Our Home, Our Family, Our Life, Too.

Heritage Hall of Dillwyn • 9 Brickyard Drive • Dillwyn, VA 23936 • (P) 434.983.2058

April 18, 2016

Center for Quality Health Services & Consumer Protection Division of Long Term Care Services 9960 Mayland Drive – Suite 401 Attn: Wietske G. Weigel-Delano, Long Term Care Supervisor Richmond, VA 23233-1463

Ms. Weigel-Delano,

Attached to this cover letter you will find Heritage Hall – Dillwyn's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during our annual survey.

If I can be of further assistance don't hesitate to contact me at (434) 983-2058.

Sincerely;

Angela H. Moore Administrator

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VDH/OLC



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495317	B. WING		04/07/2016	
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F 000	INITIAL COMMEN		F 00	00		
	survey was conducted 04/07/16. Correction compliance with 42 Term Care requirent survey/report will for	CFR Part 483 Federal Long nents. The Life Safety Code llow.				
F 281 SS=E	The census in this 60 certified bed facility was 59 at the time of the survey. The survey sample consisted of 13 current resident reviews (Residents #1 through #13) and four closed record reviews (Residents # 14 through # 17). 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS		F 28	Corrective Action(s): Resident #9's attending physician has		
	The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 17 residents in the survey sample, Resident #9; and failed to ensure one of one medication room was free from expired dressing change kits.			been notified that the facility staff fail to accurately transcribe the resident's Tylenol medication order and failed to accurately enter Tylenol order on the MAR. Resident #9's physician orders MAR's have been reviewed to ensure medication and treatment orders are correctly written and transcribed. A Facility Incident & Accident Form was completed for this incident. All of the expired Sterile Dressing chakits were removed from the medication room and disposed of. A Facility Incident & Accident Form was completed for the incident.	and all ass	
	physician's order for pain) to ensure the cadministration. Also accurately transcribe MAR (medication ad	ailed to clarify Resident #9's *Tylenol (used to treat mild order included route of , the facility staff failed to e the Tylenol order onto the ministration record) to uded route of administration		RECEIVEL VDH/OLC		
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	TITLE	(X6) DATE	

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

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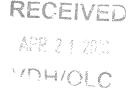
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F 281	11 Medik Mark (Brakits available for us 11/2015. The findings include 1. Resident #9 was 3/15/16. Resident # were not limited to: depressive disorder disease (a condition flow to the legs and recent MDS (minim Medicare assessmereference date) of 3 cognition as being reference date) of	room was observed to contain and) sterile dressing change e with an expiration date of e.: admitted to the facility on #9's diagnoses included but high blood pressure, major and **peripheral vascular that causes decreased blood feet). Resident #9's most um data set), a 14 day ent with an ARD (assessment /28/16, coded the resident's noderately impaired. #9's clinical record revealed a ne order dated 3/30/16 that ol 650 mg (milligrams) PRN ry) 6 hour (sic) for pain or perature)." a 2016 and April 2016 MARs stration records) documented, pain or elevated temp PRN." In nurse's initials was 0/16, indicating Resident #9 ylenol on that date. rehensive care plan reviewed anted, "He is at risk for elated to) recent surgery gery) and he has	F 28	Identification of Deficient Practices/Corrective Action(s): All other residents may have been potentially affected. The DON, ADO and/or designee will conduct a 100% review of all resident medication and treatment orders and MAR's and TAF to ensure all orders are written and transcribed correctly according to professional standards and the facility policy and procedure. All residents identified at risk will be corrected at to f discovery and an Incident & Accid form will be completed for each negatifinding. The attending physician will notified of each incorrect medication order. Additionally, the Medication Room and all Medication Carts and Treatment carts have been inspected f any expired medications or biological Any negative finds were corrected at of discovery and a facility Incident & Accident form will be completed for enegative finding. Systemic Change(s): The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of the pleare which includes, obtaining, transcribing and administering physician ordered medications and treatments puphysician order. Licensed staff will be inserviced by the DON and/or regional.	ime ent ive be or s. ime each		

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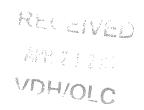
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F 281	conducted with LPN (the unit manager). physician's order ar asked LPN #1 what there was no route or physician's order ardocumented on the could correct the order stated she usually dwriting physician's orders onto the MAR and the MAR should the route, frequency diagnosis. LPN #1 order to clarify Residented with LPN documenting the abwas asked what info a physician's order. should include the dname, date of birth, medication is for. Liftime, route and dosathe MAR. The abovaloud and LPN #3 wmissing from the ordidn't put oral (route Tylenol order on Resand asked what was MAR was missing the hours and didn't doc stated if she had give	.m., an interview was I (licensed practical nurse) #1 This surveyor read the above at MAR regarding Tylenol and was missing. LPN #1 stated documented on the ad no route or frequency MAR. LPN #1 stated she der and the MAR. LPN #1 ouble checks herself when orders and transcribing the R. LPN #1 stated the order and match and should include to dosage, name and stated she would write an	F 2	281	nurse consultant on the procedure for obtaining and transcribing physician medication & treatment orders, as well as monitoring and removing any expired medication rooms and medication & treatment carts. Monitoring: The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will performs chart audit weekly coinciding with the care plan calendar in order to maintain compliance. The Unit Manager will also perform weekly inspections of all medication rooms and medication & treatment carts to monitor for compliance with expired medications and biologicals. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 16, 2016	.s	

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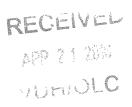
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F 281	member) #1 (the addirector of nursing) above findings. AS followed a standard above matter. ASM its own practice. At managers review of consulting pharmace. The facility policy tit documented, "Purp procedure is to estareceiving and reconordersRecording Orders- When reconspecify the type, roustrength and the reat Example: Tylenol 50 (every four hours) progreater than 101F. No further information for further medications compares the medications compares the medicaturacy and composition of or accuracy and composition.	.m., ASM (administrative staff dministrator) and ASM #2 (the were made aware of the M #2 was asked if the facility of practice regarding the M #2 stated the facility follows SM #2 stated she and other opies of orders and the dist conducts audits. Ided, 'Medication Orders'' ose: The purpose of this ablish uniform guidelines in the ding of medication Orders: 2. PRN Medication orders, ate, dosage, frequency, ason for administration. Of mg p.o. (by mouth) q4h orn mild pain or temp > (Fahrenheit)'' In was presented prior to exit. Idamentals of Nursing, 6th onted standard of practice is: are first ordered, the nurse cation recording form or the prescriber's written	F 28			
	edition Potter and P medication order is be administered by	mentals of Nursing, 6th erry, 2005, page 846, "A required for any medication to a nurseIf the medication the nurse should inform the				

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F 281	was responsible for rooms for expired to the unit of the medication room the expired kits." On 4/6/16 at 6:10 paware of the above information was presented in the properties of the above information was presented in the unit of the work of the stated mootherwise specified. A medical product is manufacturer with a reflects the time per is expected to remaining the unit of the	the DON. When asked who releaning out the medication reatment supplies she stated, manager. We just cleaned out in but we must of overlooked .m., administration was made findings. No further sented prior to exit. "Common Storage ments in part, the following: mited States Pharmacopenia ates expressed in the terms of year can be used until the last both and year unless	F 28	1		
SS=D	stored according to This information was http://www.fda.gov 483.20(k)(3)(ii) SER PERSONS/PER CAThe services provided must be provided by accordance with eaccare.	its labeled storage conditions. s obtained from the website: VICES BY QUALIFIED	F 28:	Corrective Action(s): Resident #1 & #2's attending physician has been notified that facility staff failed to apply a physician ordered Tab alarm teach resident while the residents were up in the wheelchair. A facility incident and accident form has been completed for the incident.	i i	

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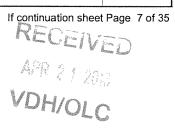
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F 282	record review and determined that fact plan of care for two sample; Residents 1. Resident #1 was occasions in her why place per the physicomprehensive plate. 2. The facility staff per Resident #2's purchased the per the physicomprehensive plate. 1. Resident #1 was occasions in her why place per the physicomprehensive plate. Resident #1 was accomprehensive plate. Initiative to anemia, high cholesterol, Not anxiety, psychotic of disorder. Resident (Minimum Data Set with an ARD (Asses 2/22/16. Resident accomprehensive) intact in decisions scoring 1 Interview for Menta coded as needing ewith transferring, drand total dependent.	tion, staff interview, clinical facility document review it was cility staff failed to follow the of 17 residents in the survey #1 and #2. Is observed on multiple neelchair without a tab alarm in cian's orders and of care. Failed to implement a tab alarm clian of care. Es observed on multiple neelchair without a tab alarm in cian's orders and of care.	F 28	Identification of Deficient	sk d e

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	asleep in her wheele observed on the whole observed on the whole observed on the whole observed on the whole observed on the wheelchair. No the wheelchair. No the wheelchair. On 4/6/16 at 2:30 p. dressing change whole observed observed observed observed observed on 4/6/16 at 3:30 p. wheelchair with no to the clinical observed on the concern relayed to the concern	.m., Resident #1 had fallen chair. No tab alarm was eelchair. a.m., Resident #1 was up in tab alarm was observed on m., Resident #1 received a lile up in her wheelchair. No rved on the wheelchair. m., Resident #1 was up in her ab alarm in place. al record revealed a nurse's ed in part, the following: (Name of Resident) dtrame) returned my call. uation of restorative ability to ambulated (sic) and rcises. Voiced understanding for resident, to continue with nity) exercisesAreas of nerapy resident is still on OT	F 2	,			
	physician on 3/1/16. Review of Resident # and revised on 2/26/	#1's care plan dated 9/2/15 15 documented in part, the b alarm while up in w/c					

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	conducted with CN. #4 regarding how C is required for each the resident's close of daily living) track be listed on that she ADL tracker form is "Nursing." CNA #4 tracker form and stordered a tab alarmago but I think it was ordered a tab alarmago but I think it was ordered with LPN When asked who with ADL tracker formorder for the safety updated by (Name chas updated the AD go ask her." On 4/6/16 at approximaterview was conducted with LPN who was responsible card she stated, "Eithe CNA manager, I responsibility." RN overlooked updating card. She stated the when new orders or On 4/7/16 at 8:35 a. conducted with LPN purpose of the care care plan to know the diagnoses and how	A.m., an interview was A (certified nursing assistant) CNAs know what safety device a resident. CNA #4 stated, "In they have an ADL (activities er form. Safety devices should eet." When asked how the updated she stated, viewed Resident #1's ADL ated, "I don't think she was a discontinued." I.m., an interview was I (licensed practical nurse) #5. Was responsible for updating an she stated, "After there is an device the care plan is of MDS nurse) and I know she of MDS nurse) and I know she of tracker card before. Let me discordinator. When asked the for updating the ADL tracker ther I do it or I give a memo to bout it is ultimately my #1 stated that she must have a Resident #1's ADL tracker at she updates the care plan changes are put in place. Im., an interview was 1#1. When asked the plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated, "We use the care plan she stated, "We use the care plan she stated, "We use the plan she stated, "We use the care plan she stated the stated stated sta	F 28	32			

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F 282	plan she stated, "E anyone." When ask be in place if it is lis stated, "Yes." On 4/6/16 at 6:10 p aware of the above information was professed in the care routines and was personnel who have care or services to according to Funda Williams and Wilking documented, "A wricommunication tool members that helps careThe nursing of information about the and goals. It contains and is used to direct revise and update the services in the services and update the services."	verybody. CNA's, nurses, ked if a safety device should sted on the care plan she o.m., administration was made of findings. No further ovided prior to exit. "Using the Care Plan" the following: "The care plan oveloping the resident's daily will be available to staff the responsibility for providing	F 2	82				
	per Resident #2's p			A SHEET AND THE PROPERTY OF TH				
T you are not assessed		Imitted to the facility on the facility on 1/22/16.						

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1	Resident #2's diagralimited to: *Alzheim fracture of the first Resident #2's most set), a 30 day Medi (assessment referent the resident's cognimaking as severely documented Reside falls since the prior Review of Resident the resident sustain - 5/13/15- Reside floor in his room (no: 6/27/15- Reside floor in his room (no: 1/19/16- Reside floor in his room (the hospital and diagnoon Resident #2's fall rist documented the resident #2's compon 3/11/16 documents at increased risk themiplegia, cogniity lack of safety aware injury C1 (first cervicuse of a cervical colvision, and debilitate Tab alarm at all times A physician on 3/29/16	noses included but were not er's disease, **hemiplegia and cervical (neck) vertebra. recent MDS (minimum data care assessment with an ARD ence date) of 2/17/16, coded tive skills for daily decision impaired. Section Jent #2 had not sustained any assessment. #2's clinical record revealed ed the following falls: ent #2 was observed on the injury). ent #2 was observed on the injury). ent #2 was observed on the eresident was sent to the sed with a cervical fracture). Sk assessment dated 1/22/16 sident was at high risk for falls. rehensive care plan revised anted, "(Name of Resident #2) for falls r/t (related to) eresic deficits from dementia, ness, arthritis, recent fall with cal vertebra) fracture and the lar at all times, impaired ed conditionApproaches:	F 28				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILE	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495317	B. WING			۱ ۵	4/07/2016
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F 282	care plan dated 3/s resident's closet) d @ (at) all times" On 4/5/16 at 2:17 p#2 was observed in No tab alarm was oresident. On 4/6/16 at 11:00 #2 was observed in The tab alarm box the resident's bed a Resident #2. On 4/6/16 at 2:07 pobserved in a whee alarm was observed in a whee alarm was observed on 4/6/16 at 2:35 pronducted with CNshe was made awadevices required for stated most of the tasfety devices was if she didn't then shown cNA #1 stated them residents' closets. Of safety devices work cNA #1 stated them chair alarm, mat on this time, Resident the hall. CNA #1 was resident and the resident. CNA #1 con an alarm.	age 11 a (certified nursing assistant) a/16 (and located in the ocumented, "Safety: tab alarm o.m. and 3:22 p.m., Resident in a wheelchair in the bedroom. observed attached to the a.m. and 11:54 a.m., Resident in a wheelchair in the bedroom. and clip was observed lying on and was not attached to a.m., Resident #2 was elchair in the hall. No tab in a tracked to the resident. b.m., an interview was A#1. CNA#1 was asked how are of the type of safety in each resident. CNA#1 ime she knew what types of required for each resident but in e asked the CNA supervisor. In the floor and a low bed. At the floor and a low bed	F 2	82			

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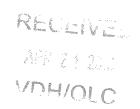
	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3)) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER GE HALL DILLWYN			STREET ADDRESS, CITY, STATE, ZIP C 119 BRICKYARD DRIVE DILLWYN, VA 23936	ODE	04/07/2016	
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	LPN #2 was asked the type of safety d resident. LPN #2 s physician's orders a lead CNA. LPN #2 safety devices were #2 reviewed the resistated, "Boots on he lift with the assist of all times to make su #2 was made aware Resident #2 without stated staff would c On 4/6/16 at 6:18 p member) #1 (the ac director of nursing) above findings. On 4/7/16 at 8:35 a. conducted with LPN #1 was asked the plans. LPN #1 state know patients and the asked who looks at stated, "Everybody; stated safety device residents' care plans residents' closets. Levices documented should be implementated the staff will identify resident's specific risestent's sp	N (licensed practical nurse) #2. how she was made aware of evices required for each tated she looks at the and she also consults with the was asked what types of used for Resident #2. LPN sident's physician's orders and eels, abdominal binder, Hoyer two (staff) and a tab alarm at ure he doesn't fall again." LPN of the above observations of a tab alarm in place. LPN #2 forrect this. I.m., ASM (administrative staff diministrator) and ASM #2 (the were made aware of the were made aware of the m., an interview was #1 (the unit manager). LPN urpose of residents' care plans to neir needs. LPN #1 was residents' care plans and CNAs and nurses." LPN #1 sare documented on and the care cards in LPN #1 confirmed safety don residents' care plans	F 2	282			

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F 282 Continued From page 13 minimize complications from falling. Policy Interpretation and Implementation: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls" No further information was presented prior to exit. *"Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+dise		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SUR\ COMPLETE	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL DILLWYN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 13 minimize complications from falling. Policy Interpretation and Implementation: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls" No further information was presented prior to exit. *"Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+dise			495317	B. WING		04/07/20	16
F 282 Continued From page 13 minimize complications from falling. Policy Interpretation and Implementation: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls" No further information was presented prior to exit. *"Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+dise					119 BRICKYARD DRIVE	and the control of th	
minimize complications from falling. Policy Interpretation and Implementation: 1. The staff, with the input of the Attending Physician, will identify appropriate interventions to reduce the risk of falls" No further information was presented prior to exit. *"Alzheimer's disease (AD) is the most common form of dementia among older people. Dementia is a brain disorder that seriously affects a person's ability to carry out daily activities." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query- meta?v%3Aproject=medlineplus&v%3Asources= medlineplus-bundle&query=alzheimer%27s+dise	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMP	X5) PLETION ATE
**Hemiplegia is the loss of muscle function in part of your body. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=hemiplegia F 323	F 323	minimize complicated Interpretation and Inwith the input of the identify appropriate risk of falls" No further information was offered in a brain disorder the person's ability to conformation was observed information was observed in the websites. It was a brain disorder the person's ability to conformation was observed in the websites was a brain disorder the person's ability to conformation was observed in the person's Aprojects and Indiana was a brain disorder in the person wa	ions from falling. Policy implementation: 1. The staff, Attending Physician, will interventions to reduce the ion was presented prior to exit. se (AD) is the most common mong older people. Dementia hat seriously affects a arry out daily activities." This tained from the website: .nih.gov/vivisimo/cgi-bin/query- emedlineplus&v%3Asources= &query=alzheimer%27s+dise loss of muscle function in part information was obtained from nih.gov/vivisimo/cgi-bin/query- emedlineplus&v%3Asources= &query=hemiplegia ACCIDENT VISION/DEVICES sure that the resident has as free of accident hazards each resident receives on and assistance devices to		F323 Corrective Action(s): Resident #1 & #2's attending physician has been notified that facility staff failed to apply a physician ordered Tab alarm to each resident while the residents were up in the wheelchair. A facility incident and accident form has been completed for thi		

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F 323	was determined that implement physicial prevent accidents for survey sample, Res 1. The facility staff of #2's physician order 2. The facility staff of Resident #1's whee physician on 2/26/1. The findings include 1. The facility staff of #2's physician order Resident #2 was ad 7/11/12 and readmit Resident #2's diagn limited to: *Alzheime fracture of the first of Resident #2's most set), a 30 day Medic (assessment referent the resident's cognit making as severely documented Reside falls since the prior at Review of Resident the resident sustained to: 5/13/15- Reside floor in his room (no 6/27/15-	and clinical record review, it the facility staff failed to an ordered assistive devices to be two of 17 residents in the sidents #2 and #1. ailed to implement Resident red tab alarm. ailed to place a tab alarm to lichair as ordered by the 65. at ailed to implement Resident red tab alarm. mitted to the facility on ted to the facility on 1/22/16. coses included but were not rer's disease, **hemiplegia and rervical (neck) vertebra. The recent MDS (minimum data rare assessment with an ARD race date) of 2/17/16, coded ive skills for daily decision impaired. Section Jet 2 had not sustained any assessment. #2's clinical record revealed red the following falls: mt #2 was observed on the injury). mt #2 was observed on the	F 32	Identification of Deficient Practices/Corrective Action(s): All other residents with physician ord tab alarms or other preventive devices prevent falls may have been potential affected. The DON and/or Unit Mana will conduct a 100% review of all residents with physician ordered tab alarms and fall prevention devices to identify residents at risk for inconsist application and monitoring of the equipment. All residents identified at will be corrected at time of discovery an Incident & Accident form will be completed for each negative finding. attending physician will be notified or each incident. Systemic Change(s): The facility policy and procedure for prevention and management has been reviewed and no revisions are warran at this time. The DON and/or regiona nurse consultant will in-service all Licensed Nursing staff regarding prof use of fall prevention equipments to include wheelchair and bed alarms to prevent falls.	ent risk and The f	

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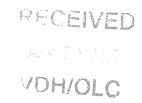
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	floor in his room (the hospital and diagnor Resident #2's fall rist documented the resident #2's compon 3/11/16 documents at increased risk hemiplegia, cognitive lack of safety aware injury C1 (first cervicuse of a cervical colvision, and debilitate Tab alarm at all times A physician's order sphysician on 3/29/16 start date of 1/25/16 Resident #2's CNA (care plan dated 3/9/resident's closet) do @ (at) all times" On 4/5/16 at 2:17 p #2 was observed in No tab alarm was obresident. On 4/6/16 at 11:00 at #2 was observed in a the resident #2. On 4/6/16 at 2:07 p.r. observed in a wheeld	e resident was sent to the sed with a cervical fracture). Sk assessment dated 1/22/16 sident was at high risk for falls. Prehensive care plan revised finded, "(Name of Resident #2) for falls r/t (related to) Pe (sic) deficits from dementia, the sease, arthritis, recent fall with cal vertebra) fracture and the lar at all times, impaired ed conditionApproaches: Personal summary signed by the standard documented an order with a standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal summary signed by the standard for a tab alarm at all times. Personal	F 323	Monitoring: The DON is responsible for maintainin compliance. The DON and/or Unit Manager will perform daily inspections all residents with physician order fall prevention devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 16, 2016	of	

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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	
		495317	B. WING _		04/	07/2016
	PROVIDER OR SUPPLIER GE HALL DILLWYN			STREET ADDRESS, CITY, STATE, ZIP CODE 119 BRICKYARD DRIVE DILLWYN, VA 23936	A	
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F 323	conducted with CN. she was made awardevices required for stated most of the transfer devices was if she didn't then she CNA #1 stated there residents' closets. of safety devices worder alarm, mat on this time, Resident the hall. CNA #1 worder and the resident and the resident and the resident and the resident and the resident. CNA #1 conducted with LPN LPN #2 was asked the type of safety deresident. LPN #2 sophysician's orders a lead CNA. LPN #2 safety devices were #2 reviewed the resistated, "Boots on he lift with the assist of all times to make sufficient would conducted staff would conducted staff would conducted staff would conducted with LPN #2 safety devices were #2 reviewed the resistated, "Boots on he lift with the assist of all times to make sufficient would conducted staff would conducted without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would conducted with LPN #2 was made aware Resident #2 without stated staff would with LPN #2 was made aware Resident #2 without stated staff would with LPN #2 was made aware Resident #2 without stated staff would with LPN #2 was made aware Resident #2 without stated staff would with LPN #2 was made aw	A.m., an interview was A.#1. CNA #1 was asked how re of the type of safety reach resident. CNA #1 ime she knew what types of required for each resident but e asked the CNA supervisor. e was also a care guide in CNA #1 was asked what types ere used for Resident #2. resident had a bed alarm, the floor and a low bed. At #2 remained in a wheelchair in as asked to observe the sident's wheelchair for an firmed the resident didn't have .m., an interview was I (licensed practical nurse) #2. how she was made aware of evices required for each tated she looks at the and she also consults with the was asked what types of e used for Resident #2. LPN ident's physician's orders and eels, abdominal binder, Hoyer two (staff) and a tab alarm at a tre he doesn't fall again." LPN e of the above observations of a tab alarm in place. LPN #2 orrect this. m., ASM (administrative staff laministrator) and ASM #2 (the	F 32	3		
The state of the s	director of nursing) above findings.	were made aware of the				

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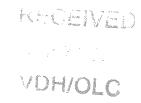
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 119 BRICKYARD DRIVE DILLWYN, VA 23936	, ZIP CODE		10772010
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F 323	Managing" docume Based on previous the staff will identify resident's specific reprevent the resident minimize complicated Interpretation and I with the input of the identify appropriate risk of falls" No further information was obstated in the input of the identify appropriate risk of falls" No further information was obstated in the input of the identify appropriate risk of falls" No further information was obstated in the input of the identification was obstated in the input of information was obstated in the input of your bandle ase **Hemiplegia is the of your body. This is the website: https://vsearch.nlm.meta?v%3Aproject-medlineplus-bundle	tled, "Falls and Fall Risk, ented, "Policy Statement: evaluations and current data, vinterventions related to the isks and causes to try to it from falling and to try to ions from falling. Policy implementation: 1. The staff, e Attending Physician, will interventions to reduce the intervention was presented prior to exit. See (AD) is the most common mong older people. Dementia hat seriously affects a arry out daily activities." This cained from the website: nih.gov/vivisimo/cgi-bin/query-medlineplus&v%3Asources= loss of muscle function in part information was obtained from inh.gov/vivisimo/cgi-bin/query-medlineplus&v%3Asources=	F 3	123			
		chair as ordered by the					

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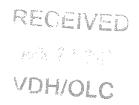
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495317	B. WING		04	1/07/2016
	PROVIDER OR SUPPLIER GE HALL DILLWYN			STREET ADDRESS, CITY, STATE, ZIP 119 BRICKYARD DRIVE DILLWYN, VA 23936		
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F 323	physician on 2/26/1 Resident #1 was ac 5/26/15 with diagnor limited to anemia, high cholesterol, No anxiety, psychotic disorder. Resident (Minimum Data Set with an ARD (Asses 2/22/16. Resident acognitively intact in decisions scoring 1 Interview for Mental coded as needing ewith transferring, drand total dependent. The following obsercourse of survey: On 4/5/16 at 4:15 prasleep in her wheel observed on the whole observed on the whole observed on the whole observed on 4/6/16 at 2:30 processing change whole that documents are that documents of the clinical of the clini	dmitted to the facility on sees that included but were not sees that included pressive #1's most recent MDS) was a quarterly assessment sement Reference Date) of #1 was coded as being the ability to make daily 5 out of 15 on the BIMS (Brief Status). Resident #1 was extensive assistance from staff essing, and personal hygiene; ce on staff with bathing. vations were made during the .m., Resident #1 had fallen chair. No tab alarm was eelchair. a.m., Resident #1 was up in tab alarm was observed on .m., Resident #1 received a nile up in her wheelchair. No rved on the wheelchair. m., Resident #1 was up in her .m., Resident #1 was up in her .m.	F 32	23		

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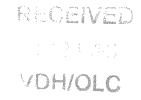
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F 323	(daughter) in law (Discussed discontinuous declining of arm erequested tab alarmer LE (lower extroncern relayed to (Occupational The Voccupational The Voccu	(Name) returned my call. tinuation of restorative in ability to ambulated (sic) and xercises. Voiced understanding rm for resident, to continue with emity) exercisesAreas of therapy resident is still on OT erapy) caseload." Resident #1's clinical record one order dated 2/26/16 that following: "Tab alarm while up in This order was signed by the 6. Int #1's care plan dated 9/2/15 26/15 documented in part, the 6 tab alarm while up in w/c It also revealed that Resident #1 It of falls the last fall documented lent #1 had a history of trying to ont #1's ADL (activities of daily evealed no documentation	F	323			

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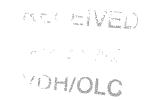
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SÜRVEY COMPLETED	
		495317	B. WING _		04/07/2016	
	PROVIDER OR SUPPLIER GE HALL DILLWYN			STREET ADDRESS, CITY, STATE, ZIP CODE 119 BRICKYARD DRIVE DILLWYN, VA 23936		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 323	ordered a tab alarmago but I think it was On 4/6/16 at 3:05 p conducted with LPI When asked who with the ADL tracker for order for the safety updated by (Name has updated the AL go ask her." On 4/6/16 at approinterview was cond Nurse) #1, the MDS who was responsible card she stated, "Ethe CNA manager, responsibility." RN overlooked updatin card. She stated the conduction of the stated the card she stated the card. She stated the conduction of the stated the conduction of the stated the conduction of the card.	n. She had one a long time	F 32	23		
F 329 SS=D	aware of the above information was pre 483.25(I) DRUG RE UNNECESSARY DE Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequer	e.m., administration was made findings. No further esented prior to exit. EGIMEN IS FREE FROM PRUGS g regimen must be free from and an unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any	F 32	Corrective Action(s): Resident #5 has had their current medication regime reviewed for unnecessary drugs and dosage reductions by the attending physician. None are warranted at this time. Resident #5's comprehensive cares plan has been		-

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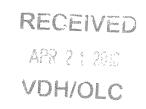
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		E SURVEY MPLETED
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F 329	resident, the facility who have not used given these drugs to therapy is necessar as diagnosed and orecord; and resident drugs receive grade behavioral intervent contraindicated, in addrugs. This REQUIREMENT by: Based on observative record, and facility of determined that fact of 17 residents drugunnecessary medical transfer of the usordered by the physical transfer of part of the physical transfer of part of the findings included Resident #5 was act 8/8/2014 and readment of the physical transfer of the physical tr	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical ats who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these with the second treatment of the second treat	F 329	reviewed and revised to reflect the prand post administration behavior monitoring to be completed for the being administered. A Facility Incide Accident Form was completed for the incident. Identification of Deficient Practices and Corrective Action(s): All residents presently receiving rout antipsychotic medication may be potentially affected. The facility will conduct a 100% review of all resident receiving antipsychotic medication for appropriate medical diagnosis to suppuse, and that routine dosage reduction behavior monitoring is being done. The attending physicians for all residents identified at risk will be contacted for appropriate intervention. A Facility Incident &Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The nursing st will be in-serviced by the DON and/oregional nurse consultant on the requirement to complete pre and post behavior monitoring on all resident receiving routine or PRN antipsychot medications and to perform GDR per pharmacist recommendations as requirements.	aldol nt & s s) ine its r cort and ne	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER GE HALL DILLWYN			STREET ADDRESS, CITY, STATE, ZIP CODE 119 BRICKYARD DRIVE DILLWYN, VA 23936		
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F 329	paralysis of one sick Non-Alzheimer's de type 2 diabetes, an most recent MDS (day scheduled asse (Assessment Refer Resident #5 was concognitively impaired decisions scoring 9 for Mental Status). requiring extensive most ADLS (Activition Review of the clinic (Gradual Dose Redirecommended a triangle The physician access 12/1/15. Review of the teleptollowing order date that do 0.25 mg (mill Further review of the following order of 0.25 mg po (by most documented the following order documented t	de of the body, ementia, psychotic disorder, d osteoarthritis. Resident #5's Minimum Data Set) was a 14 essment with an ARD rence Date) of 3/23/16. Oded as being severely d in the ability to make daily 9 on the BIMS (Brief Interview Resident #5 was code as assistance from staff with es of Daily Living). Fall record revealed a GDR fluction) dated 11/19/15 that all discontinuation for Haldol. In pted this recommendation on those order sheet revealed the ed 12/1/15 "D/C (discontinue fligrams) QHS (every night)." The telephone orders revealed dated 12/6/15 "Restart Haldol with) q pm (every evening)." The cian note dated 12/22/15 flowing: "Pt (patient) had a had d/c'd on 12/1/15. Pt increased agitation and y to d/c of Haldol of 0.25 mg." The start haldol of 0.25 mg."	F 329	Monitoring: The DON and/or Unit Manager are responsible for compliance. The Antipsychotic Drug review will be completed monthly to monitor for compliance. The results of these audits will be forwarded to the Quality Assurance Committee monthly/prn for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 16, 2016		

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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	
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F 329	"Mood State" dated 3-18-16 documents "Approaches": "Me Monitor for adverse cursing, agitation, ostaff, validate feelin (sic) later if indicate pain, thirst, warmth communication." On 4/06/16 at 5:45 conducted with LPN When asked how be stated that each timis given a prompt of ask if the resident of the frequency of be behaviors should be Haldol, she stated, #5's MARs, LPN # that order in the conwere not brought up #6 stated that Residus discontinued before behaviors so the phenodication. LPN # called the physician Haldol." LPN #6 stated that documented the not sure."		F3	29		

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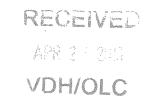
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F 329	aware of the above information was pre (Administrative State (Director of Nursing in the computer system of the computer system). Facility policy titled Monitoring docume "Monitoring 1. If the problematic behavior physician will obtain reassessments of coin the individual's be 2. The staff will docume, behavior assemble approain formation about some and frequency of the comparable approain formation about some and frequency of the comparable approain formation about some and frequency of the comparable approach as a intervention of the comparable approach and frequency of the comparable approach and freq	.m., administration was made findings. No further sented prior to exit. ASM if Member) #2, the DON is stated, "We fixed that order item." "Behavior Assessment and ents in part, the following: resident is being treated for or or mood, the staff and in and document ongoing changes (positive or negative) ehavior, mood, and function. Item in progress ressment forms, or other ches) the following pecific problem behaviors: uency of episodes; cipitating factors; impted (if psychoactive drug is on, institute appropriate	F 329			
	p.613. 483.35(i) FOOD PR STORE/PREPARE/ The facility must - (1) Procure food fro considered satisfact authorities; and	m sources approved or tory by Federal, State or local	F 371	F 371 Corrective Action(s): The expired Ham identified in the walk-in refrigerator during the initial kitchen tour was immediately removed and disposed of. A facility Incident and Accident form was completed for this incident.		

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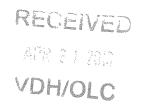
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 371	by: Based on observated determined that far a safe and sanitary Facility staff failed refrigerators was firm. The findings included on the firm of the kitchen was conducted bag containing slice the kitchen refriger documented the form of the dietary manager refrigerator is clear she stated, "Week expired items." Of lock bag that contained the form of the dietary manager refrigerator is clear she stated, "Week expired items." Of lock bag that contained the was opened the was opened the was opened the was opened the was the same ham previous week. Opolicy on expired for 11:10 on 16:5/16 at 11:10 on 16	NT is not met as evidenced ation and staff interview it was cility staff failed to store food in a manner. Ito ensure one of three kitchen ree from expired ham. Ite: Ite a.m., observation of the cted. At 11: 05 a.m., a zip lock es of ham was observed inside rator. The zip lock bag allowing: "U/b (use by) 4/2/16." Ite a.m., an interview was some (Other Staff Member) #2, etc. When asked how often the ned out for expired food items by the could not be some 2 was then shown the zip ained ham slices and 4/2/16". OSM #2 stated, "Yes good for seven days. This ed." She stated that the ham eek prior but OSM #2 could not that the ham in the zip lock bag in used on the menu the SM # 2 could not provide a	F 37	Corrective Action(s): All other residents may have been potentially affected. Certified Dietary Manager and/or Registered Dietician or randomly monitor the kitchen preparate area before, during and after meals to identify any negative findings. The freezers and refrigerators in the kitche will be monitored daily for proper stor of food items. Any expired food or beverages or other negative findings who is corrected at time of discovery and appropriate disciplinary action taken a needed. A facility Incident and Accid form will be completed for each negatifinding identified. Systemic Change(s): Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will in-service the CDM and dietary staff on the proper preparing, storing and distribution of funder sanitary conditions, as well as the policy and procedure for proper sanitary and hand washing. Monitoring: The CDM is responsible for maintainic compliance. The Administrator and/or Certified Dietary Manager will compliane The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 16, 2016	vill ion rage vill s ent ive Good ne tion ng r ete ce.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	E CONSTRUCTION	COMPLETED
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F 514	on 4/6/16 at 6:10 paware of the above information was pred 483.75(I)(1) RES RECORDS-COMP LE The facility must m resident in accordate standards and pracaccurately docume systematically orgate of the clinical record information to identify resident's assessming services provided; preadmission screen and progress notes. This REQUIREMED by: Based on staff interest and clinical record the facility staff failed clinical record for the survey sample, Resident #6's behand cocasions from Jar. 1. The facility staff Resident #6's behand cocasions from Jar. 2. For Resident #3.	tary staff for expired food o.m. administration was made infindings. No further esented prior to exit. LETE/ACCURATE/ACCESSIB aintain clinical records on each nce with accepted professional ctices that are complete; nted; readily accessible; and nized. must contain sufficient tify the resident; a record of the tents; the plan of care and the results of any ening conducted by the State;	F 371	F514 Corrective Action(s): Residents #3, #6 & #11's attending physician has been notified that the facility failed to consistently document accurate pre and post behavior monitoring prior to and after administering physician ordered antipsychotic medications. Residents #, #6 & #11 have had their antipsychotic orders reviewed and behavior monitoring clarified by the attending physician. A facility incident and accident form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All other residents may have potentially been affected. A 100% review of all residents receiving routine or PRN antipsychotic medication orders and MAR's, will be conducted by the DON and/or Unit Manager to identify residents at risk for inappropriate behavior monitoring. All negative findings will be clarified and/or correct at time of discovery. A facility Incident & Acciden form will be completed for each negative finding.	

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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	
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F 514	Seroquel (1) on the 2016 MARS (Median Seroquel is a moor manifestations of pacute mania. 3. For Resident #1 documented targer Seroquel on the Femala Seroquel on the Seroquel on the Femala Seroquel on the Seroquel on the Seroquel	e February, March and April cation Administration Records). d stabilizer used to decrease osychoses, depression, or 1, facility staff inaccurately ted behaviors for the use of ebruary, March and April 2016 de: failed to accurately document avior monitoring on multiple nuary 2016 through April 2016. dmitted to the facility on altited to the facility on altited to the facility on sitted to the facility on sessincluded but were not taken anxiety and **convulsions. to recent MDS (minimum data sessment with an ARD ence date) of 2/11/16, coded altition as severely impaired. Luary 2016 through April 2016 administration records) esident presented with the ces of behaviors: Trences ence 1- one occurrence 1- three occurrences 1- three occurrences 1- three occurrences	F 514	Systemic Change(s): The facility policy and procedure been reviewed and no changes are warranted at this time. All licensed nursing staff will be in-serviced by DON or regional nurse consultant clinical documentation standards pfacility policy and procedure. This training will include the standards maintaining accurate medical recoclinical documentation to include Physician Orders, MAR's, TAR's accurate pre and post behavior me for all antipsychotic medication administration according to the acprofessional standards and practic. Monitoring: The DON is responsible for maint compliance. The DON, and/or Un Manager will audit the MAR's we coinciding with the MDS calendar monitor for compliance. Any/all infindings will be clarified and corretime of discovery and disciplinary will be taken as needed. The result this audit will be provided to the CAssurance Committee for analysis recommendations for change in fapolicy, procedure, and/or practice. Completion Date: May 16, 2016.	the on the oer of or rds and onitoring ceptable es. aining onit bekly to egative ected at action ts of Quality s and cility of the central control of the central cen	

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F 514	1/29/16- one occur 2/3/16- one occur 2/6/16 (8:00 a.m.)-2/6/16 (4:00 p.m.)-2/7/16- one occur 2/17/16- one occur 3/2/16- one occur 3/2/16- one occur 3/11/16- three occ 3/20/16- three occ 3/30/16- three occur 4/4/16- one occur 4/4/16- three occur 4/4/16- three occur 5/10/16 (8:25 a.m.) Types: None 1/10/16 (4:28 p.m.) Types: None 1/19/16 (10:10 a.m.) Types: None 1/19/16 (5:15 p.m.) Types: None 1/20/16- Behavior 0/2/3/16- Behavior 0/2/17/16- Behavior 0/2/17	rrence ence - one occurrence - one occurrence ence rrence rrence ence urrences urrences urrences ence		14		

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F 514	3/2/16- Behavior 0 3/11/16- Behavior 0 3/20/16- Behavior 0 4/1/16- Behavior 0 4/4/16- Behavior 0 4/4/16- Behavior 0 Resident #6's comon 2/17/16 failed to regarding accurate 0 On 4/6/16 at 4:00 conducted with RN nurse responsible behaviors on 1/9/11/29/16, 2/3/16, 2/3/2/16 and 3/20/16 time she had to do couple times she computer system stated she though numeric value. RI that documented no be RN #2 stated if she behavior count) the then the documentation asked if the entries count of three and inaccurate. RN #2 that way shouldn't (meaning someon entries). On 4/6/16 at 6:18	Count 1; Behavior Types: None Count 3; Behavior Types: None Count 4; Behavior Set Count 1; Behavior Set Count 1; Behavior Set Count 2; Count 3; Behavior Set Count 4; Count 4; Count 5; Count 5; Count 6; Count 6; Count 6; Count 7; Count 7; Count 7; Count 7; Count 7; Count 8;	F5	514		

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F 514	director of nursing above findings. The facility policy Omissions" docurate medical this facility" No further inform *"Dementia is the caused by disord information was of https://vsearch.nl meta?v%3Aproje medlineplus-bund **Convulsions oc shakes rapidly ar information was of https://www.nlm.rml 2. For Resident # documented targ Seroquel (1) on the local targ seroquel is a momanifestations of acute mania. 3. For Resident # documented targ Seroquel on the local target seroquel s	titled, "Charting Errors and/or mented, "Policy Statement: I records shall be maintained by ation was presented prior to exit. I name for a group of symptoms ers that affect the brain." This obtained from the website: m.nih.gov/vivisimo/cgi-bin/query-ct=medlineplus&v%3Asources=dle&query=dementia cur when a person's body and uncontrollably. This obtained from the website: nih.gov/medlineplus/seizures.ht 13, facility staff inaccurately eted behaviors for the use of the February, March and April dication Administration Records) od stabilizer used to decrease psychoses, depression, or 11, facility staff inaccurately eted behaviors for the use of February, March and April 2016 was admitted to the facility on noses that included but were not mental status, high blood tolesterol, Non-Alzheimer's rajor depressive disorder.		514			

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F 514	with an ARD (Asse 1/7/16. Resident # cognitively impaired Interview for Mental coded as requiring and meals; and limfrom staff with all oliving). Resident # tempered and easi section D (Mood) of coded as having so section E (Behavior Review of Residen physician sheet review of Residen (classified) elswhridisturbance." Thes 1/26/16. Review of Residen April 2016 MARS in documentation: 2/3/16 (9) Behavior Types: No. 2/6/16 (9) Behavior Types: No. 3/02/16 (9) Behavior Types: No. 3/11/16 (9) Behavior Types: No. 3/30/16 (9)	t) was a quarterly assessment ssment Reference Date) of the was coded as being severely discoring 99 on the BIMS (Brief al Status). Resident #3 was supervision with ambulation lited to extensive assistance ther ADLS (Activities of Daily #3 was coded as being short ly annoyed nearly every day in of the MDS assessment; and ome episodes of wandering in rs) of the MDS. It #3's most recently signed realed the following orders: milligrams) Take 1 tab (tablet) very) day and Seroquel 12.5 po q day" for "F02.81 ther) diseases classd (elsewhere) w (with) behavioral e orders were initiated on the #3's February, March and evealed the following of the follo	F 514			

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 119 BRICKYARD DRIVE DILLWYN, VA 23936		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 514	On 4/06/16 at 5:45 conducted with LP When asked how I stated that each tiris given a prompt of ask if the resident the frequency of bethe MARS nursing having behaviors to behavior type, she documented wrong On 4/06/16 at 6:10 made aware of the information was pr 3. Resident #11 w 11/21/14 with diagnot limited to high vascular disease, stroke, and venous most recent MDS quarterly assessm Reference Date) of coded as being se the ability to make on the BIMS (Brief Resident #11 was assistance from st of Daily Living); an meals. Resident # tempered and eas of the MDS; and cother behaviors su wandering. Review of Resider Sheet) documente "Seroquel 50 mg (tab po (by mouth)"	N (licensed practical nurse) #6. Dehaviors are documented sheme a psychoactive medication on the computer system will displayed any behaviors and ehaviors. When asked why on documented Resident #3 as but then wrote "NONE" for stated, "That must have been g." I. p.m., administration was a above findings. No further esented prior to exit. as admitted to the facility on noses that included but were blood pressure, peripheral diabetes, Alzheimer's disease, is insufficiency. Resident #11's (Minimum Data Set) was a ent with an ARD (Assessment f 1/18/16. Resident #11 was verely cognitively impaired in daily life decisions scoring 99. Interview for Mental Status). Coded as requiring extensive aff with most ADLS (Activities d needing supervision with the state of the following Delusions and chas rummaging and wit #11's POS (Physician Order d the following orders: milligram) tab (tablet) Take 1		514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495317	B. WING		04/	07/2016
	PROVIDER OR SUPPLIER		119	REET ADDRESS, CITY, STATE, ZIP CODE B BRICKYARD DRIVE LLWYN, VA 23936		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 514	and 2 pm." Review of Resider April 2016 MARS of documentation: 2/3/16 (8: Behavior Types: Now 2/3/16 (1: Behavior Types: Now 2/7/16 (8: Behavior Types: Now 2/7/16 (1: Behavior Types: Now 2/17/16 (8: Behavior Types: Now 3/2/16 (8: Behavior Types: Now 3/2/16 (8: Behavior Types: Now 3/30/16 (8: Behavior Types: Now 3/30	nt #3's February, March and revealed the following 27 a.m.) Behavior Count: 1; one 23 p.m.) Behavior Count: 1; one 11 a.m.)-Behavior Count: 1; one 33 a.m.)- Behavior Count 1; one 51 p.m.)- Behavior Count 1; one 51 p.m.)- Behavior Count 1; one 1:59 p.m.)- Behavior Count 1; one 1:59 p.m.)- Behavior Count 1; one 1:13 p.m.)-Behavior Count 1; one 32 a.m.)-Behavior Count 1; one 3:53 p.m.)-Behavior Count 3; one 3:53 a.m.)-Behavior Count 3; one 3:03 p.m.)- Behavior Count 3; one 28 p.m.)-Behavior Count 3; one	F 514			

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Facility ID: VA0111

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495317	B. WING		04	/07/2016
	PROVIDER OR SUPPLIER GE HALL DILLWYN			STREET ADDRESS, CITY, STATE, ZIP CO 119 BRICKYARD DRIVE DILLWYN, VA 23936		
(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 A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	having behaviors be behavior type, she documented wrong On 4/06/16 at 6:10 made aware of the information was pre	documented Resident #11 as ut then wrote "NONE" for stated, "That must have been ." p.m., administration was above findings. No further	F 5	14		

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

Event ID: J5KP11

Facility ID: VA0111

If continuation sheet Page 35 of 35

