

GRACE HEALTHCARE OF ABINGDON

| AX COVER SHEET | PROM: |
|----------------|-------------------------------------|
| Rolney Miller | Angela Chilwood |
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(URGENT (FOR REVIEW (PLEASE COMMENT (PLEASE REPLY (PLEASE RECYCLE NOIES/COMMENTS:

MAR 15 2017 VDH/OLC



SERVING YOU FROM OUR HEART

March 13, 2017

Mr. Rodney Miller, LTC Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

Re: Grace Healthcare of Abingdon (Provider Number 1992796007)

Survey ending February 23, 2017

Dear Mr. Miller

Enclosed for your review, please find our updated plan of correction for the survey ending February 23, 2017. We submit this plan of correction as Grace Healthcare of Abingdon's allegation of compliance. Please contact me directly if you have any questions that require additional information.

Sincerely,

auje Clutwood-OWens

Administrator

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MAR 15 2017

VDH/OLC

600 Walden Road Abingdon, VA 24210

p 276.628.2111 f 276 628.8848

www.gracehe.com

| | | I AND HUMAN SERVICES & MEDICAID SERVICES | | | | PRINTED: 03/03/2017 FORM APPROVED OMB NO: 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1: PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| American A separation of the s | | 495338 | 6 WING | | with the transfer of the control of | 02/23/2017 |
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| (F 000) | 'NITIAL COMMEN' | FS | (F 00 | 0} | | 3/13/17 |
| | revisit to the 1/10/1 and the 11/10/16 st 02/22/17 through 0 required for compile federal Long Term uncorrected deficie report. Corrected of the CMS 2567-B. | Medicare/Medicard second 7 through 1/11/17 first revisit andard survey was conducted 2/23/17. Corrections are ance with 42 CFR Part 483. Care Requirements, incles are identified within this tericiencies are identified on | | | | |
| (F 309) SS≠D | 100 at the time of the consisted of 12 curil (Residents #201 the | CARE/SERVICES FOR | {F 30 | 9) | ~ECE! | |
| | | receive and the facility must | | | | Towns of the second of the sec |
| | or maintain the high mental, and psycho | ary care and services to attain lest practicable physical, social well-being, in comprehensive assessment | | _ | /DH/C | DEC |
| | and plan of care. This REQUIREMEN by: Based on staff inter review, the facility st orders for 2 of 12 Re #208. 1 For Resident #20 administered the ph | IT is not met as evidenced relevant and clinical record taff falled to follow physician esidents, Residents #204 and | | F 1. | Resident # 204 was assessed Licensed Nurse on 2/24/17 adverse outcomes were not order for Nuedexta was contained be given twice daily on 2/2 Unit Manager on the MAR Responsible Party and Phynotified of the error by the Nurse. | . No led. The rrected to 2/17 by the . The sican were |

ABORT DRY DIRECTOR'S OF TRUMBER/SUPPLIER REPRESENTATIVE'S SIGNATURE

administrator 3/13

Any deficiency (4-fement ending with an asterisk (*) genotes a deficiency which the institution may be excused from correcting providing it is determined that corrections 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 bited, an approved plan of correction is requisite to continued program participation.

(wice a day.

| | | I AND HUMAN SERVICES & MEDICA D SERVICES | | | | | NTED: 03/03/201 FORMAPPROVE B NO: 0938-039 |
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| (F 3)9) | Continued From pa | ge 1 | (F 30 |)9} | , | * | 3/13/17 |
| | administer the physical Ativan 0.5mg every peg tube. The findings include 1. For Resident #20 administered the phonedexta once a datwice a day. Per the national instruction medical treatment of (PBA) poccurs secondary to unrelated neurologic characterized by invitreduent episodes of the record review rehad been admitted to Diagnoses included. | 4, the facility staff ysician ordered medication y when the order was for itute of health nuedexta is a tion indicated for the pseudobulbar affect. PBA a variety of otherwise | | 2. | Resident # 208 was as: Licensed Nurse on 2/2 adverse outcomes were licensed nurse was in- medication administrat documentation on 2/23 Registered Nurse. The Party and Physican we the omissions of the m Licensed Nurse All orders for Neudext wer audited by the Uni 2/27/17 to ensure comp documentation. No issi identified. | 4/17. No enoted service tion and 4/17 by a Response notified by the and 4/17 b | No I. The ed on d the consible fied of the Ativan agers on |
| : : : : | essential hypertension Section C (cognitive quarterly review MDS assessment with an atate) of 02/01/17 inc | thronic kidney disease, and on. patterns) of the Residents (minimum data set) ARD (assessment reference luded a BIMS (brief interview mmary score of 8 out of a | | 3. | Licensed Nurses on we on Medication Administration Administration Assistant Director of N 2/22/17 – 3/7/17. Any Nurses not in-serviced not be allowed to work inservice education is p | stration lursing Licens by 3/7 unit th | n by the on sed /17 will ne |

FORM CMS-2567(02-99) Prezious Versions Obsolcie

The clinical record included a physician telephone order dated and signed by the physician on 01/24/17. This telephone order read "(1) Start Nudexta (sic) 20/10 PO (by mouth) Qday

Event ID T58V13

Facility ID MA0081

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MAR 15 2017

PRINTED: 03/03/2017 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF CEFICIENCES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A DUILDING ____ 02/23/2017 8 WING 495338 STREET ADDRESS, CITY STATE ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX COMMETERS (X4) (C) EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCYL 3/13/17 (F 309) (F 309) Continued From page 2 (everyday) X 7 days then increase to Nudexta (sic) 20/10 BID (twice a day) for PBA. 1 The Unit Managers were in-serviced on checking new physican orders A review of the Residents eMAR's (electronic daily to ensure the transcription was medication administration records) for January completed correctly by the Director of and February 2017 revealed that this medication had been administered one time a day beginning Nursing on 2/23/17. January 25 at 8.00 a.m. However, the facility staff failed to increase this medication to BID as ordered by the physician after 7 days (February 1) 4. An audit of 5 medication and continued to administer the medication one time a day throughout the month of February. administration records will be conducted by the Unit Managers or On 02/22/17 at approximately 3,20 p.m. designee weekly for 4 weeks for administrative staff #2 was notified that the facility residents on Nuedexta and Ativan. staff had not administered the medication as Then 3 medication administration orgered by the physician. records weekly for 4 weeks for On 02/22/17 at approximately 3.25 p.m. residents on Nuedexta and Ativan. administrative staff #2 acknowledged that the Then 1 medication administration medication had not been administered as ordered and stated the order had been corrected record weekly for 4 weeks for residents on Nuedexta and Ativan On 02/22/17 at approximately 3:50 p.m. the unit and/or 100% compliance by the manager verbalized to the surveyor that it appeared that a new nurse had entered this order Director of Nursing. The results of the into the electronic system and the nurse that had audits will be presented by the checked behind her didn't change the times to Director of Nursing to the Quality Assurance/Performance Improvement Committee for 3 months and/or until On 02/23/17 at approximately 10:40 a.m. the survey team meet with the administrative staff of substantial compliance is achieved. the facility. During this meeting the administrative staff was notified that Resident #204 had not

FORM CMS-2567(02-99) Frevious Versions Obsclete

received the physician ordered medication nuedexta as ordered by the physician.

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

Event ID 156V13

Family (0 VA0061

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| (F 309) | Continued From pa | эge 3 | {F 30 | 09} | | 3/13/17 | | |
| | 2 The facility staff physician ordered r six nours via (gastr #208. | failed to administer the medication Ativan 0.5mg every rostomy) peg tube for Resident | | | The Quality Assurance/Per Improvement Committee of at least the Administrator, I Nursing, Unit Managers, A | consists of Director of Admission | | |
| | 12/12/16. Diagnose limited to anemia, hidiabetes, aphasia. | s admitted to the facility es included, but were not hypertension, anxiety and respiratory failure | | | Director, Housekeeping Di Maintenance Director, Foo Director, Activity Director, Services Director, Therapy | ing Director, or, Food Service rector, Social | | |
| | assessment comple quarterly with an AF date) of 10/11/16, a understand and to r Section C, her cognibe a 1/1 to indicate | IDS (minimum data set) leted on this resident was a RD (assessment reference assessed the resident to rarely rarely be understood. In nitive score was assessed to both short and long term with severely impaired. | | | Director and the Medical Director. | | | |
| | revealed a physicial | t #208's clinical record his order dated 12/26/15 for visix hours via peg tube. | | | | | | |
| | facility staff had not six hours on 2/1/17 was documented as at 12:00p.m., and all was no documentatithe medication was documentation to include to warrant the | dent's current MAR stration record) indicated the t administered the Ativan every and 2/18/17. The medication is not administered on 2/1/17 it 5.00a m on 2/18/17. There tion that indicated the reason indicate an assessment was inolding of the Ativan. The liste any documentation that | | | | | | |

had been held

the physician had been notified the medication

| -, | | H AND HUMAN SERVICES E & MEDICAID SERVICES | | | PRINTED: 03/03/2017 FORM APPROVED OMB NO 0938-0391 |
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| Activities (Activities (Activi | | 495338 | B WING | Ex. 117 / None on on content. I was an automatical content of the | R 02/23/2017 |
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| | The medication nu | urse who had held the ot available for interview | , | | |
| | asked if he would have administered would depend on to of vital signs were they were requested for the days in que 2/1/17 and 82 for 2. The surveyor informative above finding dregional nurse conhave expected the the medication. Should be administered to the surveyor informatical nurse conhave expected the the medication. | med the administrative staff of on 2/23/17 at 10:40a.m. The sultant was asked if she would nurse to have administered e stated, "I would have sment and the physician." | | | |
| F 314 SS≠C | No further informat to the exit conferen 483 25(c) TREATM PREVENT/HEAL P | ENT/SVCS TO | F 31 | 4 | |
| | resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received. | rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores and tion demonstrates that bie; and a resident having sives necessary treatment and healing, prevent infection and form developing. | | F 314 1. Resident # 202 was as Assistant Director of I 2/22/17. No negative identified. The responshysician were notificomissions. | Nursing on putcomes were sible party and |
| | This REQUIREMEN by: | IT is not met as evidenced | | | · |

FORM CMS-2507(02-99) Previous Versions Obsolete

Event ID 158V13

Facility ID VACO61

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| STALEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIFR/CLIA IDENTIFICATION NUMBER | (K2) MULTIPLE CONSTRUCTION A BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| MARKE OF I | ROVIUER OR SUPPLIER | | | STRE | ET ADDRESS CITY STATE ZIP CODE | | |
| | HEALTHCARE OF AE | | | | VALDEN ROAD NGDON, VA. 24210 | And the second s | |
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| F 314 | review the facility | erview and clinical record staff failed to provide | F 3 | 14 | P. 11 - 4/016 | 3/13/17 | |
| | treatments for prev Residents, Resident 1 For Resident #2 follow physician on treatments-bed bo | entive skin care for 2 of 12 | | | Resident #210 was assess: Assistant Director of Nurs 2/22/17. No negative oute identified. The responsible physician were notified of omissions. | sing on omes were e party and | |
| | provide treatment lareas The findings include 1 For Resident #2 follow physician on treatments-bed botheel protectors, and the record review had been admitted Diagnoses include. | 02, the facility staff failed to ders in regards to the following listers, heavy zinc to sacrum. It betadine to bilateral fee: revealed that Resident #202 to the facility 02/19/14. It do not were not limited to. | | 2 | All residents in house had toe skin assessment comple 2/22/17 by the Assistant D Nursing, the Unit Manager Minimum Data Set Nurses residents requiring skin we were correctly indentified TAR. | eted on irector of rs, and the a. All bund care | |
| | pain, and anxiety discretion C (cognitive arterly MDS (min with an ARD (asset 2/08/16 was code Resident had problememory and was serills for daily decision. | e patterns) of the Residents nimum data set) assessment sement reference date) of the distribution of the distribution of the sement indicate the term severely impaired in cognitive sion making. Section G was coded (3/3) to indicate the | | 3. | Licensed Nurses on were in on following treatment ord treatment documentation by Assistant Director of Nursi 2/22/17 – 3/7/17. Any Lice Nurses not in-serviced by 3 not be allowed to work unit inservice education is provi | ers, and y the ng on nsed 1/7/17 will t the | |

FORM CMS-2567(02-95) Previous Versions Obsolute

Resident required extensive assistance of two plus people for bed mobility. Section M (skin conditions) was coded to indicate the Resident cid not have any pressure ulcers but was at risk

Event ID 158V13

Facility ID VA0061

If continuation sheet Page 6 of 20



| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | PRINTED 03/03/2017 FORM APPROVED OMB NO 0938-0391 |
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| STATEMENT | RS FOR MEDICARE OF DECIÇIENCIES OF CORRECTION | (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | | | | 3/13/17 |
| F 314 | Continued From pa | age 6 | F 31 | 4 | |
| | for developing pres | | | | |
| | The Residents CCI included the proble with ADL's (activitie nutritional deficit, a wounds to both fee vascular disease), not limited to, apply bony prominence's foot ulcer and right orders, and observ symptoms of skin b. The Residents brad documented at a 1the form this put this kin breakdown. | P (comprehensive care plan) im areas-requires assistance is of daily living), at risk for trisk for skin breakdown with it related to FVD (peripheral Approaches included, but were ream dressing to bilateral feet, provide treatments to bilateral lateral shin per physician's e for and report signs and preakdown den score dated 02/15/17 was 0. Per the preprinted code on e Resident at a high risk for | | The Unit Managers we by the DON on checking TAR's for completened. 4. An audit of 5 treatmer records will be conducted Managers or designed weeks. Then 3 treatment administration records weeks. Then 1 treatment administration records weeks and/or 100% conthe Director of Nursing the audits will be present. | ang MAR's and ss on 2/23/17. Int administration sted by the Unit weekly for 4 ent sweekly for 4 mt weekly for 4 mpliance by 3. The results of ented by the |
| | the following orders bed sides, heavy zi protectors to bilater was discontinued of wounds with petadidaily. The Resident was a A review of the Resident was treatment administrative administrative documented "N" for the following dates. For bed bolsters, he | s. Bed bolsters both bilateral inc twice daily to sacrum, heel ral feet as tolerated (this order in 02/22/17), and paint foot line and apply foam dressing on comfort care. sidents eTAR's (electronic ration records) for February RN (registered nurse) #2 had in the Residents treatments on | | Director of Nursing to Assurance/Performance Committee for 3 mont substantial compliance The Quality Assurance Improvement Commit at least the Administra Nursing, Unit Manage Director, Housekcepin Maintenance Director, Director, Activity Director, The | e Improvement hs and/or until is achieved. //Performance tee consists of tor, Director of rs, Admission g Director, Food Service ctor, Social |

daily, and heel protectors-02/06, 02/07, 02/11.

For paint foot wounds with betadine and apply foam dressing daily-02/11, 02/12, 02/13, 02/16.

02/12, 02/13, 02 16, 02/18, and 02/19

Director and the Medical Director.

| A BUILDING A BUILDING A BUILDING COMPLETED R A BUILDING R A BUILDING R A BUILDING COMPLETED R R A BUILDING R A BUILDING R COMPLETED R R R A BUILDING R A BUILDING R A BUILDING R A BUILDING COMPLETED R COMPLETED | | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | HPLE CONSTRUCTION | (X3) DATE SURVEY |
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| ### A95338 ### WING ### O2/23/2017 ### OP FROVIDER OR SUPPLIER ### PROVIDER OR SUPPLIER ### PROVIDER OR SUPPLIER ### ABINGDON ### STREET ADDRESS CITY STATE ZIP CODE ### 800 WALDEN ROAD ABINGDON, VA 24210 ### OP SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION GROUD BE (EACH CORRECTIVE ACTION SHOULD BE TAKE TAG) ### CONTINUED FROM 1.SC IDENT FYING INFORMATION) ### F 314 Continued From page 7 | | | IDENTIFICATION NUMBER | 1 ' | | COMPLETED |
| RACE HEALTHCARE OF ABINGDON AND SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION) FOR THE BOARD REGULATORY OR LSC (DENTIFYING INFORMATION) AND THE BOARD REGULATORY OR LSC (DENTIFYING INFORMATION) FOR THE BOARD REGULATORY OR LSC (DENTIFYING INFORMATION) AND THE BOARD REGULATORY OR LSC (DENTIFYING INFORMATION) FOR THE BOARD REGULATORY OR LSC (DENTIFY AND THE BOARD REGULATORY OR LSC (DENTIFY AND THE B | | | 495338 | B WING | | 02/23/2017 |
| RACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 ABINGDON, VA 24210 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CHOSE REGULATORY OR LSC IDENTIFYING INFORMATION) F 314 Continued From page 7 O2/18, 02/19, and 02/21 For the days marked with an "N" on the eTAR's RN #2 had documented the following-Not administered by assigned nursing staff or not performed by scheduled staff. On 02/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident, RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc. some orders would show up in red indicating the previous nursing staff had not documented they had completed the treatment(s). RN #2 stated that in order to proceed and access what she | AMÉ ÓF I | FROVIDER OR SUPPLIER | | 1 | STREET ADDRESS CHY STATE ZIP CODE | |
| NATION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) REFLY REGULATORY OR LSC IDENTIFYING INFORMATION) FOR THE ADDRESS PRECIDENCY MUST BE PRECIDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY; For the days marked with an "N" on the eTAR'S RN #2 had documented the following-Not administered by assigned nursing staff or not performed by scheduled staff. On 02/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident. RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc. some orders would show up in red indicating the previous nursing staff had not documented they had completed the treatment(s). RN #2 stated that in order to proceed and access what she | | | | | | |
| REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) F 314 Continued From page 7 02/18, 02/19, and 02/21. For the days marked with an "N" on the eTAR's RN #2 had documented the following-Not administered by assigned nursing staff or not performed by scheduled staff. On 02/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident. RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc. some orders would show up in red indicating the previous nursing staff had not documented they had completed the treatment(s). RN #2 stated that in order to proceed and access what she | RACE | | | | · · · · · · · · · · · · · · · · · · · | TIME LEGI |
| 3/13/17 O2/18, O2/19, and O2/21 For the days marked with an "N" on the eTAR's RN #2 had documented the following-Not administered by assigned nursing staff or not performed by scheduled staff. On O2/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident. RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc. some orders would show up in red indicating the previous nursing staff had not documented they had completed the freatment(s). RN #2 stated that in order to proceed and access what she | (X4) D REFIX TAG | ZEACH DEFICIENC | Y MHST RE PRÉCEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR | IUUD BE COMPLET |
| For the days marked with an "N" on the eTAR's RN #2 had documented the following-Not administered by assigned nursing staff or not performed by scheduled staff. On 02/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident. RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc. some orders would show up in red indicating the previous nursing staff had not documented they had completed the freatment(s). RN #2 stated that in order to proceed and access what she | F 314 | Continued From pa | age 7 | F 3 | 14 | 3/13/17 |
| RN #2 had documented the following-Not administered by assigned nursing staff or not performed by scheduled staff. On 02/22/17 at approximately 4:20 p.m. the surveyor interviewed RN #2 regarding treatments for this Resident. RN #2 verbalized to the surveyor that she had been hired in January 2017 and she did not work weekends. She then stated that at times when she would log onto the computer system to check orders etc. some orders would show up in red indicating the previous nursing staff had not documented they had completed the treatment(s). RN #2 stated that in order to proceed and access what she | | | | | | J; 13/17 |
| | | RN #2 had docume administered by as performed by scheron 00 02/22/17 at app surveyor interviewe for this Resident. Resurveyor that she hand she did not wo that at times when computer system to orders would show previous nursing st had completed the that in order to produce administered by the control of the complete of the control of | ented the following-Not signed nursing staff or not duled staff. broximately 4:20 p.m. the ed RN #2 regarding treatments and been hired in January 2017 in weekends. She then stated she would log onto the check orders etc. some up in red indicating the aff had not documented they treatment(s). RN #2 stated beed and access what she | | | |
| trastasante especialis i di 1015 i venille i l | | On 02/23/17 at app surveyor interviewe nurse) #2 LPN #2 i eMAR (electronic m 02/18/17, LPN #2 w have been responsi treatments on this of would. When asked documented that sh | he had completed the stated that sometimes we just | | | |

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

Eveni ID: T58V13

Facility ID VA0061

If continuation sheet Page 8 of 20



MAR 15 2017

| | and the second s | H AND HUMAN SERVICES E & MEDICAID SERVICES | | | PRINTED: 03/03/2017 FORM APPROVED OMB NO: 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPU A BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED R |
| | | 495338 | 8 WING | And the second s | 02/23/2017 |
| , | PROVIDER OR SUPPLIE! HEALTHCARE OF A | | 6 | TREET ADDRESS, CITY STATE ZIP CODE 00 WALDEN ROAD BINGDON, VA 24210 | |
| X4) · C PREFIX FAG | (EACH DEFICIENT | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE AUTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)» | DULD BE COMPLETION |
| F 314 | with the surveyor and Residents wounds measurements were buring a meeting 02/23/17 at approximation administrative teat the above issues. No further information provided to the surconference. 2. For Resident #2 provide treatment areas. Resident #210 was 09/30/16. Diagnos hemiplegia, atrial frypertension, hypertension, and in the most recent Mand ARD of 12/30/16 of 15 in section C, quarterly MDS. Re (comprehensive catime. It contained a "Problem/Need". R/T (related to) deincontinence. Goal skin breakdown R/days. Approaches | RN #2 (treatment nurse) shared a copy of measurements of the shown 01/25-02/22/17 these ere unchanged. with the survey team on ximately 10:40 a.m. the mof the facility was notified of ation regarding this issue was rivey team prior to the exit. 210, the facility staff failed to for the prevention of pressure as admitted to the facility on es included but not limited to fibrillation, diabetes mellitus, enlipidemia, dementia, anxiety, | F 314 | | 3/13/17 |
| | · | nical record was reviewed on | | | |

02/22/17. It contained a signed POS (physician's

| DEPART | MENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | | F | TED. 03/03/2017 ORMAPPROVED NO. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (XI) PROVIDER SUPPLIER/GLIA IDENTIFICATION NUMBER | (X2) MUI A BUILO | TIPLE CONSTRU | ICTION | (×: | DATE SURVEY COMPLETED |
| | | 495338 | D WING | 27 N. 17 A. 21 J. 200 A. 200 P. P. P. W. | and the second s | | 02/23/2017 |
| | PROVIDER OR SUPPLIER | IINGDON | | 600 WALDEN | RESS CITY STATE Z N ROAD N, VA 24210 | SIB COOF | |
| (X4) ID PRFF-X TAG | SUMMARY STA | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION; | ID PREFI TAG | q A-th | PROVIDER'S PLAN OF CH CORRECTIVE AC 65-REFERENCHD TO DEFICIENC | TION SHOULD BE THE APPROPRIAT | COMPLETION E DATE |
| F 314 | zinc oxide to glulea needed)". Resident and contained and heavy zinc oxide to prin". This entry was following days and 02/12, 02/16, 02/13, 02/14 at 7 pt section of the TAR in part "Apply heavith, ischeduled for 0 administered by as Surveyor spoke with who is the treatment since Jiworks weekdays. Stothe computer to treatments on Resident would not let her or she put something been signed for. Show It would show there in order for the proceed. Stated that treatment not admit and contained the proceed. | thich read in part "Apply heavy al area twice a day and prn (as t #210's TAR's were reviewed entry which read in part "Apply o gluteal area twice a day and s marked with "N" on the times: 02/04, 02/05, 02/10 at 7am, and 02/07, 02/12, m. Notes in the comments for each of these entries read y zinc oxide to gluteal area 32/, /2017 7:00 AM/PM, not signed nsg (nursing) staff". If RN #2 (registered nurse), nt nurse, on 02/22/17 at 0 regarding the "N" on the ed that she has been doing an 2017 and that she only she stated that when she went sign for her completed ident #210, the computer complete her treatments until in the blank areas that had not tated she was worried about up, but had to put something he computer to allow her to at she made a note saying inistered by assigned nurse | F | 314 | | | 3/13/17 |
| | interviewed LPN (I LPN #2 identified f (electronic medica #2 was then asked | proximately 0835 surveyor #2 icensed practical nurse; #2 her initials on the eMAR tion record) for 02/18/17. LPN lif she would have been impleting the treatments on this replied she would. When asked | i | | | | |

why she had not documented that she had

| DEPART | MENT OF HEALTH | HAND HUMAN SERVICES | | | PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391 |
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| CTATEMENT | RS FOR MEDICARI OF DEF-CIÈNCIES FOORRECTON | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER | | TIPLE CONSTRUCTION | (K3) DATE SURVEY COMPLETED |
| | | 495336 | B WING | | 02/23/2017 |
| NAME OF F | ROVOER OR SUPPLIER | | | STREET ADDRESS CITY STATE ZIP | CODE |
| | HEALTHCARE OF A | | | 600 WALDEN ROAD ABINGDON, VA 24210 | |
| 0117001 | | ATEMENT OF DEFICIENCIES | | PROVIDER'S PLAN OF C | ORRECTION (X5) |
| (X4) ID PREFIX TAG | ACH DEFICIENC | ATEMENT OF DEPOSENCES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | | ON SHOULD.BE COMPLETION LE APPROPRIATE DATE |
| F 314 | treatments. | t don't have time to do the | F 3 | 14 | 3/13/17 |
| | approximately 090 freatment order. Redid not have any p | th RN #2 again on 02/23/17 at 5 regarding Resident #210's N #2 stated that Resident #210 ressure areas, and the zinc preventative measure | | | |
| | completed was dis | e treatments not being cussed during a meeting with team on 02/23/17 at 0. | | | |
| {F 328} SS≖D | 483.25(k) TREATM | tion was provided prior to exit. иENT/CARE FOR SPECIAL | (F 32 | 28) F 328 | · |
| | The facility must e proper treatment a special services: Injections; Farenteral and enl Colostomy, ureters Tracheostomy car Tracheal suctionin Respiratory care; Foot care; and | ostomy, or ileastomy care; e; | | 1. Resident # 202 was Assistant Director of 2/22/17. No advers Responsible party the omissions on the was notified of the observations by the | of Nursing on e outcomes noted. was made aware of the TAR. Physician omitted |
| | by: Based on staff intraview the facility: | ENT is not met as evidenced erview and clinical record staff failed to follow physician to a PICC line for 1 of 12 ent #202 | | 2. All residents in hor toe skin assessmen 2/22/17 by the Ass Nursing, the Unit I Minimum Data Se residents requiring correctly identified | it completed on istant Director of Managers, and the Nurses. All PICC care were |

FORM CMS-2567(02-98) Provious Versions Obsorate

Event ID T58V13

Facility ID VA0061

If continuation sheet Page 11 of 20



| OEPAR. | TMEN'T OF HEALTH | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | · | RINTED: 03/03/2017 FORMAPPROVED MB NO. 0938-0391 |
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| STATEMEN | RS FOR MEDICARI FOR DE FIGENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | | ONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 49533B | B WING | | | 02/23/2017 |
| LAME OF | PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS CITY, STATE ZIP CODE | |
| 1 | HEALTHCARE OF A | | | | VALDEN ROAD IGDON, VA 24210 | L. |
| (X4) -D PREFIX TAG | (FACH DEFICIENC | ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (ÉACH CORRECTIVE ACTION SHOULD CROSS-RÉFERENCED TO THE APPROP DÉPICIENCY) | DBE COMULTINON |
| (F 328) | Continued From p | | (F 3 | 28} | 3 | /13/17 |
| | physicians order in Residen, #202 s rigand symptoms of it of a PICC line. A PICC line is a pecatheter. It is used ntravenous fluids of transfusions. The record review had been admitted Diagnoses include osteomyelitis deminyoothyroidism, challed order. | staff failed to follow the regards to monitoring got upper extremity for signs infection due to the placement eripherally inserted central for treatments such as (IV), drugs, or blood revealed that Resident #202 to the facility 02/19/14 d, but were not limited to, entia, constipation, ronic pain, and anxiety | | 3. | Licensed Nurses on were in on following treatment ordereatment documentation by Assistant Director of Nursi 2/22/17 – 3/7/17. Any Lice Nurses not in-serviced by 3 not be allowed to work uninservice education is proved. The Unit Managers were in by the DON on checking MTAR's daily for completent 2/23/17. | ers, and y the ng on nsed 8/7/17 will t the ided. n-serviced MAR's and |
| | quarterly MDS (mir with an ARD (asse 12/08/16 was code Resident had problememory and was signal and seed of the code The Residents CCI had been updated problem of osteom but were not limited signs and symptom fever, swelling, drafthe current POS (page 15). | nimum data set) assessment sement reference date) of ed (1/1/3) to indicate the lems with long and short term severely impaired in cognitive sion making P (comprehensive care plan) on 01/31/17 to include the yelitis. Approaches included, dito assess/monitor and reportes of infection i.e., redness | | 4. | An audit of up to 5 treatment administration records for a with PICC lines will be continued the Unit Managers or design weekly for 4 weeks. Then treatment administration record weeks. Then 1 treatment administration record weeks for residents with Pland/or 100% compliance be Director of Nursing. The record weeks. | resident inducted by inec up to 3 icords for weekly for ily for 4 iCC lines y the |

line in place."

FORM CMS-2567(02-98) Previous Versions Obsolete

EvenLID T58V13

Facility ID VA0061

If continuation sheet Page 12 of 20



PRINTED: 03/03/2017 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING_ 02/23/2017 B WING 495338 STREEL ADDRESS CITY STATE ZIP CODE NAME OF PROVICER OR SUPPLIER 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE FREEDA REGULATORY OR LSC IDENTIFYING INFORMATION) YAG TAC DEFICIENCY) 3/13/17 (F 328) (F 328) Continued From page 12 audits will be presented by the A review of the Residents eTAR's (electronic treatment administration records) for February Director of Nursing to the Quality 2017 revealed that RN (registered nurse) #2 had Assurance/Performance Improvement documented "N" beside the order to monitor the Committee for 3 months and/or until P.CC line on the following dates 02/06, 02/07. substantial compliance is achieved. 02/11, 02/12, 02/13, 02/16, 02/18 and 02/19. The Quality Assurance/Performance For the days marked with an "N" on the eTAR's Improvement Committee consists of RN #2 nad documented the following "not at least the Administrator, Director of administered by assigned nursing staff..." Nursing, Unit Managers, Admission On 02/22/17 at approximately 4:20 p.m. the Director, Housekeeping Director, surveyor interviewed RN #2 regarding treatments Maintenance Director, Food Service for this Resident. RN #2 verbalized to the Director, Activity Director, Social surveyor that she had been hired in January 2017 and she did not work weekends. She then stated Services Director, Therapy Services that at times when she would log onto the Director and the Medical Director. computer system to check orders etc... Some orders would show up in red indicating the previous nursing staff had not documented they had completed the treatment(s). RN #2 stated that in order to proceed and access what she needed to complete her treatments she had to document something. On 02/23/17 at approximately 8:30 a.m. the unit manager was asked about the above treatments The unit manager stated if she worked the hall she did the treatments especially for this Resident On 02/23/17 at approximately 8:35 a.m. the surveyor interviewed LPN (licensed practical nurse) #2. LPN #2 identified her initials on the

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

eMAR (electronic medication record) for 02/18/17 LPN #2 was then asked if she would have been responsible for completing the treatments on this date to which she replied she

Event ID (58V1)

Facility ID VA0061

If continuation sheet Page 13 of 20



| DEPART | MENT OF HEALTH | HAND HUMAN SERVICES E & MEDICAID SERVICES | | | PRINTED 03/03/2017 FORM APPROVED OMB NO 0938-0391 | | | |
|--|--|---|---------------------|--|---|--|--|--|
| STATEMENT | OF DEFICIENCIES IF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
| | | 495338 | B WING_ | and the second s | 02/23/2017 | | | |
| NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF ABINGDON | | | | STREET ADDRESS CITY STATE ZIP CODE 600 WALDEN ROAD ABINGDON, VA 24210 | | | | |
| (X4) II) PEFFIX TAG | / FACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | IO PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORNECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | A SHOULD BE COMPLETION | | | |
| {F 32 8 } | Continued From payould. When aske documented that streatments LPN #2 don't have time to | d why she had not the had completed the I stated that sometimes we just | (F 328 | 3} | 3/13/17 | | | |
| | 02/23/17 at approx | with the survey team on kimately 10:40 a.m. the in of the facility was notified of | | | | | | |
| 15° 43.43 | provided to the sur conference. | tion regarding this issue was vey team prior to the exit DRUG RECORDS, | (F 43° | 1) | | | | |
| {F 431} 6S=□ | LABEL/STORE DR | RUGS & BIOLOGICALS | • | • | | | | |
| | a ficensed pharma of records of receip controlled drugs in accurate reconcilia records are in ords | mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an ition; and determines that druger and that an account of all maintained and periodically | | F 431 1. The narcotic box in refrigerator on Side the refrigerator on Maintenance Direct | e 1 was secured to 2/23/17 by the | | | |
| | abeled in accordar professional princip appropriate access | als used in the facility must be nce with currently accepted ples, and include the sory and cautionary ne expiration date when | | This alleged deficit potential to affect to and was corrected. | esidents on side 1 | | | |
| | facrity must store a | State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. | | | | | | |

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

Event ID T58V13

Facility ID VA0061

If continuation sheet Page, 14 of 20



| DEPART | TMENT OF HEALTH | AND HUMAN SERVICES | | | | PRINTED 03/03/2017 FORM APPROVED OMB NO. 0938-0391 |
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| STATEMENT | RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | NSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495338 | B WING | | | R 02/23/2017 |
| NAME OF | PROVIDER OR SUPPLIER | | i | | TADDRESS CITY STATE ZIP CODE | |
| | HEALTHCARE OF AB | UNGDON | | | ALDEN ROAD BDON, VA. 24210 | |
| GRACE | | | | | PROVIDER'S PLAN OF CORRECT | TION (X5) |
| (X4) IU PREFIX TAG | ZEACH DEDICIENCS | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JED BE COMPTERIOR |
| IE 1/21) | Continued From Da | age 14 | (F 431) | • | 1- 4 | 3/13/17 |
| F 431) Continued From page The facility must propermanently affixed controlled drugs lists. Comprehensive Druc Control Act of 1976 abuse, except when package drug distributed guantity stored is mit be readily detected. This REQUIREMENT by: Based on observation record review, the facility staff faile in the refrigerator or affixed. The facility staff faile in the refrigerator or affixed. The medication room 2/23/17 at 7:55a.m. nurse) #2. The refribox that was easily the nurse. LPN # to store the narcotic asked the PN to re | | rovide separately locked, dicompartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to in the facility uses single unit abution systems in which the ninimal and a missing dose can live to the staff interview, and clinical facility staff failed to ensure the of 2 units (unit 1) was discovered. | | 3. Licensed nurses were in-sewrite a TELS work order in narcotic box needs to be seed 2/22/17 – 3/7/17 by the Diner Nursing or designee. Any Nurses not in-serviced by not be allowed to work uninservice education is professional order of the two refriger narcotic lock boxes will be by the Unit Managers or deweekly for 4 weeks. Then the two refrigerated narcotic weekly for 4 weeks. Then the two refrigerated narcotic weekly for 4 weeks and/or compliance by the Director Nursing. The results of the be presented by the Director Nursing to the Quality Assurance/Performance In Committee for 3 months as substantial compliance is a The Quality Assurance/Performance in The Quality Assurance/Performance is a The Quality Assurance/Performance in the Quality Assurance/Performance is a The Quality Assurance/Performance in the Quality Assurance/Performance is a The Quality Assurance/Performance in the Quality Assurance/Performance is a The Quality Assurance/Performance in the Quality Assurance/Performance is a The Quality Assurance/Performance in the Quality Assurance/Performan | | er if the e secure on Director of ny Licensed by 3/7/17 will unit the rovided. gerated be conducted designee en 3 audits of otic lock box or 100% tor of he audits will ctor of Improvement and/or until s achieved. |
| | The unit manager value being permane | was informed of the lock box ntly affixed on 2/23/17 at | | | Haastie | watton sheat Page 15 of 20 |

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

Event ID T56V13

Facility ID VA0061

If continuation sheat Page 15 of 20



| DEPAR" | I'MENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | PRINTED: 03/03/2017 FORM APPROVED OMB NO. 0938-0391 |
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| STATEMENT | TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
| | | 495338 | B WING _ | and the control distribution of the control distribution o | 02/23/2017 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE ZIP GODE | |
| GRACE | HEALTHCARE OF AB | INGDON | WERNAMONIA A A ALON | 600 WALDEN ROAD ABINGDON, VA 24210 | * # \9 |
| (X4) ID PREFIX TAG | JEACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUILL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JUDBE COMPLETION |
| (E 51A\ | regional nurse conson 2/23/17 at 10:40 stated, "I thought their the refrigerator; the replaced." No further informative team concerning the conference. 483 75(I)(1) RES RECORDS-COMPLLE The facility must mare resident in accordar standards and practacurately documer systematically organ. The clinical record rinformation to identifications brovided; It is stated to the control of the clinical record rinformation to identifications brovided; It is stated to the control of the clinical record rinformation to identifications brovided; It is stated to the control of the clinical record rinformation to identifications brovided; It is stated to the clinical record rinformation to identifications brovided; It is stated to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are clinically record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are considered to the clinical record rinformation to identifications are clinical record rinformation to identifications are clinical record rinformation record rinformation record rinformation rinformation record rinformation rinformation rinformation rinformation rinformation rinformation rinformation rinformation rinf | d. "It's not affixed." med the administrator and sultant of the above concern a.m. The regional nurse at the narcotic box was affixed the pharmacy must have on was provided to the survey a above issue prior to the exit. LETE/ACCURATE/ACCESSIB aintain clinical records on each nee with accepted professional tices that are complete; need; readily accessible; and nized. must contain sufficient fy the resident; a record of the ents; the plan of care and the results of any ning conducted by the State; | (F 431 | at least the Administrator Nursing, Unit Managers, Director, Housekeeping Maintenance Director, For Director, Activity Director Services Director, Therap Director and the Medical | Admission Director, ood Service or, Social by Services Director, sed by the sing on comes were ble Party and f the nurse. ed by the sing on e identified. |
| | by: Based on staff inter review the facility sta | IT is not met as evidenced view and clinical document aff failed to ensure a complete I record for 2 of 12 Residents, Resident #205. | | omissions by the licensed the physican was notified omissions. | nurse and |
| | The findings include | ed: | | | |

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

Event IO T58V13

facility ID VA0051

If continuation sheet Page 16 of 20



| DEPART | MENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | | RINTED: 03/03/2017 FORM APPROVED MB NO. 0938-0391 |
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| STATEMENT | OF DEFICIENCIES CORRECTION | (X1) FROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | ' ' | | ONSTRUCTION | (X3) DATE SURVEY GOMPLETED |
| | | 4953 38 | B WING | | 4° 100 - 000 | 02/23/2017 |
| | ROVIDER OR SUPPLIER HEALTHCARE OF AB | | | 600 V | ET ADDRESS CITY STATE, ZIP CODE VALDEN ROAD IGDON, VA 24210 | |
| (X4) IU PREEIX TAG | (EACH DEFICIENCY | TEMONT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFI) TAG | × | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE, COMPLETION |
| (F 514) | Continued From pa | ge 16 | (F 51 | 14} | | 3/13/17 |
| | accurately document the TAR (treatment Resident #210 was 09/30/16. Diagnose hemiplegia, atrial fit hypertension, hyperdepression, and installed | | | 2 | 2. All residents in house had toe skin assessment comp. 2/22/17 by the Assistant E Nursing, the Unit Manage Minimum Data Set Nurser residents requiring skin wand PICC line care were clidentified on the TAR. | leted on Director of ors, and the s. All ound care |
| | and ARD of 12/30/1 of 15 in section C, c quarterly MDS Resident #210's clir 02/22/17. It contains order summary), whas tolerated to decrify which read in contracture". This eithe following days a 02/10, 02/12, 02/13, 02/14 comments section centries read in part decrease scheduled | OS (minimum data set) with 6 coded the Resident as 0 out tognitive patterns. This is a micel record was reviewed on ed a signed POS (physician's nich read in part "Left hand roll ease contracture". Resident reviewed and contained an part "left hand roll to decrease ntry was marked with "N" on and times: 02/04, 02/05, 02/19 at 7am, and 02/07, at 7pm. Notes in the fifth hand roll as tolerated to it for 02/./2017 7:00 AM/PM. assigned nsg (nursing) staff" | | | . Licensed Nurses on were is on following treatment ordereatment documentation by Assistant Director of Nurses 2/22/17 – 3/7/17. Any Licenses not in-serviced by not be allowed to work uninservice education is proved to the DON on checking the the DON on checking the the the term of | ders, and by the ing on ensed 3/7/17 will it the vided. n-serviced the MAR's |
| | who is the treatmen approximately 1620 TAR's, RN #2 stated treatments since Jai | n RN #2 (registered nurse), t nurse, on 02/22/17 at regarding the "N' on the that she has been doing in 2017 and that she only ne stated that when she went | | 4. | An audit of 5 treatment addressed will be conducted a Managers or designee week weeks. Then 3 treatment | by the Unit |

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to the computer to sign for her completed treatments on Resident #210, the computer

Event ID T56VI3

Facility ID VA0061

If continuation sheet Page 17 of 20



| DEPAR | MENT OF HEALTH | I AND HUMAN SERVICES | | | PRINTED: 03/03/2017 FORMAPPROVED OMB NO: 0936-0391 |
|--------------------------|--|--|--------------------|--|---|
| STATEMENT | RS FOR MEDICARE TOT DEFICIENCIES OF CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1 | ILTIP F CONSTRUCTION DING | (X3) DATE SURVEY COMPLETED R |
| | | 495338 | B WING | 3 | 02/23/2017 |
| | PROVIDER OR SUPPLIER | 45350 | γ | STREET ADDRESS CITY STATE 7/P CODE | |
| | | | | 600 WALDEN ROAD | |
| GRACE | HEALTHCARE OF AE | RINGDON | | ABINGDON, VA 24210 | |
| (XA) LD PREF'X TAG | EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | EACH CORRECTIVE ACTION SHU | OFD BE COMPLETION |
| /F 514} | Continued From pa | ag e 17 | {F 5 | 514) | 3/13/17 |
| | she put something been signed for. St how it would show there in order for the proceed. Stated that treatment not admit surveyor spoke with nurse) #2 on 02/23 LPN #2 stated that Resident had hand working. LPN #2 all know this was on The concern of doctreatments was disteam during a meetaporoximately 104th. No further informat 2. The facility staff fordered treatments. Resident #205 was 2/11/17, with a diagnot timited to: diablankle and foot, dial pressure, and depromated the initial MDS (minus incomplete. Responsive when sitaff. | cumenting completed cussed with the administrative ting on 02/23/17 at 0. cion was provided prior to exit. ailed to document physician for Resident #205. cadmitted to the facility on phoses that included, but were letes, acute osteomyelitis right bettic foot ulcer, high blood | | administration records weeks. Then 1 treatment administration record week weeks and/or 100% completed Director of Nursing. The audits will be presented Director of Nursing to the Assurance/Performance In Committee for 3 months a substantial compliance is a The Quality Assurance/Performent Committee at least the Administrator, Nursing, Unit Managers, A Director, Housekeeping D Maintenance Director, For Director, Activity Director Services Director, Therapy Director and the Medical | kly for 4 liance by he results of d by the Quality mprovement addor until achieved. rformance consists of Director of Admission birector, od Service r, Social y Services |

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focus areas for pain, osteomyelitis, and activities

of daily living, cognition, incontinence, and

Facility IO VAD061

If continuation sheet Page 18 of 20



| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | PRINTED: 03/03/2017 FORM APPROVED OMB_NO: 0938-0391 |
|--------------------------|--|---|----------------------------|---|---|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPI A BUILDING | r CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495338 | B MING | Approximation control of 5 c section concernmental production and analysis | ₹ 02/23/2 <u>017</u> |
| NAME OF F | PROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE Z | IP CODE |
| GRACE | HEALTHCARE OF AB | INGDON | | 00 WALDEN ROAD BINGDON, VA 24210 | |
| (X4) ID PREFIX TAG | PRACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST RE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEPICIENCE | ON SHOULD BE COMPLETION THE APPROPRIATE DATE |
| (F 514) | Continued From pa | nge 18 | (F 514) | | 3/13/17 |
| | record contained a "Bacitracin 500 unit RLE (right lower ex keriex. Start date 2: needle sticks RUE PLCC line is in place | nicel record was reviewed. The physician's order for: apply daily to sutures wound tremity) cover with 4x4 and /11/17. No blood pressure or (right upper extremity) while e. Monitor RUE for s/s (signs infection while PICC line is in | | | |
| | revealed on 2/12/1° applied daily to sutt 4x4 and kerlex had 2/17/16, the order fineedle sticks RUE PICC line is in place infection while PICC no documentation for the property of the proper | ew was conducted with LPN #5 | | | |
| | provided the Bacitra | am. She was asked if she had acin daily treatment as ordered on 2/12/17, LPN #5 said, "I did. ant it." | | | |
| | and asked if she hat treatments she told blood pressure on t | ewed at the facility on 2/23/17 ad performed the ordered I the surveyor; "I did not do the the arm with the PICC line, but it, I did check for s/s of shed his PICC line, I did not | | | |
| | were notified of the | staff and nurse consultant above during a meeting with 02/23/17 at approximately | | HIV ID VACAN | If continuation sheet Page 19 of 20 |

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Event ID 158V13

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| | WALE OF VEGITI | HAND HUMAN SERVICES | | | | RINTED: 03/03/2017 FORM APPROVED MB NO: 0938-0391 |
|--------------------------|---|--|-------------------|--------------|---|---|
| CENTER | MENT OF HEALTY S FOR MEDICAR! OF DEPICIENCIES CORRECTION | 8 MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | DISTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495338 | B WING | STRE | ET ADDRESS CITY, STATE ZIP CODE | 02/23/2017 |
| | ROVIDER OR SUPPLIEF HEALTHCARE OF A | | | 600 V ABI | VALDEN ROAD NGDON, VA. 24210 | |
| (X4) ID PREFIX TAG | SUMMARY S | TATEMENT OF DEFICIENCIES CY VIUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | IÖ PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY! | |
| (F 514) | Continued From p | page 19 | {F 6 | 14 } | | 3/13/17 |
| | | ation regarding this issue was urvey team prior to the exit | | | | |
| | | | | | • | |
| | | | | | | |
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Facility ID VA0061

if continuation sheet Page 20 of 20

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