF DEFICIENCIES	i ID		PROVIDER'S PLAN OF CORRECTION)NI	(V6)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 205	Continued From pa	age 5	F:	205	4. Social Services Director / Design	onee	
		interview, staff interview and			during morning meeting to review	_	
		ew, the facility staff failed to					
		dents a bed hold prior to			discuss with IDT team hospital tra		
		d for one of 25 residents to	1		and room changes to ensure a bed		
		ange, Resident #21.			was offered and notification of roo		
	•	_			change if indicated. Social Servic		
		not offered a bed hold prior to			conduct quality monitoring with h	ospital	
		nospital and Resident #21's			transfers, room changes, monthly	and	
	room was changed	without notification.			PRN as indicated. Findings to be		
	The findings includ				reported to QAPI committee mont	hly	
	The findings include	e.	:		and updated as indicated. Quality	•	
	Resident #21 was o	originally admitted to the facility	1		monitoring schedule modified bas	ed on	
		mitted on 1/9/17 with, but not			findings.		
		ving diagnoses: urine			6		
		stula, unspecified ileus and					
		d to a C5-C6 injury. The most					
		ata Set (MDS) with an					
		ence Date (ARD) of 1/14/17					
		sessment. The resident was					#
		a fifteen (15) for cognitive					
	skills; able to make						4
	independent in dec	ision-making skiiis.					1
	On 5/8/17 at approx	ximately 12:45 p.m. during a					
		dent #21, the resident stated					
		formed that she was moving					
	from Unit (four) 4 to	Unit (three) 3 until she					
		lity and found her belongings					
		om "one unit to the next."			•		
		and asked if she was offered a	:				
		cation prior to going out to the	•				<u> </u>
		#21 stated, "No, I was admitted	•				1
	all my stuff was on	anuary and when I cam back Unit 3."					
		ximately 12:50 p.m., the					
		aining (AIT) identified as Other nterviewed regarding the					

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		405226	B. WING				5
		495336	B. WING			05/0	09/2017
	DER OR SUPPLIER RSING & REHAI	B CENTER ·		83	REET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE SHERSVILLE, VA 22939		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
residents show the contents of a not seem on 5 states.	was offered a build have been a ve to check and chart, then they 5/8/17 at approximate the conference and th	ige 6 ied of a room change and if bed hold. OS #5 stated, "There a letter, for a bed hold, offered. It see. If there isn't a letter in probably didn't do one." eximately 1:11 p.m. OS #5 ence room and stated, "I am g. I see where she was notified from Unit 2 to Unit 4 but I am g where she was moved from hen interviewed and asked if rovided for a bed hold, OS #5 ian's Telephone order was ical record to include the	F 2	205			
num	ber named]."	noved to Unit 3 Rm [room					
adm abov prov rega char F 224 483. SS=G MIST §483 abus prop subp	ninistrative staff we findings. No rided during the arding notification of the disconding prior to disconding the disconding of the disconding prior to disconding the disc	-	F 2	224	F 224: Prohibit Mistreatment/Neg Misappropriation 1. Resident #21 no longer reside facility. C.N.A identified in 2567 longer works at the facility.	es in the	06/23/17

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		E SURVEY
		495336	B. WING			С
			D. WING			/09/2017
	PROVIDER OR SUPPLIER FA NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP C 83 CROSSROADS LANE FISHERSVILLE, VA 22939	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 224	483.12(b) The faci implement written (b)(1) Prohibit and exploitation of resi resident property, (b)(2) Establish poinvestigate any such (b)(3) Include train §483.95, This REQUIREMED by: Based on staff inteclinical record revie (APS) review, and facility staff failed the was free from neging provided ADL (Actimenstrual cycle. A assistant) stuffed was investigated and between menstrual cycle rethe resident state humiliated and embe be out of there I cathere." The findings include Resident #21 was on 1/8/16 and read limited to, the follower retention, vaginal find quadriplegia related.	lity must develop and policies and procedures that: prevent abuse, neglect, and dents and misappropriation of licies and procedures to ch allegations, and ing as required at paragraph in interview, resident interview, ew, Adult Protective Service facility document review; the orensure one of 25 residents lect. Resident #21 was not vities of Daily Living) during her CNA (certified nursing vipes inside the resident's sulting in psychological harm. It is an interview, "I felt awful, barrassed, I am so happy to an't imagine having to go back	F 2	2. Quality review of resident completed to determine approare was provided during the cycle. Peri-care skills compected as indicated. 3. Licensed Nurses and C.N. educated by the Director of C. Services (DCS)/Designee regproviding appropriate ADL cresident's during their menstralong with Abuse/Neglect trapolicy. 4. DCS / Designee during machinical meeting will review a with IDT team newly admitteensure appropriate ADL care for female residents during the cycle. DCS/Designee through monitoring will conduct pericompetencies 3 times weekly times weekly x 2 weeks then monthly and with newly hire ensure residents receive approard are free from Abuse/Neg to be reported to QAPI command updated as indicated. Quality monitoring schedule modifie findings.	opriate ADL cir menstrual tency N.A's re- Clinical garding care to female rual cycle aining per norning and discuss ed residents to e is provided their menstrual ch random care skills y x 4 weeks, 2 random ed C.N.A's to ropriate ADL glect. Findings mittee monthly hality	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTE	42 FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	<u> J. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495336	B. WING	_		0	5/09/2017	
NAME OF I	PROVIDER OR SUPPLIER	-	:		STREET ADDRESS, CITY, STATE, ZIP CODE			
ALICHET	A NUIDONIC O BELIAI	CENTER	-		83 CROSSROADS LANE			
AUGUST	A NURSING & REHAI	CENTER			FISHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 224	was a quarterly ass assessed as being skills; able to make independent in deciresident was dischard on 5/8/17 at approximately three soaked with urine. If she was finally clea assistant) "found wi and between my leg During the interview Surveyor, "Can I ca appointment I have	ence Date (ARD) of 1/14/17 essment. The resident was a fifteen (15) for cognitive needs known and ision-making skills. The arged 01/27/17 kimately 11:30 a.m., An APS d regarding Resident #21 was are during her menstrual cycle at was found without care and "bloody wipes" were found	F 2	224				
		pened when we talk again." ed to continue the interview at					: :	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMR NO</u>	<u>). 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495336	B. WING	i		05	C /09/2017
NAME OF	PROVIDER OR SUPPLIER			[[STREET ADDRESS, CITY, STATE, ZIP CODE		
ALIGUST	A NURSING & REHA	R CENTER		8	83 CROSSROADS LANE		
A00001	A NOROMO & KENA	SOLATER			FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 224	#21 was interviewe of not being provide menstrual cycle and with urine for three felt awful, humiliate CNA pulled the covon the sheets and the #21 further stated, covers back to see humiliating." Reside have someone chait yourself but to have in blood is disgusting. "The worst part of it plan (CP) meeting a parents and my hus you are at the merchumiliating. I am so	inge 9 ximately 9:07 a.m. Resident d regarding the above findings ed ADL care during her d having to lie in bed soaked days. Resident #21 stated, "I d and embarrassed when the ers back and discovered blood between my legs" Resident "When the CNA pulled the the look on her face was ent #21 stated, "It is enough to inge you because you can't do we someone leave you laying ing. Resident #21 then stated, it all was I had to go to my care and repeat this in front of my sband, it was degrading. When ey of someone else it is just in happy to be out of there I g to go back there."	F	224	1		
	involved in the above times but no answer times but no answer on 5/9/17 the invest statement was review. Witness Statement 1/17 LPN-Called by shower room. Blood aides they were betwagina area. Reside there since 3-11 (see all night [referring to Resident also state).	etigation and witness ewed to include the following: aides doing shower to dy wipes noted, advised by tween Residents legs at ent advised they have been econd shift). I wasn't changed on her menstrual pad]. s. "My gowns not been." [ADON-assistant director of					

CENTE	NO FOR MEDICARE	A MEDICAID SERVICES				ANI DINC	<u>, 6820-038 I</u>
	T OF DEFICIENCIES DE CORRECTION	(X1) PRÓVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING	S		0.5	C 5/ 09/2017
	PROVIDER OR SUPPLIER	B CENTER		83	REET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE SHERSVILLE, VA 22939	1	70072017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOSED TO THE	D BE	(X5) COMPLETION DATE
F 224	1300 (1:00 p.m.) [F scheduled for a she and got her things room. As I was pre things together, I not legs like a napkin of was between her let the pad I was laying pulled her in the shapart and pulled a sher legs, that had not elling me she was shocked by what shocked by what shocked by what should that time I just the other shower an amed] to get the under. [Resident name]	age 10 Luesday January 17th around Resident named] was ower. As I went to her room I brought her to the shower paring myself, getting all my oticed something between her or her brief, I asked her what egs she told me "oh probably g on," So I put gloves on and ower stall and spread her legs wipe from just sitting between menstrual blood on it. She was on her period, and was a little he had seen. As I start the all care I pulled two or three her from between her legs also, st walked back from the trash ide walked in. I asked [Aide unit manager so I can show ed] was concerned so I try to informed her I got the unit		224			
	wipes were left in b aide asked if I would the wipes there to c	e incident where they said the letween her legs. The other ld her her (sic) and she placed clean her. I'm not sure if they lot. Because I did see the girl					
	administrative staff above findings. A c	ximately 1:34 p.m., the were made aware of the opy of the abuse policy was ewed to include the following:					
	Policies and Proces Subject: Resident A	dures: AbuseRevision Date: 2/1/17					
	"Neglect: Neglect is	s the failure of the facility, its					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION :		(X3) DATE COMP	SURVEY LETED
		495336	B. WING			C 05/0	9/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST. 83 CROSSROADS LANE FISHERSVILLE, VA 229		00,0	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD D TO THE APPROPE CIENCY)	BE	(X5) COMPLETION DATE
F 240	and services to a ravoid physical har emotional distress physical needs incompleted to illeting and bathing that result in harm turning a bedfast rasoiled bed" 483.10(a)(1)(2) CAPROMOTES QUADAM (a)(1) A facility murespect and dignity a manner and in a maintenance or errof life, recognizing The facility must phe resident. (a)(2) The facility rule quality care regard condition, or paymestablish and main practices regarding provision of services regarding provision of services regardled. This REQUIREME by: Based on clinical interview, and Grofailed for three of 2 sample (Residents eight residents in the sample interview).	rice providers to provide goods resident that are necessary to m, pain, mental anguish, orIntentional lack of attention to duding, but not limited to, ng. Failure to provide services to the resident, such as not resident or leaving a resident in ARE AND ENVIRONMENT		240 F240: Care and Envi Quality of Life 1. Resident #4 conceresolution. Resident did not have any item d/t the resident who wroom. Residents #14 reinterviewed on 05/2 concerns and no furth voiced. Wandering reclose observation by redirection away from rooms. Activities Din Resident Council on to wandering resident time. 2. Quality review of wander to determine interventions was contimplemented. Care prindicated with modific Discharge for alternationidicated.	ern completed w #14 and Resider is taken and/or b vandered into the and #25 were 26/17 regarding her concerns were esident remains staff for needed in other resident' rector has met w 26/01/17 with rects. No concerns of current resident appropriate inpleted after lan updated as cations. Transfer	vith nt #25 proken neir re on s vith egards at this	06/23/17

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			<u> </u>	<i>I</i> IB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		495336	B. WING	>		C 05/09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
AUGUST	A NURSING & REHA	3 CENTER		83 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CO	N SHOULD : E APPROPR	BE COMPLETION
F 240	entered her room some of her ceramic 2. Resident # 14 corresident who wands who has attempted items from the room 3. Resident # 25 co who wanders, who belonging to her roofacility effort to keep 4. Eight residents in complained about a throughout the facilitidentified as taking belonging to other rooms for the findings were: 1. Resident # 4 corresident who wands entered her room some of her ceramic. Resident # 4 in the female, was admitted most recently readed diagnoses that incluence phalopathy, acting syndrome, diable congestive heart fait chronic pain, morbid failure, chronic rena anemia, seizure dis	ers throughout the facility, who everal times, and who broke figurines. Implained about a facility and to take some of her personal in. Implained of a facility resident that attempted to take items of her out of their room. In the Group Interview if facility resident who wanders ity and who has been money and personal items esidents. Implained about a facility esident who wanders ity and who has been money and personal items esidents. Implained about a facility ers throughout the facility, who everal times, and who broke figurines. In the Group Interview if acility ers throughout the facility and who has been money and personal items esidents. In the Group Interview if acility ers throughout the facility it is a facility in the facility of the facil	F	Executive Director (ED)/I Clinical Services(DCS)/D regarding communicating behaviors and resident contime of occurrence to the along with use of the 24 h IDT review of residents wand the grievance process communicate resident conticensed Nurses and C.N. educated by the DCS/desi regarding use of Stop and documenting and communicating and communicating and communication of the ED regarding altern placement/transfer process who wander.	Director designee resident neerns at ED/DCS our report to neerns. A's regnee Watch finicating re-educating nate	of t the Sort for der for
	most recently readnd diagnoses that incluence phalopathy, ac leg syndrome, diabecongestive heart faichronic pain, morbiofailure, chronic rena anemia, seizure dis	nitted on 4/14/17 with aded obstructive sleep apnea, idosis, hypertension, restless etes mellitus, asthma, lure, bi-polar disorder, anxiety, d obesity, acute respiratory al failure, seizure disorder,				

obstructive pulmonary disease, and respirator

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CENTER	S FUR MEDICARE	& MEDICAID SEKVICES			JIVIB INU.	0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION DING	СОМ	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE				
AUGUST	A NURSING & REHAI	3 CENTER		83 CROSSROADS LANE				
				FISHERSVILLE, VA 22939				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		D BE	(X5) COMPLETION DATE		
F 240	Data Set (MDS), a Assessment Refere the resident was as (Cognitive Patterns with a Summary So During an interview approximately 2:30 complained of a resfacility and enters reme half to death on woke up in the midd the room." Continu goes in your things. (ceramic figurine). me 'Can't you get a like she's the most baby her. They are NOTE: Residents # Findings 2 and 3 ar 2. Resident # 14 coresident who wande who has attempted items from the roon Resident # 14 in the year-old female, wa 8/20/10, and most rewith diagnoses that hypertension, depresabuse, anemia, gas hyperlipidemia, psymuscle wasting and	o the most recent Minimum Significant Change, with an ence Date (ARD) of 4/21/17, sessed under Section C as being cognitively intact, ore of 15 out of 15. with Resident # 4 at p.m. on 5/3/17, the resident sident that wanders in the esidents' rooms. "She scared e night," Resident # 4 said. "I dle of the night and she was in ing, Resident # 4 said, "She She broke my favorite angel When I complained, staff told nother angel?' Staff treat her wonderful little thing. They just enabling her." 14 and 25 identified in e roommates. complained about a facility ers throughout the facility and to take some of her personal and the survey sample, an 80 as admitted to the facility on ecently readmitted on 10/2/10 included diabetes mellitus, ession, history of alcohol stroesophageal reflux disease, chotic disorder, contractures, a tatrophy. According to the	F2	resident interviews twice weekly x weeks, weekly x 4 weeks then rand twice monthly, PRN and as indicate ensure a living environment that prand enhances quality of life. DCS/Designee through morning clinical meeting review the 24 hour report documentation of residents who was other residents rooms PRN and/or indicated with changes/new onset of wandering behaviors. Social Serv ED/Designee through morning mee PRN and/or as indicated with changonset of wandering behaviors revier residents who wander to determine appropriate transfer/placement as indicated. Findings to be reported to committee monthly and updated as indicated. Quality monitoring schemodified based on findings.	domly ed to omotes c/t under in as of ices/ eting ges/new w			
	hyperlipidemia, psyd muscle wasting and	chotic disorder, contractures,						

2/22/17, the resident was assessed under

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	TIPLE CONST DING	TRUCTION		(X3) DATE SURVEY COMPLETED	
		495336	B. WING				05/0	; 99/2017
NAME OF F	PROVIDER OR SUPPLIER	• "		STREET A	DDRESS, CITY, STATE, ZIP COI	DE.		
AUGUST	A NURSING & REHA	B CENTER			SROADS LANE SVILLE, VA 22939			
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F 240	cognitively intact, w of 15.	e Patterns) as being ith a Summary Score of 15 out	· · · · · · · · · · · · · · · · · · ·	240			:	
	approximately 3:15 complained of anot facility and who ent takes things. "[Nankeeps coming in outakes things. I was and she came in arcoke." Resident # cookies on her nighon the floor next to	with Resident # 14 at p.m. on 5/4/17, the resident her resident that wanders the ers other residents' rooms and ne of wandering resident] ar room. She comes in and laying in bed one afternoon and tried to take my cookies and 14 keeps several packs of at stand, and a case of Coke the night stand. Resident # 'The staff say they can't do						
	who wanders, who belonging to her roo	omplained of a facility resident has attempted to take items ommate, and who ignores a other out of their room.						
	female, was admitted with diagnoses that depression, maniced disorder, spinal steepondylolisthesis, instanced according to the method with an ARD of 2/14 assessed under Se	e survey sample, a 60 year-old ed to the facility on 10/3/14 included anxiety disorder, depression, psychotic nosis, congenital somnia, and malaise. Ost recent MDS, a Quarterly 4/17, the resident was action C (Cognitive Patterns) intact, with a Summary Score						
	approximately 3:15	with Resident # 25 at p.m. on 5/4/17, the resident her resident that wanders the					:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A NURSING & REHAL	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP (83 CROSSROADS LANE FISHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 240	takes things. Resid # 14's remarks abo her attempts to take staff put a STOP sig right through it," Re her out, not to keep NOTE: A STOP sig STOP sign on it that a room with magne 4. Eight of nine res Interview complaine wanders and who h money and personal residents. During the Group In resident who wanded discussed. Eight of complained about the resident stated, "(N came in my room a box on top of my nig to the staff, I was to money.'" Another member of complain about the told, "Oh, leave her she is doing." Anot (staff) just pat her o her way." The findings were defined to	ers other residents' rooms and dent # 25 confirmed Resident ut the wandering resident and a cookies and Coke. "The gn up, but she just barges sident # 25 said. "It is to keep us in. This is ridiculous." In is a cloth strip with a red at is affixed to the door jamb of ts. idents present at the Group ed of a facility resident who has been identified as taking all items belonging to other atterview the subject of the ers throughout the facility was the residents present he wandering resident. One ame of wandering resident. One ame of wandering resident. One ame of wandering resident in took \$1.50 from a small ght stand. When I complained all 'Oh well, it's just a little If the group said that when you wandering resident, you are alone, she doesn't know what her group member said, "They in the head and let her go on discussed at a meeting at 3:00	F 2	40			
	p.m. on 5/8/17 with	liscussed at a meeting at 3:00 the Interim Administrator, Corporate Nurse Consultant,					

CLIVIL	NO FOR MILDICARL	A MILDICAID SERVICES			NID NO. 0930-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
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		495336	B. WING_		05/09/2017
	PROVIDER OR SUPPLIER F A NURSING & R EHA I	B CENTER		STREET AODRESS, CITY, STATE, ZIP COOE 83 CROSSROADS LANE FISHERSVILLE, VA 22939	
4	CUMBAADYOTA	TEMENT OF OFFICIENCIES	<u></u>	·	
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F 240	Continued From pa	ge 16	F 24	0	
	and the survey tear	n.			
F 241 SS=G	•	TY AND RESPECT OF	F 24	1 F241: Dignity and Respect of Individuality	06/23/17
	resident in a manner promotes maintenather quality of life reindividuality. The fapromote the rights of This REQUIREMENT by: Based on staff inter (Adult protective serecord review, the fithe dignity and responding the dignity and the facility dignified dining exponding the dignity dignified dining exponding the dignity dignity and the facility dignified dining exponding the dignity dignity and the facility dignified dining exponding the dignity dignity and the facility dignity and the facility dignity and the facility staff respect for one of 2 sample: Resident facility and the facility staff respect for one of 2 sample: Resident facility and the facility staff respect for one of 2 sample: Resident facility and the facility staff respect for one of 2 sample: Resident facility and the facility staff respect for one of 2 sample: Resident facility and the facility dignity and the facility dignity dignity and responding the digni	rview, resident interview, APS rvices) review and clinical acility staff failed to promote sect for three of 25 resident's excident stated in an ful, humiliated and m so happy to be out of there I g to go back there." Idents were Resident #4, and staff failed to ensure a erience in the facility. Is left lying in a bed soiled with pes, from the resident's ere found between the fig ADL (activities of daily g in psychological harm. If ailed to promote dignity and for the survey for		1. Resident #21 no longer resides facility. Resident #4 is provided Al care. Resident #10 is dressed approper resident choice. LPN#7 no long works at the facility. Plate lids with debris were removed from resident and the restorative dining area durin service. Resident #4 was provided incontinent care at the time and rectimely incontinent care. Resident # redressed at the time and is dressed appropriately, while honoring resid choice. Resident #10 was redressed time and currently is dressed daily appropriately, while honoring choic Currently the facility has no resident he potential (within age range) of I menstrual cycles. 2. A Quality Review of current reswas completed to determine appropance ADL care was provided during their menstrual cycle. Review of current residents to determine ADL care was provided in a dignified and respectiment manner completed. Peri-care skills competency conducted as indicated Review of meal service to ensure provident's rooms and/or the restorated dining area during meal service conducted conducted conducted as indicated dening area during meal service conducted conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area during meal service conducted and respecting area durin	DL priately ger h dining 's rooms ng meal eives 4 was daily ent d at the ces. hts with having sidents oriate ar as ful l. late lids n

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO.	0938-0391
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NAME OF F	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	55/201 1
AUGUST	A NURSING & REHA	3 CENTER		8	3 CROSSROADS LANE FISHERSVILLE, ∀A 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	in only a bra and shonly a brief. 4. The facility failed experience in 22 re. Restorative Dining Included 1. Resident #21 was urine and bloody win menstrual cycle, we resident's legs durin living) care resulting. Resident #21 was on 1/8/16 and readr limited to, the follow retention, vaginal fis quadriplegia related recent Minimum Da Assessment Refere was a quarterly ass	s put to bed on one occasion in trand on another occasion in to ensure a dignified dining sident rooms and the Room. E: Is left lying in a bed soiled with pes, from the resident's ere found between the ng ADL (activities of daily g in psychological harm. Driginally admitted to the facility mitted on 1/9/17 with, but not ving diagnoses: urine estula, unspecified ileus and I to a C5-C6 injury. The most atta Set (MDS) with an ence Date (ARD) of 1/14/17 essment. The resident was a fifteen (15) for cognitive	F	241	3. Licensed nurses and C.N.A's reeducated by the Director of Clinical Services (DCS)/designee regarding providing privacy during ADL care ensure the resident's dignity and prare honored. Facility staff re-educate the DCS/ Executive Director (ED)/designee to ensure plate lids with didebris are not present in resident's rand the restorative dining area during service. 4. DCS/ED/designee to conduct quantitative dining of meal service daily x and times weekly x 4 weeks, weekly x weeks then monthly PRN and as inducated. DCS/designee to conduct pericare competency as indicated. DCS/designeer to conduct quality monitoring r/t ADL provided in a dignified and respectif manner 5 times weekly x 4 weeks, weekly x 4 weeks, weekly x 4 weeks, weekly x 4 weeks, weekly x 4 weeks, weekly x 4 weeks and updated as indicated. Quality monitoring schedule modified base.	to ivacy ining rooms ing meal uality dicated. skill ignee to care ful times to to to to to to to to to to to to to	
	On 5/8/17 at approx report was reviewed not provided ADL ca	kimately 11:30 a.m., An APS d regarding Resident #21 was are during her menstrual cycle			findings.		
		nt was found without care					

between the resident's legs.

On 5/8/17 at approximately 1:34 p.m., the

<u> </u>	CO I CIT WILD OF THE	A MILDION NO OLIVIOLO				14.0.	0000 0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION		E SURVEY PLETED
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		495336	B. WING			05/	09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	report. The facility six were not available to employees were can at 3:20 p.m. and ago no answer. The removere no longer employees with Residual that she was not profacility staff during to approximately three soaked with urine. It she was finally clean assistant) "found wand between my lead to be under the composition of the composit	was made aware of the APS staff involved in the APS report for interview. Two of the alled multiple times on 5/8/17 pain at 5:24 p.m., but there was nainder of the staff involved ployed at the facility. Eximately 12:45 p.m. during an ident #21, the resident stated evided ADL care from the interview and that her bed was Resident #21 stated that when interview at the facility of the continue the interview at the facility of the continue the interview at interview at interview at interview at interview.	F	241			
	#21 was interviewe of not being provide menstrual cycle and with urine for three felt awful, humiliate CNA pulled the cov on the sheets and be #21 further stated, "covers back to see humiliating." Reside have someone chait yourself but to have in blood is disgustire.	kimately 9:07 a.m. Resident d regarding the above findings ed ADL care during her d having to lie in bed soaked days. Resident #21 stated, "I d and embarrassed when the ers back and discovered blood between my legs" Resident "When the CNA pulled the the look on her face was ent #21 stated, "It is enough to nge you because you can't do ve someone leave you laying ng. Resident #21 then stated, t all was I had to go to my care					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495336	B, WING			05/	09/2017
	PROVIDER OR SUPPLIER TA NURSING & REHAI			83	REET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE SHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	plan (CP) meeting a parents and my hus you are at the merchumiliating. I am so can't imagine havin On 5/9/17 at approxinvolved in the above times but no answer on 5/9/17 the investatement was review. Witness Statement 1/17 LPN-Called by shower room. Blood aides they were bet vagina area. Reside there since 3-11 (seall night [referring to Resident also states.)	and repeat this in front of my sband, it was degrading. When by of someone else it is just to happy to be out of there I ag to go back there." ximately 9:20 a.m., the CNA we incident was called three er. stigation and witness ewed to include the following: t: y aides doing shower to dy wipes noted, advised by tween Residents legs at ent advised they have been econd shift). I wasn't changed o her menstrual pad]. es. "My gowns not been s." [ADON-assistant director of		241			
	1300 (1:00 p.m.) [R scheduled for a sho and got her things I room. As I was prepthings together, I no legs like a napkin o was between her lethe pad I was laying pulled her in the sho apart and pulled a wher legs, that had metelling me she was shocked by what sho	uesday January 17th around Resident named] was ower. As I went to her room I brought her to the shower paring myself, getting all my oticed something between her or her brief, I asked her what egs she told me "oh probably g on," So I put gloves on and ower stall and spread her legs wipe from just sitting between nenstrual blood on it. She was on her period, and was a little he had seen. As I start the all care I pulled two or three					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED
		495336	B. WING	_			C 09/2017
	PROVIDER OR SUPPLIER FA NURSING & REHAL			83	REET ADDRESS, CITY, STATE, ZIP CODE B CROSSROADS LANE SHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	wipes folded togeth about that time I just the other shower ain named] to get the unher. [Resident named] to get the unher. [Resident named] the same and manager" "1/26/17 CNAThe wipes were left in baide asked if I would the wipes there to owere left there or no pull them out." On 5/9/17 at approximations.	age 20 her from between her legs also, st walked back from the trash ide walked in. I asked [Aide unit manager so I can show hed] was concerned so I try to I informed her I got the unit he incident where they said the netween her legs. The other ld her her (sic) and she placed clean her. I'm not sure if they ot. Because I did see the girl ximately 1:34 p.m., the were made aware of the	F 2	241			-
	respect for one of 2 sample: Resident # sitting in urine and f hours, and was also uncovered by an open Resident # 4 was awith a readmission recent MDS (minim change in status reassessed as being On 5/9/17 at 10:30	admitted to the facility 4/7/15 date of 4/14/17. The most num data set) was a significant eview and had Resident # 4 cognitively intact. a.m. this surveyor conducted					
	a resident interview	a.m. this surveyor conducted with Resident # 4. Resident the survey sample as part of	!				

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMR MC</u>	<i>).</i> 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUŁ A. BUIŁD		PLE CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING	_		05	C 5/09/2017
NAME OF	PROVIDER OR SUPPLIER			٠.	STREET ADDRESS, CITY, STATE, ZIP CODE		
				ξ	83 CROSSROADS LANE		
AUGUST	TA NURSING & REHAI	B CENTER		F	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 241	report included Resworker to report shifter approximately 2 that a CNA (certified into the room earlied telling the resident showever, she did not resident had a bow When the APS wor 10:45 a.m., staff we cleaning the resident briefs on as she was staff did not want to also documented the left without a brief of even though the pricesident's bed is not curtains or blinds prabout the event, and	age 21 ective services) report. The sident # 4 had called the APS e had been left sitting in urine hours. Resident # 4 reported d nursing assistant) had come or, turned off the call light she would be right back; ot return, and by this time the el movement (BM) as well. Ker arrived at the facility at ere just leaving the room after int, but had left her with no is having multiple BM's and in put a brief on her. The report interesident had not only been on, but was not clothed as well; vacy curtain was pulled, the ext to a window, which had no fulled. Resident # 4 was asked in day and that it had made her feel	F 2	241			
	right now; I put my am still waiting to be staff] have left this I told me to wash my help. I am weak in squeeze the wash of medication nurse be them on the table at take them, but I drow legs and couldn't refin the room and assessmed her where thanded me the cuppills.' If I try to tell he	on to say "I'm sitting in urine call bell on at 7:00 a.m. and I e changed. They [the CNA basin of soap and water and of top half; but I can'tI need my hands and cannot cloth out to wash myself. The rings my cup of pills in, sets and leaves the room. I try to apped the cup in between my each it. The nurse came back ked if I had taken my pills and I they were. She got them and and said 'Here- take your her I can't, and I need help, and tells me I'm robbing her					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
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		495336	B, WING			05/	09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		8:	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	week or so ago abo someone in here to said she would tell come and change happen. I take a fluid pill ard a.m., it kicks in and call bell on, they cowill be right back, a tried to explain that they tell me how budeliver breakfast triell me to just hold fluid pill kicks in, the and took me down brief; I felt not only bad and embarrass wet like that!" Resident # 4 also to care wasn't given in activities she would specifically her devinterview, the medilicensed practical room and asked the pain medicine. ReLPN # 7 was then at the resident finish if # 7 looked at Resident # 8 and 10 an	with the unit manager about a put the problem of getting of change me around 7she the oncoming day shift to me first thingthat has yet to bund 5:30 a.m. and by 7:00 It am soaked! When I put my me in, turn it off, tell me they and never come back. When I am uncomfortable and wet, asy they are, they have to ays, feed other residents, and it! I can't do that; when that at's it! They came in one day to lunch without changing my uncomfortable, but felt pretty sed to go to the dining room old this surveyor that morning in time for her to attend I like to attend, most of tools. Toward the end of the cation nurse [identified as nurse (LPN) # 7] came into the eresident if she would like her sident # 4 stated she would. asked about someone helping her bath and get dressed. LPN the details asked "Doesn't and work with you on that?"	F	241			
	Resident # 4 stated discharged from the hands are too weal washcloth; I need to room. This survey	d "Not anymore; I was erapy last week. And my k to squeeze out this nelp." LPN # 7 then left the or and Resident # 4 then view, and this surveyor was					

CENTER	48 FOR MEDICARE	& MEDICAID SERVICES			<u>_</u>	<u>IMB MO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY MPLETED
		495336	B. WING				C / 09/20 1 7
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A NURSING & REHA	3 CENTER			CROSSROADS LANE		
				FI3	HERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 241	Continued From pa	ne 23	· /	' 241			
1 271	behind LPN # 7 as	she was walking up the hall. to the nurses' station, she	Г <i>2</i> ¦	1 41 1			
	[name of resident] b	d stated "Can you go finish path? She's done the top half;					
	dressed." At that tin	ottom half and get her me, this surveyor, who had not N # 7, spoke up and told the					
	CNA that Resident a	# 4 had not finished the top what Resident # 4 had told then went and helped					
	regional nurse cons	DON (director of nursing), and sultant were informed of the 17 during a meeting with ng at 1:30 p.m.					
	No further informati exit conference.	on was provided prior to the					
	THIS IS A COMPLA	AINT DEFICIENCY.					•
	0						
	respect while caring (activities of daily liv	ed to promote dignity and g for Resident #10's ADL's ving). Resident #10 was put to in only a bra and shirt and in only a brief.					
:	on 11/19/2011 and r diagnoses including	originally admitted to the facility readmitted on 04/03/2017 with but not limited to: on Pneumonitis, COPD					
	(Chronic Obstructive Depression, Anxiety	e Pulmonary Disease),					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING		E SURVEY IPLETED		
	l				(С		
		495336	B. WING		05/	09/2017		
	PROVIDER OR SUPPLIER FA NURSING & REHAL	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		BE	(X5) COMPLETION DATE		
F 241	Continued From pa	ige 24	F:	241				
	quarterly assessment reference date) of Classessed as moder status with a total control of Classessed as moder status with a total control of Classessed as moder status with a total control of Classessed as moder status with a total control of Classessed as moder status with a total control of Classessed and certification. The control of Classessed and c	DS (minimum data set) was a ent with an ARD (assessment 04/10/2017. Resident #10 was rately impaired in her cognitive cognitive score of 10 out of 15. Ighter was interviewed on p.m. in regards to concerns int sent to the OLC (office of fication). The daughter stated, 017, Mom was put to bed in she has nightgowns here to 3, 2017, Mom's CNA (certified out her to bed in only a brief. A left by the bedside until 1:00 to shift aide found it. The ne she forgot to come back don't know why the aide left in ighttime care. Mom was day and at bedtime she got a in pill and she was very sleepy. aides and when I spoke to ut it, their solution was to move other unit instead of blem." 0:30 a.m., Resident #10 was infirmed the above information. d, "They put me to bed around get my nighttime medicine and a pain pill I get very sleepy. I y put me to bed like that. The ed in only a brief the nighttime that and dressed me for bed."						

CENTE	49 FOR MEDICARE	& MEDICAID SERVICES				<u> NNR NO</u>	<u>. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495336	B. WING	i			/09/2017	
NAME OF	PROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE			
AUGUST	A NURSING & REHA	B CENTER			33 CROSSROADS LANE FISHERSVILLE, VA 22939			
074) 155	CLIMMADV STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	DNI .		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 241	were informed of the interviews during a on 05/08/2017 at a further information team prior to the example of th	and DON (director of nursing) e above incidences and meeting with the survey team oproximately 1:35 p.m. No was received by the survey it conference on 05/09/2017. deficiency.	F2	241				
	Restorative Dining were seated at thre tables, staff assistir had turned the plate placed dining debris empty salt and pep	10 a.m. on 5/3/16, Breakfast meal served in the Room found six residents e tables. At each of the three ng the seated residents to eat e covers upside down and had s, including straw sleeves, per packets, empty sugar eer packets, and other items in						
	a plate lid containing beds in each of the plate lids containing each room. In three	nit Three found 12 rooms with g dining debris on one of the rooms, and three rooms with g dining debris on both beds in e rooms, plate lids with dining ed on overbed tables where ng.						
	plate lid containing beds in each of the	nit Two found six rooms with a dining debris on one of the rooms, and three rooms with a dining debris on overbed nts were eating.						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A NURSING & REHAL	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939		10012011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 246	p.m. on 5/8/17 with Director of Nursing, and the survey tear 483.10(e)(3) REAS OF NEEDS/PREFE 483.10(e) Respect	the Interim Administrator, Corporate Nurse Consultant, n. ONABLE ACCOMMODATION	F 2	246 F246: Reasonable Accommodation Needs/Preferences 1. Resident # 4 and Resident #10 lights are answered timely. Care Services provided timely upon an the call light for resident #4 and resident #4.	o's call and swering	06/23/17	
	the facility with reas resident needs and do so would endang resident or other resident or other resident or other resident or other resident group interview, and investigation, facility bells were answere 25 residents in the sand #4. 1. In accordance w #10, Resident #10's interview conducted	eside and receive services in conable accommodation of preferences except when to ger the health or safety of the sidents. AT is not met as evidenced interview, family interview, d in the course of a complaint y staff failed to ensure call d in a timely manner for two of survey sample, Residents #10 with an interview with Resident s daughter and in the group d during the survey, facility er call lights in a timely		#10. 2. Quality review of current residents are answered timely to answering the resident's call light answering the resident's call light answering the resident's call light answering the resident's call light 3. Facility staff re-educated by the Director of Clinical Services (DC Executive Director (ED) /Designer regarding answering residents call a timely manner. Licensed nurses C.N.A's re-educated by the DCS/Designee regarding providing car services in a timely manner upon answering the resident's call light	dents to nely. sure care upon . ne S)/ ee I lights in s and ED/ e and		
	fashion.2. The facility staff answered in a timel	failed to ensure call bells were y manner for Resident # 4 e resident sitting for extended					

PRINTED: 05/19/2017 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION A BUILDING	OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 [X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 27 F 246 Continued From page 27 1. Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 F 246 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 246 4. ED/DCS/IDT/designee through Mock Survey Rounds and Resident Interviews ensure residents call lights are answered timely / care and services provided timely,	
AUGUSTA NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 27 F 246 4. ED/DCS/IDT/designee through Mock Survey Rounds and Resident Interviews ensure residents call lights are answered timely / care and services provided timely,	03/03/2017
AUGUSTA NURSING & REHAB CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 27 1. Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not F 399 F 10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 246 4. ED/DCS/IDT/designee through Mock Survey Rounds and Resident Interviews ensure residents call lights are answered timely / care and services provided timely,	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 27 1. Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not	
F 246 Continued From page 27 Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not F 246 Ceach Corrective action Should be cross-referenced to the appropriate cross-referenced to the cross-ref	TION
1. Resident #10 was originally admitted to the facility on 11/19/2011 and readmitted on 04/03/2017 with diagnoses including, but not Survey Rounds and Resident Interviews ensure residents call lights are answered timely / care and services provided timely,	ULD BE COMPLÉTION
limited to: Paraplegia, Aspiration Pneumonitis, COPD (Chronic Obstructive Pulmonary Disease), Depression, Anxiety, Diabetes, Hypertension, Neurogenic Bladder, and Chronic UTI (Urinary Tract Infection). The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 04/10/2017. Resident #10 was assessed as moderately impaired in her cognitive status with a total cognitive score of 10 out of 15. During an interview with Resident #10's daughter on 05/03/2017 at 1:35 p.m. the issue of call lights was discussed. Resident #10's daughter stated, "Sometimes there is only one aide on the hallway, It can sometimes take ten to fifteen minutes before a light is answered. I will see staff up and down the hall, but they never stop to check on the residents. If the aides are busy the office staff could at least check on the resident and then relay the message if they aren't able to help. Mom is a paraplegic and unable to do a lot things for herself." During the group interview conducted by another member of the survey team, all participants in the group agreed that call lights being answered or the aide will come into the room, cut off the light and state, I will be right back, but they never come back.	erviews swered ed timely, s a week eeks then Findings e monthly

During Resident #10's interview on 05/08/2017 at

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495336	B. WING			l .	C 09/2017
	PROVIDER OR SUPPLIER TA NURSING & REHA	B CENTER		83 C	EET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE HERSVILLE, VA 22939	1	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	the time of day. If the morning, around then the response told I cannot help y passing out trays on the Administrator awere informed of the survey team on further information conference on 05/0. This is a complaint. 2. The facility staff answered in a time which resulted in the periods of time in under the team of the team of the team of the team of the survey team on further information conference on 05/0. This is a complaint. 2. The facility staff answered in a time which resulted in the periods of time in under the team of	nt #10 stated, "It depends on you put your light on early in d meal time or at bed time is lengthy. We are sometimes ou right now because I am r whatever." and DON (director of nursing) he above during a meeting with 05/09/2017 at 1:35 p.m. No was received prior to the exit 19/2017. deficiency. failed to ensure call bells were by manner for Resident # 4 he resident sitting for extended rine and/or feces. dmitted to the facility 4/7/15 date of 4/14/17. The most num data set) was a significant view and had Resident # 4	F 2	246			

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				<u>MR NO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	СОМ	E SURVEY IPLETED
		495336	B. WING	i		1	C 09/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALICHET	A MUDEING & DEUAI	O CENTER		8	3 CROSSROADS LANE		
AUGUŞT	A NURSING & REHA	OCNIER		F	ISHERSVILLE, VA 22939	·-··	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)) BE	(X5) COMPLETION DATE
F 246	When the APS worl staff were just leavi resident, but had let was having multiple put a brief on her. The resident had no on, but was not clot privacy curtain was next to a window, we pulled. During the in a.m., Resident # 4 and she stated yes, and that it had mad Resident # 4 went or ight now; I put my of am still waiting to be call bell on, they con will be right back, and tried to explain that they tell me how but deliver breakfast tratell me to just hold in A group interview we beginning at 1:30 puresidents. When the discussed, the group you press the call be more than an hour I what you need. Eith and tell you they'll be never see them against they further voiced.	lel movement (BM) as well. ker arrived at the facility, the ng the room after cleaning the fit her with no briefs on as she a BM's and staff did not want to The report also documented at only been left without a brief thed as well; even though the pulled, the resident's bed is which had no curtains or blinds interview on 5/9/17 at 10:30 was asked about the event, it most certainly happened the her feel "really bad." on to say "I'm sitting in urine call bell on at 7:00 a.m. and I e changed. When I put my me in, turn it off, tell me they and never come back. When I am uncomfortable and wet, say they are, they have to ays, feed other residents, and		246			
	not doing their job.	, ,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE \$URVEY COMPLETED	
		495336	B. WING	i			C / 09/2017	
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 253	regional nurse conabove findings 5/9/ facility staff beginning. No further informate exit conference. This is a complaint 483.10(i)(2) HOUS SERVICES (i)(2) Housekeeping necessary to maint comfortable interior. This REQUIREMED by: Based on observate resident interview to a privacy curtain ware sident interview to a privacy curtain ware sidents in the sure Findings include: Resident # 6 was at The admission MD 4/4/17 had Resider impairment in cognition of the compositions. Resident # 6 in beat After knocking and surveyor made introvisitors. Resident # 6 then it privacy curtain to the construction of the construction	DON (director of nursing), and sultant were informed of the 117 during a meeting with ing at 1:30 p.m. Ition was provided prior to the deficiency. EKEEPING & MAINTENANCE If and maintenance services tain a sanitary, orderly, and r; In it is not met as evidenced tion, staff interview, and the facility staff failed to ensure as clean for one of 25 rivey sample: Resident # 6. Indimitted to the facility 3/28/17. S (minimum data set) dated at # 6 assessed with moderate			F 253: Housekeeping & Maintenar Services 1. Resident #6 privacy curtain was cleaned and replaced. 2. Facility wide quality review of privacy curtains in resident rooms completed by ED and or Maintenar Director. Curtains cleaned and rep as indicated. 3. Maintenance Director /Environ Services staff re-educated regarding cleanliness of privacy curtain(s) en residents privacy curtains are clean from stains, soiling and replaced as indicated in order to maintain a san orderly and comfortable interior per regulation. Facility staff re-educate regarding communicating when pri curtain(s) are soiled and need to be cleaned and replaced to Maintenant Environmental Services.	was nce laced mental g suring , free s nitary, er ed	06/23/17	

		42 FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	<u>. 0938-0391</u>
		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	COM	E SURVEY IPLETED
			495336	B. WING	i		C 05/09/2017	
N	AME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
٨	пенет	A NURSING & REHA	R CENTER		8	3 CROSSROADS LANE		
	.00001	A NOROING & REITA	Delt's best of the state of the		F	ISHERSVILLE, VA 22939		
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		curtain there was a substance smeared asked the resident resident resident resident resident resident resident resident resident replied "W stated I was not sur "Exactly." I then as curtain had been so time now." I asked staff to the stain an On 5/3/17 at 7:55 a housekeeping was responsible to ensuratins. The manachecks the curtains cleaning of the roor changed." This sur housekeeping man resident's room. Rowere not in the roor surveyor went in to manager, after see someone to change have no idea what is curtainchocolat rate it will be changed. The administrator, I regional nurse consabove findings 5/9/facility staff beginning. No further informatic exit conference.	ay down the length of the large area with a thick, brown don the curtain. This surveyor what that was, and the hat do YOU think it is?" I re and the resident said sked the resident how long the biled and he stated "For some the resident if he had alerted do he said "No; not my job!" I.m. the area manager for interviewed about who was are the cleanliness of privacy ager stated "Housekeeping when they do the daily ms; if one is soiled it should be reyor then asked the ager to accompany me to the esident # 6 and the roommate m, and the manager and this look at the curtain. The ing the stain, stated "I will get entity that is on the te or possibly feces. At any ed right now." DON (director of nursing), and sultant were informed of the 17 during a meeting withing at 1:30 p.m. ion was provided prior to the	F	253	4. Maintenance Director/Designe conduct random quality monitoring privacy curtains in resident's room maintain a sanitary, orderly and comfortable interior per regulation weekly x 4 weeks, then weekly tim weeks then monthly and PRN. Quanonitoring schedule modified base findings. Findings to be reported to committee monthly and updated as indicated.	g of ns to twice nes 4 ality ed on o QAPI	
	F 279	THIS IS A COMPLA 483.20(d);483.21(b		Fí	279			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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		495336	B. WING			05/	09/2017	
	PROVIDER OR SUPPLIER TA NURSING & REHAL	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939				
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	Continued From pa	-	F	279	F 279: Develop Comprehensive Ca Plans	are	06/23/17	
	assessments comp months in the residence results of the assess	nust maintain all resident bleted within the previous 15 ent's active record and use the esments to develop, review dent's comprehensive care			 Resident's #4, 5 and 15 care platwere updated to reflect non-pharmacological interventions. Res# 24's Behavior care plan was updateflect wandering into other resident room and taking items belonging to others. Quality review of resident's pair 	sident ted to t's		
	(b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -							
	or maintain the resiphysical, mental, ar required under §483 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclutreatment under §46 (iii) Any specialized	services or specialized es the nursing facility will			resident's who wander/take items belonging to others have intervention place reflected on the behavior care			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MR MC	<u>). 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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AUGUST	A NURSING & REHA	BCENTER		F	FISHERSVILLE, VA 22939		
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F 279	Continued From pa	ige 33 If a facility disagrees with the	F 2	79	4. DCS / Designee during morning clinical meeting to review and disc	-	
	findings of the PAS	ARR, it must indicate its dent's medical record.			with IDT team pain care plans to in non-pharmacological interventions	clude	
	(iv)In consultation v	vith the resident and the tative (s)-			care plans for resident's who wand take items belonging to others are included on the behavior care plan.		
	(A) The resident's g desired outcomes.	goals for admission and			DCS/Designee to conduct quality monitoring with any newly admitte admitted residents, and/or changes		
	(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.				behaviors and pain and update as indicated. Findings to be reported QAPI committee monthly and update as indicated. Quality monitoring schedule modified based on finding	to ited	
	plan, as appropriate requirements set for section.	s in the comprehensive care e, in accordance with the orth in paragraph (c) of this					
	by: Based on clinical re interview, and staff failed for four of 25 sample (Residents	ecord review, resident interview, the facility staff residents in the survey # 4, 5, 15, and 24) to develop ress pain treatment and					
		r Resident # 4 failed to include macological interventions to					
		r Resident # 5 failed to include macological interventions to					:

3. The care plan for Resident # 15 failed to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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F 279	4. The care plan for include intervention entering other residue belonging to other of the use of non-pharaddress pain. Resident # 4 in the female, was admitted most recently readred diagnoses that incluence phalopathy, and leg syndrome, diable congestive heart fachronic pain, morbifailure, chronic rena anemia, seizure disgastroesophageal robstructive pulmona failure. According to Data Set (MDS), and Assessment Reference the resident was as (Cognitive Patterns with a Summary School and the seident # 4 had the to address pain:	dress pain. The Resident # 24 failed to so to address wandering, lents' rooms, and taking items residents. The Resident # 4 failed to include residents. The Resident # 4 failed to include resolved interventions to survey sample, a 66 year-old red to the facility on 4/7/15, and resident on 4/14/17 with red obstructive sleep apnea, ridosis, hypertension, restless retes mellitus, asthma, rillure, bi-polar disorder, anxiety, dobesity, acute respiratory of failure, seizure disorder, rorder, depression, reflux disease, chronic regular disease, and respirator to the most recent Minimum Significant Change, with an rence Date (ARD) of 4/21/17, resessed under Section C The sessed under Section C		279			
	oral twice daily.	(milligrams) Tablet. 10 mg ablet. Take 1 tablet by mouth					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
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		100000	1			05	/09/2017
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(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	NI.	(VC)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES OF THE APPROPRIES O	DBE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 35	F 2	279	'		
	every 8 hours as ne						
		cation Administration Record					
	as needed Oxycodo	h of March 2016 revealed the one was administered 30					1
		17 and 3/23/17. For the , the as needed Oxycodone					
		3 times between 4/1/17 and					
	problem in the area	plan included the following of pain, "The resident has mfort related to GERD					
	(Gastroesophageal pain, muscle spasn	Reflux Disease), chronic ns." The goal for the stated					
		no side effects related to the arough this review period."					
	"Administer analges side effects of pain constipation, new o restlessness, confu dysphoria, nausea, Report occurrences	or the stated problem were, sics per MD's order; Report for medication; Observe for nset or increased agitation, sion, hallucinations, vomiting, dizziness and falls; to the MD; Report to nurse of pain or requests for pain					
		pharmacological interventions address pain treatment.					
	resident was asked non-pharmacologic pain. The resident cold packs occasion cold compress will v	at 2:30 p.m. on 5/3/17, the about the use of al interventions to address her said staff have use hot and nally. "Sometimes a hot or a work. Compresses at night me all relaxed and I can sleep					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 279	resident said. The findings were p.m. on 5/8/17 wit Director of Nursing and the survey teat. 2. The care plant the use of non-phaaddress pain. Resident # 5 in the male, was admitte and most recently diagnoses that incright below the knowleft great toe wour hypertension, core gastroesophageal hyperplasia, depreheart disease. Ac	without medication," the discussed at a meeting at 3:00 h the Interim Administrator, g, Corporate Nurse Consultant,				
	(Cognitive Pattern	ssed under Section C s) as being moderately ed, with a Summary Score of 12				
	Resident # 5 had to address pain:	the following medication order	!			
	Oxycodone 5 mg every 4 hours as r	Tablet. Take 1 tablet by mouth needed for pain.				
	needed Oxycodon between 3/1/17 an	R for March 2017 revealed as see was administered 40 times and 3/31/17. Review of the MAR caled as needed Oxycodone				:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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AUGUST	A NURSING & REHAI	5 CENTER		F	FISHERSVILLE, VA 22939			
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F 279	Continued From pa	age 3 7	· F /	279	1		:	
1 2,0	· · · · · · · · · · · · · · · · · ·	43 times between 4/1/17 and	Γ 2	<u> </u>	,			
	following problem in resident has alterated postoperative discontanted knee amputation]) // (surgical wound)." "The resident will not overall function related	t # 5's care plan revealed the n the area of pain, "The . tion in pain/comfort related to omfort (recent BKA [below the AEB (as evidenced by) The goal for the problem was, ot demonstrate decline in ated to pain; The resident will ption in normal activities due to view date."						
	"Administer analges treatments or care the resident's need	or the stated problem were, sics as per orders and prior to prn (as needed); Anticipate for pain relief and respond to ain; Encourage activity and ated."						
		-pharmacological interventions address pain treatment.						
	p.m. on 5/8/17 with	discussed at a meeting at 3:00 the Interim Administrator, , Corporate Nurse Consultant, m.						
		or Resident # 15 failed to non-pharmacological dress pain.						
	female, was admitted with diagnoses that weakness, bi-polar	e survey sample, a 63 year-old ed to the facility on 11/26/14 t included generalized muscle disorder, major depressive ertension, chronic pain	·					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER A NURSING & REHAL	B CENTER		83 CI	EET ADDRESS, CITY, STATE, ZIP ROSSROADS LANE IERSVILLE, VA 22939	CODE	1 00,	03/2017
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F 279	syndrome, anemia, gastroesophageal ranxiety disorder. A MDS, a Quarterly wresident was asses (Cognitive Patterns with a Summary Schemet # 15 had to address pain: Hydrocodone-Aceta Tablet. Take 1 table needed for pain. Review of the MAR needed Hydrocodo administered 19 tim 4/30/17. Review of Resident following problem ir resident has alterat femur fracture, dise gastroesophageal ragoals for the proble demonstrate declinication. The resident wormal activities during assertion and the summar activities during assertion and the summar activities during assertion and the summar activities during assertion and the summar activities during assertion and the summar activities during assertion assertion and the summar activities during assertion assertion and the summar activities during assertion assertion and the summar activities during assertion assertion assertion and the summar activities during assertion assertion assertion and the summar activities during assertion asse	fibromyalgia, hyperlipidemia, reflux disease, asthma, and ccording to the most recent with an ARD of 4/19/17, the sed under Section C) as being cognitively intact, core of 14 out of 15. The following medication order aminophen 5 mg - 325 mg ret by mouth every 4 hours as a second process of the following medication order aminophen 5 mg - 325 mg ret by mouth every 4 hours as a second process of the following medication order aminophen 5 mg - 325 mg ret by mouth every 4 hours as a second process of the following medication order the following medication order the following form the following followin	F 2	79				
	"Administer analgestreatment or care p movement as tolera pain medication; Ol onset or increased confusion, hallucina	o the stated problem were, sics per orders and prior to rn; Encourage activity and ated; Report side effects of oserve for constipation, new agitation, restlessness, ations, dysphoria, nausea, and falls; Report occurrences						

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F 279	Continued From p	age 39	F 2	279				
·	in the care plan to	n-pharmacological interventions address pain treatment.						
	p.m. on 5/8/17 witl	discussed at a meeting at 3:00 n the Interim Administrator, g, Corporate Nurse Consultant, m.						
	include interventio	or Resident # 24 failed to ns to address wandering, dents' rooms, and taking items residents.						
	female, was admit with diagnoses that congestive heart for gastroesophageal depression, gener dysphagia, and not according to the mouth an ARD of 3/1 assessed under S	ne survey sample, a 78 year-old ted to the facility on 12/23/14 at included atrial fibrillation, ailure, hypertension, reflux disease, hyperlipidemia, alized muscle weakness, n-Alzheimer's dementia. nost recent MDS, an Annual 13/17, the resident was ection C (Cognitive Patterns) cognitively impaired, with a f 3 out of 15.						
	(Wandering - Pres resident was asse	Behavior), at Item E1000 ence and Frequency), the ssed as having behaviors of urred 4 to 6 days, but less than						
	problem addressir exhibits signs and (Behavioral and Page 1997)	are plan included the following ag wandering: "Resident symptoms of BPSD sychotic Symptoms of aviors related to dementia, AEB						

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F 279	(as evidenced by) v problem were, "Res care as needed; Re	wandering." The goals for the sident will allow staff to provide esident will demonstrate zations; Resident will maintain	F 2	79			
	"Redirect in approp Assess behaviors for Assess for changes environment; Asses indicated; Determinalleviate; Encourag activities; Invite and of choice; Labs as of per physician order	o the stated problem were, oriate behaviors as needed; for underlying medical causes; in psychosocial status and/or as resident for pain as the precipitating factors and the resident to attend group diassist as needed to activities ordered by physician; Medsers; Provide positive feedback ompliant and/or appropriate;					
	proactive measures address the resider	e plan was silent as to s to prevent wandering, to nt's wandering in to other and the resident's taking items er.					
	interviews and the comments about Rentering resident ro	of the survey, several resident Group Interview elicited tesident # 24 wandering, doms, and taking items residents. Some of the the following:					
		olf to death one night, I woke the night and she was in the					
	angel (ceramic figu	hings. She broke my favorite irine). When I complained, you get another angel?' Staff					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SUR COMPLETE	
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F 279	Continued From pa	ige 41	F 2	79		
		the most wonderful little thing. ey are just enabling her."				
	room. She comes laying in bed one at	nt # 24) keeps coming in our in and takes things. I was fternoon and she came in and okies and Coke. The staff saying."		·		
		OP sign up, but she just h it. It is to keep her out, not is ridiculous."				
	took \$1.50 from a s	t # 24) came in my room and mall box on top of my night aplained to the staff, I was told ittle money.' "				
	"Oh, leave her alon is doing."	e, she doesn't know what she				
	"They (staff) just pa go on her way."	at her on the head and let her				
	p.m. on 5/8/17 with Director of Nursing, and the survey tear 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO	F 28	F280: Right to Participate in Carplanning/Care-Revise CP	·e 06/2	23/17
SS=D	PARTICIPATE PLA	NNING CARE-REVISE CP		planning/Carc-revise Ci		
	and implementation	earticipate in the development of his or her person-centered ing but not limited to:		1. Resident # 10's indwelling ca was changed 5/4/17. Resident #6 mats were put in place on 05/10/	falls	
		cipate in the planning process, o identify individuals or roles to				

OE: TIE	TO 1 OIL MEDIONILE	C WILDIO, AD OF CALLO	, —— .			IVID ITO.	0000 0001	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 280	request meetings a revisions to the per (ii) The right to part expected goals and amount, frequency, other factors related plan of care. (iv) The right to recincluded in the plan (v) The right to see right to sign after si of care. (c)(3) The facility shright to participate i shall support the replanning process multiple of the resident representations.	planning process, the right to and the right to request son-centered plan of care. icipate in establishing the doutcomes of care, the type, and duration of care, and any dout to the effectiveness of the eive the services and/or items of care. the care plan, including the gnificant changes to the plan and inform the resident of the noise or her treatment and sident in this right. The noist—	F	280	2. Quality review of residents with indwelling catheters to verify physicorder(s) for changing catheters are oplanned was completed. Orders for frequency of catheter change modifindicated per physician order. 3. Licensed Nurses re-educated by Director of Clinical Services (DCS) Designee regarding following the replan of care for indwelling catheter changes. Facility staff re-educated regarding ensuring residents with famats are in place per the plan of care 4. ED/DCS/Designee through rand Mock Survey Rounds ensure reside require fall mats are in place per the of care 5 times weekly x 4 weeks, 3 weekly x 4 weeks, 2 times weekly x weeks, randomly 2 x monthly, PRN indicated. MDS staff/DCS/Designet through morning clinical meeting reresidents who have indwelling cathetensure their plan of care reflects catchanges per physician order random twice weekly x 2 weeks, with new	cian care died as the died as the exidents who explan times a 4 died and as exercise wheter to heter		
	cultural preferences 483.21 (b) Comprehensive	resident's personal and s in developing goals of care. Care Plans e care plan must be-			admissions/re-admissions and with new catheter orders, PRN and as inc Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring sched modified based on findings.	dicated.		
	(i) Developed withir the comprehensive	n 7 days after completion of assessment.	; 					

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F 280	Continued From pa	age 43	F 2	80			
	(ii) Prepared by an includes but is not l	interdisciplinary team, that imited to					
	(A) The attending p	hysician.					
	(B) A registered nur resident.	rse with responsibility for the					
	(C) A nurse aide wi resident.	th responsibility for the					
	(D) A member of fo	od and nutrition services staff.					
	the resident and the An explanation must medical record if the and their resident re	racticable, the participation of e resident's representative(s). It is included in a resident's e participation of the resident epresentative is determined the development of the included.					
		te staff or professionals in mined by the resident's needs the resident.					
	team after each ass comprehensive and assessments. This REQUIREMED by: Based on staff intereview, facility staff	revised by the interdisciplinary sessment, including both the diquarterly review NT is not met as evidenced erview, and clinical record failed to review and revise a e plan (CCP) for two of 25					
	residents in the sur and #6.	vey sample, Residents #10 not review and revise					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495336	B. WING		0!	C 5/ 09/2017	
	PROVIDER OR SUPPLIER TA NURSING & REHA			STREET ADDRESS, CITY, STATE, ZII 83 CROSSROADS LANE FISHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	Foley catheter. 2. Facility staff did Resident #6's CCP Findings included: Resident #10 was on 11/19/2011 and diagnoses including Paraplegia, Aspirat (Chronic Obstructiv Depression, Anxiet Neurogenic Bladde Tract Infection). The most recent M quarterly assessmereference date) of assessed as mode status with a total of the company of	age 44 P to address changes with her not review and revise to include use of fall mats. originally admitted to the facility readmitted on 04/03/2017 with g, but not limited to: tion Pneumonitis, COPD ve Pulmonary Disease), ty, Diabetes, Hypertension, er, and Chronic UTI (Urinary IDS (minimum data set) was a ent with an ARD (assessment 04/10/2017. Resident #10 was erately impaired in her cognitive cognitive score of 10 out of 15. esident #10's clinical record on p.m., the current POS leet) dated 05/01/17 through an order that stated, "18 Fricentimeter] Foley Cath change P included an entry that stated, 18Fr. 30cc Balloon size Date	F 2	 	7		
	(licensed practical Resident #10's cath will get back with you	" proximately 11:30 a.m., LPN #1 nurse) was asked to verify heter size. LPN #1 stated, "I ou." At approximately noon on stated, [Name Resident #10]	·				

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) OATE SURVEY COMPLETEO		
		495336	B. WING			i	09/ 2017
	PROVIOER OR SUPPLIER A NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, 2 83 CROSSROADS LANE FISHERSVILLE, VA 22939	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 280	Her catheter was c room] when she was The DON (director 05/03/17 at 5:50 p.i updated by the care supervisors and nu Obviously hers has No further informat	Fr. 10cc balloon catheter. hanged in the ER [emergency as there in April." of nursing) was interviewed on m. The DON stated, "CCP are e plan team, nursing rsing has been helping lately.	F 2	80			
	comprehensive car to include fall mats Resident # 6 was a The admission MD 4/4/17 had Resider impairment in cogn On 5/2/17 during a 6 and his two visito fall mat on each sid Resident # 6 was a had been at the beknow. The female they visit every two been down on each	dmitted to the facility 3/28/17. S (minimum data set) dated at # 6 assessed with moderate ition. conversation with Resident # rs, it was noted there was a de of the resident's bed. sked how long the fall mats dside, and he stated he did not visitor spoke up and stated weeks and the mats have a visit.					
	3:00 p.m. Review of included intervention wearing appropriate	was reviewed on 5/2/17 at of the CCP for falls/safety ons including ensuring resident of footwear, call light within ow position. There was no					

CLIVIL	TO LOT MEDICARE	A MEDICAID OF TAICE				ALI CINIC	<u>J. 0930-039 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING			0.	C 5/ 09/2017
NAME OF E	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		7,00,2011
	TO TIBELLO TO OCT TELET				3 CROSSROADS LANE		
AUGUST	A NURSING & REHA	B CENTER					
					FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 280	Continued From pa	ne 46	E /	280	1		
1 200	· · · · · · · · · · · · · · · · · · ·	_	! I a	200			
	had not had any fal	the fall mats. Resident # 6 Is documented.					:
	On 5/3/17 at 8:05 a	.m. LPN (licensed practical					•
		e unit manager, was asked					•
		and if a physician order was					
		nt them. LPN # 2 stated "No;					:
		It's a nursing intervention."					
		sked who would be					
		ing the intervention to the care					4
	plan and she stated plans."	I "MDS updates the care	: ·				
•	On 5/3/17 at 10:00	a.m. the MDS coordinator was					
		egistered nurse) # 1 stated					
		rking with nursing to update					:
	the care plans, but	as of yesterday [5/2/17] they					i
		of the updates themselves. I					:
		mats as I was not made aware					•
	he had any."	;					:
	On 5/3/17 at 10:15	a.m. LPN # 5 was asked when					:
		een implemented for Resident					
		d she would see if she could					
	find out that informa	ation, and get back to me.					
	At 10:46 a.m. 5/3/1	7 LPN # 5 gave this surveyor a					
		care plan and stated "The					
	mats were impleme						
	The administrator	DON (director of purpling)					
		DON (director of nursing), and sultant were informed of the					
		17 during a meeting with					
	facility staff beginning						
		·					
		on was provided prior to the					
E 004	exit conference.	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		304			
F 281	483.21(b)(3)(i) SER	VICES PROVIDED MEET	F 2	281			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495336	B. WING		ľ	C	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		09/2017	
NAIME OF	PROVIDER OR SUPPLIER		1	33 CROSSROADS LANE	=		
AUGUS1	A NURSING & REHA	AB CEN⊤ER		FISHERSVILLE, VA 22939			
			<u> </u>		·	i	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 281	Continued From p	age 4 7	F 281	F281 Services Provided Meet P	rofessional	06/23/17	
	PROFESSIONAL			Standard			
				1. Agency Licensed Nurses co	ompleted		
	(b)(3) Comprehen	sive Care Plans		the Agency Orientation Checkl	_		
				Medication error report comple			
		ided or arranged by the facility,		resident #10 per policy. LPN #2			
	as outlined by the must-	comprehensive care plan,		nurse) no longer works in the fa	` •		
	must			#3 (agency nurse) no longer wo	•		
	(i) Meet profession	nal standards of quality.		facility. Resident #10 currently			
		ENT is not met as evidenced		the facility and has no s/s of ad			
	by:			effects.			
		tion pass observation, resident		At the time of immediacy, curre	ent agency		
		erview, facility document review,		nurses present in the facility red			
		ew and in the course of a ation, facility staff failed to		immediate orientation by Nursi			
	ensure profession	al standards of nursing practice		Administration using the Agend	•	ļ !	
		ne facility for 1 (one) of 25		Orientation Checklist, which in	•	i !	
		rvey sample, Resident #10.		administration of medications,			
		dy (IJ) was identified in the		management and diabetic mana	•		
		ensive Person-Centered Care	:	Current schedule was reviewed	-	i i	
		/2017 at 1:55 p.m. The facility ediacy on 05/04/2017 at 8:55		Director of Clinical Services to	•	•	
		al of the immediacy the Scope		future confirmed pre-scheduled	•		
		owered to a Level III, isolated.	' 	personnel requiring orientation,	-		
	· ·	ŕ		orientation being provided usin			
	Immediate Jeopar			Agency Orientation Checklist,	_	1	
		iced to the State Agency (SA)		assumption of Nurse duties.	51101 10	1	
		regarding the system wide		Potential agency placements we	ere	: :	
		urses not receiving orientation ork at the facility. This issue		scheduled for orientation upon			
		t practice related to medication		their credentials by the facility	•		
		luding actual harm to residents		Resources Coordinator (HRC).			
		ole, medications not given on		` ,		1	
		cations administered and critical		personnel assumed nursing duties until the Agency Orientation Checklist had been			
	medications not a	vailable.		completed and received by the			
	The OA a manufact	and the second state of the second second		Notification occurred to all con			
		ry staff directed the survey team ity administration to obtain their		agencies of this process on 05/0		1	
	TO SUCAN WITH IACII	ity auri iliisti atiori to obtaiii tileli	!	ageneres of this process off 03/0	T/1/.		

policies and procedures regarding how agency

OLIVIL	10 I OK MEDIOVIKE	- O MILDIONID OLIVIOLO				IVID IVO.	0930-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		E SURVEY PLETEO
		495336	B. WING	i			C 09/2017
NAME OF	PROVIDER OR SUPPLIER		L		TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/1	09/2017
TOTAL OF	THO VIDEIN OIL CONTI EIEN			ı	3 CROSSROADS LANE		
AUGUST	A NURSING & REHA	B CENTER		ı	SISHERSVILLE, VA 22939		
	<u> </u>			<u> </u>	<u> </u>		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ige 48	F	281	The Executive Director/designee w	rill	
	nurses were oriente	ed to the facility and educated			review agency files weekly times 4		
	on facility policies a	and procedures for pain			weeks, then monthly and report to		:
	management, diab	etic management, and			QAPI committee to ensure complia		:
	medication manage	ement.			with the plan.	шес	
	·				•		
		2:40 p.m., a meeting was			2. Quality review of medication ca		
		y administrative staff, including			ensure medications ordered are ava		
		he administrator who would be 04/2017, the director of			was completed. Review of Agency		
	•	al director of clinical services,	i		employee files to ensure the Agend	-	
		nd the medical director. The			orientation checklist was completed	•	
		was asked how agency			to assumption of nurse duties. Pote		:
		o work at the facility were			agency placement(s) to be schedule	ed for	
		policies and procedures and			orientation upon receipt of their		
	what the process w	as. The process was			credentials by the facility Human		
	explained as follow				Resources Coordinator (HRC). No)	i
		nation received from the			agency personnel will assume nurs	ing	
		esume, CPR , background			duties until the Agency Orientation	_	
	check)	to the authors			Checklist has been completed and		ļ
	- Information put in	to the system at information is in the system			received by the HRC. Notification	to all	
	- Agency nurse con		: :		contracted staffing agencies of this		
		gency nurse receives report			process completed 5/4/17. Medicat		
		d is shown where meds are,					
	medication cart, do	· · · · · · · · · · · · · · · · · · ·			skills competency checklist compleindicated.	ned as	
	any type of compet	team was asked if there was ency checklist done by the					
		agency nurses starting work. re policies and procedures					
		nagement, medication					
		petic management and facility					1
	orientation policies.						:
		:50 p.m., the administrator					
		leader that a corporate policy					
		tation of agency staff had been					
		ded a competency checklist					
	tnat was to be com	pleted by the facility prior to					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION			<u>_U930-U39 </u>		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ING		СОМ	PLETED		
		495336	B. WING	· <u>-</u>			09/2017		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE				
AUGUST	A NURSING & REHAI	R CENTER		83 CROSSROADS LANE					
				FISHERSVILLE, VA 22939	9				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPR	BE	(X5) COMPLETION DATE		
F 281	Continued From pa	ge 49	F 2	281 3. Licensed nurses (ag	gency) educate	ed by			
	the agency nurse b	eginning work. She stated		the Assistant Director		•	· !		
		aware of the policy or the		(ADCS)/designee rega	arding "5 Rigl	nts of	!		
		had not been done for any of currently working at the facility.		Medication Administr	ration." Licen	sed			
	the agency nurses	currently working at the facility.		nurses (agency) re-edu	•				
	After consultation w	ith the SA supervisor, IJ was		ADCS/D\designee reg		•			
		7 at 1:55 p.m. for the system		of mediations per phy	` ′				
		acility to orient and educate acility practice for the		Licensed nurses (agency) re-educated by the ADCS/designee regarding facility					
		edications, pain management		systems & processes a		-			
	and diabetic manag			policy and procedures	•	iiity			
	O= 05/04/0047 at a	mmassimaatals 2:00 m ma tlaa		Agency Orientation C	_	nan			
		pproximately 2:00 p.m., the met with the facility staff. They		Resources re-educated					
	survey team again met with the facility staff. They were informed that IJ had been identified as of			Director (ED) / design	nee regarding				
	1:55 p.m. due to the facility failure to provide			potential agency place	ements to be				
	orientation to agency staff per facility policy.		scheduled for orientat	•	•				
	Directive was given to develop a plan for the removal of IJ.			their credentials by the	•				
				Resources Coordinato	` '				
		of IJ was presented on		Resources, Unit Mang					
		p.m. The plan included the 5 clude how the agency staff		ADCS re-educated by Education Specialist/I		u			
		how the facility would deem	!	regarding no agency p	•				
		competent in the training		assume nursing duties		ncv			
	received.		•	Orientation Checklist	_	-			
	On 05/04/2017 at 5	:00 p.m., the second plan of		and received by the H		•			
		sented and accepted.		nurses (agency) re-edu	ucated by the				
	·	·		Assistant Director of I	O (,			
	The facility staff pre			Designee regarding lo					
		training information to the lifted on 05/04/2017 at 8:55		medication cut-off del		nd			
	p.m.	11.00 011 00,0 11.20 17 Qt 0.00		medication re-ordering	g process.		 		
	-						 -		
							ı		

For Resident #10, the facility staff medicated

	DER/SUPPLIER/CLIA FICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					(o [*]
	495336	B. WING			05/0	09/2017
NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHAB CENTER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID SUMMARY STATEMENT OF I PREFIX (EACH DEFICIENCY MUST BE PF TAG REGULATORY OR LSC IDENTIFYI	RECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281 Continued From page 50 Resident #10 with the wrong of which resulted in altered ment decreased oxygen saturations pneumonitis which resulted in the hospital for opioid overdost treated a blood sugar of 25 with physician and receiving orders. Findings included: Resident #10 was originally action on 11/19/2011 and readmitted diagnoses including, but not lith Paraplegia, Aspiration Pneum (Chronic Obstructive Pulmona Depression, Anxiety, Diabetes Neurogenic Bladder, and Chronic Tract Infection). The most recent MDS (minim quarterly assessment with an reference date) of 04/10/2017 assessed as moderately impastatus with a total cognitive so Resident #10's clinical record 05/02/2017 at 2:15 p.m. and a at 11:00 a.m. Included in Resident #10's clinical record 05/01/17 through 06/30/17 was 04/03/17 that stated: "Morp MG (milligrams) Tablet ER (export MS Contin Take 1 (one) The proprise of Morphine Sulfate Take 1 (every 4 (four) Hours As Neede	tal status, s, and aspiration an overnight stay at se. Facility staff thout notifying the sto treat. dmitted to the facility on 04/03/2017 with mited to: nonitis, COPD ary Disease), s, Hypertension, onic UTI (Urinary onic UTI (Urinary on the core of 10 out of 15. was reviewed on again on 05/03/2017 sident #10's most sheet) dated is an order dated hine Sulfate ER 60 ktended release) as by Mouth Every order dated 04/04/17 ate 15 MG Tablet one) Tab by Mouth	F2	281	4. The Executive Director (ED)/ Di of Clinical Services (DCS)/designe review agency nurse files prior to the assumption of duties with new agenurses. ED to conduct random quareview of agency nurse files 5 times weekly x 4 weeks, 3 times weekly x weeks, 2 times monthly, PRN and a indicated. DCS/designee to conduct quality monitoring of "5 Rights of Medication Administration" 2 time weekly x 4 weeks, weekly x 4 week PRN and as indicated. DCS/design conduct random quality monitoring medication carts to ensure medication available per physician orders 3 times weekly x 2 weeks, twice weekly x 2 weeks, 2 x monthly, PRN and as indicated. DCS/designee to conduct medication skills competency check indicated. Findings to be reported to committee monthly and updated as indicated. Quality monitoring scheen modified based on findings.	e to he ncy lity s x 4 as t s cs, hee to g of ons are hes 4 t klist as o QAPI	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495336	B. WING				C / 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA			83 CI	EET ADDRESS, CITY, STATE, ZIP CODE ROSSROADS LANE HERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 281	tablets are an opic the management of require daily, aroust reatment and for coptions are inaded. WARNING: ADDIC LIFE-THREATENI DEPRESSION; AC Life-Threatening F Serious, life-threat depression may of sulfate extended-respiratory depress of morphine sulfate following a dose in Clinical Presentati morphine is manific depression, sommer coma, skeletal muskin, constricted p	ne sulfate extended-release oid agonist product indicated for of pain severe enough to nd-the-clock, long-term opioid which alternative treatment	F 2	81			
	tablets: Get emergency he much morphine su When you first sta tablets, when your too much (overdos	elp right away if you take too ulfate ER tablets (overdose). rt taking morphine sulfate ER dose is changed, or if you take se), serious or life-threatening s that can lead to death may					
	https://dailymed.nl	ras obtained from the website: m.nih.gov/dailymed/druglnfo.cf c-6ce2-4c5c-8c3f-c24fd334280			-		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER: `		LTIPLE	(X3) OATE SURVEY COMPLETEO		
		495336	B. WING				00/2047
NAME OF	PROVIDER OR SUPPLIER	1	D. 11	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	l uoi	<u>09/201</u> 7
AUGUST	TA NURSING & REHAI	B CENTER		l	3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH OEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
TAG	Continued From part 4 (END OF NOTE* An "Interdisciplinary Late Entry" included 4/2, I took report from 130 and I noticed #10 falling asleep in her oxygen level was and her oxygen car being toileted she mafter that around 3 because she had triphone and she did change of condition well she doesn't so little bit.' About an I spoke with me. I resported respirations low, an appeared the same had a UTI (urinary to grimacing and she checked. I read he (urinalysis) C&S (cowas negative for nit transport and they i availability until 9:30 called (Name) and at aprox 6:50 pm. (daughter had told in the control of the control	age 52 *** by Progress Note" dated "4-6-17 and the following: "On Sunday om (Name) RN, (registered moved from Unit 4, at aprox around 1pm, (Name) Resident reading newspaper. I checked as 88% her O2 was placed on me up to normal levels, after requested to go to bed. A little pm her daughter called ried to call her on her cell not answer. I reported the in to her daughter, she stated ound right so I will see you in a hour later she arrived and she ead her the vital signs which I ad her temp was elevated and and we both agreed that she e way she had the last time she tract infection), including facial should be sent out to be er the last lab result for U/A ulture and sensitivity) and it itrates. I spoke with (Name) informed me they had no 0 p-10 pm. At that time I obtained claim # for transport (Name) Resident #10's me that her 'mother had not felt I taken that extra pain pill.' I	F 2			PRIATE	DATE
	administration shee error. I also asked respiratory assessn p.m.) the crew was (unintelligible word)	et) and saw the medication (Name) another RN to do a ment. At aprox 1915 (7:15 s still not here so I called the) my ride # for (Name) At aprox 1930-1945					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			· ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495336	B. WING			ŀ	09/ 2017
	PROVIDER OR SUPPLIER TA NURSING & REHA	B CENTER		8:	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	(Name) Resident # supervisor, (Name) room) aware of all I (patient)." A second "Interdiso "4/2/17 1945" (7:45	e crew arrived to transport 10. (Name) Physician, nursing Hospital ER (emergency nealth issues of said pt. iplinary Progress Note" dated p.m.) included the following	F2	281			
	nurse to assess lur medication error ca This nurse ausculta lung sounds w/resp Low respiratory cou minute w/ periods of the nurse working f ER at (Name) hosp	urse on front hall asked this ag fields of resident d/t (due to) using respiratory depression. ated all lung fields noting clear pirations slow and shallow. Int of 10-12 breaths per of apneaThis nurse advised front hall to admit resident to ital for further evaluation d/t bry and the medication given tory issues."					
	dated 4/2/17, seen p.m.). "Chief Cor History of Present I (Name) nursing hot overdose. Patient (milligrams) long-ad 11AM today. She be throughout the day ED for evaluation. and history and at a painDifferential D physical exam a differential considered, but was overdoseED Cou 76-year old female facility with concernoverdose. She is s	al from the emergency room by MD (physician) 21:14 (9:14 mplaint: Altered Mental State; llness:She was sent from me with concern for accidental reportedly received 60mg cting morphine at 9AM and recame less responsive and was eventually sent to the Patient is unable to provide rest grimaces to riagnosis: After history and ferential diagnosis was not limited to narcotic rese/Procedures: Patient is a who presents from nursing of for accidental narcotic removed and, at ternal rub.					•

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405226	B. WING		C
NAME OF I	PROVIDER OR SUPPLIER	495336	D. WING	STREET AODRESS, CITY, STATE,	05/09/2017
	A NURSING & REHA	B CENTER		83 CROSSROADS LANE FISHERSVILLE, VA 22939	ZIF GOOE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		CTION SHOULD BE COMPLÉTION O THE APPROPRIATE DATE
F 281	Pneumonia, urinary encephalopathy; Consposition: Admitted ED" Hospitalist H&P date	Secondary Diagnosis: v tract infection, acute condition: Guarded; ed to (Initials) hospital from sed 04/03/17 0312 (3:12 a.m.)	F 2	81	
	facility after she wa somnolent.	to the ED from her nursing s found to be progressively			
	usual state of healt she inadvertently re long-acting morphir chronic pain. It app at 9 AM and a seconeeded dose of her at 11 AM. She was increasingly somno so was sent to the	appears to have been in her h until earlier in the day when eceived twice the dose of her ne which she takes for her bears that she received 60 mg and dose of 60 in lieu of a as immediate release morphine then noted to become lent and less responsive and emergency and Plan: (1) Sepsis: The			
	17,000 in the settin what appears to be meeting criteria for suspect that her so have clinical suspice	with fever and leukocytosis of g of some mild hypoxia and right lower lobe infiltrate sepsis. At this time I still urce is pulmonary and further ion that the patient may have and inadvertent morphine	:		1
	overdose resulting (2) Aspiration pneu apparent right lowe in the setting of her represents a chemi (4) Acute encephale reportedly increasir facility however upo alert and oriented x	in an aspiration pneumonitis monitis: The patient has r lobe airspace disease which presentation I believe cal aspiration pneumonitis opathy: The patient was agly somnolent at the nursing on evaluation she is awake, 3 and so I believe that her thy was due to an inadvertent			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION		E SURVEY MPLETED
		495336	B. WING				C / 09/201 7
	PROVIDER OR SUPPLIER	3	1	ST 83	REET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE SHERSVILLE, VA 22939	1 03/	09/201/
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE .	(X5) COMPLETION DATE
F 281	Nursing Facility H.p.m.), signed by the "Assessment/Plar Aspiration pneumoration patient today to rehospitalization for aspiration pneumoration pneu	e which is now resolved" &P dated 4/4/17 1611 (4:11	F	281			

	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495336	B. WING				C 09/2017
	PROVIDER OR SUPPLIER TA NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, 83 CROSSROADS LANE FISHERSVILLE, VA 22939	ZIP CODE	<u>, 03,</u>	03/2017
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 281	"Adverse Drug Readiscrepancy; Effect Medication discrepancy reactions are docu Medication discrepadminister, b) Adm Administered wron Administered to writhrough wrong rout Medication. Adverunintended/undesignesult of giving a market of givin	estigation was the policy, actions & Medication tive Date: 11/30/2014; Policy: ancies and adverse drug mented and reported. ancy refers to: a) Failure to inistered at the wrong time, c) g amount of medication, d) ong resident, e) Administered te, f) Administered the wrong se reaction refers to an rable effect that occurs as a redication" Itursing 6th Edition on page 841 medication administration, se actions that ensure safe to ensure safe medication nurse should be aware of a called the six rights of stration. All medication errors of me way, to an inconsistency in rights of medication ade the following: 1. The right right dose 3. The right client 5. The right time 6. The right	F 2	.81			

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION DING	Į.	(X3) OATE SURVEY COMPLETED		
		495336	B. WING				C 09/2017
	PROVIOER OR SUPPLIE A NURSING & REH			STREET ADORESS, CITY, STATE, 83 CROSSROADS LANE FISHERSVILLE, VA 22939	ZIP COOE	<u> </u>	00/201/
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEOED BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		TION SHOULD I	BE	(X5) COMPLETION DATE
F 281	states concerning with a change in a responsible for di of the most litigate kept the physiciar condition. To informust perform a condition. To informust perform a condition of the client to dethat are significant physician's tasks Nurses must be ophysician was not response, the nur responseIf a veshould be written soon as possible, LPN #2 (licensed was interviewed of #2 stated, "There diabetes. I asked LPN #3 (Agency of 105/03/17 at 11:10 in report of low ble PA (physician asswas 127. I don't knotified." PA was interviewed stated, "I was not came in. I don't knotified or not. I a on-call last night as a concerning with the concernin	-	F2	281			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495336	B. WING				C 09/201 7
	PROVIDER OR SUPPLIER A NURSING & REHAL	1	·	83	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939	1 03/	03/201/
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 58	F2	281			
	entered the confere surveyor the following Whom It May Cond Resident #10, I was that her accuchek (gave her a glucose was administered a about any input from knew. I called over call made to the on orders. This incide	eroximately 1:00 p.m. the PA ence room and handed this ing note: "5-3-17 Noon To eern: In regard to (Name) is notified at 0908 (9:08 a.m.) blood sugar) was 25. Nursing tab and pudding. She then a Glucagon injection. I inquired in the on call doctor but no one office (sic) and there was no call physician to direct these int occurred about 5:30 a.m. k at time of exam was 136"					
	were notified of the meeting with the su approximately 5:45	and DON (director of nursing) above findings during a survey team on 05/03/2017 at p.m. No further information a survey team prior to the exit 19/2017.					
		Patricia A. and Perry, Anne G. ursing. St. Louis: Mosby,					
	This is a complaint 483.21(b)(3)(ii) SEF PERSONS/PER CA	RVICES BY QUALIFIED	F 2	282	F282: Services By Qualified Perso. Care Plan	ns/Per	06/23/17
		ive Care Plans led or arranged by the facility, comprehensive care plan,			1. Resident #10 skin integrity reviews completed on 05/09/17 and we thereafter.		
	(ii) Be provided by accordance with eacare.	qualified persons in och resident's written plan of					

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY
		495336	B. WING			1	C 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		83	FREET ADDRESS, CITY, STATE, ZIP CODE B CROSSROADS LANE ISHERSVILLE, VA 22939	1 00	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	by: Based on staff intereview, facility staff plan for one of 25 r Residents #10. 1. Facility staff did assessments. Findings included: Resident #10 was con 11/19/2011 and diagnoses including Paraplegia, Aspirat (Chronic Obstructiv Depression, Anxiet Neurogenic Bladde Tract Infection). The most recent Miquarterly assessmentererence date) of Cassessed as model status with a total control of the control of	originally admitted to the facility readmitted on 04/03/2017 with g, but not limited to: ion Pneumonitis, COPD re Pulmonary Disease), y, Diabetes, Hypertension, rr, and Chronic UTI (Urinary DS (minimum data set) was a rent with an ARD (assessment 04/10/2017. Resident #10 was rately impaired in her cognitive ognitive score of 10 out of 15. resident #10's clinical record on p.m., Resident #10's CCP net stated, "Weekly Skin red: 02/02/16" Review of rity Review" sheets revealed nad been completed, 11/27/16, 01/17/17, 01/24/17, 01/30/17, 04/05/17, 04/11/17, 04/18/17	F 2	282	 A quality review was complete current resident's skin evaluations to being current. Skin evaluations cor as indicated. Licensed nurses re-educated by Director of Clinical Services (DCS designee regarding completion of vskin evaluations per policy. DCS/Designee through mornin clinical meeting review weekly ski evaluations to ensure compliance policy 5 times weekly x 2 weeks, 3 weekly x 4 weeks, twice weekly, P as indicated. Findings to be report QAPI committee monthly and updaindicated. Quality monitoring schemodified based on findings. 	the)/ veekly g n er times RN and ed to ated as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION S		PLETED
		495336	B. WING		05/0) 09/ 201 7
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	03/05/17, 03/12/17 The facility policy for Date: 11/30/2014; included the following will complete a total resident weeklyP Nurse will complete each resident weeklyP Nurse will complete each resident weeklyP Nurse will complete each resident weeklyP Nurse will complete each resident weeklyP Nurse will complete each resident weeklyP Nurse will complete each resident should be a total complete and the policy of the policy of life is a feach the state of the policy of life is a feach the policy o	on one of nursing) was interviewed on m. The DON stated, "The skin not been done routinely." of nursing) was received by the survey kit conference on 05/09/17.		,	rate was O2 ysician red long r. ration n y since mal 13 nd gen	
	483.25 Quality of c Quality of care is a applies to all treatn facility residents. B assessment of a re	ent with the resident's sessment and plan of care. are fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure tive treatment and care in		saturation level monitoring d/c per physician on 06/01/17. Resident #2 longer resides in the facility. Resident #18 r longer resides in the facility. Resident #18 r longer resides in the facility. Resident #18 r longer resides in the facility. Resident administered Vitamin D per physici without failures to administer occur since 05/09/17.	ent #11 no ent #6 is an order	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		E CONSTRUCTION		E SURVEY PLETED
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		495336	B. WING	-		05/0	09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAL	B CENTER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 33 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	practice, the compressive plan, and the resident with profite comprehensive and the residents who requiservices, consistent of practice, the comprehenses of practice, the comprehenses. This REQUIREMENT by: Based on resident facility document reand in the course of facility document reand in the course of facility staff failed to the highest practice residents in the sur (substandard qualities, #13, #21, #11, resulted in harm to #18. 1a) Facility staff fail Resident #10's oxygordered by the physical part of the properties of the physical properties of the physical properties.	ofessional standards of rehensive person-centered residents' choices, including refollowing: ent. sure that pain management is the swho require such services, ressional standards of practice, person-centered care plan, goals and preferences. cility must ensure that sire dialysis receive such the the with professional standards reprehensive person-centered residents' goals and NT is not met as evidenced interview, staff interview, eview, clinical record review of a complaint investigation, or provide care and services for able well being for 10 of 25 revey sample resulting in SQC by of care), Residents #10, #18, #6, #4, #5 and #15. This Resident #10, #21, #11, and red to monitor and record gen saturations every shift as	F	309	Resident #4 non-pharmacological printerventions added to plan of care of 05/05/17. Resident #5 pain level reevaluated on 05/15/17 and docum Resident #5 non-pharmacological printerventions added to plan of care of 05/15/17. Resident #5 Fentanyl pate applied per physician order. Resided Cyanocobalamin discontinued 05/02. Quality review of MAR's/TAF ensure medications are administered physician orders was completed. Quality review of MARs/TARs to ensure or saturation rate is documented per physician order was completed. Quareview of Treatment record to ensure wound treatments are completed per physician order was completed. Quareview of skin / wound documentate completed per policy. Quality review residents receiving pain management ensure mediations available and administered per physician order was completed. Quality review of reside receiving pain management to ensure the documented per policy was completed. Quality reviews of reside receiving pain management to ensure the documented per policy was completed. Quality reviews of reside receiving pain management have not pharmacological interventions were completed. Quality review of reside with orders requiring intermittent catheterization are followed per phyorder.	ented. ain on ch ent #15 9/17. R's to d per uality eygen ality ion is w of nt to as ents re pain ents on-	

to unavailability of the medication.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
444	495336	B. WING		05/09/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
AUGUSTA NURSING & REHAB CENTER			83 CROSSROADS LANE FISHERSVILLE, VA 22939	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE COMPLETION

F 309 Continued From page 62

- 2. Facility staff failed to monitor and record Resident #12's oxygen saturations every shift per physician order.
- 3. Facility staff failed to monitor and record Resident #13's oxygen saturation every shift per physician order.
- 4. Resident #21 was not provided pain medications for the treatment of chronic pain related to a C5-C6 (cervical spine injury at the 5th and 6th vertebrae of the spine), which resulted in harm to the resident.
- 5. The facility staff failed to assess non-pressure areas on the foot of Resident #11 and obtain physician ordered wound clinic treatment for Resident #11 with resulting harm. Physician orders for a wound clinic consult written on 02/23/2017 were not implemented by the facility staff until they were re-ordered on 03/27/2017. Resident #11 was not seen at the wound clinic until 04/04/2017. Review of facility documentation included Weekly Skin Integrity forms and per instruction on those forms, "If any skin condition present, proceed to skin condition record for each site identified. On 03/01/2017 the Weekly Skin Integrity Form documented bilateral boggy heels and a blackened area on the left fifth metatarsal. The Non-Pressure Skin Condition Record was reviewed. Measurements of the area on the left fifth metatarsal was measured at .4 cm by .4 cm. on 02/24/2017, 03/02/2017, 03/10/2017 and 03/17/2017. The facility failed to measure the areas after 03/17/2017. Weekly Skin Integrity Reviews on 03/08/2017 and 03/22/2017 documented skin intact and treatment in place. There was no further mention of the bilateral

F 309 3. Licensed nurses re-educated by the DCS/designee regarding administration of medications per physician order, documentation on the MARs/TARs without omission and providing skin/ wound treatment per physician orders. Licensed nurses re-educated by the DCS/ designee regarding completion of skin/ wound documentation per policy. Licensed nurses re-educated by the DCS/ designee regarding documenting resident's pain level per policy. Licensed nurses reeducated by the DCS/designee regarding following the plan of care for residents receiving non-pharmacological interventions for pain management. Licensed nurses re-educated by the DCS/ designee regarding residents requiring intermittent catheterization per physician order.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			<u> </u>	<u> MB NO.</u>	<u>0938-0391</u>
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ALIGHST	A NURSING & REHA	RCENTER		83	CROSSROADS LANE		
AUGUST	A NORSING & KEITAI	SOLNIER		Fl	SHERSVILLE, VA 22939		
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F 309	Continued From particles boggy heels. When the wound clinic, 40 was placed, wound Left dorsal fifth toe, thickness non-healislough; Right laters non-healing wound eschar covered, 1-2 6. The facility staff order's to catheteriz survey sample: Reassess and monitor to the resident bein which resulted in harmonic to the survey sample: 8. For Resident #4 attempt the use of interventions to add 9a. For Resident #4 assess the level of pain prior to the use	ge 63 n Resident #11 was seen at days after the initial order is were described as follow: .6 am X .9 Cm X .1 cm, fulling wound with 76-100 % at heel, 1.9 X .4 X .2, with undermining, 76-100% 25 % slough. failed to follow physician's are one of 25 residents in the sident #18, and also failed to for urinary retention, leading gradmitted to the hospital arm. failed to administer Vitamin Deer for one of 25 residents in Resident #6. If the facility staff failed to non-pharmacological ress pain control. 5, the facility staff failed to pain, and the location of the er of pain medication.	F 3			brning ks, 3 x veeks, cated. of x 2 weekly veeks, cated. ough v skin/ ly x 2 ks, 2 DCS/ luct s/TARs is 3 5 veeks,	
	attempt the use of a interventions to add 9c. For Resident # follow physician orc Fentanyl pain patch	5, the facility staff failed to ers for the application of a .			Managers/designee to conduct requality review of Treatment receensure skin /wound treatments is completed per physician order 3 weekly x 2 weeks, 2 times week weeks, weekly x 4 weeks, PRN	andom ords to s times dy x 2	
		15, the facility staff failed			indicated.		

follow physician orders for the administration of

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				r	ISHERSVILLE, VA 22939		
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F 309	Continued From pa	ge 64	F:	309	DCS/Unit Managers/designee to co random quality review of residents receiving pain management to ensu		
	i inanigo inoladoa:				mediations available and administe	red per	
	1a) Facility staff faile	ed to monitor and record			physician order 3 times weekly x 2	weeks,	
		gen saturations every shift as			2 times weekly x 2 weeks, weekly	x 4	
	ordered by the phys	sician.			weeks, PRN and as indicated. DCS	S/Unit	
					Managers/designee to conduct rand	om	
		originally admitted to the facility readmitted on 04/03/2017 with			quality review of residents receiving	g	
	diagnoses including				vitamin supplements is administere	d per	
		on Pneumonitis, COPD			physician order 3 times weekly x 2	weeks,	
		e Pulmonary Disease),			2 times weekly x 2 weeks, weekly	x 4	
		y, Diabetes, Hypertension,			weeks, PRN and as indicated. Med	ication	
		r, and Chronic UTI (Urinary			Skills competency checklist randor	nly	
	Tract Infection).				PRN as indicated. DCS/Unit Man	agers/	
-	The most recent MI	OS (minimum data set) was a			designee to conduct random quality	7	
		ent with an ARD (assessment			review of residents receiving pain		:
		4/10/2017. Resident #10 was			management to ensure pain level is		
		ately impaired in her cognitive			documented per policy 3 times wee	kly x 2	
	status with a total co	ognitive score of 10 out of 15.			weeks, 2 times weekly x 2 weeks, v	veekly	
		cal record was reviewed on			x 4 weeks, PRN and as indicated. Unit Managers/designee to conduct	DCS/	
		p.m. The most recent POS			random quality reviews of residents		
		eet) dated 05/01/17 through					
	06/30/17 included to				receiving pain management has not		
		Sats (oxygen saturation) 7P-7A" Review of TARS			pharmacological interventions 3 tir		
		ration sheets) included the			weekly x 2 weeks, 2 times weekly		
		ation: March 2017 7A-7P no			weeks, weekly x 4 weeks, PRN and	ias	
		vere recorded on 3/19, 3/20,			indicated.		
		no O2 Sats were recorded					
	3/03, 3/11, 3/22, 3/2						
	The DON (director)	of nursing) was interviewed on	! 				
		mately 5:45 p.m. regarding	i !			ļ	
		5. The DON stated, "If there	i				
		d then we have to assume	i i			!	

they were not done."

CLIVILI	10 I OIT WILDIOAIL	Q MEDIOAID SERVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		495336	B. WING	i			C 09/2017
NAME OF F	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	03/2011
	A NURSING & REHA	3 CENTER		8	3 CROSSROADS LANE TSHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Continued From pa		F:	309	DCS/Unit Managers/designee to co random quality review of residents orders requiring intermittent	with	
	morphine per physic withdrawal sympton to unavailability of the	failed to administer long acting hysician order resulting in proms and subsequent harm due of the medication. catheterization is followed per physician order twice weekly x 2 weeks, weekly x 4 weeks, PRN and as indicated. Findings to be reported to QAPI committee monthly				kly x 4 lings to	
	Included in Resident #10's POS was an order and updated as indica-		monitoring schedule modified base	d on			
	sheets) for Residen that Resident #10 d Morphine Sulfate 60 a.m. or 8:00 p.m. ar on 05/01/17 at 8:00 resident received si	S (medication administration at #10 included documentation lid not receive a dose of Dmg ER on 04/30/17 at 8:00 and also did not receive a dose a.m. The first dose the nce 04/29/17 at 8:00 p.m. was roximately 10:00 p.m.					
	by mouth on 04/29/ 2:10 a.m. and 9:00 prn (as needed) do documentation on the	administered Morphine 15 MG 17 at 7:40 p.m., 04/30/17 at p.m. She received no other ses according to he MAR. Resident #10 also MG on 04/30/17 at 1:00 p.m.					
	05/03/17 at 1:35 p.r this conversation Ro "On Friday 4/28 a	ghter was interviewed on m. per her request. During esident #10's daughter stated, hard script was needed for MG every 12 hours. She					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION			E SURVEY PLETED
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NAME OF	PROVIOER OR SUPPLIER	49000	0. 11110	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u> DDE	05/	09/2017
AUGUST	A NURSING & REHA	B CENTER		83 CROSSROADS LANE FISHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 309	missed a dose on S Sunday, 4/30 at 8:0 on Monday, 05/01 at (physician assistant prescription at 10:3 The medicine came p.m. Monday night. was late. I spoke w 7A-7P and she wou stated, 'Another dos for Morphine.' I, my Sunday evening and doctor was going to make sure Mom's Non Monday. The net the Administrator of They gave Mom he weekend every four it. Mom called me stated: "I can't take LPN #1 (licensed printerviewed on 05/0 p.m. regarding the doses. LPN #1 state on Friday and not or ran out of Morphine The Medical Director went into withdrawa acting Morphine over conversation with the approximately 3:00 Resident #10 was in 10:30 a.m. Resider long acting Morphine over sold acting Morph	Saturday, 4/29 at 8:00 p.m., 20 a.m., 8:00 p.m., and a dose at 8:00 a.m. (Name) the PA at 9 gave the nurse a 20 a.m. on Monday, 05/01. From the pharmacy at 10:30 Her Monday bedtime dose with the Sunday nurse working all dot call the doctor. Nurse ctor will not write a prescription yself called the on-call doctor bund 10:00 p.m. The on-call of call the nurse at the facility to Morphine would be delivered curse working didn't know who and a the facility to morphine over the representation of the weekend. The facility to morphine over the representation of the would take sunday evening, crying and at this pain much longer. The facility to missed Morphine Sulfate ER and the facility to morphine over the rectical nurse) was 13/17 at approximately 2:00 missed Morphine Sulfate ER and the facility to more the weekend. The form not having her long and from not having her long and surveyor on 05/03/17 at surveyor o	F3	309			

<u> </u>	TO TOTA MEDICALE	TO MILDION ND OLIVIOLO				1VID 140.	0000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		495336	B. WING				C 00/2017
NAME OF	PROVIDER OR SUPPLIER	.0000	1		REET ADDRESS, CITY, STATE, ZIP CODE	05/	09/2017
	A NURSING & REHA	B CENTER		83	CROSSROADS LANE SHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Morphine because The Administrator a	a take a lot of the other	F3	309	,		
	the survey team on DON stated, "The hobtained on Friday from the pharmacy	05/03/17 at 5:45 p.m. The nard script should have been and the medicine ordered and received at the facility ident #10 ran out of medicine.					
	This is a complaint	deficiency.					
		ed to monitor and record gen saturations every shift per					
	on 01/12/10 and readiagnoses including Disease, Hypertens Depression, COPD	originally admitted to the facility admitted on 03/01/14 with g, but not limited to: Heart sion, Hemiplegia, Anxiety, (Chronic Obstructive e), Stroke, Dysphagia and ion.					
	quarterly assessme reference date) of 0 assessed as model	DS (minimum data set) was a ent with an ARD (assessment 02/01/17. Resident #12 was rately impaired in her cognitive gnitive score of 12 out of 15.					
	05/04/17 at 7:45 a.r (physician order sho 05/31/17 included a O2 Sats every shift.	cal record was reviewed on m. The most recent POS eet) dated 04/09/17 through an order: "06/19/14: Check 03/07/14: O2 at 2L/Min (2 a Nasal Cannula every Shift				·	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						. (C
		495336	B. WING			05/	09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAE	3 CENTER		83	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	₿E	(X5) COMPLETION DATE
F 309	following dates with January 2017: 7A-7 1/17, 1/20, 1/21, 1/2 February 2017: 7A-2/24, 2/25, 2/28; 7P March 2017: 7A-7F 3/21, 3/23, 3/24, 3/2 3/23, 3/25. The DON (director of 05/03/17 at approximate blanks on the TARS are no sats recorded they were not done.	#12's TARS revealed the lout O2 Sats documented: 7P: 1/5, 1/6, 1/10, 1/15, 1/16, 22, 1/23, 1/24, 1/27, 1/317P: 2/17, 2/19, 2/22, 2/23, 2/7A: 2/17, 2/25, 2/28. 2: 3/3, 3/11, 3/15, 3/19, 3/20, 25; 7P-7A: 3/3, 3/11, 3/21, of nursing) was interviewed on mately 5:45 p.m. regarding S. The DON stated, "If there ad then we have to assume."	F	309			
	Resident #13's oxyg physician order. Resident #13 was of on 02/22/12 and readiagnoses including Fibrillation, Heart Did Dementia, Parkinso COPD. The most recent ME quarterly assessme reference date) of 0 assessed as severe	gen saturation every shift per originally admitted to the facility admitted on 07/17/15 with g, but not limited to: Atrial isease, Diabetes, Stroke, on's Disease, Seizures and DS (minimum data set) was a sent with an ARD (assessment 04/29 17. Resident #13 was ely impaired in her short and and daily decision making					

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<u> </u>	TO TOTAL INITIAL TOTAL	G MEDIO/ ND OLIVIOLO			··· · · · · · · · · · · · · · · · · ·	VINID IAC	. 0000-0091
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER						
AUGUST	A NURSING & REHAI	3 CENTER			3 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	DBE	(X5) COMPLETION DATE
F 309		cal record was reviewed on	F3	309			
	dated 04/01/17 throoder: "07/20/15:	m. The most recent POS ough 05/31/17 included an O2 Sat Every Shift, 06/07/16: asal Cannula continuous every of breath"					
	following dates with January 2017: 7A-	#13's TARS revealed the lout O2 Sats documented: 7P: 1/2, 1/5, 1/6, 1/10, 1/15, 21, 1/22, 1/23, 1/24, 1/31;					
	February 2017: 7A 2/25, 2/28.	-7P: 2/19, 2/22, 2/23; 7P-7A: P: 3/1, 3/15, 3/20, 3/21, 3/24; 11, 3/22, 3/23, 3/25.					
	05/03/17 at approxi	of nursing) was interviewed on mately 5:45 p.m. regarding 5. The DON stated, "If there d then we have to assume					
	No further informati	on was received by the survey it conference on 05/09/2017.					
	This is a complaint	deficiency.					
	related to a C5-C6 and 6th vertebrae of harm to the residen mcg (micrograms) abruptly and the res	s not provided pain treatment of chronic pain (cervical spine injury at the 5th if the spine), which resulted in t. Resident #21's Fentanyl 125 patch was discontinued sident was not provided any or the relief of breakthrough					

pain.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' ′	TIPLE CONSTRUCTION	1		E SURVEY IPLETED
		495336	B. WING				C 09/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 83 CROSSROADS LANE FISHERSVILLE, VA 22939	IP CODE	•	00/201/
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI; TAG		TON SHOULD I	BE	(X5) COMPLETION DATE
F 309		oage 70 originally admitted to the facility dmitted on 1/9/17 with, but not	. F3	309		·	
	limited to, the follor retention, vaginal f quadriplegia relate recent Minimum D Assessment Refer was a quarterly as- assessed as being skills; able to make	owing diagnoses: urine fistula, unspecified ileus and ed to a C5-C6 injury. The most Data Set (MDS) with an rence Date (ARD) of 1/14/17 esessment. The resident was g a fifteen (15) for cognitive e needs known and cision-making skills.					
	(adult protective se agency's office wa allegations of the r care and services. During the review #21's clinical recordocumented that the complained of pair discontinued due to	eximately 1:00 p.m., An APS ervices) report filed in the State as reviewed regarding multiple resident not being provided while in the nursing facility. of the APS report, Resident rd was reviewed and it was the resident frequently a after a Fentanyl patch was to an allegation of drug o the resident's spouse.					
	Medical Director wabove allegation. that he was aware would have done of director further staresponsible if she was not my patient made aware that F for a while and tha after the allegation the Resident's hus stated that "he was	oximately 1:40 p.m., the was interviewed regarding the The medical director stated of the above and that "he differently." The medical ated that he "did not want to be (the resident) overdosed; she at." The medical director was Resident #21 was on Fentanyl at it was discontinued shortly of a drug diversion concerning sband. The Medical Director is aware of something like that peak to the situation."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495336	B. WING		05	C / 09/2017		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZI 83 CROSSROADS LANE FISHERSVILLE, VA 22939		103/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 309	the resident was alternatives for the therefore according resident was unalled daily living) on set on 5/8/17 at apprevals clinical recommendation of the following nursing of the following nursing of the following nursing of the following nursing of the following nursing of the following nursing of the following nursing of the following nursing of the following that has been about having to remain the following of the following	ctor was also made aware that not offered any other e treatment of her pain and ng to the nurse's notes, the ole to perform ADL (activities of veral occasions. oximately 11:30 a.m., Resident and was reviewed to include the notes: 1:00 p.m.) Res (resident) was isn't allowed on grounds until per for the missing Fentanyl or Zofran 4 mg po (by mouth) qow or Zofran 4 mg po (by mouth) qow (nausea and vomiting) & IM (intramuscular) q 6 prn (as yo for N/V x (times) 2 weeks. In notified. Resident was upset temove patches. 100 mcg & 25	F3	309				
	Xanax, Flexeril is but is aware too e early pt (patient) s Hostile attitude("12/4/16 late entry	now requesting dilaudid for pain early want tyl again but it is too short and curt c (with) staff.						
	Resident would a	sk for pain medication early and						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING	(×	(X3) DATE SURVEY COMPLETED		
	495336	B. WING			C 05/09/2017		
NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP C 83 CROSSROADS LANE FISHERSVILLE, VA 22939	CODE			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI	E COMPLETION DATE		
certain time. Pt starme whatever you come whatever you come whatever you come what it is just give in left for pain that she was not protected about my pain." On 5/8/17 at approximates what she was not protected and unhusband." Resident took me off of 125 it tapering me off of it bed or turn because on 5/8/17 at 3:20 p.m. did not answer. The	nurse didn't give pt (patient) ted that at one point to "Give an give." Is been verbally hostile c (with)" Int word by CNA (certified Give me anything, I don't care me something. "has nothing a hasn't already taken" In the company of	F3	609				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495336	B. WING				C 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		83 CF	ET ADDRESS, CITY, STATE, ZIP CODE ROSSROADS LANE IERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	On 5/9/17 at appro Statement for Resi include the followin nursing assistant] r 10:30 I saw the sho offer her a shower stated that [Reside showershe stated because she was it more time before I [Resident named] so fit later and was so of it later and so	ximately 9:20 a.m. A Witness dent #21 was reviewed to g: "1/27/17 [CNA-certified named On 1/10/17Around ower aide go into her room and [CNA shower aide named] she nt named] declined her d that she did not want it yet n a lot of pain! offered one left at 3:00 p.m. that day and stated that she would take care still in pain." ximately 1:34 p.m., the were made aware of the failed to assess non-pressure f Resident #11 and obtain wound clinic treatment for	F3	609			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIOER/SUPPLIER/CLIA	(V2) MIII		V2) DATE CUDVEV		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILO		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495336	B. WING				C 09/201 7
NAME OF E	PROVIOER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	09/201/
	A NURSING & REHAL	3 CENTER		83	3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 74	F 3	, 309			
	measure the areas Skin Integrity Revie 03/22/2017 docume	after 03/17/2017. Weekly ws on 03/08/2017 and ented skin intact and treatment no further mention of the					
	40 days after the initiation were described as fram X 0.9 Cm X 0.1 wound with 76-100 1.9 X 0.4 X 0.2, nor	was seen at the wound clinic, itial order was placed, wounds follow: Left dorsal fifth toe, 0.6 cm, full thickness non-healing % slough; Right lateral heel, n-healing wound with 0% eschar covered, 1-25 %					
	on 11/13/2015. Her not limited to: End a encephalopathy, atr wegner's Granulom	originally admitted to the facility or diagnoses included but were stage renal disease, rial fibrillation, hypertension, atosis with renal involvement, disease and gangrene.					
	a significant change (assessment refere Resident #11 was a with both long and s	DS (minimum data sheet) was a assessment with an ARD nce date) of 05/05/2017. Assessed as having a problem short term memory and being with daily decision making					· : : : : : :
	05/03/2017. Observection were the fol [12:13 p.m.] Wound and "3-27-17 1312	was reviewed beginning on ved in the physician order lowing orders: "2-23-17 1213 care clinic consult for feet" [1:12 p.m.] Wound care clinic Indication-Dx [diagnosis] ".					

The unit manager, LPN (licensed practical nurse)

CENTE	49 LOK MEDICAKE	& MEDICAID SERVICES	,			<u> INIB NU.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY
		495336	B. WING				C 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAI	B CENTER		83	FREET ADDRESS, CITY, STATE, ZIP CODE B CROSSROADS LANE SHERSVILLE, VA 22939		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	regarding Resident wound clinic. She was first seen at the "April 4th." She was in the length of time and the actual appoint had been at the fact been there at the time stated she did not knot been made. She staff member who re	#10:00 a.m., on 05/03/2017 #11's appointment at the was asked when Resident #11 e wound clinic. She stated, s asked why there was a delay the initial order was written bintment. She stated that she ility for one month and had not me of the initial order. She know why the appointment had the directed this surveyor to the	F3	09			
	a.m. on 05/03/2017 role in making apportunce in making apportunce in making apportunce in making apportunce in making appointment. Such a provintment in appointment in a provintment in a provintment in a provintment in a provintment at the until 03/27/2017 at a provintment in making appointment at the until 03/27/2017 at a provintment in a prov	wed at approximately 10:15 . She was asked what her bintments for residents was at ted that when she received a aff she made appointments for ged for their transportation to he was asked if she knew appointment for the wound made when originally ordered er looking through her branch this surveyor that she information regarding an wound clinic for Resident #11 which time an appointment 04/04/2017 and transportation					
	Skin Integrity forms forms, "If any skin of skin condition recor 03/01/2017 the Wed documented bilaters	and per instruction on those condition present, proceed to d for each site identified. On ekly Skin Integrity Form al boggy heels and a the left fifth metatarsal. The					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		495336	B. WING				C 09/2017	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		1 03/	<u> </u>		
AUGUST	A NURSING & REHA	3 CENTER			CROSSROADS LANE SHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 309	Non-Pressure Skin reviewed. Measure fifth metatarsal was cm. on 02/24/2017, 03/17/2017. The fa areas after 03/17/20 Reviews on 03/08/2 documented skin in There was no further boggy heels. A physician progress reviewed and including was to see this papossible infection to dialysis staff noticed erythematous and the feet reveals a esome purulent matemild erythema over and the heel. Similaright footThe area palpationImpress will immediately platimes daily X [times	Condition Record was ements of the area on the left ameasured at 0.4 cm by0 .4 03/02/2017, 03/10/2017 and utility failed to measure the 017. Weekly Skin Integrity 2017 and 03/22/2017 tact and treatment in place. For mention of the bilateral as note date 03/27/2017 was ded the following information: attent by nursing staff for the her feetApparently the diner toes that were the left fifth toe apparently was lent materialInspection of rythematous left fifth toe with the distal portion of the foot ar findings are noted on the first mildly tender with the cion Cellulitis of both feetI ce her on Keflex 500 mg 4 17 days. I will have the first the wound clinic and have	F3	09				
	reviewed. On the TA "Clean right heel wi apply optifoam and added on 02/22/2010 on 2/22/2017 and 0 were blank. An ord added on 02/22/2010 on 02/24/2017. The	t administration records) were AR for February an order to th DWC [wound cleanser] and heel cup for protection" was 7 and marked as completed 2/24/2017. All other days er for "Foam boot daily" was 7 and marked as completed e same orders for treatment of March. Cleaning of the heel						

CLIVILI	13 LOW MEDICAKE	A MILDICAID SERVICES				AL GIVIC	<u>, </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
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	PROVIOER OR SUPPLIER	B CENTER		83	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE	1 00	70072017
				FI	ISHERSVILLE, VA 22939		
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F 309	Continued From pa	ige 77	F	309			
	· · · · · · · · · · · · · · · · · ·			000			;
		narked as completed on 7 of	I				:
		am boot either placed or	i 				!
		dent on 25 of 31 days. LPN #1					
		ne holes on the TAR for			•		!
		h. She stated, "I don't know if					
		e done or not." LPN #1 was					
		e doing the dressing change					
		heduled for that day					
		stated that she would be doing					
		sked to be present when the					
		as completed. LPN #1 agreed					
	to the request.						
	101	f 0.4/0.4/0.047					
		from 04/04/2017, 40 days					
		r was placed, were reviewed.					
,		ribed as follow: Left dorsal	į				
		.9 Cm X 0.1 cm, full thickness					
		with 76-100 % slough; Right					!
		0.4 X 0.2, non-healing wound	! !				
		6-100% eschar covered, 1-25					
	•	documentation included: "This					
		atient with COPD, Coronary					ļ
		re/dialysis and history of	•				
		is who comes into the wound					
		with more wounds on her feet					
		been treated off and on since					
		some of her wounds are due to					
		t on her wheelchair at her					İ
		neshe essentially does not in a wheelchair and sleeps in a					
		cles and painful to touch					
		ft dorsal fifth toe is a full					
		ng wound and has received a					
		d. Initial wound encounter					
		0.6 cm length X 0.9 cm width					
		h an area of 0.424 sq cm and					
		cubic cmthere is a scant					
		guineous drainage noted					
		Wound bed is 76-100%					
	willuli ilas Ilu uuul	. * * • • • • • • • • • • • • • • • • •					1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	COM	E SURVEY PLETED
		495336	B. WING				C 09/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A NURSING & REHAI	3 CENTER			3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	Wound #6 Right, La covered Non-healin status of Not Heale measurements are X 0.2 cm depth, wit a volume of 0.119 cbeen noted at 12:00 maximum distance drainage notedWand 1-25% slough, multiple wounds on herself on somethin [peripheral vascular patient who is injuri. have a chronic vasc appearance of her contained the follow 4/11/2017 her legs wave forms and the ischemia. Both of hon the right and the left is occludedWa Toeno change in progressionWound in length X 1 cm in wound is deteriorati same or slowly gett her inflow from the and wounds are unlischemiasevere fand other health iss not be able to heal his likely to come to a server of the status of the solution of the solut	aund skin exhibited: Erythema. Exteral Heel is an eschar of wound and has received a d. Initial wound encounter 1.9 cm length X 0.4 cm width the an area of 0.597 sq cm and subic cmundermining has 0 and ends at 12:00 with a of 0.5 cm. There was no ound bed is 76-100% eschar 1-25% granulationShe has both feet as she injures of in her environmentPVD of disease] in a chronically illing her skinShe appears to culitis based on the extremities." Ind clinic visit on 04/18/2017 ving: On the vascular study of bilaterally have monophasic are is distal bilateral critical firer tibial arteries are occluded posterior tibial artery on the bound #5 Left dorsal Fifth the wound at #6 Right lateral heel2 cm width X .2 cm depththe fing worse. Is apparent that wascular study is very poor likely to heal given the critical eventsI think it is likely we will ther wound of the feet and she in the standard of the feet and she in the count of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the feet and she in the critical of the c	F 3	09			
	tamily member for F	Resident #11 came to the			•]

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CLIVIL	13 FOR MILDICARE	A MILDICAID SERVICES				<u>ONI DIVIC</u>	<u>. </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC		LE CONSTRUCTION		E SURVEY MPLETED
		495336	B. WING				C / 09/2017
NAME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP COOE	03/	109/2017
MAINE OF I	FROVIDER OR SUFFLIER						
AUGUST	A NURSING & REHA	B CENTER			33 CROSSROADS LANE		
				F	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	She identified herse attorney) for Reside to speak with you a quality and quantity down hereI want She showed this su of Resident #11's fe 03/27/2017. She st gotten worse and we care of them and treshouldshe has all sent her to the wou should have been in On 05/03/2017 the position on 04/01/20 regarding Resident delay in obtaining the regard to the outcoul lack of skin assess measurements at the Resident #11's measurements at the time frame, but clinic when originall changed the quality stated that had Residinic when ordered Gangrene" as opposed to the wewound clinic sooner	espeak with this surveyor. The stated of the POA (power of the H11. She stated, "I wanted bout my sister's carethe of staffing has really gone to show you some pictures." The stated of taken of the the the the the the the the the the	F	309			
		00 p.m., on 05/03/2017, LPN ference room to tell this					

surveyor that she was ready to do the dressing

CENTERS FOR MEDICARE & MEDICAID SERVICES					C	<u>MB NO.</u>	<u> 0938-0</u> 391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	СОМ	E SURVEY IPLETED
		495336	B. WING				09/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
		D OFNITED		83	3 CROSSROADS LANE		
AUGUST	A NURSING & REHAI	3 CENTER		F	ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	she would be there surveyor arrived on and this surveyor st Resident #11's roor hall. LPN #1 stated LPN #4. She stated dressing change." to this surveyor) was stated, "Well it's alrasked LPN #4 if she for the evening. Shother side (referring opposite side of the asked, "Why did yod ressing change?" familiar with the dre LPN #4 stated, "I cato, it's only schedule doing very well and stated, "No, I don't through that, but if the changed again I was #1 verbalized her undirector of nursing consultant at 5:45 prinformation was disvoiced regarding the resident #11 due to wound clinic appoint assessments for the lack of docume the areas. They we wounds had not be to the dressing beir surveyor got to the	at #11. This surveyor told her in just a minute. This in just a minute. This is the unit at 5:10 p.m., LPN # 1 tarted down the hall to in. LPN #4 was coming up the did, "Where are you going?" to did, "I've already done the LPN #1 stated, "She (pointing anted to see it." LPN #4 eady done." This surveyor in was caring for Resident #11 in estated, "No, I work on the did to the other units on the did to the other units on the land building)" This surveyor in come over here to do the LPN #1 stated, "She is more easing change than I am." and do it again if you want me and of it again if you want me and every other dayshe's not is in pain." This surveyor want to put the resident the dressing needs to be ant to see the wounds." LPN inderstanding. With the administrator, the DON of and the regional nurse out, on 05/03/2017 the above coussed and concerns were e possibility of harm to the delay in obtaining the	F3				

OLIVILI	VO I OIL MEDICARE	- A MEDIONID SERVICES				<u>/IVID IVO</u>	<u>. 0930-039 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COM	E SURVEY MPLETED
		495336	B. WING	i			C / 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		8:	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE	(X5) COMPLETION DATE
F 309	in assessing her fee stated, "Yes." On 05/04/2017, LP this surveyor if the Resident #11's feet to be changed. On 05/08/2017 whe the facility the DON could see the woun The DON stated, "[[passed away over the stated of the s	staff to be all the more diligent et and extremities. The DON N #1 was again asked to get dressings were changed on the dressings did not need and the survey team returned to I was asked if this surveyor ads on Resident #11's feet. Name of Resident #11] the weekend." ion was obtained prior to the 05/09/2017.	F	309			
	order's to catheterize survey sample: Resurvey sample: Resurvey sample: Resurvey sample: Resurvey sample: Resident being which resulted in harmonic survey sample. Resident # 18 was admitted to the diagnoses to include degenerative joint of the hemorrhage, benign (enlarged prostate of	failed to follow physician's ze one of 25 residents in the sident # 18, and also failed to r for urinary retention, leading g admitted to the hospital arm. a closed record review and a facility 3/20/17 with le, but were not limited to: disease, history of intracranial in prostate hyperplasia gland), and osteoarthritis. S (minimum data set) dated					
	3/27/17 had Reside	ent # 18 assessed with long n memory problems, and					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING			O.F	C 5/ 09/201 7
NAME OF D	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	1/09/2017
	A NURSING & REHAL	3 CENTER		8	3 CROSSROADS LANE		
7.00001				F	ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 82	F3	309	ı		
	•	in daily decision making skills.					
	at 10:00 a.m. The l summary) at admis documenting "May (twice a day) prn (a retention/inability to	was reviewed 5/4/17 beginning POS (physician order sion included an order l/O (in and out) cath BID s needed) for urinary urinate." A review of nurses' through 3/28/17 revealed the			•		
	cath. No void 7a-7p of cath. Urine bega	cumented] : "Rsd straight . Clot noted to come out end an flowing very slowlyrsd Abd.(abdomen) not very					
	small amt. 1:30 a.m	"void mod amt. 9:30 p.m. and a. straight cath with cath kit- e400 cc concentrated od clot"					
	3/24/17 7:00 a.m. " moderate amt"	void through the night once					
	3/26/17 7:00 a.m. "I bladder this shift	Pt. incontinent of bowel and ."					
	extremely lethargic to be weak and mor for 1000 cc normal	ren] "Rsd noted to be but able to answer. Rsd noted uth dry. MD notified. Order cc given by IV by end of alert stating 'I feel a lot					
	of water but back to	alerttook meds with 1/2 cup sleep quicklyf/c (Foley lark brown urine with sediment					

noted. 2,000 emptied, 1500 light straw

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	()	(X3) DATE SURVEY COMPLETED	
		·				С	
		495336	B. WING			05/0	9/2017
	PROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 83 CROSSROADS LANE FISHERSVILLE, VA 22939	·DE		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B		(X5) COMPLETION DATE
F 309	(It should be noted order to "Place Fole physician). A review of the TAF record) revealed the two times during the facility. On 5/4/17 hospital reviewed. The doc emergency room vipatient was discharfacility] and his Fole with plans for international time in the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterizations where the catheterization with the catheteriz	that there was a physician ey catheter now" written by the R (treatment administration e resident was straight cathed e eight days he was in the records were obtained and umentation from the sit documented "The reged [3/20/17] to [name of ey catheter was discontinued mittent urinary catheterization. For the patient received any lile he was at the facility. A placed with immediate return and the patient is continued to biropathy. The case was on-call hospitalist and e made for direct admission ent and Plan" was e of resident] is a very unate gentleman now atternal failure secondary to pathy with a known history of	F3	309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OWR NO	<u>). 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		PLE CONSTRUCȚION 3		TE SURVEY MPLETED
		495336	B. WING	i		05	C 5 /09/2017
NAME OF F	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALIGUAT	'A NUIDONIO O DELLA	D OCHTED		1	83 CROSSROADS LANE		
AUGUST	A NURSING & REHAI	B CENTER		1	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ngo 94	: :	200			
1 303	•	-	: г .	309	3		
		as pretty fired up about it."	i				i :
		or then informed this surveyor					i
	ne would send a pa	nge to that physician and ask	İ				
	nim to call me.		ı				
	On 5/8/17 at 12:05	p.m. LPN (licensed practical					
		rviewed. LPN # 2 was also					
	asked if there were	any other staff who may have					
		out Resident # 18. LPN # 2					
		y know much about him; other					İ
		e either not here anymore, or					:
		I did do the transfer					:
		ospital, but I had only been					•
		ys before that happened. I the resident and did not know					·
		nd unfortunately, there's no					
	one here now that o		: !				
	On E/9/17 at 1:15 n	m the conjutant madical	: 				
		.m. the assistant medical surveyor. The assistant	1				
		is asked about the care and	ļ				
		or the resident while he was in					
		g the reason he had been sent					
		assistant medical director	 				
	stated "The first tim	e I saw the patient was					
		nim out after the catheter was	!				1
	•	was palpable and tender at					
		pilicus and had a huge volume					
		's hard to speak to the care	! ! !				
		ed while he was in the facility; of urine obtained tells the story.					
		end in light of the amount of	r I :				
		eporting it [name of resident]					
	is now on Hospice.						
	On 5/0/17 during a	mosting with facility staff					
		meeting with facility staff .m., the administrator, DON					1
		, and regional nurse					1

consultant were informed of the above findings.

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION			E SURVEY IPLETED
		495336	B. WING				C 09/201 7
	PROVIDER OR SUPPLIER TA NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP 6 83 CROSSROADS LANE FISHERSVILLE, VA 22939	CODE	<u> </u>	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 309	No further informate exit conference. THIS IS A COMPL. 7. The facility staff per physician's ord the survey sample. Resident # 6 was a The admission MD 4/4/17 had Resider impairment in cogr. The clinical record 3:00 p.m. The currency included 3/30/17 for "Vitami capsule Take one of Monday." A review of the MA record) was then compared off area for evere blank for Mor April 17th 2017. The contain any document of the more contain any document of the more services a note- or contain and the property of the more services. On 5/2/17 at 3:30 p. nurse) # 2 was ask the blank areas on administration. LP there's a note- or contain any document of the property of the more services and the property of the property	team were informed of the evel deficiency at that time. tion was presented prior to the AINT DEFICIENCY. failed to administer Vitamin D er for one of 25 residents in Resident # 6. admitted to the facility 3/28/17. S (minimum data set) dated ont # 6 assessed with moderate	F3	109			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION			E SURVEY PLETED
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		495336	B. WING			05/0	09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, 3 83 CROSSROADS LANE FISHERSVILLE, VA 22939	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 309	after review stated Vitamin D; there's r either. I don't know The administrator, regional nurse cons above findings 5/9/ facility staff beginni	al record for review. LPN # 2, "I don't see anything about the to documentation on the MAR what happened." DON (director of nursing), and sultant were informed of the 17 during a meeting with	F	309			
	attempt the use of interventions to add Resident # 4 in the female, was admitted most recently readred diagnoses that incluence phalopathy, and leg syndrome, diable congestive heart fachronic pain, morbifailure, chronic rena anemia, seizure disgastroesophageal robstructive pulmonafailure. According to Data Set (MDS), and Assessment Referente resident was as	survey sample, a 66 year-old ed to the facility on 4/7/15, and mitted on 4/14/17 with uded obstructive sleep apnea, sidosis, hypertension, restless etes mellitus, asthma, illure, bi-polar disorder, anxiety, d obesity, acute respiratory al failure, seizure disorder, order, depression, eflux disease, chronic ary disease, and respirator o the most recent Minimum Significant Change, with an ence Date (ARD) of 4/21/17, sessed under Section C) as being cognitively intact,					

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	COV	TE SURVEY MPLETED
		495336	B. WING	i			C / 09/2017
NAME OF F	PROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE		-
AUGUST	A NURSING & REHA	B CENTER		ı	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 309	Continued From pa	ge 87	F;	309)		
	Resident # 4 had the to address pain:	e following medication orders					
	oral twice daily.	(milligrams) Tablet. 10 mg ablet. Take 1 tablet by mouth seded for pain.					
	(MAR) for the mont as needed Oxycode times between 3/1/ month of April 2017	cation Administration Record h of March 2016 revealed the one was administered 30 17 and 3/23/17. For the t, the as needed Oxycodone 3 times between 4/1/17 and					
	record, including the comments section of Administration Record documentation that	of Resident # 4's clinical e Nurse's Notes and the of the Medication ord (MAR), failed to reveal any non-pharmacological lress the resident's pain were					
	resident was asked non-pharmacologic pain. The resident cold packs occasion cold compress will van sometimes get through the night wiresident said. Furth clinical record failed	at 2:30 p.m. on 5/3/17, the about the use of al interventions to address her said staff have use hot and hally. "Sometimes a hot or a work. Compresses at night me all relaxed and I can sleep ithout medication," the ner review of the resident's I to reveal any documentation sional use of hot and cold					:
		liscussed at a meeting at 3:00 the Interim Administrator,	:				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING			05	C 5/ 09/201 7
	PROVIDER OR SUPPLIER			83 C	EET ADDRESS, CITY, STATE, ZIP CODE ROSSROADS LANE HERSVILLE, VA 22939	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	Continued From pa Director of Nursing and the survey tear	, Corporate Nurse Consultant,	F3	309			
	assess the level of	# 5, the facility staff failed to pain, and the location of the e of pain medication.					
	male, was admitted and most recently rediagnoses that including the below the knew left great toe wound hypertension, coror gastroesophageal resulting the properties of the p	e survey sample, a 76 year-old d to the facility on 10/29/16, readmitted on 12/31/16 with uded gout, hyperlipidemia, se amputation stump wound, d, diabetes mellitus, mary artery disease, reflux disease, benign prostatic ssion, and arteriosclerotic cording to the most recent with an ARD of 2/5/17, the ssed under Section C s) as being moderately d, with a Summary Score of 12					
	Resident # 5 had the to address pain:	ne following medication order					
	Oxycodone 5 mg Ta every 4 hours as no	ablet. Take 1 tablet by mouth eeded for pain.					
	needed Oxycodone between 3/1/17 and for April 2017 revea	R for March 2017 revealed as e was administered 40 times d 3/31/17. Review of the MAR aled as needed Oxycodone 43 times between 4/1/17 and					
		of Resident # 5's clinical e Nurse's Notes and the					

CENTE	13 FOR MEDICARE	& MEDICAID SERVICES				IND INC	. 0930-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	CON	TE SURVEY MPLETED
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NAME OF I	200, 4000 00 01 1001 100	43000		_		l na	<u>/09/201</u> 7
	PROVIOER OR SUPPLIER A NURSING & REHAL	B CENTER		8	STREET AODRESS, CITY, STATE, ZIP CODE 33 CROSSROADS LANE FISHERSVILLE, VA 22939		
040.10	CLINANA DV CTA	TEMENT OF DEFICIENCIES	10		DROVIDED'S DI AN OF CORRECTIO	ıkı	. (275)
(X4) IO PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	Continued From pa	age 89	F:	309	•		
	•	of the MAR, failed to reveal	. `	-			
		the resident was assessed for or the location of his pain.					
	9b. For Resident#	5, the facility staff failed to					
	attempt the use of	non-pharmacological					
	interventions to add	dress pain control.					
	A thorough review of	of Resident # 5's clinical					
		e Nurse's Notes and the					
	comments section						
		ord (MAR), failed to reveal any	•				
			1				
		non-pharmacological					
		dress the resident's pain were					
	attempted.		:				
-		5, the facility staff failed to	:				
	follow physician ord Fentanyl pain patch	ders for the application of a	ï				
		ne following physician's	:				· I
	medication order:	ie following physician s					
		(micrograms per hour). Apply					
	1 patch topically ev	ery 3 days.					
	NOTE: Fentanyl is	an opiod analgesic used to	:				
		severe pain. Ref. Mosby's	1				
		Reference, 30th Edition, page					
	496.	, , , , , ,	: 				
		for the month of March 2017	: :				
•		inical record revealed the					!
	patch scheduled for	r application on 3/20/17 was	•				
	not signed as havin						:
		p.m. on 5/3/17, LPN # 2					ŧ
		Nurse), the Unit Manager on					:
	(Licensed Practical	nurse), the Unit Manager on					:

CLIVIL	13 FOR MILDICARE	A MILDICAID SERVICES				CIVID	NO. 0936-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST		(X3	B) DATE SURVEY COMPLETED
		495336	B. WING				C 05/09/201 7
NAME OF	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP COL	DF	00/00/201
	A NURSING & REHAI	B CENTER		83 CROS	SROADS LANE SVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI ROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	
F 309	Continued From pa	ge 90	F:	309			
	Unit 2, was asked to Fentanyl patch was 3/20/17. At 2:10 p.s surveyor that the Fe	o determine whether or not the applied as ordered on m., LPN # 2 advised the entanyl patch not been signed sheet. "It was not applied,"					
	p.m. on 5/8/17 with	liscussed at a meeting at 3:00 the Interim Administrator, Corporate Nurse Consultant, n.		: :			:
		15, the facility staff failed lers for the administration of					
	female, was admitte with diagnoses that weakness, bi-polar disorder, gout, hype syndrome, anemia, gastroesophageal r anxiety disorder. A MDS, a Quarterly w resident was assess	e survey sample, a 63 year-old ed to the facility on 11/26/14 included generalized muscle disorder, major depressive ertension, chronic pain fibromyalgia, hyperlipidemia, eflux disease, asthma, and ccording to the most recent each of 4/19/17, the sed under Section C					
	with a Summary Sc) as being cognitively intact, ore of 14 out of 15. he following physician's order:					
	Cyanocobalamin 10 milliliter) vial. Give intramuscularly eve anemia.	000 mcg/1 ml (micrograms per 1 ml (1000 mcg) ry month on the 27th for					
		amin (Vitamin B 12) is water d to treat vitamin B 12					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		495336	B. WING			C 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	3 CENTER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 33 CROSSROADS LANE FISHERSVILLE, VA 22939	1 00/	00,20,1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 91	F 309			
	deficiency and pern	icious anemia. Ref. Mosby's Reference, 30th Edition, page				
	Resident # 15 told t	on tour at 1:00 p.m. on 5/2/17, he surveyor, "I didn't get my min) last month (March)."				
	March 2017 revealed not signed off as bedate of clinical reco	nt # 15's MAR for the month of ed the Cyanocobalamin was sing given. As of 5/8/17, the rd review, the March injection had not been administered.				
	p.m. on 5/8/17 with Director of Nursing, and the survey team					
	483.24(a)(2) ADL C DEPENDENT RES	ARE PROVIDED FOR IDENTS	F 312	F 312: ADL Care Provided For Dependent Residents		06/23/17
	activities of daily livi services to maintain personal and oral h This REQUIREMEN by: Based on staff inte clinical record revie ensure ADL (activiti	no is unable to carry out ng receives the necessary n good nutrition, grooming, and ygiene. IT is not met as evidenced rview, resident interview, and w, the facility staff failed es of daily living) was provided bendent residents. Resident's		 Residents 2, 11, 20 and 21 no loreside in the facility. Quality review of residents bath preferences were reviewed and updindicated. Nursing staff re-educated by the Director of Clinical Services (DCS) Designee to ensure bathing services consistently provided and document 	ning lated as	
	1. Resident #2 was bathing.	not provided ADL care for				
	2. Resident #21 was bathing and groomi	s not provided ADL care for ng.				

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	_			OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING	i	 _		C / 09/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A NURSING & REHA	3 CENTER			3 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	bathing. 4. Resident #20 was bathing. The findings include 1. Resident #2 was bathing. Resident #2 was ac 12/2/16 with, but no diagnoses: dementimajor depressive di obstructive pulmonamost recent Minimu. Assessment Refere was a significant chresident was assessiong-term memory i impaired in decision (ADL) for bathing the	s not provided ADL care for s not provided ADL care for e: not provided ADL care for dmitted to the facility on the following its with behaviors, anxiety,	F:	312	4. ED/DCS/Designee through I Clinical meeting process to ensu consistent bathing services are p and documented. Executive Dire to randomly interview resident f choices being honored. Finding reported to QAPI committee moupdated as indicated. Quality moschedule modified based on find	re rovided ector (ED) or bathing s to be nthly and onitoring	
	#2's shower sheets	kimately 10:30 a.m., Resident were reviewed; the he shower sheets were as					
	4/8/17 21:34 (9:34 p 4/19/17 22:34 (10:3 4/22/17 17:42 (5:42	4 p.m.) Partial					
		cimately 11:30 a.m., the unit a licensed practical nurse and	i ! !				

will be identified as LPN #5 was interviewed regarding the above documentation and the

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO</u>	<u> 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		PLE CONSTRUCTION		TE SURVEY
		495336	B. WING	i		0!	C 5/09/2017
NAME OF 8	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	83 CROSSROADS LANE		
AUGUSI	A NURSING & REHA	B CENTER		F	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 312	Continued From pa	ne 93	' 	312)		
1 012	residents ADL care have." When interviresident received the	LPN #5 stated, "This is all I sewed and asked if the street baths from admission on LPN #5 stated, "This is all that	F 3	712			
	2. Resident #21 wa bathing and groomi	s not provided ADL care for ng.	·				
	on 1/8/16 and readr limited to, the follow retention, vaginal fis quadriplegia related recent Minimum Da Assessment Refere was a quarterly ass assessed as being skills; able to make independent in deci (ADL) for bathing the being a 4/4 (Total as On 5/8/17 at approx report was reviewed being provided ADL cycle, bathing was re-	sion-making skills. Section G e resident was assessed as					
	administrative staff findings. The facility findings were not ave the employees were 5/8/17 at 3:20 p.m.	cimately 5:49 p.m., the was made aware of the above staff involved in the above vailable for interview. Two of e called multiple times on and again at 5:24 p.m., but to nder of the staff involved were					

no longer employed at the facility.

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION		ATE SURVEY OMPLETED
		495336	B. WING	i			C 5/09/2017
NAME OF F	PROVIDER OR SUPPLIER			ξ	STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
					83 CROSSROADS LANE		
AUGUST	A NURSING & REHAI	3 CENTER			FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 94	F	312	2		
	interview with Reside that she was not proposed facility staff during the approximately three soaked with urine. It she was finally clear assistant) "found with and between my let the During the interview Surveyor, "Can I can appointment I have telling you what hap this Surveyor agree a later time. On 5/9/17 at approximately approximat	kimately 12:45 p.m. during an dent #21, the resident stated ovided ADL care from the ner menstrual cycle for a days and that her bed was Resident #21 stated that when ned a CNA (certified nursing pes stuffed inside my vaginates saturated with blood." Resident #21 stated to this Il you back I have an to attend and I can finish opened when we talk again." The ded to continue the interview at discovered blood days. Resident #21 stated, "I dead and embarrassed when the ers back and discovered blood between my legs" Resident "When the CNA pulled the the look on her face was ent #21 stated, "It is enough to nege you because you can't do we someone leave you laying the grand repeat this in front of my shand, it was degrading. When yof someone else it is just happy to be out of there I					
		g to go back there (sic)."					

On 5/9/17 at approximately 9:20 a.m., the CNA

CENTE	13 FOR MEDICANE	A MEDICAID SERVICES			OIVID IVC). 0930-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495336	B. WING	<u>.</u>		C
NAME OF	DDOVIDED OD OUDDUIED	<u> </u>	D. Mitte			/09/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	JODE	
AUGUST	A NURSING & REHA	B CENTER		83 CROSSROADS LANE		
				FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE
F 312	Continued From pa	age 95	· F·	312		
	•	ve incident was called three	' '	312		
	times but no answer					i
	times but no answ	51.				
	On 5/9/17 the inve	stigation and witness				
		iewed to include the following:		•		
	Witness Statemen	t ·				
		y aides doing shower to				
		dy wipes noted, advised by				
		tween Residents legs at				
		ent advised they have been				
	there since 3-11 (s	econd shift). I wasn't changed				
		also states. "My gowns not	•			
		3 days." [ADON-assistant				
	director of nursing	named] made aware"	:			
	1/17/17 CNA-On T	uesday January 17th around				
	1300 (1:00 p.m.) [F	Resident named] was	:			
		ower. As I went to her room				
		I brought her to the shower				
		paring myself, getting all my				
		oticed something between her				İ
		or her brief, I asked her what				
		egs she told me "oh probably g on," So I put gloves on and				
		nower stall and spread her legs				
		wipe from just sitting between	İ			
		nenstrual blood on it. She was				
		on her period, and was a little				
		he had seen. As I start the				
		al care i pulled two or three				
	wipes folded togeth	ner from between her legs also,				
		st walked back from the trash				!
		ide walked in. I asked [Aide	1			
		unit manager so I can shoe	:			
	-	ed] was concerned so I try to	:			
		I informed her I got the unit	:			
	manager(sic)."			1		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495336	B. WING			1	C 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAL	B CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939	, 03/	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	wipes were left in b aide asked if I woul the wipes there to c	e incident where they said the etween her legs. The other d her (sp) her and she placed clean her. I'm not sure if they ot. Because I did see the girl	F3	312			
		kimately 1:34 p.m., the were made aware of the					
	3. Resident #11 did scheduled.	d not receive showers as					
	on 11/13/2015. Her not limited to: End encephalopathy, atr Wegener's Granulo	originally admitted to the facility or diagnoses included but were stage renal disease, rial fibrillation, hypertension, matosis with renal eral vascular disease and					
	a significant change (assessment refere Resident #11 was a with both long and s	DS (minimum data sheet) was a ssessment with an ARD nce date) of 05/05/2017. Issessed as having a problem short term memory and being with daily decision making					
	05/03/2017. Bath reto 05/03/2017 were According to the do Resident #11 receiv	was reviewed beginning on ecords from January 1, 2017 requested and received. cumentation obtained red one shower in January, e tub bath in February, no March or April. All					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NC	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY
							С
		495336	B. WING			0.5	5/09/2017
NAME OF F	ROVIDER OR SUPPLIER			\$1	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALIGUET	A NUIDONIO O DELLA	CENTER		83	3 CROSSROADS LANE		
AUGUS I	A NURSING & REHAI	SCENIER		FI	ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 97 were partials or bed baths.	F3	312			
	The Administrator whaths. She stated son 02/08/2017. She arrival, the facility unall baths and shower stated that she felt is agency personnel at team making each assistant) responsible baths and showers had been some corresponsible baths and showers had she did not know if observed on the based documentation is subbeen getting baths. facility had identified having showers/bate from Adult Protectivarea had been a for assurance committed current survey finding per the AOC date of the AOC date of the AOC date of the AOC date of the AOC date of the AOC date of the AOC don't knowersI don't knowersI don't knowers don't always are for it is hard to showers don't always	was interviewed regarding the she took over as administrator e stated that prior to her sed a shower team to provide ers to the residents. She that was not a good use of and she dissolved the shower CNA (certified nursing ole for their assigned residents. She stated that at first there of the shower of the shower of the shower of the shower of the shower of the shower of the shower of the shower of the showers of the problems with the showers of the residents had not she also stated that the diproblems with residents his completed per a report of the Services. She stated that the cus of the QA (quality she). However, based on the she were not corrected of 03/30/2017. If the survey CNAs were the survey CNAs were the survey CNAs were who asked not to be also stated their ow about everyone when we have 20 patients to get everything done and the					
	meeting with the DO	ion was discussed in a N and the administrator on p.m. The administrator nor					:

the DON could confirm that dependent residents

were receiving showers as scheduled.

CENTE	13 LOV MEDICAVE	& MILDICAID SERVICES				IND INC	. 0930-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING				C
		49000	D. WING			05	/09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAE	3 CENTER		83 C	EET ADDRESS, CITY, STATE, ZIP CODE ROSSROADS LANE HERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 98	F:	312			
	(licensed practical r conference room. S Residents have got smell them or see the do I ask the CNA to She was asked if the stated, "No more the tell you every reside over the weekend s everyone was bathe	on was obtained prior to the 05/09/2017.					
	4. Resident #20 dic scheduled.	d not receive showers as					
	facility on 12/21/201	nost recently readmitted to the 6. His diagnoses included to: Dementia, Hypertension, and dysphagia.					
	quarterly assessme reference date) of 0 assessed as having	OS (minimum data set) was a ant with an ARD (assessment i3/30/2017. Resident #20 was a cognitive summary score noderate impairment with his					
	due to being named	added to the survey sample I in an APS (adult protective t was converted to a complaint					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		495336	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER	49330	D. WING		REET ADDRESS, CITY, STATE, ZIP CODE	05/	09/2017
	TA NURSING & REHA	B CENTER		83	CROSSROADS LANE SHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	complainant allege were not groomed showers 2 times per The clinical record 05/04/2017. Bath in May were reviewed documentation, Reshower in March, to in May. All docume bed baths. The Administrator where bed baths. The Administrator where bed baths. The Administrator where bed baths and shower stated that she felt agency personnel at team making each assistant) responsible baths and showers had been some corbaths/showers had she did not know if observed on the bad documentation is subseen getting baths. facility had identified having showers/bath from Adult Protectivarea had been a for assurance committic current survey finding the AOC date of the showers had one the AOC date of the AOC da	nsure and certification. The d that residents in the facility adequately and provided with a week. was reviewed beginning on ecords for March, April and . According to the sident # 20 received one wo showers in April, and none nted baths were partials or was interviewed regarding the she took over as administrator e stated that prior to her sed a shower team to provide ers to the residents. She that was not a good use of and she dissolved the shower CNA (certified nursing tole for their assigned residents. She stated that at first there infusion and some of the been missed. She stated that the problems with the showers the records was a e or if the residents had not She also stated that the diproblems with residents hs completed per a report re Services. She stated that the cus of the QA (quality ee). However, based on the mass they were not corrected for 03/30/2017.	F3	12			
		of the survey CNAs were SNA who asked not to be					

OLIVILLI	TO FOR MEDIONICE	A MEDIONID CERVICEO				CIAIC LAC	<u>. 0330-033 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COV	E SURVEY IPLETED
		495336	B. WING				C /09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		83	REET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE SHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	showersI don't kn else'ssometimes	My residents get their ow about everyone when we have 20 patients to get everything done and the	F3	312			
	had been discussed and the administrator in	dents were receiving baths d in a meeting with the DON or on 05/03/2017 at 5:45 p.m. for the DON could confirm that is were receiving showers as					
	surveyor spoke with	pproximately 10:20 a.m., this n Resident #20 about his baths tated, "They wipe me off that's					
	(licensed practical r conference room. Residents have got smell them or see t do I ask the CNA to She was asked if th stated, "No more th tell you every reside	pproximately 1:00 p.m., LPN hurse) # 5 was in the She stated, "I don't know if ten their baths or notI don't heir hair looking greasyIf I take them to the shower." hat happened very often. She an at any other facilityI can ent here got a bath or shower to we could be certain ed."					
	No further informati exit conference on	on was obtained prior to the 05/09/2017.	:				
F 315 SS=G	This is a complaint 483.25(e)(1)-(3) NO RESTORE BLADD	CATHETER, PREVENT UTI,	F3	315	F315: No Catheter, Prevent UTI Bladder	, Restore	06/23/17
	(e) Incontinence.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETEO
		495336	B. WING			C / 09/2017
NAME OF	PROVIOER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CODE	! 05/	109/2017
AUGUST	TA NURSING & REHA	AB CENTER		83 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ULD BE	(X5) COMPLETION DATE
F 315	continent of bladder receives services a continence unless or becomes such to maintain. (2) For a resident won the resident's cracility must ensure (i) A resident who indwelling catheter resident's clinical cracineterization was (ii) A resident who indwelling catheter is assessed for reras possible unless demonstrates that and (iii) A resident who receives appropria prevent urinary traccontinence to the expension of the resident's continence to the expension of the resident who incontinent of bower treatment and service bowel function as particular interview, and staff	st ensure that resident who is er and bowel on admission and assistance to maintain his or her clinical condition is hat continence is not possible with urinary incontinence, based comprehensive assessment, the exthat- enters the facility without an is not catheterized unless the condition demonstrates that an or subsequently receives one moval of the catheter as soon the resident's clinical condition catheterization is necessary is incontinent of bladder the treatment and services to contine the total incontinence, based comprehensive assessment, the exthat a resident who is extracted to restore as much normal visions and to restore as the receives appropriate vices to restore as much normal.	F	1. Resident #4 re-admitted 4 with no s/s of UTI. Resident discharged on 01/27/17. Resident performs self care of supra-purcatheter per physician order. It able to demonstrate competer supra-pubic care. 2. A quality review of resident results to ensure physician no completed. Review of resident indwelling and supra-pubic care and supra-pubic care are is provided per physician competency checklist as indicated. Peri-care shallowed birector of Clinical Services designee regarding physician notification of lab results. Lienurses and C.N.As re-educat DCS/designee regarding provocatheter per physician order.	# 21 was dent #7 abic Resident cy of Int lab tiffication at with atheters to expect a cated. Interest to expect a comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparison of the comparisor of the comparisor of the comparisor of the comparisor of the comparisor of the comparison of the comparisor of the comparison of the comp	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495336	B. WING	;	05,	C / 09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TA NURSING & REHA	B CENTER		83 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	_ '	.D BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 102 # 4, 7 , and 21), to provide	F:	315 4. DCS/Designee to Quality		

sample (Residents # 4, **7**, and 21), to provide care and services to prevent and treat urinary tract infections, and to provide routine urinary catheter care.

- 1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.
- 2. For Resident # 21, the facility staff failed to provide routine catheter care resulting in the resident being hospitalized, which constituted harm.
- 3. Facility staff did not follow physician orders regarding the care of Resident #7's supra-pubic catheter. Facility staff were to provide catheter care every shift and clean around the catheter with dermal wound cleanser, paint betadine around catheter every day. During an interview with Resident #7 he stated that he was providing his own catheter care and had all the supplies in his bedside table.

The findings include:

1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.

monitoring residents who receive catheter care 5 x weekly x 2 weeks, 3 times weekly x 4 weeks, twice weekly x 4 weeks, weekly x 2 weeks, PRN and as indicated. DCS/Designee through Morning Clinical meeting process ensures physician is notified of laboratory results. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

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CENTE	13 FOR MEDICARE	A MEDICAID SERVICES				<u> </u>	<u>). 0936-039 (</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING			05	C 5/09/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				83 (CROSSROADS LANE		
AUGUST	A NURSING & REHAI	B CENTER			HERSVILLE, VA 22939		
				113	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 103	F3	15			
	Resident # 4 in the	survey sample, a 66 year-old					:
		ed to the facility on 4/7/15, and					
		mitted on 4/14/17 with					
	_	uded obstructive sleep apnea,	İ				
	_	cidosis, hypertension, restless					
		etes mellitus, asthma,					
		ilure, bi-polar disorder, anxiety,					
		d obesity, acute respiratory					
		al failure, seizure disorder,					1
	anemia, seizure dis						İ
	•	reflux disease, chronic	i !				
		ary disease, and respiratory	 				
		to the most recent Minimum	i i !				:
		Significant Change, with an	!				:
		ence Date (ARD) of 4/21/17,					•
		sessed under Section C					
	•) as being cognitively intact,					•
	with a Summary Sc						
		ladder and Bowel), the					
		sed as occasionally					
	incontinent of bowe	l and bladder.					
	Review of the Interd	disciplinary Progress (Nurses)					
	Notes revealed the	following entry:					
	3/13/17 - 3:00 n m	"Told this nurse she thought					l
		nary Tract Infection) d/t (due					
		nationMD notified."	i				
	to, burning with the	ICHOTAIVID HOUNGU.	! :				
	On 3/13/17 a talani	hone order from the					:
		nt was received for the					<u> </u>
	following:	W WAS LECEIVED TO THE	:				!
	ronowing.		 -				
	"IA (Hringhaia) EC	S Duridium 200 m ~	!				
		OS, Pyridium 200 mg	:				
		mouth) tid (three times a day)					
	x (times) 2 days."						,
							. 1

NOTE: Pyridium is an over the counter

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY
		405220					С
		495336	B. WING			05/	/09/2017
	PROVIDER OR SUPPLIER	B CENTER		83 C	EET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE HERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	by irritation of the uburning, and the feurgently or frequent Further review of the (Nurses) Notes revealed the following waken. Once awakeye contact, no faci breathing deep, ski (saturation) 89, BS signs) 103 - 136 (problem of the following waken. Once awakeye contact, no faci breathing deep, ski (saturation) 89, BS signs) 103 - 136 (problem of the following waken. Once awakeye contact, no faci breathing deep, ski (saturation) 89, BS signs) 103 - 136 (problem of the following washed to send to be signed to send to be sident to be admitted	"relieve symptoms caused rinary tract such as pain, eling of needing to urinate tly." Ref. www.WebMD.com. The Interdisciplinary Progress ealed the following entries: This nurse went in to resident resident asleep hard to resident asleep hard to resident non-verbal, made ial grimacing. Resident resident nosweaty. O2 (Oxygen) sat (Blood Sugar) 269, VS (vital ulse), 32 (respirations), 134/58 on call (MD) called was ED (Emergency Department). It was taken to ED at 5:30 and earty) notified." "Called AH ER (hospital for condition update. The initted to ICU (Intensive Care of machine."	F	315			
	admitted to ICU. Some pressure requiring requiring pressure requiring requiring requiring requiring requiring requiring requiri	nary tract infection and was he dropped her blood pressors (a medication used to e). The patient was found to					

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CENTLI	AS FUR WIEDICARL	A MEDICAID SERVICES				OINID INC	<u>J. 0936-039 I</u>
	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		495336	B. WING	;_		0;	C 5/09/2017
NAME OF F	PROVIDER OR SUPPLIER			[:	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	TA NURSING & REHA	POENTED	ļ	1	83 CROSSROADS LANE		
A0000.	. А NURSING & NEIDA	D CENTER		<u>ا_</u> ا	FISHERSVILLE, VA 22939		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315	Continued From pa	age 105	F:	315	5		
	·	od cultures positive for strep	i i		•		
	mitis (streptococcus	is mitis)She also grew E-coli urine, penicillin sensitive"					
	Resident # 4 was d	lischarged back to the facility					
		gnoses that included septic	!				
		urinary tract infection.					
	4 thorough review	of Resident # 4's clinical record					
		results of the UA ordered on	1				
	3/13/17. At approx	timately 1:00 p.m. on 5/8/17, at	:				į
		surveyor, LPN # 2 (Licensed	: •				
		as able to obtain a copy of the from the laboratory that	•				
		e sample. According to the UA					<u> </u>
	report, dated 3/14/1	17, the results indicated					
	Resident # 4 had a	UTI. Asked if the resident's					
		was notified of the UA results,					
	LPN # 2 said, "He v	Nas not notined.					
		asked about EOS. LPN#2			• •		
		is a protocol and stands for					
		ation Order Set for suspected					
		a blank copy of the EOS £2, the protocol included the					
	following:	2, the protocormorado and					
	-	·					
		ns (BP, pulse, resp rate, temp,	1				
	pulse ox) every 6 he 2) Record fluid intal	ke each shift for 3 days.	i				
		irector or provider on call if					
	fluid intake is less the	han 1600 ml per day.	1				
		al director or on-call provider if					
	condition worsens on next morning.	or if no improvement by the	!				· :
		lical director or on-call provider	1				
		the resident's condition daily."					
		•	i .				

Asked if the EOS protocol was initiated for

CENTER	(S FUR MEDICARE	& MEDICAID SERVICES				<u> NAIR IAO.</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	СОМ	E SURVEY IPLETED
		495336	B. WING				C 09/2017
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
AHGHET	A NURSING & REHAE	CENTER		83 (CROSSROADS LANE		
AUGUST	A NURSING & REHAD	CENTER		FIS	HERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI, TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
······································	Continued From particle Resident # 4, LPN # At approximately 2: interview was conducted recent hospitalization Nurse) for 27 years you I'm having trouble The resident went of had a UTI for four of and pressure when PA) ordered Pyridiu pressure, but it did not be unit Manage # 4 went on to say the total thing I know I was in and put on IV (intravent on to say, "When said," We thought we continuing, Resider time this (a UTI) has time I ended up in the should know by now	ge 106	F 3	15		THATE	
	The findings were dp.m. on 5/8/17 with	just now, but always." liscussed at a meeting at 3:00 the Interim Administrator, Corporate Nurse Consultant, 1.					:

CENTE	49 FOR MEDICARE	A MEDICAID SERVICES				MR MO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILE		E CONSTRUCTION	COM	TE SURVEY MPLETEO
		495336	B. WING			1	C / 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAL	3 CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939	-	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 107	F	315	1		
	monthly as ordered	atheter was not changed ; the resident developed a inary tract infection resulting in					
	on 1/8/16 and readr limited to, the follow retention, vaginal fis quadriplegia related recent Minimum Da Assessment Refere	originally admitted to the facility mitted on 1/9/17 with, but not ving diagnoses: urine stula, unspecified ileus and It to a C5-C6 injury. The most ata Set (MDS) with an ence Date (ARD) of 1/14/17 essment. The resident was					
	assessed as being skills; able to make independent in deci						
		kimately 11:30 a.m., Resident I was reviewed to include the					
	an order was written follows: Treatments	Sheet (POS) dated 12/31/16 on on the POS on 10/10/16 as 10/10/16 Change 14F every month on the 1st of needed"					
	reviewed to include catheter (Foley) mo November and Dec	ninistration Records were the following: "Change nthly" Upon review of the ember TARs, the Foley was ng last changed on 11/30/16.					
	10/20/16 was review "Focus: The resider	on 4/13/16 and updated on wed to include the following: nt has altered bladder elling catheterInterventions:					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NC	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING	i		05	C 5/ 09/2017
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
****		. OF UTER		8	83 CROSSROADS LANE		
AUGUST	A NURSING & REHA	SCENIER		F	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 108	F3	315			
		ed and prn (as needed)."					:
	A hospital Discharg reviewed to include	ge Summary dated 1/9/1 7 was the following:					
	urinary tract infectionresident of a local presented with naus infection. She report been changed for such as consistent with UTI Hospital Course: Our removed and replace started on Rocephia and she rapidly imp	ses: 1. Catheter -associated on9. Chronic FoleyHistory: I nursing care facility who sea, vomiting, and urinary tract ted that her catheter has not ome time. Urinalysis was and she was admitted. In admission, Foley was seed. She was empirically in. Her leukocytosis resolved rovedThe plan is to h ongoing antibiotics to finish.					
	Has chronic Foley v	Plan: Problems: (1) rinary tract infection) A&P: which had not been changed ed in ED (emergency					
	administrative staff findings. The facility findings were not at the employees were 5/8/17 at 3:20 p.m. no avail. The remain no longer employed During the course of through 5/9/17, no of	cimately 1:34 p.m., the was made aware of the above vistaff involved in the above viallable for interview. Two of excalled multiple times on and again at 5:24 p.m., but to nder of the staff involved were at the facility. If the survey from 5/2/17 other information was provided catheter being changed as					

ordered.

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<u> </u>	TO TOT MEDIO, ITE	A MILDIOAID OLIVIOLO				1110	. 0330- 033 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CO	TE SURVEY MPLETED
		495336	B. WING			l .	C / 09/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	, ,,	
AUGUST	A NURSING & REHA	3 CENTER			3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 315	Continued From pa	ge 109	f; F;	315	I		
	regarding the care catheter. Facility st care every shift and with dermal wound around catheter ever with Resident #7 he his own catheter cathis bedside table. Resident #7 was according to the control of the catheter to t	not follow physician orders of Resident #7's supra-pubic aff were to provide catheter I clean around the catheter cleanser, paint betadine ery day. During an interview e stated that he was providing re and had all the supplies in dmitted to the facility on agnoses included, but were plegia (incomplete), MRSA to staphylococcus aureus), a bladder, chronic pain, urinary a history of DVT (deep vein filter.					
	quarterly assessment reference date) of Cassessed as being cognitive summary On 05/02/2017 at a Resident #7 was interested.	pproximately 3:00 p.m., terviewed regarding his care at					
	Resident #7 was as catheter care. He shave all the supplie The clinical record orders were observed order sheet) dated to	ourse of the discussion, sked about his suprapubic stated, "I do that myselfI s here in my drawer." was reviewed. The following ed on the POS (physician 05/01/2017 through eter care every shift" and					

"...Cleanse area around catheter with dermal

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
		495336	B. WING				C 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAE	B CENTER		83	REET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE SHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	every day." At approximately, 3: practical nurse) #2 vasked if Resident # catheter care. She #2 was told that Reshis bedside table for that he was doing it administration record the entries for the were wither circled a #2 was asked what stated, "It looks like no entries on the bathe care had not be order was needed frown care and to have bedside table. She staked in the care had not be order was needed frown care and to have bedside table. She staked in the care had not be order was needed frown care and to have bedside table.	aint betadine around catheter 3:30 p.m., LPN (licensed was interviewed. She was 47 was providing his own stated, "No, we do that." LPN sident #7 had his supplies in or catheter care and had stated thimself. The TAR (Treatment rd) was reviewed for April. All e catheter care and cleaning as not done or left blank. LPN the entries meant. She e it wasn't done." There were ack of the TAR explaining why sen done. She was asked if an for Residents to provide their ve items needed at their stated, "Yes, and he should be nine if he can do it properly."	F3	115			
	meeting with the ad (director of nursing) No further information exit conference on (ion was obtained prior to the 05/09/2017.					26/22/17
	483.25(d)(1)(2)(n)(1 HAZARDS/SUPERV	1)-(3) FREE OF ACCIDENT VISION/DEVICES	F3	323	F323: Free of Accidents and Hazar	ds	06/23/17
((d) Accidents. The facility must en	sure that -			1. Resident #20 has been placed or restorative dining for cuing during meals. No straw order remains in pl	lace.	
		vironment remains as free rds as is possible; and			Physician order remains in place for checking oral cavity for residual after the checking oral cavity for resi		
	(2) Each resident re	eceives adequate supervision	i i		meals/medications.		:

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY
		495336	B. WING			05/0) 19/2017
NAME OF F	PROVIDER OR SUPPLIER	,		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A NURSING & REHA	B CENTER			3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	(n) - Bed Rails. The appropriate alternatived rail. If a bed or must ensure correct maintenance of bed to the following eler (1) Assess the residence from bed rails prior (2) Review the risks the resident or resident or resident or resident or resident or resident or resident formed consent perior (3) Ensure that the appropriate for the This REQUIREMENT by: Based on observative and in the resident or review and in the resident or the residen	ices to prevent accidents. e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and drails, including but not limited ments. dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain	F3	323	2. Quality Reviews of residents recueing during meal service and restruse of straws. Follow up based on fig. Licensed nurses and C.N.A's reeducated by the Director of Clinical Services (DCS)/designee regarding following resident's dietary restricting during meal service per physician of Licensed nurses and C.N.A's reeduced by the Director of Clinical Services (DCS)/designee regarding providing residents' assistance with meals per care. 4. DCS/designee to conduct quality reviews during meal services for following resident's dietary restrictions per physician orders 2 times weekly x 4 weeks, weekly x 4 weeks, 2 x month PRN and as indicated. DCS/designer conduct quality review 5 times per the 2 weeks then weekly X 2 weeks the	ons rder. cated g plan of lowing thly, ee to week X	
		ne to one assistance for by			weekly X 4 weeks then monthly and	1	

Resident #20.

mouth intake and restrictions regarding the use of

straws were in place for one of 25 residents,

Resident #20 was not assisted with food and

drink as ordered by the physician. Orders on the physician order sheet were: "...continues to

require 1:1 assistance for by mouth intake- do not feed patient unless patient is alert-check oral cavity for residue at end of meals/meds." An additional order, "No straws" was also on the physician order sheet. Resident #20 was observed on 05/04/2017 and 05/08/2017 in his room with cups of fluid on his bedside table and a straw in his large water cup. On 05/08/2017,

findings.

during meal services to ensure residents are

Findings to be reported to QAPI committee monthly and updated as indicated. Quality

monitoring schedule modified based on

provided assistance per plan of care..

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE	SURVEY PLETED
		495336	B. WING				09/ 2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 83 CROSSROADS LANE FISHERSVILLE, VA 22939	DE	00/1	JUI 20 11
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	IX5) COMPLETION DATE
F 323	butter and jelly sand of milk with a straw present. On 05/08/observed in the din were no staff provide Findings were: Resident #20 was refacility on 12/21/20 but were not limited acute kidney injury. The most recent MI quarterly assessment reference date) of assessed as having of "09", indicating recognitive status. On 05/04/2017 the Observed on the Podated 04/01/2017 the following orders: "Following orders	also observed eating a peanut dwich, a banana, and a carton in his room without staff (2017, Resident #20 was ing room with his tray. There ding assistance to him. most recently readmitted to the 16. His diagnoses included to: Dementia, Hypertension,	F3	323			
	stuffed inside, an er and a large covered Resident #20 was a belonged to him. H my coffee, that one	mpty cup used for med pass, d water cup with a straw. asked if the items on the table e stated, "Yes, I just finished (pointing to the med pass nurse gave me to drink and				:	

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES			C	<u>MB NO</u>	<u>). 0938-0391 </u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		495336	B. WING	i	10 - 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		C 5/09/2017
NAME OF I	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALIGUET	EA MUDOINO O DELLA	O CENTED		8	3 CROSSROADS LANE		
AUGUSI	TA NURSING & REHAI	5 CENTER		F	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	Continued From pa	ige 113	FS	323	'		:
	and inquired about She stated, "I gave scheduled, he alwa asked why the cup stated, "I watched?" On 05/08/2017, at a observed sitting in bedside table was a liquid, an opened be covered water cup was asked if the ite stated, "Yes." Residuals hungry and wo The unit manager, station. This survey	Licensed practical nurse) #7 the med pass cup in his room. that to him when it was ays drinks it all." She was was still in his room. She him drink it." 10:15 a.m., Resident #20 was his room. Beside him on the a cup of coffee containing ottle of Coca-Cola, and a large with a straw. Resident #20 ams on the table were his. He dent #20 also stated that he					
	At 10:25 a.m., LPN butter and jelly sand of milk to Resident him and placed a si	#1 took a half of a peanut dwich, a banana, and a carton #20. She opened the milk for traw in the carton. She asked ny further assistance and left					
	the sandwich, and of straw. There was rin the vicinity outside went back to the nuthe chart. The order meals and the direct have a straw had no	ident #20 was observed eating drinking his milk with the no one in the room with him or le of his room. This surveyor urse's station and re-reviewed ers for 1:1 assistance with ction for the resident to not ot been discontinued. LPN #1 station. She was asked if the					

orders were still in effect. She looked at the

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES						<u>Q</u>	<u>MB NC</u>	<u>). 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRU				CO	TE SURVEY MPLETED
		495336	B. WING							C 5/ 09/2017
NAME OF F	PROVIDER OR SUPPLIER				STREET ADD	RESS, CITY	, STATE, Z	P CODE	<u>, </u>	
					83 CROSSR	OADS LAN	E			
AUGUST	A NURSING & REHAR	3 CENTER			FISHERSV	ILLE, VA	22939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EA	CH CORRE	CTIVE ACT	CORRECTIOI ION SHOULD THE APPROPI Y)) BE	(X5) COMPLETION DATE
F 323	Continued From pa	ane 114	F3	305	3					
1 020	•	"I will go back down there.")	5					
		if she had been aware of the								
	observed in the res	noon, Resident #20 was storative dining room. He was								
	One CNA (certified	able with his back to the door. nursing assistant) was in the e was at the opposite end of								
		pack to Resident #20, and was								
		sident's hair. Resident #20	:							
	was feeding himsel	If lunch and he had a straw.								
		d at the nurse's station where ed. She was asked if Resident								
		itive dining. She stated she								
		ported back to this surveyor								
		d just liked to eat in there.								
		5/08/2017 the speech								
		worked with Resident #20 was								
	interviewed. She st	tated, "I made the bout him receiving assistance								:
		to have strawswe think he	:							:
	is having TIAs (tran	nsient ischemic attacks-mini	:							
	strokes)we can't d	to the testing for that to be								
		as a pacemakerhis								!
		of that fluctuates from day to a bad day then he needs the	i.							
		like today he is okay to eat								
		he was asked about the								
	· · · · · · · · · · · · · · · · · · ·	l, "There is a risk of aspiration								
		es a strawthe fluids have a								
		n the wrong way." She was ependant on his alertness.								
		e should never have a straw."								
	A meeting was held	d with the DON (director of								

nursing), the administrator, and the regional

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		SURVEY PLETED
		495336	B. WING		05/0) 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHAL	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	12:45 p.m., and the discussed. On 05/08/2017 at a #5 brought a clarific The new order was eval/tx [evaluation/t over 2 wks [weeks] SLP (speech languation pt receives mech [miliquids, NO STRAW diet." LPN #5 was a #20 could eat witho "No."	ge 115 a 05/08/2017 at approximately following information was approximately 3:30 p.m., LPN eation order to this surveyor. "Pt to receive skilled ST reatment] 5 times/treatments for oropharyngeal dysphagia. age pathologist) recommends nechanical] soft solids, thin (S, as safest, least-restrictive asked if that meant Resident ut 1:1 assistance. She stated, on was received prior to the	F 323			
	exit conference on the conference on the conference on the conference on the conference of the confere	deficiency. OF MEDICATION ERROR MORE s. The facility must ensure rates are not 5 percent or NT is not met as evidenced on administration observation, ty document review and w, facility staff failed to ensure	F 332	F332: Free of Medication Error Ra 5% Or More 1. LPN #3 no longer works at the facility. Resident #12 has physician clarification order for multivitamin minerals on 05/03/17. Resident recomultivitamin with minerals per manufacturer's recommendations. In not crush medications are administed without crushing. Resident #12 recommedications within acceptable wind	n and eives Do ered eives	06/23/17

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	<u> 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495336	B. WING			C 09/2017
NAME OF R	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT		
ALICHET	'A NURSING & REHAI	CENTED		83 CROSSROADS LANE		
AUGUST	A NURSING & REHAI	BCENTER		FISHERSVILLE, VA 2293	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 332	(delayed release) a release) with her m medications were or recommendation. Resident #12 receive physician order and 8:00 a.m. medication and 25 minutes pass receiving these medication administ practical nurse). Limedication administ practical nurse). Limedications for Resident grace into the medication out of the hopicked up the aspiriplaced into the medications, opened the poured into the crusto receive Omeprazions obtained against markesident #12 was estated, "She is still going to interrupt he the prepared meds	o receive Omeprazole DR nd Oxybutin ER (extended edications. Both of these trushed against manufacturer wed the wrong Multivitamin per Resident #12 received her ons at 10:25 a.m., one hour st the acceptable window of dications. D a.m. this surveyor observed tration with LPN #3 (licensed PN #3 prepared all sident #12 outside of Resident ghed and stated, "I'm a little #3 proceeded to drop an ouse stock bottle onto the cart, in with her bare hands and dication cup. LPN #3 then es from the pills with her bare capsules bare handed and shed meds. Resident #12 was cole DR (delayed release) and ided release) with her of these medications were anufacturer recommendation. Pating breakfast. LPN #3 eating her breakfast. I'm not the remeal." LPN #3 wasted all of for Resident #12.		Consultant Nurse/desg infection control practi preparation of medicat Consultant Pharmacy National Cons	inee for following ices during ion completed. Nurse / Designee to ills competencies/ ed. Follow up based on administration sician order to administered per table time frame per e-educated by the rvices (DCS) / llowing infection g preparation of nurses re-educated g medication per thin acceptable time and in accordance edication f Do not crush	
		#3 prepared the medications pain, crushed all meds and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		495336	B. WING				C 09/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A NURSING & REHAL	3 CENTER			CROSSROADS LANE HERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 332	Continued From pa	-	F3		. DCS/Designee to conduct randuality monitoring of Licensed N		
	•	ith her bare hands and resident. Resident #12 had a		•	egarding following infection cont		
		Thera-M 9mg-400mcg one			ractices during preparation of	.01	
		N #3 stated, "I do not see this			nedication(s) twice weekly x 4 w	eeks	
	in the house stock.	I will have to ask and see			reekly times 4 weeks then month		
		n using." At 10:25 a.m., LPN			nd as indicated. DCS/Designee	-	
	#3 administered a "				onduct random quality monitorin		
		pplement" to Resident #12.				_	
		the unit director this is what			icensed Nurses regarding admini		
	they use for her The	era-Ivi.			f medications within acceptable t		
	Minerals - Dietary S following: "Vit. A 50 400 IU, Thiamine 2 20 mg, Vit. B6 1 mg Acid 1 mg, Calcium Phosphorus 11.6 m Magnesium 10 mg, mcg, Manganese 1 There is no dosage anything on the labe	Zinc 3.75 mg, Selenium 5 mg and Chromium 5 mcg." equivalent to 9mg-400mcg of el.		w P re u	rame per regulation twice weekly veeks, weekly times 4 weeks then RN and as indicated. Findings to eported to QAPI committee mont pdated as indicated. Quality mochedule modified based on finding	monthly, be hly and nitoring	
	LPN #3 popped a C and Gabapentin fro bare hands and pla LPN #3 dropped a E picked up with her b med cup. While ge house stock bottle, into the lid, placed t	edications for Resident #13. cogentin, Metoprolol, Geodon m the bubble cards into her ced into the medication cup. Buspar onto the med cart, pare hand and placed into the ting Tylenol tablets from the LPN #3 poured several tablets wo into the med cup and ck into the house stock bottlends.					

The Administrator and DON (director of nursing) were informed of the above observation during a meeting with the survey team on 05/03/17 at 5:45

p.m. Facility policy for "Medications-Oral

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495336	B. WING		C 05/09/2017
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	00/00/201
		_	{	33 CROSSROADS LANE	
AUGUST.	A NURSING & REHA	B CENTER	I	FISHERSVILLE, VA 22939	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 332	Continued From paradministration Of I Policy: It is the policy safe and accurate a medication. Proceed powders, capsules medications should scored or if they are sustained release of the sustained	Effective Date: 11/30/2014. icy that the resident can expect administration of oral dure:Refrain from touching or pills with handsMost d not be crushed if they are not e enteric coated, or if they are or long-actingWash hands" cion was received by the survey kit conference on 05/09/17. DENTS FREE OF DERRORS on Errors. Insure that its- e free of any significant NT is not met as evidenced erview, clinical record review of a complaint investigation, or ensure one of 25 residents ficant medication error resulting	F 333	F333: Resident Free of Significant Medication Errors 1. Agency Licensed Nurses completed the Agency Orientation Checklist. Medication error report completed for resident #10 per policy. LPN #2 (facility nurse) no longer works in the facility. LPN #3 (agency nurse) no longer works in the facility. Resident #10	06/23/17
	Findings included:		: : :	duties.	
		originally admitted to the facility readmitted on 04/03/2017 with	: : :		

CLITTE	TO LOT MEDIONITE	O WILDIOAID OLIVVIOLO				INIO INO.	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
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	_	495336	B. WING			05/	09/2017
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A NURSING & REHA	B CENTER		l	3 CROSSROADS LANE		
A00001	A NOROMO & REMA			F	ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	Continued From padiagnoses including Paraplegia, Aspirat (Chronic Obstructiv Depression, Anxiet Neurogenic Bladde Tract Infection). The most recent M quarterly assessmereference date) of Cassessed as mode status with a total continuous experience of the status with a total continu	ige 119 g, but not limited to: ion Pneumonitis, COPD re Pulmonary Disease), y, Diabetes, Hypertension, r, and Chronic UTI (Urinary DS (minimum data set) was a rent with an ARD (assessment 04/10/2017. Resident #10 was rately impaired in her cognitive ognitive score of 10 out of 15. ical record was reviewed on p.m. and again on 05/03/2017 ded in Resident #10's most cian order sheet) dated 6/30/17 was an order dated d: "Morphine Sulfate ER 60 blet ER (extended release) re 1 (one) Tab by Mouth Every re and an order dated 04/04/17 phine Sulfate 15 MG Tablet te Take 1 (one) Tab by Mouth s As Needed for Pain" y Progress Note" dated "4-6-17 d the following: "On Sunday om (Name) RN, (registered			Potential agency placements were scheduled for orientation upon recetheir credentials by the facility Hur Resources Coordinator (HRC). No personnel assumed nursing duties a Agency Orientation Checklist had a completed and received by the HRC Notification occurred to all contract agencies of this process on 05/04/1 The Executive Director/designee were view agency files weekly times 4 weeks, then monthly and report to QAPI committee to ensure complia with the plan. 2. Review of residents receiving personagement completed by DCS/deto ensure mediations available and administered per physician order. 3. Licensed nurses re-educated by Director of Clinical Services (DCS) designee regarding administration of controlled pain medications per phy order. Licensed nurses re-educated DCS/designee regarding process for ordering and re-ordering controlled pain medications from pharmacy.	ript of man agency antil the been C. ted 7. fill the ance ain signee the by sician by the r	DATE
	#10 falling asleep reher oxygen level wa and her oxygen car being toileted she refer that around 3 because she had trephone and she did	noved from Unit 4, at aprox around 1pm, (Name) Resident eading newspaper. I checked as 88% her O2 was placed on me up to normal levels, after equested to go to bed. A little pm her daughter called ied to call her on her cell not answer. I reported the to her daughter, she stated			Licensed nurses re-educated by the designee regarding eKit and conten		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495336	B. WING		05/0	09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 333	little bit.' About an spoke with me. I re obtained. I reporter respirations low, an appeared the same had a UTI (urinary to grimacing and she checked. I read he (urinalysis) C&S (cu was negative for nit transport and they it availability until 9:30 called (Name) and at aprox 6:50 pm. (daughter had told nright since she had went to check the Madministration sheet error. I also asked respiratory assessing.m.) the crew was (unintelligible word) ambulance service. (7:30-7:45 p.m.) the (Name) Resident # supervisor, (Name) room) aware of all the supervisor. (Name) room) aware of all the supervisor. (Taylor) assess lumination assess luminati	und right so I will see you in a nour later she arrived and she had her the vital signs which I d her temp was elevated and d we both agreed that she way she had the last time she ract infection), including facial should be sent out to be the last lab result for U/A alture and sensitivity) and it rates. I spoke with (Name) informed me they had no 0 p-10 pm. At that time I obtained claim # for transport (Name) Resident #10's ine that her 'mother had not felt taken that extra pain pill.'	F3	4. DCS/Unit Managers/designee to conduct random quality review of re receiving controlled pain medication ensure mediations available and administered per physician order 3 tweekly x 2 weeks, 2 times weekly x weeks, weekly x 4 weeks, then mon and PRN and as indicated. Findings reported to QAPI committee monthl updated as indicated. Quality monito schedule modified based on findings	sidents n(s) to imes 2 thly to be y and oring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495336	B. WING_		0	C 5/09/2017		
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 83 CROSSROADS LANE FISHERSVILLE, VA 22939		0,0312017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 333	Continued From pa	ge 121	F 3:	33				
	ER at (Name) hosp	ront hall to admit resident to bital for further evaluation d/t bry and the medication given tory issues."						
	dated 4/2/17, seen p.m.). "Chief Cor History of Present I (Name) nursing hot overdose. Patient I (milligrams) long-act 11AM today. She to throughout the day ED for evaluation. and history and at the painDifferential D physical exam a differential Considered, but was overdoseED Cou 76-year old female facility with concern overdose. She is shest, grimaces to she Diagnosis: Sepsis; Pneumonia, urinary encephalopathy; Co	iagnosis: After history and ferential diagnosis was so not limited to narcotic rse/Procedures: Patient is a who presents from nursing a for accidental narcotic omnolent on arrival and, at ternal rub Primary Secondary Diagnosis: varact infection, acute						
	"HPI:presented	ted 04/03/17 0312 (3:12 a.m.) to the ED from her nursing s found to be progressively						
	usual state of healt she inadvertently re	appears to have been in her huntil earlier in the day when eceived twice the dose of her her which she takes for her						

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) OATE SURVEY COMPLETED		
		495336	B. WING				C / 09/2017	
	PROVIDER OR SUPPLIER	B CENTER		83 (EET ADDRESS, CITY, STATE, ZIP CODE CROSSROADS LANE HERSVILLE, VA 22939		100/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 333	at 9 AM and a seconeeded dose of her at 11 AM. She was increasingly somnow so was sent to the roomAssessment patient presented with 17,000 in the setting what appears to be meeting criteria for suspect that her so have clinical suspice aspirated following overdose resulting (2) Aspiration pneurous apparent right lower in the setting of her represents a chemical to the	pears that she received 60 mg and dose of 60 in lieu of a as a immediate release morphine at then noted to become alent and less responsive and emergency and Plan: (1) Sepsis: The with fever and leukocytosis of g of some mild hypoxia and a right lower lobe infiltrate sepsis. At this time I still urce is pulmonary and further and inadvertent morphine in an aspiration pneumonitis monitis: The patient has a r lobe airspace disease which is presentation I believe it cal aspiration pneumonitis opathy: The patient was angly somnolent at the nursing on evaluation she is awake, as and so I believe that her thy was due to an inadvertent which is now resolved"	F3	:33				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	- -	495336	B. WING			05/	09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA			83 CROSSROAD FISHERSVILLE			_
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F 333	AM included, "Med Morphine 15mg por errorPRN Order tablet insteadOu provided: Resider respiratory/alertner admitted for sepsis Reason for Error: that administered was morphine.	r Report" dated 4/2/17 1105 lication as ordered: prn o (orally) Description of for Morphine 15mg; took 60mg tcome to resident and care at had a change to ss status. Sent to hospital and sType of Error: Wrong dose; Misread error" Signed by RN wrong medication and dose of	F	333			
	investigation regar investigation was reading a dose of her morph realized we sent he included in the inverse Drug Reading and discrepancy; Effect Medication discrepaddinister, b) Administered wrom Administered to with through wrong rou Medication. Adverse Drug Reading and discrepancy; Effect Medication discr	was asked for a copy of any ding the above incident. The eccived by this surveyor. The ed, "She was given the wrong ine and when the error was er to the emergency room." estigation was the policy, actions & Medication ctive Date: 11/30/2014; Policy: pancies and adverse drug mented and reported. pancy refers to: a) Failure to pancy refers to: a) Failure to pancy refers to: a) Failure to pancy resident, e) Administered at the wrong time, c) ag amount of medication, d) rong resident, e) Administered the wrong reservation refers to an rable effect that occurs as a medication"					
	states concerning "Standards are tho nursing practice.	Nursing 6th Edition on page 841 medication administration, use actions that ensure safe To ensure safe medication purse should be aware of a	; ; ;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
ı		495336	B. WING		C 05/09/2017	
NAME OF PROVID				STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939	1 00,00	<i>5/2011</i>
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X5) COMPLETION DATE
nursi medi can badhe admi admi medi 4. Tl docu No fu team This (1) P Fund 2005 F 360 483.6 SS=D EACI The finouri meet dieta prefe This by: Base clinic comphono order samp	cation administed linked, in so ring to the six nistration. The nistration 2. The ne right route is mentation." (1 arther informat prior to the exist a complaint otter, Patricia amentals of No. 60 PROVIDED H RESIDENT facility must propose shis or her dary needs, taking rences of eac REQUIREMENT al record revisional record rec	alled the six rights of stration. All medication errors ome way, to an inconsistency in rights of medication e six rights of medication de the following: 1. The right right dose 3. The right client 5. The right time 6. The right on was received by the survey kit conference on 05/09/17. deficiency. A. and Perry, Anne G. dursing. St. Louis: Mosby, DIET MEETS NEEDS OF Tovide each resident with a alle, well-balanced diet that aily nutritional and special ag into consideration the harmonic resident. NT is not met as evidenced interview, staff interview, ew and in the course of a ation, the facility staff failed to rences and follow dietary 5 residents in the survey		1. Resident #9 receives milk on tray Resident discharged on 05/31/17. Prodischarge resident received milk per dietary preferences from 05/03/17 ur the discharge. 2. Residents to be interviewed ensur preferences are being honored compount of the dietary communication for the to ensure resident preferences are being honored compount of the total preferences are being honored compount of the total preferences are being honored compount of the total preferences are being honored completed.	rior to ntil ring leted. rd	06/23/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			01	MB NO. 0938-0391
F 360 Continued From pawith a readmission MDS (m 2/22/17 assessed lintact. During an interview 1:45 p.m. he comminterview pertaining milk on his meal trasay "I asked the CI why I wasn't getting she told me I wasn always ask for two for snack at night, can't have it at lund resident I would se going on. The clinical record p.m. In the front se dietary communica 2/15/17 and include soft diet, thin liquid was dated 2/28/17 modification. Pt to solids, thin liquids. water." LPN (licensitting at the nurses relayed what Reside	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495336	B. WING			C 05/09/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	00,00,101,
AUGUST	TA NURSING & REHA	B CENTER		83 CROSSROADS LANE FISHERSVILLE, VA 22939		
PRÉFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPE	BE COMPLETION
F 360	with a readmission admission MDS (m 2/22/17 assessed F intact. During an interview 1:45 p.m. he comm	ge 125 date of 2/15/17. The inimum data set) dated Resident # 9 as cognitively with Resident # 9 5/2/17 at ented during the portion of the to food that he doesn't get	F3	Director of Clinical Service designee regarding ensuring provided per physician or Nurses re-educated by the regarding ensuring dietary form matches current phy Dietary staff re-educated by	ces (DCS) ng diets ar der. Licen e DCS/desi y communi sician orde	re nsed gnee ication ers.
	milk on his meal tra say "I asked the CN why I wasn't getting she told me I wasn' always ask for two for snack at night, a can't have it at lunc resident I would see	lys. Resident # 9 went on to IA (certified nursing assistant) a milk carton on my tray, and t supposed to have it. I fudge rounds and two milks and I get it, so I don't see why I h." This surveyor told the e if I could find out what was		regarding obtaining and en preferences are honored. I educated by the DCS regardiet preferences are honor on the diet slip. Facility seducated by the DCS regaresident requests/preferences. 4. Registered Dietitian/C manager/DCS/designee to	nsuring resolutions of the control o	sident's off re- oring lected oring
	The clinical record was reviewed 5/2/17 at 4:15 p.m. In the front section of the record there two dietary communication forms. One was dated 2/15/17 and included an order for "Mechanical soft diet, thin liquids, water only." The other form was dated 2/28/17 and directed "Diet modification. Pt to receive mechanical soft solids, thin liquids. Pt may have liquids other than water." LPN (licensed practical nurse) # 5 was sitting at the nurses' station, and this surveyor relayed what Resident # 9 had stated about milk. LPN # 9 stated she wasn't sure what was going on, but before she could speak further, the Registered Dietitian (RD) for the facility spoke up and stated "I think I can help you clear that up." The RD then reviewed the two forms and stated "He clearly can have milk if he wants it; let me go see what I can find out from the kitchen." A few minutes later, the RD returned to the nurses'			resident's diet ensuring pr being honored 3 times we times weekly x 2 weeks, v PRN and as indicated. Re Dietitian/Certified dietary designee review current d meals are being provided order 3 times weekly x 2 weekly x 2 weekly x 2 weeks, weekly and as indicated. Register Certified dietary manager, review resident's diet to e communication form and per physician order 3 time weeks, 2 times weekly x 2 weeks, PRN and as indi-	references ekly x 2 weekly x 2 registered manager/liets to ensure per physic weeks, 2 tily x 2 week red Dietitia/DCS/designsure dieta tray ticket es weekly 2 weeks, w	veeks, 2 weeks, DCS/ ure cian mes s, PRN an/ gnee ary match x 2

station and told this surveyor "This dietary

communication form got overlooked; it was still in

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED			
	495336	B. WING		C 05/09/2017			
PROVIDER OR SUPPLIER	<u></u>	s	TREET ADDRESS, CITY, STATE, ZIP CODE				
A NURSING & REHA	B CENTER	I					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLÉTION			
F 360 Continued From page 126 the box, but the new order never got instituted we have fixed that now and he will start getting milk on his meal trays."			F 360 Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule.				
The administrator, regional nurse cons above findings 5/9/facility staff beginni	DON (director of nursing), and sultant were informed of the 17 during a meeting with ng at 1:30 p.m.			į			
483.65(a)(1)(2) PR SPECIALIZED REF (a) Provision of serrehabilitative service physical therapy, spoccupational therapy rehabilitative service intellectual disability intensity as set forth in the resident's confacility must- (1) Provide the required services from a provider of special and is not excluded federal or state heat section 1128 and 17. This REQUIREMENT.	OVIDE/OBTAIN HAB SERVICES vices. If specialized les such as but not limited to beech-language pathology, by, respiratory therapy, and les for mental illness and ly or services of a lesser h at §483.120(c), are required mprehensive plan of care, the uired services; or vith §483.70(g), obtain the from an outside resource that is alized rehabilitative services I from participating in any alth care programs pursuant to 156 of the Act. NT is not met as evidenced	F 406	Rehab Services 1. Resident #21 no longer reside facility. 2. Review of residents discharge Speech Therapy previous 30 days ensure resident(s) received proper notification of discontinuation of services. Review of residents disc from Speech Therapy previous 30 to ensure services were appropriate	s in the d from to charged days tely and			
	PROVIDER OR SUPPLIER A NURSING & REHAI SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa the box, but the nev instituted we ha start getting milk or The administrator, I regional nurse cons above findings 5/9/ facility staff beginning No further informative exit conference. THIS IS A COMPLA 483.65(a)(1)(2) PRO SPECIALIZED REFI (a) Provision of service physical therapy, specupational therapy rehabilitative service intellectual disability intensity as set forth in the resident's confacility must- (1) Provide the required services from a provider of special and is not excluded federal or state head section 1128 and 17 This REQUIREMENT by:	A NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 126 the box, but the new order never got instituted we have fixed that now and he will start getting milk on his meal trays." The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m. No further information was provided prior to the exit conference. THIS IS A COMPLAINT DEFICIENCY. 483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced	A BUILDING 495336 B. WING ROVIDER OR SUPPLIER A NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 126 the box, but the new order never got instituted we have fixed that now and he will start getting milk on his meal trays." The administrator, DON (director of nursing), and regional nurse consultant were informed of the above findings 5/9/17 during a meeting with facility staff beginning at 1:30 p.m. No further information was provided prior to the exit conference. THIS IS A COMPLAINT DEFICIENCY. 483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by:	FORRECTION A STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 SUMMARY STATEMENT OF DEFICIENCYS SUMMARY STATEMENT OF DEFICIENCYS PROVIDER OR SUPPLIED (EACH ORDIFICE) DENTIFYING INFORMATION)			

CENTERS FOR MEDICARE & MEDICAID SERVICES							<u>DMB NO. 0938-0391</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY MPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	00,2017	
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F 406	ensure specialized one of 25 residents. Resident #21's Spewithout the resident therapy services we administrator. The findings include Resident #21 was con 1/8/16 and read limited to, the follow retention, vaginal fisquadriplegia related recent Minimum Datassessment Referewas a quarterly assassessed as being skills; able to make independent in decident without prior notice services were exhaut upon return to she was told that he longer be available asked the reason stherapy, Resident #	w, the facility staff failed to services were provided for , Resident #21. ech therapy was discontinued is knowledge and before ere exhausted by the facility's e: priginally admitted to the facility mitted on 1/9/17 with, but not ving diagnoses: urine etula, unspecified ileus and it to a C5-C6 injury. The most at a Set (MDS) with an ence Date (ARD) of 1/14/17 essment. The resident was a fifteen (15) for cognitive needs known and sion-making skills. Admately 12:35 p.m. during an ilent #21, the resident stated rvices were discontinued and before her therapy usted." Resident #21 stated the facility from the hospital er Speech therapy would no to her. When interviewed and he was receiving Speech 21 stated, "I was getting it for ce retraining because of the	F4	‡06	3. Therapy staff and Executive Director re-educated regarding protification of discontinuation of Speech Therapy services and enservices were appropriately and discontinued per resident's plan care. 4. Therapy Director/Designee to review and discuss with IDT teat through weekly Utilization Review Meeting residents receiving Spectory Services are delivered per resident plan of care and/or resident(s) received proper notification of discontinuation of services. The Director/Designee to conduct que monitoring weekly, PRN and as indicated to ensure residents received resident's plan of care along with proper notification of discontinuation of services. Executive Director (ED) to concrandom quality monitoring monitoring monitoring monitoring monitoring endition of discontinuation of services. Executive Director (ED) to concrandom quality monitoring monitoring monitoring endition of care and/or resident(s) received proper notification of discontinuation of services. Find the plan of care and/or resident(s) received proper notification of discontinuation of services. Find the plan of care and/or resident(s) received proper notification of discontinuation of services. Find the plan of care and/or resident(s) received proper notification of discontinuation of services. Find the plan of care and/or resident(s) received proper notification of discontinuation of services. Find the plan of care and/or resident(s) received proper notification of discontinuation of services.	suring safely of so mew each alized nt's rapy uality seive diper nthly dint's		
	Speech therapist w	kimately 12: 40 p.m., the tho will be identified as Other nterviewed regarding the			to be reported to QAPI committed monthly and updated as indicated	tee		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING			E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPE	BE	(X5) COMPLETION DATE
F 406	OS #4 stated, "I witherapy from the allegation of abus and asked the coreceiving Speech "I don't know I was on 5/8/17 at appropriate of Service: Justification / Coreceiving Speech Them was reviewed to in "Date of Service: Justification / Coreceiving Speech Them was reviewed to in "Date of Service: Justification / Coreceiving Skilled Services: necessary to provide the provided in the spinal abscess of medical status, supdate pt's personaddress pt's disonimprove pt's vocal efficiency, and extreduce pt's risk of pathologies. With tx, pt was at incresince ased weaknown, reduce heads wants and pathology, reduce occupational sett rehospitalization in the spinal pathology of t	page 128 scharged from Speech therapy. was told to discharge her from administrator due to the se of drugs. When interviewed briefation of the resident in and drug abuse, OS #4 stated, as just doing what I was told. Toximately 4:30 p.m., Resident iterapy (ST) Discharge Summary include the following: 11/9/16-1/14/17 Supervision/ mmunication: Justification for Skilled ST intervention was vide skilled evaluation and voice skills secondary to pt with e in vocal function following in C5-C6. Due to pt's complex killed ST services necessary to bracked POC (plan of care) to bracked vocal function in order to all function, pulmonary toilet expressive communication and of physical injury and vocal mout skilled ST intervention and bracked risk of pneumonia, bress, weight loss, skin breed benefit from therapeutic bracked benefit from therapeutic bracked benefit from therapeutic bracked ability to communicate bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal bracked participation in social and bracked symptoms, vocal	F	406			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495336	B. WING		١٥	C 5/ 09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP CO 83 CROSSROADS LANE FISHERSVILLE, VA 22939		<u>, 3120 17</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE	SHOULD BE	(X5) COMPLETION DATE
F 425	ST. OS #4 stated, 'for discharge but I's the administrator (s On 5/9/17 at approadministrative staff above findings. 483.45(a)(b)(1) PH	t was ready for discharge from "I did not feel she was ready was doing what I was told by sic)." eximately 1:34 p.m., the ware made aware of the	F 4	.06 .25 F425: Pharmaceutical SVC-A	Accurate	06/23/17
	(a) Procedures. A pharmaceutical ser that assure the acc dispensing, and ad biologicals) to mee (b) Service Consult employ or obtain the pharmacist who (1) Provides consult provision of pharma This REQUIREMEI by: Based on family in record review and investigation, facility medications were a one of 25 residents Resident #10 result 1a) Facility staff fail morphine per physi withdrawal symptor to unavailability of the service of the se	facility must provide rvices (including procedures curate acquiring, receiving, ministering of all drugs and to the needs of each resident. Itation. The facility must be services of a licensed litation on all aspects of the acy services in the facility; NT is not met as evidenced exterview, staff interview, clinical in the course of a complaint by staff failed to ensure available for administration for a in the survey sample, ting in harm. Iled to administer long acting ician order resulting in ms and subsequent harm due the medication.		Procedures 1. Resident #10 Hard script of Morphine, received from phar currently available. Resident # Morphine per physician order #10 Nystatin Swish and Swall administered 5/5-5/9 2017per order. 2. Review of residents receive controlled pain medication(s) by DCS/designee to ensure meavailable and administered per order completed. Review of receiving Nystatin Swish and ensure medications available administered per physician or completed.	obtained for rmacy and #10 received . Resident low physician ring completed edication r physician esidents Swallow to and	
	1b) Resident #10 h	ad a physician order for				:

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	<u> MB NO.</u>	<u> 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A MUDOMO O DELIA	CENTER		8	3 CROSSROADS LANE		
AUGUST	A NURSING & REHAI	BCENIER		F	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	DBE	(X5) COMPLETION DATE
F 425	As of 05/04/17, Resany doses of the or The findings include 1a) Facility staff fail morphine per physi withdrawal symptor to unavailability of the Resident #10 was con 11/19/2011 and diagnoses including Paraplegia, Aspirati (Chronic Obstructiv Depression, Anxiety Neurogenic Bladde Tract Infection). The most recent Miguarterly assessment reference date) of Cassessed as model status with a total control of the Resident #10's clini 05/02/2017 at 2:15 (physician order shoof/30/17 included to 04/03/17 that stated MG (milligrams) Talent in the resident might be control of the resident with a total control of the resident #10's clini 05/02/2017 at 2:15 (physician order shoof/30/17 included to 04/03/17 that stated MG (milligrams) Talent might be control of the resident with a total	Swallow ordered on 05/01/17. sident #10 had not received dered Nystatin. e: ed to administer long acting cian order resulting in an subsequent harm due the medication. originally admitted to the facility readmitted on 04/03/2017 with	F	125	3. Licensed nurses re-educated by Director of Clinical Services (DCS designee regarding administration of controlled pain medications per phyorder. Licensed nurses re-educated DCS/designee regarding process for ordering and re-ordering controlled medications from pharmacy. Licenturses re-educated by the Director Clinical Services (DCS)/designee regarding administration of Nystati Swish and Swallow per physician of Licensed nurses re-educated by the designee regarding eKit and context. DCS/Unit Managers/designee to conduct random quality review of residents receiving controlled pain management to ensure mediations available and administered per phy order 3 times weekly x 2 weeks, 2 weekly x 2 weeks, weekly x 4 week monthly and PRN and as indicated Unit Managers/designee to conduct random quality review of residents receiving Nystatin Swish and Swalensure mediations available and administered per physician order 3 weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 2 weeks, 2 times weekly x 3 weekly x 4 weeks, PRN and indicated. Findings to be reported QAPI committee monthly and updated.	of ysician I by the or I pain nsed of n order. DCS/ nts. o sician times ks, then I. DCS/ t low to times x 2 I as to	
	12 Hours for Pain" and an order dated 04/04/17 that stated: "Morphine Sulfate 15 MG Tablet For Morphine Sulfate Take 1 (one) Tab by Mouth every 4 (four) Hours As Needed for Pain"				indicated. Quality monitoring sche modified based on findings	dule	

PRINTED: 05/19/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u>U</u>	<u> </u>	<u>). 0938-0391 </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				83 C	ROSSROADS LANE		
AUGUST	A NURSING & REHAI	B CENTER			HERSVILLE, VA 22939		
(VA) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	i ID	:	PROVIDER'S PLAN OF CORRECTIO		(45)
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F 425	Continued From pa	ae 131	F۷	, 425			
	•	S (medication administration	•	0			
		nt #10 included documentation					
		lid not receive a dose of					
		0mg ER on 04/30/17 at 8:00					
a.m. or 8:00 p.m. and also did not receive a dose				•			
on 05/01/17 at 8:00 a.m. The first dose the							
resident received since 04/29/17 at 8:00 p.m. was on 05/01/17 at approximately 10:00 p.m.							
	Danidant #40	administered Morphine 15 MG					
		17 at 7:40 p.m., 04/30/17 at p.m. She received no other					
	prn (as needed) do						
		he MAR. Resident #10 also					
		MG on 04/30/17 at 1:00 p.m.					·
	for anxiety.	,					
	Resident #10's dau	ghter was interviewed on					
		m. per her request. During					
		esident #10's daughter stated,					
		hard script was needed for					:
	Mom's Morphine 60	MG every 12 hours. She					1
	missed a dose on S	Saturday, 4/29 at 8:00 p.m.,	: !				1
		0 a.m., 8:00 p.m., and a dose	: : :				
		at 8:00 a.m. (Name) the PA					
	(physician assistan		! ! !				
		0 a.m. on Monday, 05/01.	:				i i
		e from the pharmacy at 10:30					
		Her Monday bedtime dose	! ! !				!
		vith the Sunday nurse working all ont call the doctor. Nurse	!				1
		ctor will not write a prescription	:				
		yself called the on-call doctor					:
		ound 10:00 p.m. The on-call					
		call the nurse at the facility to	:				
		Morphine would be delivered					·
		urse working didn't know who					•
		o call was for the weekend					

They gave Mom her prn Morphine over the

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPL	E CONSTRUCTION	Т	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					MPLETED
		495336	B. WING	.		١ ۵	C =/00/2047
NAME OF I	PROVIDER OR SUPPLIER	45555		,	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	5/09/2017
				1	3 CROSSROADS LANE		
AUGUST	A NURSING & REHA	B CENTER		F	FISHERSVILLE, VA 22939		
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F 425	Continued From pa	age 132	F	425	I		
	weekend every fou	r hours when she would take					
		Sunday evening, crying and ethis pain much longer."					
		ractical nurse) was					
	interviewed on 05/03/17 at approximately 2:00 p.m. regarding the missed Morphine Sulfate ER						:
		ited, "A hard script was needed					
		obtained. She (Resident #10) e over the weekend."					
	The Medical Direct	or confirmed Resident #10					
		al from not having her long					
		er the weekend during a his surveyor on 05/03/17 at					
	approximately 3:00						
		nterviewed on 05/08/17 at					
		nt #10 stated, "I ran out of my ne that weekend. My legs hurt					
		onstant pain, then turned to					
		into my thighs. It was					
	Morphine because	a take a lot of the other it didn't help."	! !				
	•	•					
		and DON (director of nursing) ne above during a meeting with	 - -				1
		05/03/17 at 5:45 p.m. The	:				
	DON stated, "The I	nard script should have been	į				
		and the medicine ordered and received at the facility	:				
		sident #10 ran out of medicine.	:				
	I don't know how th						
	This is a complaint	deficiency.	:				
		ad a physician order for					
	Nystatin Swish and	Swallow ordered on 05/01/17.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION NG	COL	(X3) DATE SURVEY COMPLETED	
		495336	B. WING			C 05/09/2017	
	PROVIDER OR SUPPLIER A NURSING & REHA			STREET ADDRESS, CITY, STATE, Z 83 CROSSROADS LANE FISHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 425	any doses of the or During review of R 05/03/17 at approx telephone order was 1213 (12:13 p.m.) 100,000 units po (or (times) 7 days. Ma Indication: Thrush During an interview on 05/03/17 at 1:35 her Mother had be a couple of days agany. Review of the administration reconot received any described any described and suspension. On 05/04/17 at 8:3 practical nurse) was Resident #10's Nys with the pharmacy on Tuesday asking needing the amound dispense. They secream not the swist the pharmacy this out Nystatin swish pharmacy." The Administrator awere informed of the meeting with the stapproximately 1:35	sident #10 had not received rdered Nystatin. esident #10's clinical record on timately 11:00 a.m., a physician as noted that stated, "5-1-17 Nystatin Oral Suspension orally) tid (three times daily) x ay swish and swallow.	F 4	25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495336	B. WING _		1	C / 09/2017	
NAME OF	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	100,2017	
ALICHET	A NURSING & REHA	D CENTED		83 CROSSROADS LANE			
AUGUSI	A NURSING & REHA	B CENTER		FISHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION DATE	
F 441	Continued From pa	age 134	F 44	.1			
F 441 SS=D	483.80(a)(1)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	e)(f) INFECTION CONTROL, D, LINENS	F 44	F441: Infection Control Prevent Linens	Spread,	06/23/17	
	The facility must es	stablish an infection prevention		1. LPN #3 was re-educated regarded following infection control practices to the control practices are the control practices and the control practices are the control practices.	ces		
	a minimum, the foll	•		during medication pass. Resident received her medication per physicorder and did not suffer and s/s of	cian		
	investigating, and communicable dise	eventing, identifying, reporting, controlling infections and eases for all residents, staff,		infection and/or adverse effects fr administration of medication by I House stock Tylenol was remove	PN #3.		
	providing services of arrangement based conducted according	d upon the facility assessmenting to §483.70(e) and following standards (facility assessment		the medication cart, discarded and replaced. Medication pass observe have been conducted with LPN #. 2. Licensed nurses monitored for following infection control practice.	l ations 3. r		
		ds, policies, and procedures nich must include, but are not	:	during medication pass observation DCS/designee completed. Consul Pharmacy Nurse / Designee to comedication skills competencies as	tant nduct		
	possible communic	reillance designed to identify cable diseases or infections read to other persons in the		indicated. Follow up based on fin 3. Licensed Nurses re-educated Director of Clinical Services (DC Designee regarding following info	dings. by the S) /	:	
		nom possible incidents of ease or infections should be		control practices during medication	n pass.		
		ransmission-based precautions revent spread of infections;					
	(iv) When and how resident; including	isolation should be used for a but not limited to:	i i !	•			
						1	

CENTE	AS LOK MICHICALE	A MEDICAID SERVICES			<u> </u>	IND INO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED
		495336	B. WING				C 09/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8:	3 CROSSROADS LANE		
AUGUST	A NURSING & REHAI	B CENTER		F	ISHERSVILLE, VA 22939		
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F 441	Continued From part (A) The type and do depending upon the involved, and (B) A requirement to least restrictive posticized in the involved, and (B) A requirement to least restrictive posticized restrictive posticized in the involved in the involved in the facility's to least the involved in the facility's to least the involved in th	age 135 curation of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility eyees with a communicable skin lesions from direct ents or their food, if direct to the disease; and ene procedures to be followed direct resident contact. cording incidents identified PCP and the corrective e facility. enel must handle, store, cort linens so as to prevent the The facility will conduct an electric procedure and the procedure and the conduct and the procedure and the proc		141		lom urses rol reeks, onthly edule ngs to	
		ractical nurse) failed to use le while preparing and cations on Unit #3.	 				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495336	B. WING	B. WING		C 05/09/2017	
	NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP 83 CROSSROADS LANE FISHERSVILLE, VA 22939		70072017	
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F 441	medication administrations for Reference with the property of	0 a.m. this surveyor observed stration with LPN #3 (licensed PN #3 prepared all esident #12 outside of Resident g this preparation LPN #3 used ghed and stated, "I'm a little #3 proceeded to drop an ouse stock bottle onto the cart, in with her bare hands and dication cup. LPN #3 then les from the pills with her bare capsules bare handed and	F4	41			
	placed the extra ba all with her bare ha The Administrator a were informed of the	ack into the house stock bottle					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
AUGUST	A NURSING & REHAL	3 CENTER		83 CROSSROADS LANE FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pap.m. Facility policy: Administration Of Epolicy: It is the polisafe and accurate a medication. Proceed powders, capsules medications should scored or if they are sustained release of No further informati team prior to the ex 483.35(d)(7) NURS REVIEW-12 HR/YF (d)(7) Regular In-Set (d)(7) Reg	ge 137 for "Medications-Oral Effective Date: 11/30/2014. cy that the resident can expect administration of oral dure:Refrain from touching or pills with handsMost not be crushed if they are not e enteric coated, or if they are or long-actingWash hands" on was received by the survey it conference on 05/09/17. E AIDE PERFORM E INSERVICE ervice Education mplete a performance review at least once every 12 provide regular in-service the outcome of these training must comply with the 33.95(g). MT is not met as evidenced rview, facility document of the survey process with the standard quality of care, the ure the certified nursing	F 4	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	-12 uffer nger ho	
	As part of the surve identification of sub additional information	y process with the standard quality of care, on was requested from the r at 10:00 a.m. 5/9/17 to				

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AND PLAN OF CORRECTION SUPPLIER AND PLAN OF CORRECTION A. BUILDING B. WING STREET ADDRESS, CITY. STATE, ZIP CODE B. WING STREET ADDRESS, CITY. STATE, ZIP CODE B3 CROSSROADS LANE FISHERSVILLE, VA 22939 FISHERSVILLE, VA 22939 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER CONTINUED IN TAG PROVIDER CONTINUED IN TAG PROVIDER PLAN OF CORRECTION PREFIX TAG PROVIDER PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 497 Continued From page 138 Include, but was not limited to: CNA registry verification, CNA annual performance reviews and education (to include staff yearly training/in-servicing of 12 hours). On 5/917 at approximately 2:30 p.m., the facility administrator, DON (director of nursing), and Regional Nurse Consultant told the survey team there had not been any performance evaluations completed for the CNA staff. The Survey team was told some performance reviews had been completed over the weekend when the problem was identified. The DON further informed the survey team there were no in-servicing records available for any of the CNA's. A list of all currently employed CNA's was requested. The list was received and compared to the performance evaluations completed over the weekend. Not all staff had been evaluated; some staff currently working in the facility had been employed since 2013, with no evidence of performance evaluations or required in-servicing. On 5/8/17 at approximately 3:00 p.m., six CNA's were interviewed, two of the six CNA's had been working at the facility of more than one year and working at the facility of more than one year and working at the facility of more than one year and working at the facility of more than one year and working at the facility of more than one year and working at the facility of more than one year and working at the facility of more than one year and working at the facility of more than one year and working at the f	CENTE	VO LOK MIEDICHKE	A MICDICAID SERVICES			<u>UNI DIVID</u>	<u>J. 0936-039 I</u>	
NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 CALL DEPARTMENT OF DEFICIENCIES PREFIX PREFIX PREFIX PREFIX PREFIX TAG							COMPLETED	
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F 497 Continued From page 138 include, but was not limited to: CNA registry verification; CNA annual performance reviews and education (to include staff yearly training/in-servicing of 12 hours). On 5/9/17 at approximately 2:30 p.m., the facility administrator, DON (director of nursing), and Regional Nurse Consultant told the survey team was told some performance reviews had been completed over the weekend when the problem was identified. The DON further informed the survey team there were no in-servicing records available for any of the CNA's. A list of all currently employed CNA's was requested. The list was received and compared to the performance evaluations completed over the weekend. Not all staff had been evaluated; some staff currently working in the facility had been employed since 2013, with no evidence of performance evaluations or required in-servicing. On 5/8/17 at approximately 3:00 p.m., six CNA's were interviewed; two of the six CNA's had been	AUGUST	A NURSING & REHA	3 CENTER					
include, but was not limited to: CNA registry verification; CNA annual performance reviews and education (to include staff yearly training/in-servicing of 12 hours). On 5/9/17 at approximately 2:30 p.m., the facility administrator, DON (director of nursing), and Regional Nurse Consultant told the survey team there had not been any performance evaluations completed for the CNA staff. The survey team was told some performance reviews had been completed over the weekend when the problem was identified. The DON further informed the survey team there were no in-servicing records available for any of the CNA's. A list of all currently employed CNA's was requested. The list was received and compared to the performance evaluations completed over the weekend. Not all staff had been evaluated; some staff currently working in the facility had been employed since 2013, with no evidence of performance evaluations or required in-servicing. On 5/8/17 at approximately 3:00 p.m., six CNA's were interviewed; two of the six CNA's had been	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETION	
both stated they had not received any yearly training, nor had a performance evaluation been done to let them know how they were doing. Four of the CNA's were recent hires of the facility, with less than 1 year employment. The four CNA's recently hired stated upon hire, they "followed" another CNA for 3-5 days as orientation, and then were "put out on the floor to care for residents." One CNA stated "I will tell you this since you're asking; I don't feel as though I've had enough training to be put out here and working with residents I don't know very much about." receive their annual performance evaluation presented to them by the DCS/designee during the month of their annual date of hire. Human Resource Coordinator to develop a file alerting the DCS of annual performance reviews due monthly. C.N.A's to complete annual competencies per the Consulate Education Calendar.	F 497	include, but was no verification; CNA ar and education (to in training/in-servicing approximately 2:30 DON (director of nu Consultant told the been any performante CNA staff. The performance review the weekend when The DON further in were no in-servicing the CNA's. A list of was requested. The compared to the performance of performance of performance of performance interviewed; to the facility had been evaluated; so the facility had been of evidence of performance of	at limited to: CNA registry innual performance reviews include staff yearly gof 12 hours). On 5/9/17 at p.m., the facility administrator, ursing), and Regional Nurse survey team there had not ince evaluations completed for survey team was told some with higher the problem was identified. Formed the survey team there grecords available for any of all currently employed CNA's elist was received and erformance evaluations weekend. Not all staff had me staff currently working in employed since 2013, with formance evaluations or g. Eximately 3:00 p.m., six CNA's wo of the six CNA's had been the formance evaluation been the formance evaluation been ow how they were doing. Four recent hires of the facility, with apployment. The four CNA's dupon hire, they "followed" of days as orientation, and then the floor to care for residents." will tell you this since you're as though I've had enough ut here and working with		current CNA files on May determine completion of education. CNA's educate per the 2017 Consulate Education by ADCS/Desig completed. Human Resource Coordinator responsible feducation information in member's personnel file. complete orientation and competencies prior to wo independently. CNA's to Consulate Health Care corequirements per guideling Resource Coordinator is a for maintaining the approach documentation in the emit Human Resource Coordinator in the emit Human Resource Coordinator in the DCS and I receive their annual performantal date of hire. Resource Coordinator to alerting the DCS of annual performance reviews due C.N.A's to complete annual competencies per the Core	y 8, 2017 to appropriate ed on topics ducation gnee ource for placing the staff New hires to orking o complete ompetency ne. Human responsible opriate ployee file. nator to ality Monitor ED. CNAs to ormance nem by the month of Human develop a file al monthly.		

The CNA statements reflected lack of training in

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE		
AUGUST	A NURSING & REHAE	B CENTER		l	3 CROSSROADS LANE		
ı				<u>_</u>	FISHERSVILLE, VA 22939		
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F 497	Continued From pa the area of Resider	age 139 nt Care as evidenced by	F،	497	UV EB/B US/ UI/I S/IIB US IV VUUV		
F 498 SS=F	Resident # 4 who we feces for approximation unclothed by an oper F241). Resident # separate occasions CNA staff (see F24 assistant) provided care for Resident # While the CNA's who were no longer emptored adequate dependent resident 483.35(c); 483.95(g) DEMONSTRATE CMA STATE	vas left sitting in urine and ately two hours, and also left ten window by CNA staff(see to 10 was put to bed on two swithout proper bedclothes by the interest of 10. A CNA (certified nursing improper menstrual cycle to 21's (see F224 and F241), the provided the deficient care ployed by the facility, current trained, in serviced, and/or education to care for ts in their care. (a)(1)(2)(4) NURSE AIDE COMPETENCY/CARE NEEDS the sure that nurse aides are ablest to the service of the sure that nurse aides are ablest to the sure that the sure th	F٠	498	by the Division Education Specialis regarding completion of C.N.A eduper the Consulate Education Calend completing Orientation and competer prior to working independently and completion of annual performance evaluations. Human Resources reducated by the DCS regarding responsibility for maintaining the appropriate documentation in the employee file, providing a copy of the Quality Monitor monthly to the DC ED along with maintaining a file system to alert the DCS of annual performance evaluation in the employee files are to conduct rando quality monitoring monthly and PR new employee files to ensure education.	the S and ystem ance s. Dm N of tion	
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95				and competencies are completed pri working independently per the educ calendar. DCS/Designee to conduc random quality monitoring monthly regarding Annual Education and	cation t		
	(g) Required in-serv	vice training for nurse aides.			competencies are completed by C.N per the education calendar. Human		
		to ensure the continuing se aides, but must be no less			Resources/ED/Designee to conduct random quality monitoring monthly regarding completion of C.N.A anni performance evaluations. Quality	ual	;
	(g)(2) Include deme resident abuse prev	entia management training and vention training.			monitoring schedule modified based findings. Findings to be reported to committee monthly and updated as		
	(g)(4) For nurse aid	des providing services to			indicated.		

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	IDER/SUPPLIER/CLIA IFICATION NUMBER:	' '	IPLE CONSTRUCTION		E SURVEY
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	·
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F 498 Continued From page 140 individuals with cognitive impaddress the care of the cognitive impaddress the care of the cognitive impaddress the care of the cognitive impaddress the care of the surview, and as part of the surview, and as part of the surview, and as part of the surview, and identification of substandard facility failed to ensure the coassistant's (CNA) demonstrationing on resident care need. As part of the survey processidentification of substandard additional information was refacility administrator at 10:00 include, but was not limited the verification; CNA annual perfacility and education (to include state training/in-servicing of 12 house demonstration of competence to the facility. On 5/9/17 at a p.m., the facility administration nursing), and Regional Nurse survey team there had not be evaluations completed for the there were no orientation/coavailable for new hires. On 5/8/17 at approximately 3 were interviewed. Four of the hires of the facility, with less employment. The four CNA' stated upon hire, they "follow 3-5 days as orientation, and the floor to care for residents will tell you this since you're a state of the since you're a s	intively impaired. In met as evidenced cility document Invey process with the Interest quality of care, the Interest quality of care, the Interest quality of care, Interest		1. Resident #21 no longer refacility. C.N.A no longer wo facility. Resident #10 provide per resident choice. Resident provided ADL care. Audit completed of all current May 8, 2017 to determine if education was completed. All CNA's educated on the teducation was completed. All CNA's educated on the teducation provided by the designee. Education began on 05/09/20 and will be completed by Jur When the education is completed by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the education provided by Jur When the educ	esides in the rks at the ed bedclothes t #4 was at CNA files of appropriate opics per the alendar as the ADCS or 017 at 9:00 AM the 23, 2017. Iteed, the or/designee will aformation in I file. It will complete estency the etency the source of the maintain on. In the control of the etency the source of the maintain on. In the control of the etency the source of the toleron in the control of the etency the source of the toleron in the control of the etency the source of the toleron in the control of the etency the source of the toleron in the control of the etency the source of the etency the source of the etency the source of the etency the et	

though I've had enough training to be put out here

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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				83 CROSSROADS LANE		
AUGUST	A NURSING & REHA	B CENTER		FISHERSVILLE, VA 22939		
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				DEFICIENCY)		
				This information will be presented mon		
F 498	Continued From pa	ge 141	F 4	98 the QAPI meeting to attain and maintain	n	
	•	sidents I don't know very		compliance.	į	
		CNA further stated another	:	CNAs will receive an annual performan		
		ow to use a Hoyer lift and Sit	!	evaluation presented to them by the DC		
		eturn demonstration was not		designee on their anniversary date. The		
	part of that informat	tion. "All the information was	; ; ;	Resource Coordinator/designee will dev		
	verbal; there was no	o return demonstration and no	<u>.</u>	file to alert the DCS when their annual	review	
		in any training; all four CNA's		is due.		
		tion was done by another		This information will be presented mon		
	CNA.		1	the QAPI meeting to attain and maintain	n	
			! :	compliance.		
		ts reflected lack of training in	: ! :	2. Quality Review of current resider	nts was	
		t Care as evidenced by		completed to determine appropriate	i	
		as left sitting in urine and	! !	care was provided completed. Peri-c		
		ately two hours, and also left		• •		
		en window by CNA staff(see 10 was put to bed on two	i L	skills competency conducted as indic		
		without proper bedclothes by	! !	Quality review completed of current	CNA	
		1). A CNA (certified nursing	! !	files on May 8, 2017 to determine		
		improper menstrual cycle	: I	completion of appropriate education		
		21's (see F224 and F241).	:	CNA's educated on topics per the 20	17	
		no provided the deficient care	!	Consulate Education Calendar comp	leted.	
		ployed by the facility, current	! 	C.N.As to complete annual competer	ncies	
		trained, in serviced, and/or		per the Consulate 2017 Education Ca		
		education to care for	: !	Luman Dagauraa Caardinatar ragnar	acible	
	dependent resident		; ! !	for placing education information in of staff member's personnel file. New	the	
F 505	483.50(a)(2)(ii) PRO	OMPTLY NOTIFY PHYSICIAN	F 5	os staff member's personnel file. New	hires to	
SS=G	OF LAB RESULTS		!	complete orientation and competence		-
			; ;	•		
	(a) Laboratory Serv	ices	!	prior to working independently. CN	ASIO	
	(0) The feetith			complete Consulate Health Care		
	(2) The facility must	(-		competency requirements per guidel	ine.	
	(ii) Promptly notify t	he ordering physician,		Human Resource Coordinator is		
		nurse practitioner, or clinical		responsible for maintaining the appro	_	
		aboratory results that fall		documentation in the employee file.	Human	
	•	eference ranges in accordance		Resource Coordinator to provide a co	opy of	
	with facility policies			the Quality Monitor monthly to the I		
		ctitioner or per the ordering		of Clinical Services (DCS) and Exec		
		,		Director (ED).	· •	

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NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939		
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F 505 Continued From page 142

physician's orders.

This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interview, the facility staff failed, for two of 25 residents in the survey sample (Residents # 4 and 10), to promptly notify the residents' attending physician of abnormal lab results, resulting in harm.

- 1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.
- 2. For Resident # 10, the facility staff failed to notify the resident's attending physician of low blood sugar and the initiation of hypoglycemic measures.

The findings include:

1. For Resident # 4, the facility staff failed to notify the resident's attending physician of a lab result that identified the resident as having a urinary tract infection (UTI), leading to a one month delay in treatment, which lead to the resident being hospitalized and intubated, which constituted harm.

Resident # 4 in the survey sample, a 66 year-old female, was admitted to the facility on 4/7/15, and most recently readmitted on 4/14/17 with diagnoses that included obstructive sleep apnea, encephalopathy, acidosis, hypertension, restless leg syndrome, diabetes mellitus, asthma,

F 505

- 3. ED/DCS/UM's/ADCS re-educated by the Division Education Specialist/designee regarding completion of C.N.A education per the 2017 Consulate Education Calendar, completing Orientation and competencies prior to working independently. Human Resources reeducated by the ED/DCS/designee regarding responsibility for maintaining the appropriate documentation in the employee file and providing a copy of the Quality Monitor monthly to the DCS and ED.
- 4. DCS/Designee to conduct random quality monitoring monthly and PRN as indicated of new employee files to ensure orientation and competencies are completed prior to working independently per the 2017 education calendar. ED/ DCS/Designee to conduct random quality monitoring monthly and PRN and as indicated of current C.N.As to ensure education completed per the 2017 Consulate Education Calendar and competencies are completed by C.N.As per the 2017 education calendar. Human Resources to conduct random quality monitoring monthly and PRN as indicated of employee files to ensure annual education, competencies and orientation is completed per guideline. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495336	B. WING			C 09/2017	
	PROVIDER OR SUPPLIER A NURSING & REHA			STREET ADDRESS, CITY, STATE, ZIP C 83 CROSSROADS LANE FISHERSVILLE, VA 22939		00/2017	
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F 505	chronic pain, mortifailure, chronic reranemia, seizure digastroesophageal obstructive pulmoralilure. According Data Set (MDS), a Assessment Refer the resident was a (Cognitive Pattern with a Summary Service of the Interesident was a (Tognitive Pattern with a Summary Service of the Interesident was a (Tognitive Pattern with a Summary Service of the Interesident was a (Tognitive Pattern with a Summary Service of the Interesident was a (Tognitive Pattern with a Summary Service of the Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern with a Summary Service of Interesident was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (Tognitive Pattern was a (To	ailure, bi-polar disorder, anxiety, bid obesity, acute respiratory hal failure, seizure disorder, isorder, depression, reflux disease, chronic hary disease, and respirator to the most recent Minimum a Significant Change, with an rence Date (ARD) of 4/21/17, assessed under Section C s) as being cognitively intact, accore of 15 out of 15.	F	1. Resident #10 suffered no affects and did not require to higher level of care. Resider parameters in place and hyp hyperglycemic protocol. Resadmitted 4/27/17 with no s/s 2. A Quality Review of cut with physician orders for sli insulin and/or Insulin dependent completed to verify finger strongly sugar (FSBS) checks are in high/low parameters, hypo/hyprotocols and when to contate Quality Review of physiciant tresidents with low FSBS padministration of oral glucosing glucagon is present in the macompleted. A quality review resident lab results ordered to 30 days to ensure physician present and documented in the record.	ransfer to a ant #10 has bo/ sident #4 residents of UTI. rrent residents ding scale dent was tick blood place with hyperglycemic act physician. In notification rese or IM and addical record we completed of within the last notification		

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19 LOK MEDICAKE	_ & IVILDICAID SERVICES				IVID IVO.	<u>. บองด-บงษ เ</u>
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	E SURVEY
	495336	B. WING			1	C 09/2017
PROVIDER OR SUPPLIER	- <u>-</u>	' 	S-	TREET ADDRESS, CITY, STATE, ZIP CODE	00,	00,201,
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A NURSING & REHA	AB CENTER					
			FI	ISHERSVILLE, VA 22939		
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Continued From pa	oce 144	FF	กร	1		
		'			the	
	,			•		•
						:
				hypo/hyperglycemic protocol PRN	per	:
				physician orders and when to conta	ct	
						:
•						<u>.</u>
RP (Responsible P	'arty) notified."			•		:
				2 1 2	idents	
			with low FSBS per order and/or		<u> </u>	
					or IM	į
				_		
Unit) on a breathing	g machine."			0 0 1		
•	1	İ		•		
Resident # 4's hosr	pitalization came				sician	İ
				contact information along with		
					2	
100	1			• • • • • • • • • • • • • • • • • • • •		
Review of the hosp	oital Discharge Summary	İ		•		
				` ′	•	
10100.02	······································					
"This is a 66-year-o	old female with a history of			of lab results with documentation in	1 the	
				medical record.		
		!		Illeanen 10001a.		!
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		:				
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		1				
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	•					İ
urine, penicillin sen	isitive"					!
Resident # 4 was d	discharged back to the facility					
	PROVIDER OR SUPPLIER A NURSING & REHA SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa waken. Once awal eye contact, no fact breathing deep, ski (saturation) 89, BS signs) 103 - 136 (p (blood pressure). (advised to send to 911 called, resident RP (Responsible P 4/9/17 - 11:10 a.m. Emergency Room) Resident to be adm Unit) on a breathing Resident # 4's host approximately one identified her as ha Review of the hosp revealed the followi "This is a 66-year-of morbid obesity, obe seizure disorder, di who was brought to lethargy and unrest emergency room he maintain her sats, se found to have a uri admitted to ICU. Se pressure requiring raise blood pressur have 2 out of 4 blood mitisShe also gre urine, penicillin sen	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495336	OF DEFICIENCIES FOORRECTION (X1) PROVIDER/SUPPLIER/CITATION NUMBER: 495336 B. WING ROVIDER OR SUPPLIER A NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 144 waken. Once awake resident non-verbal, made eye contact, no facial grimacing. Resident breathing deep, skin sweaty. O2 (Oxygen) sat (saturation) 89, BS (Blood Sugar) 269, VS (vital signs) 103 - 136 (pulse), 32 (respirations), 134/58 (blood pressure). On call (MD) called was advised to send to ED (Emergency Department). 911 called, resident was taken to ED at 5:30 and RP (Responsible Party) notified." 4/9/17 - 11:10 a.m. "Called AH ER (hospital Emergency Room) for condition update. Resident to be admitted to ICU (Intensive Care Unit) on a breathing machine." Resident # 4's hospitalization came approximately one month after the UA lab the identified her as having a UTI. Review of the hospital Discharge Summary revealed the following: "This is a 66-year-old female with a history of morbid obesity, obesity hypoventilation syndrome, seizure disorder, diabetes, diastolic heart failure, who was brought to the emergency room with lethargy and unresponsiveness. In the emergency room had difficulty breathing. To maintain her sats, she was ventilated. She was found to have a urinary tract infection and was admitted to ICU. She dropped her blood pressure requiring pressors (a medication used to raise blood pressure). The patient was found to have 2 out of 4 blood cultures positive for strep mitisShe also grew E-coli and Proteus in the urine, penicillin sensitive"	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495336 B. WING	OF DEFICIENCIES F CORRECTION (X1) PROVIDER SUPPLIER 495336 B WING STREVIDER OR SUPPLIER A NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 144 waken. Once awake resident non-verbal, made eye contact, no facial grimacing. Resident breathing deep, skin sweaty. O2 (Oxygen) sat (saturation) 89, BS (Blood Sugar) 259, VS (vital signs) 103 - 136 (pulse), 32 (respirations), 134/58 (blood pressure). On call (MD) called was advised to send to ED (Emergency Department). 991 called, resident was taken to ED at 5:30 and RP (Responsible Party) notified." Resident # 4's hospitalization came approximately one month after the UA lab the identified her as having a UTI. Review of the hospital Discharge Summary revealed the following: "This is a 66-year-old female with a history of morbid obesity, obesity hypoventilated. 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She dropped her blood pressure requiring pressors (a medication used to raise blood pressure). The patient was found to have a curiany tract infection	OF DEFICIENCIES FORRECTION (X1) PROVIDER SUPPLIER A SUBJECT ON NUMBER: 495336 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 D. PROVIDER STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 144 waken. Once awake resident non-verbal, made eye contact, no facial grimaging. Resident breathing deep, skin sweaty. O2 (Oxygen) sat (saturation) 89, BS (Blood Sugar) 269, VS (vital signs) 103 - 136 (pulse), 32 (respirations), 134/56 (blood pressure). On call (MD) called was advised to send to ED (Emergency Department). 911 called, resident was taken to ED at 5:30 and RP (Responsible Party) notified." 4/9/17 - 11:10 a.m. "Called AH ER (hospital Emergency Room) for condition update. Resident to be admitted to ICU (Intensive Care Unit) on a breathing machine." Review of the hospital Discharge Summary revealed the following: "This is a 66-year-old female with a history of morbid obesity, obesity hypoventilation syndrome, seizure disorder, diabetes, diastolic heart failure, who was brought to the emergency room with leithargy and unresponsiveness. In the emergency room had difficulty breathing. To maintain her sats, she was ventilated. She was found to have a unriany tract infection and was admitted to ICU. She dropped her blood pressure." The patient was found to have a unriany tract infection and was admitted to ICU. She dropped her blood pressure; The patient was found to have a unriany tract infection and was admitted to ICU. She dropped her blood pressure; The patient was found to have 2 out of 4 blood cultures positive for strep mitis. She also grew E-coil and Proteus in the urine, penicillin sensitive"

on 4/14/17 with diagnoses that included septic

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0		0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		495336	B. WING			1	C 09/2017
NAME OF F	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ALICHET	A NUIDONO O DELLA	OCNIER		8	33 CROSSROADS LANE		
AUGUST	A NURSING & REHA	CENTER		F	FISHERSVILLE, VA 22939		
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F 505	Continued From pa	ge 145	' F.5	505			
	· ·	urinary tract infection.	1 0	,00	4. DCS/Designee during morning	ig clinic	al
	SHOOK SCOUNDARY LO	umary tract infection.			meeting to conduct quality monit	oring of	
	A thorough review of	of Resident # 4's clinical record			physician orders for new admissi	_	
		results of the UA ordered on			related to FSBS, high/low param		
		mately 1:00 p.m. on 5/8/17, at			when to contact physician, and h		
		urveyor, LPN # 2 (Licensed			hyperglycemic protocols daily x	_	v
	Practical Nurse) wa	s able to obtain a copy of the			x 4 then monthly, PRN and as inc		
		rom the laboratory that			DCS/Designee to conduct quality		
		sample. According to the UA			monitoring related to timely phys		
		had a UTI. Asked if the					
		physician was notified of the			notification of residents who requ		
	UA results, LPN # 2	said, "He was not notified."			administration of hypoglycemic		
	LDN # 2 was also a	sked about EOS. LPN#2			per physician order with docume		n
		is a protocol and stands for			the medical record daily x 4, wee	•	
		tion Order Set for suspected			then monthly, PRN and as indica	ted.	
		a blank copy of the EOS			DCS/Designee through Morning	Clinical	
		2, the protocol included the			meeting process ensures physicia	n is	
	following:	_, ,			promptly notified of laboratory re	esults	
	Ŭ				daily x 4, weekly x 4 then month		
	"1) Obtain vital sign	s (BP, pulse, resp rate, temp,			and as indicated. Findings to be:		
	pulse ox) every 6 ho				E .		
		ce each shift for 3 days.			to QAPI committee monthly and		
		rector or provider on call if			as indicated. Quality monitoring	schedule	*
		nan 1600 ml (milliliters) per			modified based on findings.		
	day.	l dinestan en en eell musiden if					
		al director or on-call provider if or if no improvement by the					
	next morning.	in no improvement by the					
		cal director or on-call provider					
		ne resident's condition daily."					
	Asked if the EOS pr Resident # 4, LPN #	rotocol was initiated for # 2 replied "No."					

and the survey team.

The findings were discussed at a meeting at 3:00 p.m. on 5/8/17 with the Interim Administrator, Director of Nursing, Corporate Nurse Consultant,

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495336	B. WING			05/	/09/2017
	PROVIDER OR SUPPLIER A NURSING & REHA	B CENTER .		8:	TREET ADDRESS, CITY, STATE, ZIP CODE 3 CROSSROADS LANE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTIES OF THE A	BE .	(X5) COMPLETION DATE
F 505	Continued From pa	age 146	F	505			
	Resident #10 was on 11/19/2011 and diagnoses including Paraplegia, Aspirat (Chronic Obstructiv Depression, Anxiet	ed to notify the physician of a of 25 for Resident #10. originally admitted to the facility readmitted on 04/03/2017 with g, but not limited to: ion Pneumonitis, COPD ve Pulmonary Disease), y, Diabetes, Hypertension, er, and Chronic UTI (Urinary					
	quarterly assessment reference date) of Cassessed as mode status with a total of During review of Reson 05/03/17 at appropriate of Cassessed as mode status with a total of During review of Reson 05/03/17 at appropriate of Cassessed as mode of Reson 05/03/17 at appropriate of Cassessed of Reson 05/03/17 0500 resident's BS (bloothe resident a glucobut she couldn't cheglucagon shot to rawas 85. I called he will notify the MD (propriate of Cassessed of Cassess	-					
	interviewed on 05/0 stated, "There are i	ractical nurse) was 03/2017 at 10:55 a.m. LPN #2 no standing orders for hat when I got here."					

STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
	· 	495336	B. WING				C 09/201 7	
	/IDER OR SUPPLIER	3 CENTER		83 CF	ET ADDRESS, CITY, STATE, ZIP CODE ROSSROADS LANE IERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
LP a.n blo ass kno PA PA wh wa wa let	n. LPN #3 stated od sugar this most sistant) knows. I have if the on-call of was interviewed stated, "I was not en I came in. I dis notified or not. I dis on-call last night	ge 147 ewed on 05/03/2017 at 11:10 d, "Received in report of low bring. (Name) PA (physician rechecked; it was 127. I don't doctor was notified." on 05/03/2017 at 11:15 a.m. offied this morning at 9:08 on't know if the on-call doctor I am going to find out who at and ask them myself. I will also didn't get her bedtime	F	505				
On ent sur Wh Rea tha gav wa abo kne call	05/03/2017 at all ered the confere veyor the following om It May Concosident #10, I was ther accuchek (I we her a glucose is administered a but any input fron ew. I called over I made to the on ers. This incider	pproximately 1:00 p.m. the PA nce room and handed this ng note: "5-3-17 Noon To ern: In regard to (Name) notified at 0908 (9:08 a.m.) blood sugar) was 25. Nursing tab and pudding. She then Glucagon injection. I inquired in the on call doctor but no one office (sic) and there was no call physician to direct these int occurred about 5:30 a.m. of at time of exam was 136"						
wei me app was cor F 520 483 SS=F CO	re notified of the eting with the su proximately 5:45	?)(i)(ii)(h)(i) QAA BERS/MEET	F !	520				

PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 520 Continued From page 148 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME TAGE OF TAGE O	STATEMENT O AND PLAN OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER AUGUSTA NURSING & REHAB CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 520 Continued From page 148 STREET ADDRESS, CITY, STATE, ZIP CODE 83 CROSSROADS LANE FISHERSVILLE, VA 22939 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY) F 520 CONTINUED FROM PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY) F 520 CONTINUED FROM PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY) F 520 CONTINUED FROM PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY) F 520 CONTINUED FROM PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY) F 520 CONTINUED FROM PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMED TO THE APPROPRIATE DEFICIENCY)			495336	B. WING	s		i .	
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 520 Continued From page 148 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 520 F 520: QAA Committee-Members/Meet O6/2			B CENTER	•	8	3 CROSSROADS LANE	, 00,	00/2017
F 520 To Continued From page 140	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
(g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary, and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for	() (i an (i sa ir () c ic an (i sa ir sa ir sa ir c) c ic an (i sa ir sa ir sa ir c) c ic an (i sa ir sa ir sa ir c) c ic an (i sa ir sa ir sa ir c) c ic an (i sa ir sa ir sa ir c) c ic an (i sa ir sa ir c) c ic an (i sa ir sa ir c) c ic an (i sa ir sa ir c) c ic an (i sa ir c) c ic an	g) Quality assessment and assurance comminimum of: 1) The director of noting and assurance comminimum of: 2) The director of noting and assurance comminimum of: 3) The Medical Director of noting and assurance and assurance and evaluation and e	nent and assurance. naintain a quality assessment amittee consisting at a ursing services; ector or his/her designee; ther members of the facility's f who must be the er, a board member or other ership role; and essessment and assurance arterly and as needed to luate activities such as ith respect to which quality esurance activities are plement appropriate plans of entified quality deficiencies; formation. A State or the require disclosure of the mittee except in so far as elated to the compliance of the requirements of this faith attempts by the fy and correct quality	F	520	Quarterly/Plans 1. Facility Quality Assurance Performance Improvement (QAPI) committee reviewed findings on 5/2 identified during annual survey on 5 2017 to include the identification of substandard Quality of Care r/t pain pressure related wounds and not foll physician orders. Findings identifie have a plan of correction (POC) to i immediate correction, quality review education and ongoing quality monit with review by the QAPI committee 2. Facility Quality Assurance Performance Improvement (QAPI) committee reviews findings identified during annual survey 5/2-5/9 2017, maintains and updates PIP/quality monitoring as indicated. Follow up revision based on findings. 3. QAPI committee/Executive Direction IDT re-educated by RVPO regardin conducting an effective QAPI committee in the properties of	, 5/17 5/2-5/9 , non- lowing ed nclude ev, re- storing e.	06/23/17

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/19/2017

	AND HOMAN SERVICES				FORM APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES	,		0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	B. WING			C 05/09/2017
NAME OF PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
ALIGUATA AUGODIO A DELLA FA	ACUTED		83 CF	ROSSROADS LANE	
AUGUSTA NURSING & REHAE	S CENTER		FISH	ERSVILLE, VA 22939	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLÉTION
by: Based on survey firensure an effective assurance program quality of care in the the identification of areas of compreher planning and nursin Findings were: An onsite survey was through 05/04/2017 conducted 05/08/20 During the survey prodeficient practice we identification of subspattern of harm in the Residents were not	IT is not met as evidenced andings the facility failed to system wide quality to prevent substandard area of Quality of Care and immediate jeopardy in the asive person-centered care	F :	4 v fin the implication of the i	QAPI committee to meet weekly weeks, then as indicated by QAPI dings, but a minimum of monthly breafter to review performance provement related to areas identifying Annual Survey May 2-9 20-1 antify, develop and implement quaprovement measures. ED/DCS/signee to continue ongoing QI onitoring of Plan of Correction quantitoring through QAPI meeting ocess. The Regional Vice Presidential Services/designee to conduction and/or Regional Director inical Services/designee to conduction of the Facility's QAPI pekly times 4 weeks, monthly time on this, then randomly thereafter we commendations for improvement licated. QAPI meeting held 5/25/riew 2567 and POC with medical	ified 17 ality ality ent of r of ct process es 2 ith as /17 to

Immediate jeopardy was identified in the areas of Comprehensive Person-Centered Care Planning and Nursing Services. Agency licensed nurses were permitted to enter the facility and implement nursing care to residents, including the administration of medications, without receiving orientation to the facility or being deemed competent in facility tasks, policies or procedures. CNA (certified nursing assistant) staff were not evaluated annually on their performance nor were they provided with ongoing in-service training by the facility.

During the survey it was ascertained that the turnover of facility staff including administrative

harm to residents.

director in attendance. PIP's reviewed and

modified as needed.

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AUGUST	A NURSING & REHA	B CENTER			ROSSROADS LANE IERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 520	place at the time of been taken over the was leaving the fact administrator taking facility on 05/01/20 accordingly. The Dhired on 03/17/201 took over his position downward position. During a conversat (Admin #1) she state identified problems completed, medical assessments. She focused on. However they were not corresponded to 3/30/2017. Admin #1 also state number of agency of which were only the survey process to interview staff in questions arose duwere no longer at the With such a large that administrative staff constant for improvement care, staff development of the pual QA committee show failure to implement competency and extends the survey information.	oing. The administrator in the survey team's entry had a facility on 02/08/2017 and sility on 05/06/2017. The general place arrived at the 17 and assumed duties DON (director of nursing) was 7 and the Medical Director on on 04/01/2017. Ion with the administrator ted that the facility had with residents having showers tion administration, and sking stated those areas had been wer, based on survey findings acted per the AOC date of the survey team were unable wolved with resident care when the facility. Surnover of staff, including at the facility, the one ring and monitoring resident ment and competency should ity assurance committee. The old have been aware of the tracility policies regarding staff ducation.		520			
		of the facility on 05/09/2017					:

during an end of survey meeting.

CENTE	19 LOK MEDICAKE	A MEDICAID SERVICES				<u>, Ori aivit</u>	0930-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED	
		495336	B. WING				C 09/2017	
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
					3 CROSSROADS LANE			
AUGUST	A NURSING & REHAI	B CENTER						
					ISHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 520	Continued From pa	ge 1 5 1	F 5	520	'			
	No further informati exit conference on	ion was obtained prior to the 05/09/2017.						
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