DADTMENT OF HEALTH AND HUMAN CEDVICES

PRINTED: 03/21/2017

		& MEDICAID SERVICES				0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
		495177	B. WING _		03/	16/2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	NITY MEMORIAL			125 BUENA VISTA CIRCLE		
			<u> </u>	SOUTH HILL, VA 23970		i
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	3			
	An unannounced N	Medicare/Medicaid standard		is plan of correction is respectfull		
		sted 3/14/17 through 3/16/17.	su	bmitted as evidence of alleged co	mpliance.	1
	Corrections are rec	quired for compliance with 42	Th	e submission is not an admission	that the	1
		eral Long Term Care ere were no complaints	de	eficiencies existed or that we are i	n	
		the survey. The Life Safety	ag	reement with them. It is an affirm	nation that	1
	Code survey/report		со	rrections to the areas cited have I	been made	Table State
	The concus in this	161 certified bed facility was	an	d that the facility is in compliance	e with the	***
	92 at the time of the consisted of sixtee	e survey. The survey sample n current resident reviews	pa	rticipation requirements.		
		gh 16) and three closed record				
F 157 SS=D		IFY OF CHANGES	F	L57 Notify of Changed (Injury/Dec	line, Etc)	
	(g)(14) Notification		Co	rrective Measure for Residents A	ffected	1
	(i) A facility must im	nmediately inform the resident;	Th	e attending physician of Resident	# 4 was	
	consult with the res	sident's physician; and notify,	no	tified of the healed pressure ulcer	on her	
		or her authority, the resident	sa	crum and the mepilex dressing wa	S	
400 mm	representative(s) w	men there is-	dis	scontinued on 3/15/17.		
	(A) An accident inv	olving the resident which	i	we was soul as the same	s.E.	
	results in injury and physician interventi	d has the potential for requiring		entification of Other Residents wi	tn	
	physician interventi	1011,	Po	tential To Be Affected		
		ange in the resident's physical,	Ot	her residents with potential to be	affected	
		ocial status (that is, a alth, mental, or psychosocial	1	ere identified through review of th		
		threatening conditions or		ound reports on 3/24/17. There we	-	
	clinical complicatio	ns);	1	rrant residents affected		· ·
	(C) A need to alter	treatment significantly (that is,				
	a need to discontin	ue an existing form of dverse consequences, or to			3 1 2017	

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

commence a new form of treatment); or

TITLE

ADMINISTRATOR

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OMB NO 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				0930-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ľ	IPLE CONSTRUCTION NG		E SURVEY PLETED
		495177	B. WING _			16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
COMMU	NITY MEMORIAL			125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 157	Continued From pa	ge 1	N	leasures to Prevent Recurrence		
	resident from the fa §483.15(c)(1)(ii).	ansfer or discharge the acility as specified in	to	n-service to licensed nurses will be o reiterate the facility's policy for a nd for notifying the physician of a		
	(14)(i) of this sectional pertinent information	otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the	re	esident's/patient's change in cond	lition.	
	(iii) The facility must resident and the re when there is-	st also promptly notify the sident representative, if any,	re	he Director of Nursing (DON) or do eview the Weekly Wound Report a nedical record to ascertain if physi een notified of healing or changes	and resident cian has	
	(A) A change in roc as specified in §48	om or roommate assignment 3.10(e)(6); or	w	ounds. Audits will be conducted	weekly X 4	Martine and Annual Control Annual Ann
	(B) A change in res State law or regula (e)(10) of this secti	sident rights under Federal or tions as specified in paragraph on.	th	nen monthly X 2. Findings will be r ne QAPI Committee and further ac s appropriate.		
	update the address phone number of the This REQUIREME by: Based on staff interview, the facility physician of a charmed action of the supplysician was not the supply	st record and periodically is (mailing and email) and the resident representative(s). NT is not met as evidenced erview and clinical record staff failed to notify the the one in condition for one of 19 rvey sample. Resident #4's notified when a pressure ulcering in continued prescribed	C	orrection Date: 4/15/2017		
				_		

RECEIVED

Facility ID: VA0071

treatment/dressing changes to the area.

Resident #4 was admitted to the facility on 9/24/16 with a re-admission on 11/18/16.

The findings include:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-03	91
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL SUMMARY STATEMENT OF DEFICIENCIES 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970						(X3) DATE SURVEY COMPLETED	MMOCOLIMA
COMMUNITY MEMORIAL STREET ADDRESS: CITY, STATE ZIP CODE 125 BUENA VISTA EXPRODE 125 BUENA VISTA 125 BUENA VISTA EXPRODE 125 BUENA VISTA E			495177	B. WING _		03/16/2017	
(X4.) ID PRIFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) WIST BE PRECEDED BY FULL TAG (FORST-TREATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 157 Continued From page 2 Diagnoses for Resident #4 included Parkinson's disease, chronic dehydration, Crohn's disease, urinary tract infection and left femur fracture. The minimum data set (MDS) dated 12/16/16 assessed Resident #4 as cognitively intact. Resident #4's clinical record documented the resident was assessed with a stage 2 pressure ulcer on her sacrum from 11/18/16 until 1/25/17. A re-admission nursing assessment dated 11/18/16 documented the resident had a stage 2 pressure ulcer on her sacrum measuring 5 cm x 3 cm x 0 cm (length by width by depth in centimeters). A physician's order dated 11/18/16 stated, "Clean sacrum with normal saline, pat dry, apply Mepilex" with instructions to change the dressing every 3 days. Resident #4's treatment records documented dressing changes to the sacral pressure ulcer every three days as ordered. A nursing note dated 11/25/17 documented the sacral pressure ulcer was healed. A wound assessment record dated 11/25/17 also listed the stage 2 pressure sore as "resolved." Resident #4's physician was not notified the	NAME OF	PROVIDER OR SUPPLIER	4		STREET ADDRESS, CITY, STATE, ZIP		
F157 Continued From page 2 Diagnoses for Resident #4 included Parkinson's disease, urinary tract infection and left femur fracture. The minimum data set (MDS) dated 12/16/16 assessed Resident #4 as cognitively intact. Resident #4's clinical record documented the resident was assessed with a stage 2 pressure ulcer on her sacrum from 11/18/16 until 1/25/17. A re-admission nursing assessment dated 11/18/16 documented the resident was accommended the resident had a stage 2 pressure ulcer on her sacrum measuring 5 cm x 3 cm x 0 cm (length by width by depth in centimeters). A physician's order dated 11/18/16 stated, "Clean sacrum with normal saline, pat dry, apply Mepilex" with instructions to change the dressing every 3 days. Resident #4's treatment records documented dressing changes to the sacral pressure ulcer every three days as ordered. A nursing note dated 1/25/17 documented the stage 2 pressure sore as "resolved." Resident #4's physician was not notified the	сомми	INITY MEMORIAL					
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records documented continued treatment with the ordered Mepilex dressing every three days to the resident's sacral area from 1/25/17 through 3/12/17 even though the pressure ulcer was resolved. Nursing notes documented no notification to the physician regarding the change in the status of the resident's pressure sore. On 3/15/17 at 11:20 a.m. the licensed practical nurse (LPN #1) responsible for wound treatments		Diagnoses for Residisease, chronic de urinary tract infection minimum data set (assessed Resident Resident #4's clinic resident was assessulcer on her sacrum A re-admission nurs 11/18/16 documente pressure ulcer on he 3 cm x 0 cm (length centimeters). A phystated, "Clean sacruapply Mepilex" with dressing every 3 da records documented sacral pressure ulce ordered. A nursing documented the sacral pressure ulce ordered. A wound as 1/25/17 also listed the "resolved." Resident #4's physic sacrum pressure ulce ordered Mepilex dre resident's sacral are 3/12/17 even though resolved. Nursing motification to the physic the status of the resolved of the resolved. On 3/15/17 at 11:20	ident #4 included Parkinson's ehydration, Crohn's disease, on and left femur fracture. The (MDS) dated 12/16/16 at #4 as cognitively intact. Ital record documented the sed with a stage 2 pressure on from 11/18/16 until 1/25/17, sing assessment dated ed the resident had a stage 2 ler sacrum measuring 5 cm x in by width by depth in sysician's order dated 11/18/16 um with normal saline, pat dry, instructions to change the large year. Resident #4's treatment did dressing changes to the large revery three days as note dated 1/25/17 cral pressure ulcer was seessment record dated the stage 2 pressure sore as learn was not notified the large revery three days to the large as from 1/25/17 through the pressure ulcer was lotes documented no sysician regarding the change esident's pressure sore. a.m. the licensed practical	F 15	7		

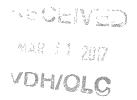
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was interviewed about Resident #4's sacral pressure ulcer. LPN #1 stated the resident's

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Facility ID: VA0071

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STATEMEN AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		(X3) DAT	TE SURVEY MPLETED
		495177	B. WING	"Management and the control of the c		no de ante	03.	/16/2017
	PROVIDER OR SUPPLIER			125 BUE	ADDRESS, CITY, STA ENA VISTA CIRCLE I HILL, VA 23970			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		EACH CORRECTIV ROSS-REFERENCEI		BE	(X5) COMPLETION DATE
	pressure ulcer healishe decided to conta protective measure that sometimes after area was tender and back up. When ask notified the open pressure to continue treatment occurrent to continue treatment after the sore was reather the physician was not treatment options af LPN #1 stated, "The The National Pressur (NPUAP) defines a proceed to a medical or other present as intact skin be painful. The injurintense and/or prolor combination with she a stage 2 pressure so loss of skin with exposed is viable, pink or present as an intact of blister. Adipose (fat) tissues are not visible and eschar are not pink. The manufacturer's in Mepilex as a patenter designed for a wide in the stage of	ed on 1/25/17. LPN #1 stated inue the Mepilex dressings as inc. LPN #1 stated she found or a pressure ulcer healed the dishat the potential to open are different was ressure ulcer had healed, LPN be a note notifying the doctor." It was no new order received into the resident's sacrum resolved. When asked why contacted about desired the the wound had healed, by give us leeway with that." The Ulcer Advisory Panel pressure ulcer/sore as the skin and underlying soft of bony prominence or related or device. The injury can in or an open ulcer and may be or an open ulcer and may be or an open ulcer and may go occurs as a result of the pressure or pressure in the pressure of pressure in the pressure of pressure or pressure in the pressure of pressure in the pressure of pressure in the pressure of the wound red, moist, and may also or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and deeper the defines or ruptured serum-filled its not visible and for rupture	F1	57				

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These findings were reviewed with the

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		E SURVEY IPLETED				
		495177	B. WING		03/	16/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	meeting on 3/15/17 (1) NPUAP Pressure National Pressure www.npuap.org/	director of nursing during a 7 at 4:00 p.m. Ire Injury Stages. 2016. Ulcer Advisory Panel. 3/17/17. Sacrum. Molnlycke Health weden. 2014.	F 1	57		
SS=D	SAFE/CLEAN/COMENT (e)(2) The right to represent the rights or hereidents. §483.10(i) Safe enverse.	retain and use personal ding furnishings, and clothing, unless to do so would infringe nealth and safety of other vironment. The resident has a an, comfortable and homelike	E C	Environment Corrective Measure for Residence were no specific residence affected by this citation were in the day room on the removed on 3/16/2017.	i dents Affected ents cited as having n. The items that	
	treatment and support The facility must provide (i)(1) A safe, clean, environment, allowing her personal belong (i) This includes entreceive care and sephysical layout of trindependence and (ii) The facility shall the protection of the or theft.	ding but not limited to receiving ports for daily living safely. Tovide- comfortable, and homelike ing the resident to use his or gings to the extent possible. suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. Exercise reasonable care for e resident's property from loss NT is not met as evidenced	T a tl	dentification of Other Residential To Be Affected There were no other resident in three other day rooms in three were inspected on 3/16 innecessary items or equipment of the property of the property in the	ts affected. There the facility and all 6/17 for	





Facility ID: VA0071

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CENTE	19 LOV MEDICAVE	& MEDICAID SERVICES		(<u> </u>	. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION		E SURVEY IPLETED	
		495177	B. WING		03/	16/2017	
NAME OF I	PROVIDER OR SUPPLIER		i	STREET ADDRESS, CITY, STATE, ZIP CODE			
COMMU	NITY MEMORIAL		ı	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 252	Continued From pa	ge 5	F 252				
	facility failed to ensi	ion and staff interview, the ure a homelike environment ng units. Reclining chairs,	Me	asures to Prevent Recurrence			
		undecorated Christmas tree	In-s	ervice to staff regarding the resider	nts' right	WAS DEPOSITED TO A STATE OF THE	
	were stored in the r	esident day room on unit. In	to a safe, clean, comfortable environment will				
	addition, the piano i	n the room was not eclining chairs stored in front	be conducted. Staff will also be reminded where				
	of the instrument.	on my orian octored in none	iten	ns/equipment are to be kept when	not in		
,	The findings include	e:	use.				
		p.m. the day use room on unit	Мо	nitoring:			
		en used for a private family m had a sofa, chairs, a	The	Director of Nursing or designee wil	l conduct		
		television and a piano for	daily inspections of the resident day rooms to				
		d in the room were two	ensı	ure they are kept uncluttered. Rour	ıds will		
		s. The reclining chairs were f the piano keyboard making it	be c	onducted daily X 4 weeks then if no	issues		
	inaccessible. Three	e wheelchairs, one with a	are	identified, weekly X 2 months. Find	ings will		
		xygen cylinder, were stored r the piano. An undecorated	be reported to the QAPI Committee and further				
	Christmas tree was	positioned next to the door at	actio	ons taken as appropriate.	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		
	the entrance to the room. On 3/16/17 at 8:45 a.m. the unit 1 resident day use room was observed again. The two reclining chairs were still positioned in front of the piano and three wheelchairs were stored in the room along with the undecorated Christmas tree.		Corr	rection Date: 4/15/2017	3		
	nurse (LPN #3) wor about the day room intended for resident elevision or telepho other rooms on the wheelchairs and res						
	On 3/16/17 at 9:00 a	a.m. the registered nurse				ĺ	

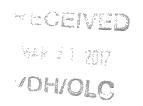


clinical coordinator (RN #1) was interviewed

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	42 LOK MEDICAKE	A MEDICAID SERVICES			<u> </u>	J 140. 0330-033 i
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X	3) DATE SURVEY COMPLETED
		495177	B. WING	9		03/16/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	, CODE	
COMMU	NITY MEMORIAL			125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIVE ACTIO	ON SHOULD BE HE APPROPRIA	
F 252	Continued From pa	ge 6 equipment and undecorated	F:	252		
	tree in the resident room was setup so television, use the telephone conversa telephone. RN #1 in the room should designated storage	day room. RN #1 stated the residents could watch computer or have private ations with use of the portable stated the resident equipment have been stored in rooms. RN #1 stated she did christmas tree had not been		F 279 Develop Comprehensive	. Caro Plans	
				r 279 Develop Comprehensive	Care Flairs	· !
	These findings wer administrator and of meeting on 3/16/17 483.20(d);483.21(b COMPREHENSIVE	irector of nursing during a at 9:40 a.m.)(1) DEVELOP	-	Corrective Measure for Reside Resident # 4's care plan was up 3/15/17 to include the intraven	odated on	Observation of the Control of the Co
00 0	483.20 (d) Use. A facility nassessments compmonths in the resid	nust maintain all resident eleted within the previous 15 ent's active record and use the esments to develop, review	**************************************	being administered thru an intr Care of the site was also include plan update.	ed in the ca	-
		dent's comprehensive care		Identification of Other Residen Potential To Be Affected	its with	;
	483.21 (b) Comprehensive		t :	On 3/23/17, other residents wire affected were identified through the care plans of residents with	ough reviev orders for	v of i.v.
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n	t develop and implement a son-centered care plan for sistent with the resident rights (c)(2) and §483.10(c)(3), that is e objectives and timeframes a medical, nursing, and mental eeds that are identified in the essment. The comprehensive cribe the following -		fluids or medication administra line. Two other residents met tl both have appropriate care pla	he criteria b	out

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u> ЭМВ NO.</u>	. 0938- 0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
		495177	B. WING			03/	16/2017
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY MEMORIAL				5 BUENA VISTA CIRCLE DUTH HILL, VA 23970		
(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)	LD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 7	F 2	279			A view investigation of the view of the vi
		t are to be furnished to attain	No. ocean measure	Vlea:	sures to Prevent Recurrence		
	physical, mental, ar	dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and			rvice to nurses and the interdiscip team members regarding the faci		Yes in communication and the communication a
	under §483.24, §48 provided due to the	at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6).	v	vill b on ca	ocol for care plan development ar se conducted. Special focus will be are planning for i.v. fluid administi and care of the i.v. site.	placed	
	rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's resident's represent (A) The resident's represent (A) The resident's redesired outcomes. (B) The resident's refuture discharge. For the resident community was assolical contact agence entities, for this purious (C) Discharge plans plan, as appropriate	If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document at's desire to return to the sessed and any referrals to sies and/or other appropriate pose. Is in the comprehensive care e, in accordance with the	n id c id r	The Energy needs from the second conditions	Director of Nursing or designee with cal records audits of i.v. orders to propriate care plan is in place. This ucted daily X 2 weeks then if no is ified, weekly X 10. Findings will be red to the QAPI Committee and fins taken as appropriate.	ascertair s will be sues are	
	plan, as appropriate			3			** · · · ·

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by:

This REQUIREMENT is not met as evidenced

Based on observation, resident interview, staff

Event ID: RDU811

Facility ID: VA0071

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING				TE SURVEY MPLETED	
	495177	B. WING		03	/16/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL		12	REET ADDRESS, CITY, STATE, ZIP C 5 BUENA VISTA CIRCLE DUTH HILL, VA 23970	ODE	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
staff failed to develor for one of 19 reside Resident #4 had no regarding care for his site and daily administered at 12 through an IV acceuper chest. Resident #6 cadministered a bag prevent dehydration. Resident #7 was ac 9/24/16 with a re-act Diagnoses for Resident with a re-act Diagnoses for Resident with a set of the assessed Resident with a set of the assessed Resident with a set of the administered at 12 through an IV acceuper chest. Resident with a life administered a bag prevent dehydration. Resident #4's clinic physician's order dehydration. Resident #4's clinic physician's order dehydration. Resident #6's clinic physician's order dehydration. Resident #6's clinic physician's order dehydration.	al record review, the facility op a comprehensive care planents in the survey sample. It care plan developed her intravenous (IV) access histration of IV fluids. The desire that included Parkinson's dehydration, Crohn's disease, on and left femur fracture. The (MDS) dated 12/16/16 that as cognitively intact. The dent #4 was histravenous fluid was being smilliliters (ml) per hour less port in the resident's left dent #4 was interviewed at this uids. Resident #4 stated she is with dehydration due to her disease and she was gof IV fluids each day to m.	e			

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				ONB NO.	0936-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		E CONSTRUCTION		E SURVEY PLETED	
		495177	B. WING			03/	16/2017	
NAME OF F	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
COMMUN	NITY MEMORIAL				25 BUENA VISTA CIRCLE			
COMMO	NIT WEWORIAL			S	OUTH HILL, VA 23970			
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				1				
F 279	Continued From pa	-		1				
		of care (revised 3/1/17)						
		ms, goals and/or interventions		28	2			
	or the daily IV fluid	ent's IV "mid-line" access site		20.	2			
	or the daily iv ilulu	administration.		orr	ective Measure for Residents A	ffected		
	On 3/15/17 at 9:45	a.m. the registered nurse (RN						
	#2) responsible for care plan development was			Resident # 6 was screened by Occupational				
		Resident #4's IV fluids and IV			apy staff on 3/16/2017 and the			
		reviewing the resident's care			er needs the palm guards. The p		1	
		she did not see anything on the IV site or IV fluid		_		•		
administration.		t the tv site of tv hala			discontinued the order for their		1	
			C	are	plan was updated to reflect this			
		e reviewed with the				. 1		
		director of nursing during a	1	`	tification of Other Residents wi	th		
E 202	meeting on 3/15/17 at 4:00 p.m. 483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN		P	ote	ential To Be Affected			
CS-D			_				*	
33-0			1		er residents with potential to be	_		
	(b)(3) Comprehens		n	urs	ing staff's non-compliance with p	ohysician-		
		ded or arranged by the facility,	0	rde	red palm guards were identified	through	1	
	•	comprehensive care plan,	r	evie	ew of physician orders on 3/22. T	here were		
	must-		t	wo	with orders and observation indi	cated the	PORTION AND THE PROPERTY AND THE PROPERT	
	(ii) Be provided by	qualified persons in	n	alm	n guards are in use.		!	
	accordance with ea	ach resident's written plan of	P	ann	rgadius are in ase.			
	care.		N	Лeа	sures to Prevent Recurrence		1	
		NT is not met as evidenced	1				:	
	by: Based on staff inte	erview and clinical record	Ir	n-se	ervice to nursing staff will be con-	ducted to	· !	
		failed to follow interventions			rate compliance with physician-			
	on a comprehensiv	e care plan (CCP) for one of	1		plan-directed interventions for p		į	
	19 residents in the	survey sample, Resident #6.			•		1	
	Facility at off falls -1	to place bilateral palm guarda			r prevention. Focus will be on th	•		
	into Resident #6's	to place bilateral palm guards hands as included in the CCP.			of palm guards, Prevalon boots, a	and off-		
	THE INCOMENT #05	Tando do moiadea m me OOF.	lo	oadi	ing of heels.		:	
	Findings included:						<u> </u>	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		E SURVEY IPLETED
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NAME OF F	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY MEMORIAL		i	25 BUENA VISTA CIRCLE		
	y			SOUTH HILL, VA 23970	·	
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F 282	Continued From pa	ge 10				
	on 01/31/2006 and diagnoses including Diabetes, Hyperten Dysphagia, Feeding Contractures. The most recent MI quarterly assessme reference date) of 1 assessed as severe long term memory at Resident #6's medio 03/15/2017. The C included an interverstated, "Bilateral pexcept during bathin care" Resident #6 was ob a.m. and again at 1 guards were not in pobservation. CNA #2 (certified nuinterviewed at approximately 4 geris palm no, wait a minute. In she has are these (#6's bilateral geris left) her palms." At approximately 11 practical nurse) was	DS (minimum data set) was a cent with an ARD (assessment 12/22/2016. Resident #6 was cely impaired in her short and and cognitive skills. cal record was reviewed on CP for Self Care Deficit intion dated 11/09/16 that coalm guards at all times ing and dressing and hygiene deserved in her room at 7:45 1:00 a.m. Bilateral palm	The insp paln heel wee repo	Director of Nursing or designee well ections to ascertain compliance we guards, prevalon boots and off-lest. Audits will be conducted daily bely X 10. Findings of these audits worted to the QAPI Committee and constaken as appropriate. Tection Date: 4/15/2017	vith use of oading of (10 then will be	1

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(Gestured to the computer). Here it is on the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	THE CONSTITUTION	(X3) DATE SURVEY COMPLETED
	495177	B. WING		03/16/2017
NAME OF PROVIDER OR SUPPLIE COMMUNITY MEMORIAL	٦		STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION

F 282 Continued From page 11

orders, but it is an OT (occupational therapy) order. It doesn't show up anywhere else. That is why it's not on the TAR (treatment administration sheet) for us to sign off. The original order was written 2/19/16. When therapy stopped she should have been referred to restorative and then to us (meaning nursing). I will have to call the family and then get an OT order for an evaluation. We can't just throw palm guards in there if she hasn't been using them."

LPN #2, CNA #2 and this surveyor went to Resident #6's room. LPN #2 stated, "Here are her palm guards in the drawer." The palm guards were located in the drawer of the nightstand. LPN #2, CNA #2 and this surveyor observed Resident #6's palms. No breakdown was noted on either hand.

The Administrator and DON (director of nursing) were informed of the above during a meeting with survey team on 03/15/17 at 4:00 p.m. No further information was received prior to the exit conference on 03/16/17.

F 309 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES SS=D FOR HIGHEST WELL BEING

483.24 Quality of life

Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

483.25 Quality of care

F 309 Provide Care/Services for Highest Well Being

Corrective Measure for Residents Affected

Resident # 12's CPAP mask and nebulizer mask were placed in a plastic bag as soon as surveyor finding was known. He was discharged home on 3/21/17 and further action is not necessary.

Identification of Other Residents With Potential To Be Affected

Other residents with potential to be affected were identified through review of orders on

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PRINTED: 03/21/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT AND PLAN 0	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
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F 309	Quality of care is a applies to all treatr facility residents. E assessment of a rethat residents receaceordance with practice, the compeare plan, and the but not limited to the comprehensive and the residents. (I) Dialysis. The facility must e provided to reside consistent with provided to residents who require services, consiste of practice, the concare plan, and the preferences. This REQUIREMED by: Based on observices and the preferences. The failed, for one sample (Resident orders. The facility's oxygen items the physician. The findings were resident # 12 in the part of the preferences. Resident # 12 in the preference of the physician.	fundamental principle that nent and care provided to lased on the comprehensive esident, the facility must ensure sive treatment and care in refessional standards of rehensive person-centered residents' choices, including ne following: Lent. Insure that pain management is not swho require such services, of essional standards of practice, the person-centered care plan, goals and preferences. Lacility must ensure that uire dialysis receive such not with professional standards mprehensive person-centered the residents' goals and ENT is not met as evidenced lation, clinical record review, do resident interview, the facility end of 19 residents in the survey # 12), to follow physician's the standards at a zip lock bag as ordered by	Ir fa comp st C comp recomp approximately ap	reatments. Their nebulasks are being stored use. They will be monotinued compliance. leasures To Prevent For a services to nursing stored to continue the compliance of the coring CPAP/BIPAP and esterated. Residents what was and/or their familiarity will also be educated orage of these devices to make the compliance who compliance who can be compliance where the compliance were proposed to QAPI and for a propriate.	Ilizer or CPAP/BIP I in plastic bags we nitored to ensure the securrence the securrence that is a securrence that is a securrence that is a securrence to policies will be the with facility policies will be the with facility policies will make the securrence of the property of the storage of the securrence of the security of th	PAP when not e cy for s will be piratory consible er ds to will be sliance is	

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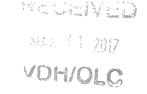
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NING		TE SURVEY MPLETED
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F 309	heart failure, hypereflux disease, disease, chronic recataracts, dyspnethypertension. Ac Minimum Data Se Reference Date of assessed under Seas being cognitive of 13 out of 15. During the orienta 3/14/17, Resident seated in a wheel permission to ent noticed a nebulizer, did, and he also see When asked when Resident # 12 sais the night stand. At the resident, the sested in the resident # 12 sais the night stand. At the resident # 12 sais the night stand. At the resident # 12 sais personal mask the Neither the nebuli were stored in production of the practical Nurse) wand C-PAP masks should be in bags.	ertension, gastroesophageal abetes mellitus, hyperlipidemia, chronic obstructive pulmonary respiratory failure with hypoxia, ea, and secondary pulmonary cording to the Admission et with an Assessment of 2/27/17, the resident was Section C (Cognitive Patterns) ely intact, with a Summary Score et ation tour at 6:30 p.m. on at # 12 was observed in his room, chair. After obtaining er the room, the surveyor er mask on top of the night stander resident's bed. Asked if he Resident # 12 replied that he stated that he used a C-PAP. The the C-PAP mask was stored, dit was in the second drawer of after obtaining permission from surveyor opened the drawer and AP mask in the drawer. dithe C-PAP mask was his at he brought from home. The treatment of the C-PAP mask was stored at the C-PAP mask was his at he brought from home. The treatment of the C-PAP mask was stored at the C-PAP mask was his at he brought from home. The treatment of the C-PAP mask was his at he brought from home.		309		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495177	B. WING		03/16/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
COMMUNITY MEMORIAL			125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
PREFIX (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 COMPLETION
				

F 309 Continued From page 14 2/20/17:

"Auto C-PAP when asleep."
"Oxygen: store oxygen items in a zip lock bag each shift at Shift 1, Shift 2, Shift 3."

The failure to store Resident # 12's nebulizer mask and C-PAP mask in bags was discussed during a meeting at 4:30 p.m. on 3/15/17 that included the Administrator, Director of Nursing, and the survey team.

F 314 483.25(b)(1) TREATMENT/SVCS TO SS=F PREVENT/HEAL PRESSURE SORES

- (b) Skin Integrity -
- (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-
- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
- (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and clinical record review, the facility staff failed to accurately assess and/or implement interventions for the prevention of pressure ulcers for four of 19 residents in the survey sample.

F 314

Corrective Measure for Residents Affected

The attending physician of Resident # 4 was notified of the healed pressure ulcer on her sacrum and the mepilex dressing was discontinued on 3/15/17. The inaccurate weekly skin assessment cannot be corrected as the open areas have healed. Staff will ensure going forward that this resident's weekly skin assessments are accurate.

Resident # 6 was screened by Occupational Therapy staff and the resident no longer needs the palm guards. The physician has discontinued the order for their use.

Prevalon boots were applied on Resident # 7 during survey. Staff involved in her care has been made aware of this intervention and compliance is being monitored by the clinical coordinators/charge nurses.

Resident # 10 was re-evaluated and is noncompliant with elevating his heels. An order for Prevalon boots was obtained on 3/23/17.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		& MEDICAID SERVICES			IB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	l i	X3) DATE SURVEY COMPLETED	
		495177	B. WING		03/16/2017	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS	S, CITY, STATE, ZIP CODE		
COMMU	NITY MEMORIAL		125 BUENA VIST SOUTH HILL, V			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH C	IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD & EFERENCED TO THE APPROPR DEFICIENCY)		
F 314	Continued From pa	ge 15	!			
	1. Resident #4 had	pressure sore	Identification of	Other Residents with		
	treatments/dressing	g changes to her sacrum a month after the pressure	Potential To Be	Affected		
	sore was assessed	as healed without a	Based on review	of weekly Wound Repor	rt and	
		continue the treatment.	medical records	on 3/24/17, there were	no	
	inaccurately listed t	he resident's skin as "intact"	other current res	sidents affected by nurse	es'	
		vas being treated for a sacral	failure to notify t	he physician of a healed		
	pressure sore and a left ear.	an open skin area behind her	pressure ulcer.			
		not have physician ordered	Review of physic	ian orders on 3/22 ident	ified	
	palm guards in use	for pressure ulcer prevention.	two current resid	lents with orders for pal	m	
	3. Resident #7 did i	not have physician ordered	guard. Observati	ons indicated that they a	are still	
		se for pressure ulcer	appropriate and	they are being used.		
		d and the second and	Review of physic	ian orders on 3/22 ident	ified	
		eels were not elevated as of care for the pressure ulcer	several current re	esidents with orders for	:	
	prevention.	or saile for the pressaile sheet	Prevalon boots and observations indicated that			
			they are in use. T	he same review also ind	icated	
	The findings include	a.	several residents	with orders for elevatin	g	
	The initiality include	<u>.</u>	heels. Further re	view of the need or		
	1a) Resident #4 ha		effectiveness of t	hese interventions will b	oe !	
	month after the pre	g changes continued for over a ssure sore was assessed as sysician's order to continue the	conducted and a	ctions taken as appropri	ate.	
	treatment.	Typicial to order to continue the	Other residents a	ffected by the inaccurac	cy in	
		1 - 20 - 1 1 - 13 - 15 - 120		ssments will be identifie		
		dmitted to the facility on dmission on 11/18/16.	through review o	f physician-ordered trea	tments	

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Diagnoses for Resident #4 included Parkinson's

urinary tract infection and left femur fracture. The

disease, chronic dehydration, Crohn's disease,

minimum data set (MDS) dated 12/16/16 assessed Resident #4 as cognitively intact.

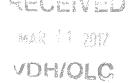
Event ID: RDU811

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be addressed.

and weekly skin assessments. Discrepancies will

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495177	B. WING		03/16/2017
NAME OF PROVIDER OR SUPPLIE	₹		STREET ADDRESS, CITY, STATE, ZIP CODE	
COMMUNITY MEMORIAL			125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
PREFIX (EACH DEFICIEN	FATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION

F 314 Continued From page 16

Resident #4's clinical record documented a re-admission nursing assessment dated 11/18/16 assessing the resident with a stage 2 pressure sore on her sacrum measuring 5 cm x 3 cm x 0 cm (length by width by depth in centimeters). A physician's order dated 11/18/16 stated, "Clean sacrum with normal saline, pat dry, apply Mepilex" with instructions to change the dressing every 3 days. Resident #4's treatment records documented dressing changes to the sacral pressure sore every three days as ordered. A nursing note dated 1/25/17 documented the sacral pressure sore was healed. A wound assessment record dated 1/25/17 also listed the stage 2 pressure sore as "resolved."

Resident #4's physician was not notified the sacrum pressure sore was healed. Treatment records documented continued treatment with the ordered Mepilex dressing every three days to the resident's sacral area from 1/25/17 through 3/12/17 even though the pressure sore was resolved. Nursing notes documented no notification to the physician regarding the change in the status of the resident's pressure sore. There was no physician's order obtained to continue treatment of the sacral area with the Mepilex dressing.

Resident #4's care plan (revised 3/1/17) listed the resident had potential for altered skin integrity. Interventions to prevent skin breakdown included, "Monitor skin condition q [each] shift...If any changes notify MD and treat as soon as possible..."

On 3/15/17 at 11:20 a.m. the licensed practical nurse (LPN #1) responsible for wound treatments

Measures to Prevent Recurrence

In-service to licensed nurses will be conducted to reiterate the facility's policy for notifying the physician of changes in resident condition.

Licensed nurses and C.N.A.'s will be in-serviced on pressure ulcer prevention strategies, and compliance with physician-ordered pressure ulcer prevention devices. The Weekly Skin Assessment form will also be reviewed with licensed nurses with focus on accuracy of skin assessments and documentation.

Monitoring:

The Director of Nursing or designee will review the Weekly Wound Report and resident medical record to ascertain if physician has been notified of healing or changes in residents' wounds. Audits will be conducted weekly X 4 then monthly X 2.

The Director of Nursing or designee will review weekly skin assessments for accuracy. Audits will be conducted weekly X 4 then monthly X 2.

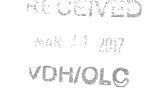
The Director of Nursing or designee will conduct rounds to ascertain compliance with use of palm guards, Prevalon boots and elevating of heels. Audits will be conducted daily X 10 then

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NAME OF PROVIDER C		1		STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
DREELY (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
pressure she decia a protect that som area was back up notified #1 state LPN #1 to continuafter the the physic treatment LPN #1 On 3/15 Resident dressing #5 state now and done to On 3/15 Resident register area has of the older removes had not skin irrite On 3/15 (DON) with continuations assesses should here.	rviewed able ulcer. LF e ulcer head ded to contive measuretimes aft is tender are. When as the open pd, "I don't stated there ue treatmers is stated there as ore was intoptions as stated, "The stated, "The stated, "The stated are made in the Mepile of the Mepile of the dress redness, not at 1:50 was intervied treatment of the dress redness, not at 1:50 was intervied treatment as healed as healed as healed as healed as healed as healed are the stated ar	bout Resident #4's sacral 1'N #1 stated the resident's led on 1/25/17. LPN #1 stated tinue the Mepilex dressings as ire. LPN #1 stated she found er a pressure ulcer healed the nd had the potential to open ked if the physician was ressure ulcer had healed, LPN see a note notifying the doctor." It was no new order received ent to the resident's sacrum resolved. When asked why not contacted about desired after the wound had healed, ney give us leeway with that." p.m. LPN #5 caring for neterviewed about ongoing to the resident's sacrum. LPN ent's sacral skin was "clear" ex dressing changes were still of the resident's sacral skin was "clear" ex dressing changes were still of the resident's sacral at the time dated 3/12/16. LPN #5 sing. The resident's sacral area to open areas and no signs of	Fi Q, ap	eekly X 10. ndings of these audits will be repo API Committee and further actions opropriate. orrection Date: 4/15/2017		

PRINTED: 03/21/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SUR COMPLETE	
	495177	B. WING			03/16/20	017
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL			STREET ADDRESS, CITY, STA 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	TE, ZIP CODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIV CROSS-REFERENCEI		BE COM	(X5) PLETION DATE
The National Press (NPUAP) defines a "localized damage t tissue usually over a to a medical or othe present as intact sk be painful. The inju intense and/or prolo combination with sh a stage 2 pressure loss of skin with exp bed is viable, pink of present as an intact blister. Adipose (fa tissues are not visib and eschar are not The manufacturer's Mepilex as a patent "designed for a wide such as pressure ul traumatic wounds." These findings were administrator and d meeting on 3/15/17 1b) Resident #4's w inaccurately listed th when the resident w pressure sore and a left ear. Resident #4's clinica re-admission nursin	inue, discontinue or change ea. ure Ulcer Advisory Panel pressure ulcer/sore as to the skin and underlying soft a bony prominence or related er device. The injury can in or an open ulcer and may ary occurs as a result of onged pressure or pressure in near" This reference defines sore as, "Partial-thickness cosed dermis. The wound or red, moist, and may also at or ruptured serum-filled to is not visible and deeper ole. Granulation tissue, slough present" (1) information insert described the dadhesive dressing er range of exuding wounds licers, leg and foot ulcers and (2) er reviewed with the irector of nursing during a	F 3	14			
FORM CMS-2567(02-99) Previous Versions		1	Facility ID: VA0071	If continuati	on sheet Page	19 of 45

Nag 33 2017 10H/OLG

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

Facility ID: VA0071

PRINTED: 03/21/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		495177	B. WING			03/	16/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	amana merementare TO	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 314	cm (length by widt physician's order of sacrum with normal Mepilex" with instruevery 3 days. Foll were documented dated 2/9/16, 12/1 1/4/17, 1/9/17, 1/1 record dated 1/25/"resolved." A nursidocumented the reopen skin area be stated, "I found a swollen and what I moment resident in now it was an openoted" A physic required bacitracin area twice per day records documented startiskin integrity sheer resident's skin integrity sheer resident's skin as 12/20/16, 1/5/17 amade no mention present on the reson the forms were sheets dated 3/6/1 resident's skin wa of the open skin a ear. Body diagram blank.	n measuring 5 cm x 3 cm x 0 in by depth in centimeters). A lated 11/18/16 stated, "Clean al saline, pat dry, apply uctions to change the dressing ow up assessment records for the sacral pressure sore 2/16, 12/21/16, 12/28/16, 8/17 and 1/25/17. The wound 17 listed the pressure sore as ing note dated 3/1/17 esident was assessed with an inind her left ear. This note an area that was red and ooked to be a scabAt this had picked off the scab and in area with very slight bleeding an's order dated 3/1/17 to be applied to the open skin of the bacitracin was applied with the bacitracin was applied with the bacitracin was applied in the stage 2 pressure sore ident's sacrum. Body diagrams blank. Weekly skin integrity 7 and 3/13/17 documented the strintact" and made no mention rea behind the resident's left in son these forms were also		314			

If continuation sheet Page 20 of 45

PRINTED: 03/21/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MILST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 314 Continued From page 20 was interviewed about the accuracy of the weekly skin integrity sheets. LPN #1 stated the weekly skin integrity sheets. LPN #1 stated resident's sacral pressure sore was presented from urses were responsible for completed the wound tracking records and the floor nurses may not have been reviewing the entire body or including the current open areas on the weekly skin assessment sheets. RN #3 stated the weekly stated the weekly skin assessment sheets. RN #3 stated the skin integrity sheets with a seem and should be indicated on the form. On 3/15/71 at 1:30 p.m. the registered nurse clinical coordinator (RN #3) was interviewed about the weekly skin assessment sheets. RN #3 stated the skin integrity sheets were supposed to be done weekly by the floor nurses. RN#3 stated Resident #4's skin assessment sheets. RN #3 stated the skin integrity sheets were supposed to include an assessment of all areas of the resident's skin. When asked why the sacral pressure sore was not indicated on the floor. RN #3 stated. If don't know. Maybe they [nurses] were not looking at her sacrum." RN #3 stated in the old in the nurses should be looking at the entire body when doing skin assessments and any open areas should be indicated on the form. On 3/15/17 at 1:35 p.m. an assessment of	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
COMMUNITY MEMORIAL Tas Buena vista circular (CA) Discuminary Statement of Deficiencies (EACH Deficiency Must Be preceded by Full Tag (EACH OFFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX (EACH OFFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX TAG (EACH OFFICIENCY) PREFIX TAG (EACH OFFICIENCY) CHAPTOPRIATE OF CROSS-REFERENCE TO THE APPROPRIATE OF CROSS-REFERENCE TO THE APPROPRIATE OF CASS-REFERENCE TO THE APPROPRIATE OF TAG (TAG (TAG (TAG (TAG (TAG (TAG (TAG		495177	B. WING		03	/16/2017
FREEK REGULATORY OR LSC IDENTIFYING INFORMATION) F 314 Continued From page 20 was interviewed about the accuracy of the weekly skin integrity sheets. LPN #1 stated the weekly skin sasessment sheets were started during December 2016. LPN #1 stated resident's sacral pressure sore was presented from 11/18/16 until 1/25/17 when the sore was assessed as healed. LPN #1 did not know why the weekly skin integrity sheets did not reflect the pressure sore was presented from 11/18/16 until 1/25/17 when the sore was assessed as healed. LPN #1 stated reflect the reflect the pressure sore. LPN #1 stated she routinely completed the wound tracking records and the floor nurses were responsible for completing the weekly skin sheets. On 3/15/71 at 1:30 p.m. the registered nurse clinical coordinator (RN #3) was interviewed about the weekly skin assessment swere supposed to be done weekly skin assessment was scheduled for each Monday evening. RN #3 stated Resident #4's skin assessment was scheduled for each Monday evening. RN #3 stated assessments were supposed to include an assessment of all areas of the resident's skin. When asked why the sacral pressure sore was not indicated on the weekly skin sheets dated 12/20/16, 1/5/17 and 1/23/17, RN #3 stated, "1 don't know. Maybe they [nurses] were not looking at her sacrum." RN #3 stated she thought the nurses should be looking at the entire body when doing skin assessments and any open areas should be indicated on the form.				25 BUENA VISTA CIRCLE		
was interviewed about the accuracy of the weekly skin integrity sheets. LPN #1 stated the weekly skin assessment sheets were started during December 2016. LPN #1 stated resident's sacral pressure sore was presented from 11/18/16 until 1/25/17 when the sore was assessed as healed. LPN #1 did not know why the weekly skin integrity sheets did not reflect the pressure sore. LPN #1 stated she routinely completed the wound tracking records and the floor nurses were responsible for completing the weekly skin checks. LPN #1 stated the floor nurses may not have been reviewing the entire body or including the current open areas on the weekly skin sheets. On 3/15/71 at 1:30 p.m. the registered nurse clinical coordinator (RN #3) was interviewed about the weekly skin assessment sheets. RN #3 stated the skin integrity sheets were supposed to be done weekly by the floor nurses. RN#3 stated Resident #4's skin assessment was scheduled for each Monday evening. RN #3 stated assessments were supposed to include an assessment of all areas of the resident's skin. When asked why the sacral pressure sore was not indicated on the weekly skin sheets dated 12/20/16, 1/5/17 and 1/23/17, RN #3 stated, "I don't know. Maybe they [nurses] were not looking at her sacrum." RN #3 stated he looking at the entire body when doing skin assessments and any open areas should be indicated on the form.	PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	; COMPLETION
Resident #4's skin was conducted by LPN #5 and registered nurse (RN) #3. The resident's sacral area had a Mepilex dressing in place dated 3/12/16. LPN #5 removed the dressing. The resident's sacral area had no redness, no open	was interviewed abskin integrity sheets skin assessment sincember 2016. Let pressure sore was 1/25/17 when the stated she routinely tracking records are responsible for conchecks. LPN #1 stated she reviewing the current open are current open are considered as the skin in the stated she reviewing the current open are current ope	bout the accuracy of the weekly s. LPN #1 stated the weekly heets were started during LPN #1 stated resident's sacral presented from 11/18/16 until fore was assessed as healed. It was a sacral presented from 11/18/16 until fore was assessed as healed. It was a sacral presented from 11/18/16 until fore was assessed as healed. It was a sacral presented the wound and the floor nurses were impleting the weekly skin reated the floor nurses may not any the entire body or including reas on the weekly skin sheets. In the registered nurse (RN #3) was interviewed kin assessment sheets. RN integrity sheets were supposed by the floor nurses. RN#3 is were supposed to include an areas of the resident's skin. The sacral pressure sore was the weekly skin sheets dated and 1/23/17, RN #3 stated, "I see they [nurses] were not looking N #3 stated she thought the poking at the entire body when ments and any open areas don the form. In the provided by LPN #5 and the sacral president's sacral to dressing in place dated the provided the dressing. The sacral pressure dated the dressing. The				

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Event ID: RDU811

Facility ID: VA0071

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		DATE SURVEY COMPLETED
		495177	B. WING			03/16/2017
	ROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 314	breakdown. A sm present behind the area was approxing The open area has bed with no redness infection. On 3/15/17 at 1:50 (DON) was intervited assessments for large of the prior to December system for document assessments. The 2016 they started sheets. The DON were responsible and reporting any for ongoing treatment stated the weekly any open skin are DON stated sheer issues with getting accurately and time. These findings were administrator and 3/15/17 at 4:00 p. (1) NPUAP Press National Pressure www.npuap.org/ (2) Mepilex Borde Care. Goteborg, States and States and States are well as the pressure www.npuap.org/ (2) Mepilex Borde Care. Goteborg, States are well as the pressure www.npuap.org/ (3) Mepilex Borde Care. Goteborg, States are well as the pressure www.npuap.org/ (3) Mepilex Borde Care. Goteborg, States are well as the pressure www.npuap.org/ (4) Mepilex Borde Care. Goteborg, States are well as the pressure well as the pressure www.npuap.org/ (5) Mepilex Borde Care. Goteborg, States are well as the pressure well	all circular open skin area was e resident's left ear. The open mately 1/4 inch in diameter. d red/pink tissue in the wound ss, drainage or signs of D. p.m. the director of nursing ewed about the inaccurate skin Resident #4. The DON stated 2016 there was not a formal enting routine skin e DON stated in December weekly skin assessment I stated the direct care nurses for performing assessments open areas to the wound nurse nent and monitoring. The DON skin assessment should reflect as present on the body. The ecognized there were ongoing the assessments done nely. Pere reviewed with the DON during a meeting on m. Figure 1. Stages. 2016. Full Correct World With the CON during a meeting on m. Fur 1. Sacrum. Molnlycke Health Sweden. 2014.		314		
CODIA CNAS 25	2. Resident #/ wa	as observed without physician as Obsolete Event ID: RDU8	311	Facility ID: VA0071	If continuation sh	neet Page 22 of 45

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMF		
	495177	B. WING		03	/16/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL	,		STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	•	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
Resident # 7 was a with a readmission for Resident # 7 ind muscle weakness, disease, and pneur. The most recent M quarterly review da coded as having shmemory problems, daily decision maki. On 3/15/17 at 9:00 observed laying in Resident # 7 did not the feet. The clinical record. The current POS (pincluded an order or "Prevalon booties a identified as being at the feet and ankle/I contracted position several times throut Prevalon booties or On 3/15/16 at 11:00 assistant) # 1 was a Resident # 7. The as LPN (licensed pincled present. CNA # 1 sthe resident's booties where they mare	ooties (device for the feet to reas) applied. dmitted to the facility 8/8/06 date of 10/5/16. Diagnoses sluded, but was not limited to: high blood pressure, heart monia. DS (minimum data set) was a ted 1/4/17. Resident # 7 was nort term and long term and severe impairment in ning skills. a.m. Resident # 7 was bed with her eyes closed. It have any devices applied to was reviewed at 9:15 a.m. obysician order summary) arried forward from 10/5/16 for it all times." Resident # 7 was eat risk for pressure areas to ower leg area due to her. Resident # 7 was observed ghout the morning without the	F 3			
	ded to open them from the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495177	B. WING	Name of the Park o	03/16/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL			STREET ADDRESS, CITY, STATE, ZIP COI 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE COMPLETION
she stated "I think laundry." LPN # 1 the go to laundry it back." This survey Resident # 7 had b week. LPN # 1 qui guess she had the asked since she che daily, if she had ob booties on. LPN # care for the facility, On 3/15/17 at 2:30 Resident # 7's drest CNA # 1, the booties the feet as ordered on the booties, and open new booties week also. I guess happens when the On 3/15/17 at 4:00 meeting with facility (director of nursing operations were managers over to the hold one here in house taking so long to grather costly."	e was unwrapping the booties hers may have gone to stated "Yes, sometimes when takes a week to get them for then asked LPN # 1 if leen without the booties for a cickly stated "Oh, I don't know; I m on." LPN # 1 was then hanged Resident # 7's dressing served the resident without the 1 stated she did all the wound and really did not remember. p.m. during observation of sing change with LPN # 1 and the swere observed applied to desire the commented of LPN # 1 stated "Yes; I had to for her (Resident # 7) last is we need to find out what by go to the laundry." p.m. during an end of the day by staff the administrator, DON and vice president of ade aware of the above inistrator stated "Some laundry is go. We will find out why it's let the booties back; they are		314	
 Facility staff fail 	ed to place bilateral palm	I		ì
· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·			

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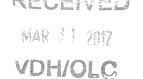
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL SUMMARY STATEMENT OF DEFICIENCIES PREFIX FAG SUMMARY STATEMENT OF DEFICIENCY PREFIX FAG SUMMARY STATEMENT OF DEFICIENCY PREFIX FAG SUMMARY STATEMENT OF DEFICIENCY PREFIX FAG SUMMARY STATEMENT OF DEFICIENCY PREFIX FAG SUMMARY STATEMENT OF DEFICIENCY PREFIX FAG SUMMARY STATEMENT OF DEFICIENCY FAG SUMMARY STATEMENT OF CORRECTION DEFICIENCY FACTOR STATEMENT OF CORRECTION DEFICIENCY FAG SUMMARY STATEMENT OF CORRECTION DEFICIENCY FAG SUMMARY STATEMENT OF CORRECTION DEFICIENCY FAG SUMMARY STATEMENT OF CORRECTION DEFICIENCY FAC SUMM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
COMMUNITY MEMORIAL 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970			495177	B. WING	·	03	/16/2017	
F314 Continued From page 24 guards into Resident #6's hands per physician order. Resident #6 was originally admitted to the facility on 01/31/2006 and readmitted on 12/15/2011 with diagnoses including, but not limited to: Stroke, Diabetes, Hypertension, Glaucoma, Seizures, Dysphagia, Feeding (PEG) Tube and Contractures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/2016. Resident #6 was assessed as severely impaired in her short and long term memory and cognitive skills. Resident #6's medical record was reviewed on 03/15/2017. The current POS (physician order sheet) dated March 2017 included an order dated 02/19/16 that stated, "OT (occupational therapy) - Patient to wear bilateral palm guards at all times except during bathing and dressing in order to decrease risk for contracture/skin breakdown" Resident #6 was observed in her room at 7:45 a.m. and again at 11:00 a.m. Bilateral palm guards were not in place during either observation. CNA #2 (certified nursing assistant) was interviewed at approximately 11:02 a.m. regarding Resident #6's palm guards. CNA #2 stated, "Yes, no, wait a minute. No she doesn't use those. All she has are these (CNA #2 gestured to Resident #6's bilateral geris sleeves) and they cover part of					125 BUENA VISTA CIRCLE	E, ZIP CODE		
guards into Resident #6's hands per physician order. Resident #6 was originally admitted to the facility on 01/31/2006 and readmitted on 12/15/2011 with diagnoses including, but not limited to: Stroke, Diabetes, Hypertension, Glaucoma, Seizures, Dysphagia, Feeding (PEG) Tube and Contractures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/2016. Resident #6 was assessed as severely impaired in her short and long term memory and cognitive skills. Resident #6's medical record was reviewed on 03/15/2017. The current POS (physician order sheet) dated March 2017 included an order dated 02/19/16 that stated, "OT (occupational therapy) - Patient to wear bilateral palm guards at all times except during bathing and dressing in order to decrease risk for contracture/skin breakdown" Resident #6 was observed in her room at 7:45 a.m. and again at 11:00 a.m. Bilateral palm guards were not in place during either observation. CNA #2 (certified nursing assistant) was interviewed at approximately 11:02 a.m. regarding Resident #6's palm guards. CNA #2 stated, "Yes, no, wait a minute. No she doesn't use those. All she has are these (CNA #2 gestured to Resident #6's bilateral geri sleeves) and they cover part of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	EX (EACH CORRECTIVE A CROSS-REFERENCED T	ACTION SHOULD BE O THE APPROPRIATE	COMPLETION	
At approximately 11:10 a.m. LPN #2 (licensed	F 314	guards into Reside order. Resident #6 was on 01/31/2006 and diagnoses includin Diabetes, Hyperte Dysphagia, Feedin Contractures. The most recent of quarterly assessment reference date) of assessed as sevel long term memory. Resident #6's med 03/15/2017. The sheet) dated Marco 02/19/16 that state therapy) - Patient all times except do order to decrease breakdown" Resident #6 was of a.m. and again at guards were not in observation. CNA #2 (certified interviewed at approximate the same these with the same the sam	ent #6's hands per physician briginally admitted to the facility direadmitted on 12/15/2011 withing, but not limited to: Stroke, insion, Glaucoma, Seizures, ing (PEG) Tube and MDS (minimum data set) was a sent with an ARD (assessment 12/22/2016. Resident #6 was rely impaired in her short and and cognitive skills. dical record was reviewed on current POS (physician order the 2017 included an order dated ed., "OT (occupational to wear bilateral palm guards at uring bathing and dressing in risk for contracture/skin beserved in her room at 7:45 11:00 a.m. Bilateral palm in place during either in place during either nursing assistant) was proximately 11:02 a.m. regarding in guards. CNA #2 stated, "Yes, No she doesn't use those. All at (CNA #2 gestured to Resident sleeves) and they cover part of		314			

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Event ID: RDU811

Facility ID: VA0071

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495177	B. WING				3/16/2017	
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COI 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	DE		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 314	Resident #6's palm don't think she use (Gestured to the coorders, but it is an order. It doesn't shwhy it's not on the sheet) for us to sig written 2/19/16. Wishould have been to us (meaning nur family and then gewe can't just throw hasn't been using the LPN #2, CNA #2 a	s interviewed regarding guards. LPN #2 stated, "No, I s those. Let me look. It is on the OT (occupational therapy) how up anywhere else. That is TAR (treatment administration noff. The original order was then therapy stopped she referred to restorative and then it is on the order for an evaluation. It is palm guards in there if she		314				
	her palm guards in were located in the #2. CNA #2 and th	n. LPN #2 stated, Here are the the drawer." The palm guards drawer of the nightstand. LPN is surveyor observed Resident eakdown was noted on either						
	were informed of the survey team on 03	and DON (director of nursing) he above during a meeting with /15/17 at 4:00 p.m. No further ceived prior to the exit 16/17.						
	4. Facility staff fail heels while in bed	led to float Resident #10's as ordered by the physician.	t b					
	03/07/17 with diag to: Right hip fractu	admitted to the facility on noses including, but not limited ure with repair, Chronic kidney opathy, Alzheimer's disease						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495177	B. WING			/16/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	, CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ARAGA DECEDENACED TO TI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	an initial assessm reference date) of assessed as mod status with a total Resident #10's me 03/15/17. The cursheet) dated 3/1/2 an order dated 03 (miscellaneous) -	rage 26 MDS (minimum data set) was ent with an ARD (assessment 03/14/17. Resident #10 was erately impaired in his cognitive cognitive score of 08 out of 15. Redical record was reviewed on rrent POS (physician order 2017 through 3/31/17 included /07/17 that stated, "Misc Float heels while in bed prn (as sk every shift for placement"		314		
	a.m. and again at his heels floated of approximately 11: practical nurse) w floating resident's know, let's check to get up soon and (gestured to the company).	s observed on 03/15/17 at 7:40 11:00 a.m. lying in bed without off the mattress. At 04 a.m. LPN #3 (licensed ras interviewed regarding heels. LPN #3 stated, "I don't the orders. He's getting ready d go to therapy. Here it is, omputer screen). His heels are pating when in bed."				
	p.m. regarding he order as stated at mean float heels	viewed a second time at 3:00 or interpretation of the physician bove. LPN #3 stated, "I take it to when in bed (and) prn. It needs cause it really doesn't specify ver."	0			
	were informed of the survey team of 4:00 p.m. No furt the survey team p 03/16/17.	r and DON (director of nursing) the above during a meeting with on 03/15/17 at approximately ther information was received by prior to the exit conference on	y	240		
F 318	3 483.25(c)(2)(3) IN	ICREASE/PREVENT		318		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	THE CONTOUNT OF THE CONTOUR OF THE C	(X3) DATE SURVEY COMPLETED
	495177	B. WING		03/16/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL	1		STREET ADDRESS, CITY. STATE. ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
(FACH DEFICIENC)	TEMENT 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 APPROPF DEFICIENCY)	BE COMPLETION

F 318 Continued From page 27 SS=D DECREASE IN RANGE OF MOTION

- (c) Mobility.
- (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.
- (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.

 This REQUIREMENT is not met as evidenced

Based on observation, staff interview, and clinical record review, facility staff failed to ensure devices were used to increase or prevent a decrease in ROM (range of motion) for one of 19 residents in the survey sample, Resident #6.

Facility staff failed to place physician ordered palm guards into Resident #6's hands.

Findings included:

Resident #6 was originally admitted to the facility on 01/31/2006 and readmitted on 12/15/2011 with diagnoses including, but not limited to: Stroke, Diabetes, Hypertension, Glaucoma, Seizures, Dysphagia, Feeding (PEG) Tube and Contractures.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/22/2016. Resident #6 was assessed as severely impaired in her short and long term memory and cognitive skills.

F 318 Increase or Prevent Decrease in Range of Motion

Corrective Measure for Residents Affected

Resident # 6 was screened by Occupational Therapy on 3/16/17 and the screening indicated she no longer needs the palm guard. An order to discontinue the palm guard was given by the physician on 3/16 and its use was discontinued.

Identification of Other Residents With Potential To Be Affected

Records were reviewed on 3/22/17 to identify other residents with orders for palm guard. Two other residents have palm guard orders and inspection of these residents hands indicated that they are being used as ordered.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HOWAIN OLIVIOLO				AFFROVEL
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	r		T	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY IPLETED
		495177	B. WING		03/	16/2017
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	25 BUENA VISTA CIRCLE		
COMMUI	NITY MEMORIAL		5	SOUTH HILL, VA 23970		
(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 CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	Continued From pa	nge 28	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
		cal record was reviewed on	Mea	asures To Prevent Recurrence		
	03/15/2017. The c sheet) dated March 02/19/16 that stated therapy) - Patient to all times except durorder to decrease r breakdown" Resident #6 was of a.m. and again at 1 guards were not in observation.	urrent POS (physician order a 2017 included an order dated d, "OT (occupational o wear bilateral palm guards at ring bathing and dressing in risk for contracture/skin oserved in her room at 7:45 1:00 a.m. Bilateral palm	reito dev rang pati gua will	ervices to nursing staff will be concerate compliance with physician of ices to increase or prevent decreage of motion. The policy for reass ent/resident for continued need find and other contracture preventialso be included in the in-services initoring:	orders for se in essing the for palm ve devices	
	interviewed at appr Resident #6's palm no, wait a minute. she has are these (#6's bilateral geri sher palms." At approximately 1' practical nurse) wa Resident #6's palm don't think she uses (Gestured to the coorders, but it is an office order. It doesn't she why it's not on the	oximately 11:02 a.m. regarding guards. CNA #2 stated, "Yes, No she doesn't use those. All (CNA #2 gestured to Resident eeves) and they cover part of 1:10 a.m. LPN #2 (licensed s interviewed regarding guards. LPN #2 stated, "No, I s those. Let me look. I computer). Here it is on the DT (occupational therapy) now up anywhere else. That is TAR (treatment administration	to id resid obsidail repo actid	dentify new orders for palm guard dents with palm guard orders will erved for compliance. This will be a X 10 then weekly X 10. Findings orted to QAPI Committee and furtions taken as appropriate.	s and be conducted will be	- A ADDITION OF THE PROPERTY O
	written 2/19/16. W should have been r to us (meaning nur	n off. The original order was hen therapy stopped she referred to restorative and then sing). I will have to call the an OT order for an evaluation.				

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

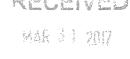
hasn't been using them."

We can't just throw palm guards in there if she

Event ID: RDU811

Facility ID: VA0071

If continuation sheet Page 29 of 45





IDENTIFICATION NUMBER					TE SURVEY MPLETED		
		495177	B. WING	***************************************		03	/16/2017
	PROVIDER OR SUPPLIER			125 BU	T ADDRESS, CITY, STATE, ZIP CODE JENA VISTA CIRCLE TH HILL, VA 23970		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Resident #6's room her palm guards in were located in the #2, CNA #2 and thi #6's palms. No bre hand. The Administrator a were informed of the survey team on 03/1 (1900)	and this surveyor went to a. LPN #2 stated, "Here are the drawer." The palm guards drawer of the nightstand. LPN s surveyor observed Resident eakdown was noted on either and DON (director of nursing) he above during a meeting with 15/17 at 4:00 p.m. No further beived prior to the exit 6/17. DRUG REGIMEN IS FREE BARY DRUGS besary Drugs-General begregimen must be free from and An unnecessary drug is any se (including duplicate drug	C R th Ic P ic th	329 Dr rugs orrective esident nerefore tentific otentia ecords lentify of	rug Regimen Is Free from Unive Measure for Residents Aformula and the second state of the second sec	fected 1/17 taken. th 27/17 to ion orders inistered erders wer	
	paragraphs (d)(T) t	mough (3) or this section.	i				\$ 7 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED		
		495177	B. WING			03/	16/2017
	PROVIDER OR SUPPLIEF			1	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	resident, the facilit	tropic Drugs. rehensive assessment of a ty must ensure that have not used psychotropic			asures To Prevent Recurrence ervices to licensed nursing staff wi	ll be	
	medication is nece	on these drugs unless the essary to treat a specific losed and documented in the	p a	oli accu	ucted to reiterate compliance wi cy for 24-hour chart check to ensu racy of medication orders. Focus n on the need to obtain physician	re	
	gradual dose redu interventions, unle an effort to discon	o use psychotropic drugs receive actions, and behavioral ess clinically contraindicated, in tinue these drugs; ENT is not met as evidenced	d behavioral Pharmacy director has directed pharmacy staff not to fill medication orders when they involve		acy staff y involve		
	Based on clinical interview the facili residents in the suensure the resident medications. Resorder for Clonaze	record review and staff ty staff failed, for one of 19 urvey sample (Resident # 12), to nt was free of unnecessary ident # 12 had a physician's pam that included two dose h assessment of which option to	t c	he o ic pti her QAP	DON or designee will audit physic lentify medication orders with two ons. This will be conducted daily X weekly X 10. Findings will be reported to the committee and further actions to opriate.	o-dose 2 weeks, orted to	
	year-old male, wa 2/20/17 with diagr fibrillation, corona heart failure, hypereflux disease, dia anxiety disorder, disease, chronic reataracts, dyspnehypertension. Acceptable of the coronic results of the c	he survey sample, an 80 s admitted to the facility on noses that included atrial ry artery disease, congestive extension, gastroesophageal abetes mellitus, hyperlipidemia, chronic obstructive pulmonary espiratory failure with hypoxia, a, and secondary pulmonary cording to the Admission		• •	ection Date: 4/15/2017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495177	B. WING	03/16/2017
NAME OF PROVIDER OR SUPPLIES COMMUNITY MEMORIAL		STREET ADDRESS, CITY, STATE, Z 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	IP CODE
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
was assessed un- Patterns) as being Summary Score of Resident # 12 had dated 2/20/17: "Clonazepam 1 m bedtime at 2100 (mg) to 1 tablet (1 unspecified for In- (NOTE: Clonazep unlabeled use for Mosby's 2017 Nu Edition, page 276 Review of the Ele Administration Re February 2017, ar 3/15/17, the date Resident # 12 red There was no dod February or Marc Clonazepam was Further review of failed to reveal ar determining unde resident was to be whole tablet of Cl At 10:00 a.m. on the Administrator the survey team, was discussed. No	ARD) of 2/27/17, the resident der Section C (Cognitive grognitively intact, with a of 13 out of 15. If the following physician's order, grown (milligram) tablet. Oral at 9:00 p.m.). Give 1/2 tablet (0.5 mg) for sleep. Anxiety disorder, somnia." It am is an anticonvulsant with an anxiety and insomnia. Ref. rsing Drug Reference, 30th and March 2017 as of the of record (E-MAR) for the month of the derived Clonazepam as ordered. Sumentation on the E-MAR for the indicating which dose of administered. Resident # 12's clinical record by assessment mechanism for rwhat circumstances the end administered a half tablet or a		

PRINTED: 03/21/2017 FORM APPROVED OMB NO. 0938-0391 (x3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED	
		495177	B. WING		03/	16/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	went on to indicate to the nurse giving 483.80(d)(1)(2) INF PNEUMOCOCCAL	e one or the other." The DON the dose administered was up the Clonazepam. FLUENZA AND IMMUNIZATIONS	F 329		eal Vaccino	
	(1) Influenza. The fand procedures to (i) Before offering the each resident or the receives education potential side effect (ii) Each resident is immunization Octo	neumococcal immunizations facility must develop policies ensure that- he influenza immunization, e resident's representative regarding the benefits and ts of the immunization; s offered an influenza ber 1 through March 31 e immunization is medically	Co Re va an	34 Influenza and Pneumococ rrective Measure for Resident sident # 4 was administered a ccination on 3/15/17 pursuant d physician order. entification of Other Residents tential To Be Affected	ts Affected pneumococcal to her request	}
	contraindicated or immunized during (iii) The resident or	the resident has already been	oth the do	cords were reviewed on 3/24/ ner residents who may not have e vaccine. Those who have no cumentation to indicate the va ered or administered will be o	ve been offered accine was	3
	documentation that following: (A) That the reside was provided educand potential side immunization; and (B) That the reside	ent either received the influenza	Me In-	ered or administered will be officine. easures To Prevent Recurrence service to licensed nursing standucted to review the facility's ecination policy. In-service will appletion of Admission Nursing	e ff will be s pneumococca reinforce	
		d not receive the influenza to medical contraindications or				Ann may





MAR 3 1 2017

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495177	B. WING		03/	16/2017	
	PROVIDER OR SUPPLIER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE OUTH HILL, VA 23970			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 334	Continued From p	age 33	F 334		:		
	(i) Before offering immunization, each representative recommunization; (ii) Each resident immunization, unleadically contrain already been immunization that the opportunit (iv) The resident's documentation that following: (A) That the resident of has provided educand potential side immunization; and (B) That the reside pneumococcal impunitation of this REQUIREMED by: Based on staff intended and potential record to offer a pneumococcal impunitation of the presidents in the had not been offer	h resident or the resident's eives education regarding the stial side effects of the soffered a pneumococcal ess the immunization is dicated or the resident has unized; representative to refuse immunization; and medical record includes at indicates, at a minimum, the sent or resident's representative cation regarding the benefits effects of pneumococcal in the entitle of the munication or did not receive immunization due to medical indicates.	asserein Mo The Nur doc ider pne will mon Con app	appliance with 24-hr review of admitessments by the clinical coordinato forced. Initoring: DON or designee will audit the Adsing Evaluation forms and/or transuments of newly admitted patients of the string those who may not have been umococcal vaccination upon admited be conducted weekly X 4 weeks the other than the string will be reported amittee and further actions taken a propriate. Tection Date: 4/15/2017	mission fer to offered ssion. This en to QAPI		

Event ID: RDU811

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495177	B. WING		03/16/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL			STREET ADDRESS, CITY, STATE, 2 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	ZIP CODE
PRETY (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
immunization statu resident about the effects of the vacci The findings includ Resident #4 was as 9/24/16 with a re-as Diagnoses for Residisease, chronic de urinary tract infection minimum data set assessed Resident Resident #4's clinic 3/15/16. The record resident's pneumor of any education to benefits and potent A resident immunization Resident #4 had not and/or refusal for the record docume form signed by the pneumococcal immunication and pneumococcal immunication requested at this time. On 3/16/17 at 9:40 Resident #4 had not pneumococcal vaccing the registered nur	cal record had no the resident's pneumococcal is or of any education to the benefits and potential side one. e: dmitted to the facility on dmission on 11/18/16. Ident #4 included Parkinson's ehydration, Crohn's disease, on and left femur fracture. The (MDS) dated 12/16/16 is #4 as cognitively intact. cal record was reviewed on the resident about the tresident action/screening record for the pneumococcal vaccine. The pneumococcal vaccine on the pneumococcal vaccine on the pneumococcal vaccine. The pneumococcal vaccine on the pneumococcal vaccine on the pneumococcal vaccine on the pneumococcal vaccine. The pneumococcal vaccine on the pneumococcal vaccine on the pneumococcal vaccine on the pneumococcal vaccine. The pneumococcal vaccine on the pneumococcal vaccine on the pneumococcal vaccine on the pneumococcal vaccine. The pneumococcal vaccine on the pneumococca	The same of the sa		RECEIVED MAN 31 2017 VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495177	B. WING		03	3/16/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 334	asked her [Resider consented." On 3/of nursing (DON) w #4's pneumococcal stated all residents screened upon adminfluenza and pneu stated a vaccine his obtained upon adm was no consent for concerning the pne stated, "We asked [3/15/17] and she g stated the resident	ige 35 inccine. RN #4 stated, "We st #4] last night and she 16/17 at 9:45 a.m. the director has interviewed about Resident vaccine status. The DON were supposed to be hission and offered the mococcal vaccine. The DON story was supposed to be ission. The DON stated there mobtained from Resident #4 umococcal vaccine. The DON her [Resident #4] yesterday ave us consent." The DON had not been offered the cine prior to last night	The state of the s	34		
	9/24/12) stated the ensure patients rec pneumococcal vacce evidence-based gui and regulations. The and observation statinfluenza and/or proto being vaccinated surrogate decision information Statemoregarding the benefit effects of the influence vaccineDocument immunization status pneumococcal vaccinetis medical reinfluenza and pneumococcal vaccinetis protococcal vaccinetis and regulations.	cination for Patients (revised purpose of the policy was to eived influenza and sinations consistent with delines and applicable laws he policy stated, "All inpatients it is patientsare screened for eumococcal vaccinationPrior, all patients, or their maker, received the Vaccine ents (VIS) providing education its, risks and potential side haza and/or pneumococcal station of the patient's station of the patient's stations, is maintained in the cordNursing completes the mococcal vaccine screening ent admission assessment				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	COMPLETED
		495177	B. WING		03/16/2017
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
(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 SHOUL CROSS-REFERENCED TO THE APPROFINED DEFICIENCY)	D BE COMPLETION
F 441 SS=D	PREVENT SPREA	e)(f) INFECTION CONTROL, D, LINENS		41 Infection Control rective Measure for Residents Affe	ected
	The facility must eand control progra a minimum, the fol	stablish an infection prevention m (IPCP) that must include, at lowing elements:	as s	ident # 8"s CPAP mask was placed soon as surveyor finding was known monitored to ensure staff complian	. She will
	investigating, and communicable discommunicable discommunicabl	eventing, identifying, reporting, controlling infections and eases for all residents, staff, and other individuals under a contractual d upon the facility assessmenting to §483.70(e) and following standards (facility assessment Phase 2);	we wa: 3/2	ident # 12's CPAP mask and nebulize placed in a bag as soon as surveys known. He was discharged home 1/17 and further action is not necessitication of Other Residents with ential To Be Affected	or finding on ssary.
	(2) Written standar for the program, w limited to:	rds, policies, and procedures hich must include, but are not	nur	ner residents with potential to be afficient sing staff's non-compliance with pro	oper
t.	possible communi	veillance designed to identify cable diseases or infections bread to other persons in the	thro	rage of respiratory masks were iden ough review of physician orders on I corrective measures were taken as propriate.	3/21/17
	(ii) When and to w communicable dis reported;	hom possible incidents of ease or infections should be		asures to Prevent Recurrence ervice to nursing staff will be condu	acted to
	(iii) Standard and to be followed to p	transmission-based precautions revent spread of infections;	reit	erate compliance with facility's poli- rage of respiratory masks.	· · · · · · · · · · · · · · · · · · ·
	(iv) When and how resident; including	v isolation should be used for a but not limited to:	PAAAA TIA MARANA TIA M		
	(A) The type and depending upon the	duration of the isolation,	4		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		SURVEY PLETED
		495177	B. WING			03/1	16/2017
	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1: S	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE GOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVINGED CORRECTION SHOUL CROSS-REFERENCED CORRECTION SHOULD CORRECTION S	D BE	(X5) COMPLETION DATE
F 441	involved, and (B) A requirement least restrictive posicircumstances. (v) The circumstanmust prohibit emplidisease or infected contact with reside contact will transmit (vi) The hand hygical by staff involved in (4) A system for refunder the facility's actions taken by the (e) Linens. Person	that the isolation should be the ssible for the resident under the access under which the facility oyees with a communicable of skin lesions from direct ents or their food, if direct it the disease; and ene procedures to be followed direct resident contact. Seconding incidents identified IPCP and the corrective ne facility. Innel must handle, store, sport linens so as to prevent the	i : : : : : : : : : : : : : : : : : : :	and, will thes Mor The concord the Company of the C	dents who are using respiratory may for their family member/responsible also be educated on the proper stocked devices. Director of Nursing or designee will be deviced to ascertain compliance will age of respiratory masks. Audits will ducted daily X 10 then if substantial poliance is maintained, weekly X 10 these audits will be reported to the mittee and further actions taken a ropriate.	ll conducth proper ill be li condings	
	(f) Annual review. annual review of it program, as neces This REQUIREME by: Based on observaresident interview, staff failed, for two sample (Residents respiratory device prevent possible contact and a C-PAP mas	The facility will conduct an s IPCP and update their sary. ENT is not met as evidenced ations, clinical record review, and staff interview, the facility of 19 residents in the survey s # 8 and 12), to protect in a manner that would contamination. Resident # 8 k, and Resident # 12 had a and a C-PAP mask that was not cive bag.			f .	7EIVE	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION DING		MPLETED
		495177	B. WING			/16/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	COMPLETION DATE
F 441	Resident # 12 in the year-old male, was 2/20/17 with diagn fibrillation, coronar heart failure, hyper reflux disease, dia anxiety disorder, of disease, chronic recataracts, dyspneathypertension. Accomminimum Data Ser Reference Date (Awas assessed und Patterns) as being Summary Score of During the oriental 3/14/17, Resident seated in a wheeld permission to entendiced a nebulize located next to the used a nebulizer, I did, and he also stop when the resident, the significant when the resident, the significant when the sident # 12 said the resident # 12 said personal mask that the resident # 12 said personal mask # 12 sa	red in a protective bag. The survey sample, an 80 is admitted to the facility on coses that included atrial by artery disease, congestive rension, gastroesophageal betes mellitus, hyperlipidemia, hronic obstructive pulmonary espiratory failure with hypoxia, a, and secondary pulmonary cording to the Admission to (MDS) with an Assessment (MDS) with an Assessment (MDS) with an Assessment (MDS) and to (Cognitive cognitively intact, with a factor of 13 out of 15. The room, the surveyor of the room, the surveyor of the night standard resident from the that he ated that he used a C-PAP. The the C-PAP mask was stored, the twas in the second drawer of the obtaining permission from the company of the drawer and the C-PAP mask was his at the brought from home.		441.		

Facility ID: VA0071

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		MPLETED
	495177	B. WING		0:	3/16/2017
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL			STREET ADDRESS, CITY, STATE, ZIP 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	CODE	
DREELY (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
Practical Nurse) was and C-PAP masks should be in bags," Further review of R revealed the followid 2/20/17: "Auto C-PAP when "Oxygen: store oxygeach shift at Shift 1 At 11:10 a.m. on 3/ (DON) was asked in the storage of neburnasks. "There is in breathing treatmen masks in a bag. It "Even in the hospita continued. "That is at." The Potter-Perry Foundation of the following: "Sites Care-Associated In Contaminated respondation, 2009, page 2. Resident # 8 has stored in a protective Resident # 8 in the female, was admitt with diagnoses that	on tour, LPN # 4 (Licensed as asked how nebulizer masks should be stored. "They LPN # 4 said. esident # 12's clinical record ng physician's orders, dated asleep." gen items in a zip lock bag, Shift 2, Shift 3." 15/17, the Director of Nursing f there was a facility policy for alizer masks and C-PAP to policy for storage of t (nebulizer) masks and C-PAF is a practice," the DON said. The is a practice, the DON something we will have to look undamentals of Nursing notes as for and Causes of Health affectionRespiratory Tract: irratory therapy equipment." Fundamentals of Nursing, 7th e 648.) d a C-PAP mask that was not		41		

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SU IDENTIFICATIO		` '	TIPLE CONSTRUCTION ING	_	COMPLETED
		495	177	B. WING			03/16/2017
NAME OF PROVIDE		3			STREET ADDRESS, CITY, ST 125 BUENA VISTA CIRCLE SOUTH HILL, VA 2397	<u>.</u>	
	ACH DEFICIENC	TATEMENT OF DEFICIE BY MUST BE PRECEDI LSC IDENTIFYING INF	ED BY FULL	ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPR CICIENCY)	BE COMPLETION
disord dysph obesit to the 12/5/Sectic cogni of 15 Durin 3/14/the n C-PA Furth reveal 4/11/""C-PA Dr. (r Durin about been use if Revie Admi 2017 clinic the Cunde Docu appet the Core Revier reveal and the Core Reveal an	agia, generaty, and chroremost recent 16, the reside on C (Cognititively intact, or generated the following the orientant of the following the fol	sion, hypothyroid alized muscle weat ic kidney disease and I have near and I have near and I have near a size of the C-Fars and I have near a size of the C-Fars and I have near a size of the cars a size of the cars and I have near a size of the cars and I have near a size of the cars a size of the care a size of the cars and I have near a size of the cars and I ha	akness, e. According h an ARD of d under being Score of 15 out of the end of	F	141		
follov FORM CMS-2567(02-99		ns Obsolete	Event ID: RDU81	<u> </u> 1	Facility ID: VA0071	If continuati	on sheet Page 41 of 45

PRINTED: 03/21/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
	495177	B. WING		03	/16/2017
NAME OF PROVIDER OR SUPP			STREET ADDRESS, CITY, STATE, ZIP C 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	CODE	
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 441 Continued From	m page 41	F 4	41		
For January 20 For December For November For October 20 In each instant notation "Held on the "PRN R portion of the E During a meeti included the Ad team, Residen was discussed use it," the DO in case she do F 514 483.70(i)(1)(5) SS=D RECORDS-CO LE (i) Medical reco (1) In accordar standards and	RES DMPLETE/ACCURATE/ACCESSIE ords. Ince with accepted professional practices, the facility must cal records on each resident that	tt.	14		
•		· •		RECEIV	
(iii) Readily acc		*		wa .	
(iv) Systematic					
(5) The medica	al record must contain-	: : : : : : : : : : : : : : : : : : : :		VDH/OL	.C

Event ID: RDU811

PRINTED: 03/21/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	_E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495177	B. WING		03/16/2017
NAME OF F	PROVIDER OR SUPPLIER		į.	STREET ADDRESS, CITY, STATE, ZIP CODE	
сомми	NITY MEMORIAL		1	25 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
(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 APPROPED DEFICIENCY)	D BE COMPLETION
F 514				14 Resident Record is Complete/A	ccurate
	(i) Sufficient inform	ation to identify the resident;	and	Accessible	
	(ii) A record of the	resident's assessments;	Cor	rective Measure for Residents Affe	cted
	(iii) The compreher provided;	nsive plan of care and services		ident # 12 was discharged home on	3/21/17
	(iv) The regults of a	any preadmission screening	and	no further action can be taken.	
	and resident review			ntification of Other Residents with	
	- A AAAA AAAA AAAAA AAAAA AAAAA AAAAA AAAA	rse's, and other licensed	On	3/27/17, physician orders of curren dents were reviewed to identify oth	
	(vi) Laboratory, rac	liology and other diagnostic		dents with medication orders that h	
	services reports as	required under §483.50. NT is not met as evidenced			
	by:	NT IS not met as evidenced		dose option and no parameters for to give. Physician clarification will	
	Based on clinical interviews, the faci	record review and staff lity staff failed, for one of 19	İ	ained for residents that were affect	
	maintain a comple	esidents in the survey sample (Resident # 12), to naintain a complete and accurate clinical record. The facility staff failed to accurately document the		asures to Prevent Recurrence	
	dose of Clonazepa	im administered to Resident #	In-s	ervice to nursing staff will be condu	cted to
	12.		reit	erate the need for obtaining clarific	ation
	The findings were:		fror	n the physician when a medication i	s
				ered with a two-dose option withou	, ,
		ne survey sample, an 80 s admitted to the facility on	•	meters for choosing which dose to	
	2/20/17 with diagn	oses that included atrial		cial focus will be on proper transcrip	
	heart failure, hyper	y artery disease, congestive rtension, gastroesophageal	onto	the MAR for these types of orders	
	reflux disease, dia	betes mellitus, hyperlipidemia,	The state of the s		
	anxiety disorder, c	hronic obstructive pulmonary espiratory failure with hypoxia,		1	
	cataracts, dyspnea	a, and secondary pulmonary			Table of the state
		ording to the Admission t (MDS) with an Assessment			

Facility ID: VA0071

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
		495177	B. WING			03/1	16/2017
	PROVIDER OR SUPPLIER			12	REET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	Reference Date (A was assessed und Patterns) as being Summary Score of Resident # 12 had dated 2/20/17: "Clonazepam 1 mg bedtime at 2100 (9 mg) to 1 tablet (1 runspecified for Institution, page 276.) (NOTE: Clonazepa unlabeled use for a Mosby's 2017 Nursedition, page 276.) Review of the Elect Administration Resident # 12 received and March, under Results and Documer Results and Results and Documer Results and Documer Results and Documer Results and Re	RD) of 2/27/17, the resident er Section C (Cognitive cognitively intact, with a 13 out of 15. the following physician's order, (milligram) tablet. Oral at 1:00 p.m.). Give 1/2 tablet (0.5 ng) for sleep. Anxiety disorder, omnia." am is an anticonvulsant with an anxiety and insomnia. Ref. sing Drug Reference, 30th (c) tronic Medication cord (E-MAR) for the months of d March 2017 as of the 15 frecord review, revealed (c) even Clonazepam as ordered. The ending "PRN (as needed) mentation Report," there were icate which dose of		not I a do Mor The audi cond of th Com	macy director has directed pharm to fill medication orders when the sage range without defining pararelitoring: Director of Nursing or designee with sof physician orders. Audits will be ducted daily X 10 then weekly X 10 these audits will be reported to the mittee and further actions taken a opriate. ection Date: 4/15/2017	y involve neters. ill conduc be . Findings QAPI	
	Practical Nurse) wadministration of a Clonazepam to Rewas no way to tell by looking at the Epossible to tell by to see which dose Diebold System is	as interviewed regarding the half tablet or a whole tablet of esident # 12. Advised there which dose was administered E-MAR, LPN # 6 said it might be ooking at the Diebold System was obtained. (NOTE: The an automated system used to use controlled medications.)			Mak	EIVE	(SEALING STATE OF STA

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLI	E CONSTRUCTION		E SURVEY PLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING .			· was been t have seed
	495177	B. WING	3334447		03/	16/2017
NAME OF PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUNITY MEMORIAL			1	25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
OLUMBAN DV CT	ATEMENT OF DEFICIENCIES	ı ID	1	PROVIDER'S PLAN OF CORRECTION	NC	(X5)
PREEK (FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	-IX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETION DATE
F 514 Continued From pa	age 44	F	514			
Room where the D After several minut access the medica According to the D tablets of Clonazer asked about admir said it would take t Diebold, obtain the two, and a second wasting (throwing administered. LPN nurse obtaining the manually enter the Diebold System. At 10:00 a.m. on 3 the Administrator, the survey team, t was discussed. It	surveyor to the Medication Diebold System was located. Ites, LPN # 6 was able to ation list for Resident # 12. Diebold System, only whole pam were available. When instering a half tablet, LPN # 6 two nurses, one to access the e whole tablet and break it in a nurse to witness the first nurse away) the half tablet not N # 6 went on to say that the e whole tablet would need to be obtaining of a half tablet in the Director of Nursing (DON), and he resident's Clonazepam orde was pointed out that entries on oted that Clonazepam was not which dose.	r				
·		· VANADO-ARRA A				
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					MAR ?	2017
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