PRINTED: 10/11/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495393	B. WING	ì			09/2	29/2016
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		160	REET ADDRESS, CITY, STATE, ZIP C 21 BROADROCK BLVD** CHMOND, VA 23224	CODE	007.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	rs	F 0	000				
	survey was conduct Corrections are requ CFR Part 483 Fede requirements. The	Life Safety Code low. Three complaints were		THE CHARLES THE PARTY OF THE PA				
F 176	194 at the time of the consisted of 27 curre (Residents 1-27) and (Residents 28-30).	100 certified bed facility was e survey. The survey sample ent Resident reviews d 3 closed record reviews	F 1	76	REC	<b>EIV</b> (	ED	
: :	An individual resider the interdisciplinary	nt may self-administer drugs if		**************************************	<ol> <li>Address how corrections be accomplished for the residents found to had</li> </ol>	those	n will	
	by: Based on observation documentation reviet the facility staff failed (Resident #19) in a serie Residents was afforced administer medication. Resident #19 was obspirive inhaler without assessment for ability medications, nor care	ded his right to self ons. Deserved administering his ut a physician's order, y to self administer e plan.			affected by the deficience a. Resident # 19 assessed by the linterdisciplina (IDT). MD ordinated and contained and contained and contained are suppossed in the second sec	ent prac has bee ne nry Team ler has b	etice. en n	
	The findings included	1:					s -	
DODATODY	DIDECTORIS OF PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATLICE		TITI F		····	(6) DATE

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

program participation.

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	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILD				С
		495393	B. WING			09	/29/2016
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		16	REET ADDRESS, CITY, STATE, ZIP CODE 801 BROADROCK BLVD ICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Resident #19, a man 12/7/15. His diagnor gastroesophageal resident gastroesophageal ga	ge 1  lle, was admitted to the facility beses included blepharitis, eflux disease, hypertension, erlipidemia, congestive heart n, anxiety, seizures, liovascular disease, atrial ression.  It recent MDS (minimum data ssessment reference date) of as a quarterly assessment, roded as having no memory e to make his own daily life t #19 was coded as being uiring standby assistance of operform his activities of daily otion of bathing. For bathing, reding total assistance of one	F 1	76		g the ethe er ed. ethe ent ess of	
	taking the oral medi Spiriva inhaler and I Resident #19. Resi one puff of the inhal inhaler back to LPN #19 he needed to ta Resident #19 took to inhaler back to LPN	cations, LPN A prepared the nanded the inhaler to dent #19 self-administered er and attempted to hand the A. LPN A advised Resident ke another inhalation. The puff and handed the A. LPN A prepared the put the mask on Resident		ese es e e e e e e esta orianna mana manama estados. 🙃	medication.  4. Licensed nurses will be educate during orientation and annually the process for self administration of medications.  5. 11/9/2016	on /	



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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED C		
		495393	B. WING				29/2016		
	PROVIDER OR SUPPLIER	ERANS CARE CENTER		STREET ADDRESS, CITY, ST 1601 BROADROCK BLVD RICHMOND, VA 23224					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPR FICIENCY)	BE	(X5) COMPLETION DATE		
F 176	Continued From pa	age 2	F 1	76					
	a signed physician Handihaler one inhaccompanying ent (electronic medica nurses' initials indiadministered daily	nt #19's clinical record revealed i's order that included, "Spiriva nalation daily." An ry was placed on the eMAR tion administration record) with cating the medication had been. No physician's order was nt #19 to self-administer the	Communication and Communication Communicatio						
	no evidence Resid his ability to self-ac of the comprehens	of the clinical record revealed lent #19 had been assessed for dminister the inhaler. Review sive care plan, also revealed non developed for Resident #19 medications.	THEN THEN THE THEN THE TANK A DOMINONIMENTALINA						
	administered Residual same way. LPN A handing the inhale	6 at 10:10 a.m., she always dent #19's medications the stated she did not realize that r to Resident #19 was ministering medications							
	Review of the facil "Self-Administratio	ity's policy entitled n of Medication" included:	40 44-9-14 440 44000000000000000000000000000000						
		ninistration of medication					Yes a humanism of tradition		
	residents that voice medication.  1. Verify the reself-administer me medication he or s  2. The social Mini-Mental state of	completed only on those e a desire to self-administer esident's desire to edications and the specific he wants to self-administer. worker will complete the examination. Only residents or above will be considered for							

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUC	(X3) DATE SURVEY COMPLETED		
			" " " " " " " " " " " " " " " " " " "				
		495393	B. WING			09/2	29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRE	ESS, CITY, STATE, ZIP CODE		
OFTEN	AND DADEOUT VETE	DANC CADE CENTED		1601 BROADR	OCK BLVD		
SHIER	AND BARFOOT VETE	RANS CARE CENTER		RICHMOND,	VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EAC	OVIDER'S PLAN OF CORRECTIO H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	Continued From pa	ige 3	F	176			
	self-administration	of medications.					
		nt does not score 24 or above					
		Examination, the Evaluation		-		ar production	
		stration of Medication need not		2			
		ify the physician and			•		
		late and time of notification	i				
	and the physician's	response in the progress	1				
	notes.					1	
		d nurse will explain the				1	
		nplete the Evaluation for Self-					
	each area of the ev	of Medications addressing					**
		ciplinary Team will review the			<i>2</i>		
		s complete and sign the					
	bottom portion of th		:				
		sciplinary Team determines				:	
		capable to self-administer				:	
		sicians order will be obtained					
	that specifies which	medication may be self-					
		s well as whether the resident					
	•	ation in his/her room.	Liver of the liver				
		sciplinary Team and/or the		:			
		ree the resident is able to					
		dications, the licensed nurse or				:	
	social worker should					:	
		the back of the evaluation					
		s the rationale behind the onale should be explained to				:	
		physician, the licensed					
	nurse, or the so						
	•	nt has been evaluated as	****	2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			
		administer medication, update	*	1			
		lect this, along with any					
		on. Include whether or not the					
		I be kept in the resident's				:	
	room.		r	, •			
	9. Ensure the p	provision"		41 V 2			
	The administrates -	nd ADON (assistant director		7000 N			
		nd ADON (assistant director					D 1-550
FORM CMS-25	667(02-99) Previous Versions	Obsolete Event ID:0VCW1	17	Facility ID: VA0396	if continua	audii Sneet	rage 4 01 53

Facility ID: VA0396

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	١, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495393	B. WING		1	C <b>29/2016</b>	
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIER	RANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BROADROCK BLVD RICHMOND, VA 2322#			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 279	of the failure of the was assessed for the medications, to obta administration of more plan regarding administering his in 483.20(d), 483.20(f). COMPREHENSIVE to develop, review comprehensive plan. The facility must deplan for each reside objectives and time medical, nursing, a needs that are identical assessment.  The care plan must be furnished to a highest practicable psychosocial well-to \$483.25; and any side to the resident due to the resident.	staff to ensure Resident #19 the safety of self-administering ain a physician's order for self edication, and to develop a g Resident #19 self thaler. (x)(1) DEVELOP E CARE PLANS  The results of the assessment and revise the resident's and revise the resident's and revise the resident's and revise the assessment and revise the resident's and revise the resident's and mental and psychosocial attified in the comprehensive  It describe the services that are attain or maintain the resident's apphysical, mental, and being as required under arevices that would otherwise §483.25 but are not provided s exercise of rights under the right to refuse treatment	F 176	F 279	ring aids. rices d on ne use of uarterly ns audit of Any		
	by: Based on resident observation, facility record review, the	NT is not met as evidenced interview, staff interview, documentation, and clinical facility staff failed to develop a in of care for one Resident		4b. Results of the audit will be by the QA committee for three mont determine if further action is need 5a. 11/9/2016	hs to		

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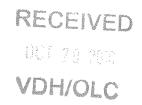
STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HIND PLAN O	CONTECTION			-		С	
		495393	B. WING			09/2	29/2016
	ROVIDER OR SUPPLIER	RANS CARE CENTER		16	REET ADDRESS, CITY, STATE, ZIP CODE 101 BROADROCK BLVD ICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE ·	(X5) COMPLETION DATE
	Continued From particles (Resident #17) in a Residents.  For Resident #17, the develop a comprehease of hearing aids. The findings included Resident #17 was a 12/30/13 and readra 3/23/15. Diagnose hypertension, depreheart disease.  Resident #17's most hypertension, depreheart disease.  Resident #17 was cod Resident #14 was a to total assistance perform his activitie coded as using hearing had a clear colored 9/27/16 at 3:30 p.m got some hearing a hearing really good.  On 9/28/16 at 9:00	ge 5 survey sample of 30  he facility staff failed to ensive care plan to include the ed: admitted to the facility on mitted after hospitalization on as included diabetes, ession, legal blindness, and est recent MDS (Minimum Data Assessment Reference Date) ed as a quarterly assessment. Coded a BIMS (Brief Interview core of 15, cognitively intact. ealso coded as needing limited of one staff member to es of daily living. He was aring aids.  Observed on initial tour of the est 3:30 p.m., on 9/28/16 at 8:15 p.m. At all observations, he I hearing aid in each ear. On an each ear. On an each ear. On an each ear. I'm inow."  a.m., a review of Resident		279	DEFICIENCY)		
	#17's clinical recor	d was conducted. A review of careplan did did reveal a care	I or morning				The transformation of
	A review of Reside	nt #17's progress notes					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	COMPLETED		
		495393	B. WING_		09/29/2016		
NAME OF F	PROVIDER OR SUPPLIER	430000		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2010	*********	
		RANS CARE CENTER	1	1601 BROADROCK BLVD			
SHIEK	ND BARFOOT VETE	TANS CARL CENTER		RICHMOND, VA 23224			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	ON	
F 279	Continued From pa		F 27	79			
	(patient) had appt ( clinic at 9:30 a.m. a a.m. Pt. returned v Hearing aids are fu	ing note dated 4/30/16, "Pt appointment) with the hearing and returned back at 11:00 with hearing aids in both ears. nctional and resident stated ive. Will continue with current time."					
	briefing, the Admini of Nursing) were in	p.m. during an end of day istrator and the DON (Director formed of Resident #17's re plan that did not include his					
	RN (registered nurs regarding Resident plan. RN E said Re problems with his h showed up wearing	0 a.m., the MDS coordinator, se) E, was interviewed #17's comprehensive care esident #17 never exhibited hearing. RN E stated, "He just hearing aids after an n April. It (the care plan) was					
	under Procedures i	lity's policy entitled 'Care Plan', read, "7. The Care Plan is ted as necessary, but not less nen there is a change in the"					
	the DON were inforto develop a compr	5 p.m., the Administrator, and rmed of the failure of the staff rehensive care plan for ncluded the use of hearing		F 281  1a. Resident # 13 MD was noti	fied		
F 281 SS=D		RVICES PROVIDED MEET STANDARDS	F 28	,,	Ar e e e e e e e e e e e e e e e e e e e		
	The services provid	ded or arranged by the facility		1b. Resident # 25 MD was noti 10/14/16. Insulin orders were o			

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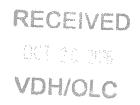
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495393	B. WING		C 09/29/2016
	PROVIDER OR SUPPLIER	<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BROADROCK BLVD RICHMOND, VA 23224	03/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 281	·	ional standards of quality.	F 281	<ul><li>2a. All residents have the potential affected.</li><li>3a. Licensed nurses will be educated.</li></ul>	i :
	by: Based on staff intereview and clinical failed to follow prof for medication adm (Resident #13 and sample of 30 resident #1 ensure medications  2. For Resident #1 ensure medications  2. For Resident #2 clarify sliding scale  The findings includ  Resident #13, was 10-7-15. Diagnose chronic obstructive type II diabetes me (CVA) cerebrovasc disorder.  Resident #13's most set) with an ARD (a 6-28-16 was coded Resident #13 was of deficits and was ab decisions. Resider meeding extensive member to perform	3, the facility staff failed to swere administered.  25, the facility staff failed to insulin orders.  ed;  admitted to the facility on is included; hyperlipidemia, pulmonary disease (COPD), llitus, hypertension, stroke ular accident, and depressive is trecent MDS (minimum data assessment reference date) of as a quarterly assessment. Coded as having no memory let to make his own daily life in #13 was also coded as to total assistance of one staff activities of daily living.		the following: following Physician of completing documentation following medication administration, clarifying orders as needed, following the six of medication administration (right medication, right dose, right patien route, right time, right documentation and medication administration for residents on frequent LOA (leave of absence).  3b. The Unit Manager / designee with review new insulin orders daily to express order is clear. Questionable orders clarified with the Physician as need Nurses will be educated on clarifying orders if indicated.  4a. The QA nurse / designee will a four charts (MARs) a week for three months for review of missed medications can made and discuss with MD as need.	orders, orders
	medication adminis	t #13's eMAR (electronic stration record), Nursing d the facility "Resident Leave			

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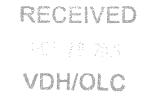
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495393	B. WING			1	C <b>29/2016</b>
NAME OF	DOMESTIC OF CHIEF	<u> </u>			TREET ADDRESS, CITY, STATE, ZIP CODE	03/	29/2010
NAME OF	PROVIDER OR SUPPLIER						
SITTER	AND BARFOOT VETE	ERANS CARE CENTER			601 BROADROCK BLVD		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			K	RICHMOND, VA 23224		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	3	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 281	evidence that he was following medication the reasoning given 9-6-16 Fluticasone 9:00 a.m. and Adva omitted and the reasoning note. The refilled by pharmacy 9-7-16 Gabapentin Baclofen at 2:00 p.r reason was given a There were no nurs LOA tracking note obeing signed out at 9-13-16 Aspirin (lon (supplement), multiv (major depression), rhinitis), hydrochlorolidocaine (knee pair rhinitis), norvasc (hy (supplement), which once per day each a orders at 9:00 a.m. regarding the omiss tracking note showe at 8:45 a.m., and agrevealed that the 9:0 have been administ	Tracking form", revealed as not administered the ons, on the following days, and in by staff for the omissions;  (seasonal allergic rhinitis) at air (COPD) at 9:00 a.m., both ason was given as "#9 See nursing note stated "being y".  (neuropathy) at 1:00 p.m., and m., both omitted and the as "#3 Absent from home". Sing notes for this day, and the did not show the Resident as all for that day.  Ing term use), calcium (supplement), effexor, fluticasone (seasonal othiazide (hypertension), in), loratidine (seasonal ypertension), and vitamin D in was to be administered only according to physician's  There were no nursing notes sion for this day, and the LOA ed the Resident checked out gain at 12:00 noon. This 00 a.m. medications could tered before the Resident left	F 2	281	4b. The QA nurse / designee will a two charts a week of residents that insulin to ensure orders are clear fronths.  4c. Results of the audit will be brothe QA committee for three month determine if further action is need.  5a. 11/9/2016	or three  ought to	:
	which would have be out at 12:00 noon., a only given once per	-					
:		did not receive advair (COPD) (constipation) at 9:00 a.m.,					and the second s

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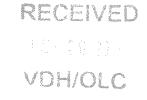
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495393	B. WING		nc	C 0/29/2016	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		7/23/2010	
		ERANS CARE CENTER		1601 BROADROCK BLVD RICHMOND, VA 23224			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 281	Continued From pa	age 9	F 2	B1		*	
	(neuropathy) at 9:0 9:00 a.m., on 9-13- multiple times per	tes) at 9:00 a.m., gabapentin 10 a.m., and situssin (cough) at 16, which were ordered day, however, could have been 15 a.m. before the Resident					
	p.m., and gabapen There were no nurs omission for this da showed the Reside however does not i returned. The play day medication, an 9:00 p.m. medication	rebrovascular disease) at 5:00 tin (neuropathy) at 5:00 p.m sing notes regarding the ay, and the LOA tracking note ent checked out at 1:00 p.m., ndicate when the Resident ix medication was a once per d the record indicated that all ons were administered to this medication could have been he returned.					
	p.m., There were nomission for this dashowed the Resider and the Resident replayix medication wand the record indication.						
	and gabapentin (ne Nursing notes rega day revealed that the "returned after lunc showed the Reside however does not in Resident returned.	muscle spasm) at 2:00 p.m., europathy) at 1:00 p.m. rding the omissions for this ne Resident left early and h". The LOA tracking note nt checked out at 9:20 a.m., andicate the exact time the These 2 medications were after lunch, and were not.					

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	. (	(X3) DATE SURVEY COMPLETED	
		495393	B. WING				09/2	29/2016
	PROVIDER OR SUPPLIE			160	REET ADDRESS, CITY, STATE, ZIP CO 01 BROADROCK BLVD CHMOND, VA 23224	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD I	BE ;	(X5) COMPLETION DATE
F 281	medications again baclofen, and 5:0	page 10 uld not have received these in until 10:00 p.m. for the 0 p.m. for the gabapentin, and is could have been administered,	F	281				
	p.m., and gabape Nursing notes reg day revealed that p.m.". The LOA t Resident checked was a once a day	erebrovascular disease) at 5:00 entin (neuropathy) at 5:00 p.m. garding the omissions for this the Resident "returned at 8:15 racking note showed the dout at 1:05 p.m The plavix medication, and could have d upon the Resident's return to		anderdramments to the 1.5 m and announcement of many immunities before a series	n svat	· .		
		v of Resident #13's clinical so evidence he refused the	Andrea agreement of the control of t	The state of the s				
	(DON) and Admir stated they would DON delivered a Tracking record, interviewed the D medications could the doctor could lone time per day time than what we	80 p.m., the Director of Nursing histrator were interviewed, and I look into the discrepancy. The copy of the E-MAR, LOA and nursing notes. When ON stated that the once per day d have been administered, and be called to ok administration of meds to be given at a different as originally planned, so that e missed, she stated "it is what it	AND THE PROPERTY OF THE PROPER					
	provided the facil medication is bei time, prescribed Resolve any cond	tursing (DON) and Administrator ity policy which stated "Verify the ng administered at the proper dose, and by the correct route. cerns about the medication with scriber, and/or staff involved with		THE PROPERTY OF THE PROPERTY O				

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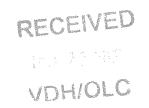
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495393	B. WING		0:	C 09/29/2016	
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		STREET ADDRESS, CITY, STATE, 1601 BROADROCK BLVD RICHMOND, VA 23224			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 281	"Potter Perry" as the Guidance for nursing administration of me "Fundamentals of N Potter-Perry, p. 705 such as the America Nursing: Scope and Practice (2004) appadministration. To policy the six rights medication errors of an inconsistency in medication adminismedication administrator at the administrator at were informed of the medications were adays in September	The Administrator stated eir nursing standard.  In standards for the edication is provided by Jursing, 7th Edition, is: Professional standards, an Nurses Association's d Standards of Nursing ply to the activity of medication prevent medication errors, of medications. Many an be linked, in some way, to adhering to the six rights of tration. The six rights of tration include the following: edication see ent ute	F 2	281			
200	2. For Resident #29 clarify sliding scale	5, the facility staff failed to insulin orders.		* man		The surrent state of the state	
		year old, was admitted to the is diagnoses included dney disease and				10 mars 10 mar	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF IDENTIFICATION		IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495393	B. WING		ne	C 9/29/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		7/23/2010
SITTER A	ND BARFOOT VETE	ERANS CARE CENTER		1601 BROADROCK BLVD RICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 281	281 Continued From page 12		F2	81		
	assessment was a assessment refere coded with a Brief	st recent Minimum Data Set quarterly assessment with an nce date of 7/26/16. He was Interview of Mental Status ng moderate cognitive	The state of the s			A CONTRACTOR OF THE CONTRACTOR
	score of 12 indicating moderate cognitive impairment.  According to the clinical record and the September 2016 Medication Administration Record (MAR), Resident #25 had the following physician orders for insulin administration:  1. Lantus, inject 40 units one time a day, do not hold (9:00 a.m.)  2. Humulin R, inject 10 units one time a day (9:00 a.m.)  3. Humulin R, inject 16 units one time a day, HOLD if lunch intake is <25% (11:30 a.m.)  4. Humulin R, inject 16 units one time a day (4:30 p.m.)  5. Humulin R, inject per sliding scale three times per day (6:30 a.m., 11:30 a.m., 4:30 p.m.):  0-70= 0 units, notify MD (doctor)  71-90= 0 units, subtract 1 unit from the meal dose  91-150= 0 units, give along with scheduled meal dose  201-250= 4 units, give along with scheduled meal dose  251-300= 6 units, give along with scheduled meal dose  301+= 8 units, call MD for blood glucose greater than 400					
	Issues with the admorders included:	inistration of the insulin				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495393	B. WING				C <b>29/2016</b>
	PROVIDER OR SUPPLIER  AND BARFOOT VETI	ERANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 1601 BROADROCK BŁVD RICHMOND, VA 23224	CODE	00//	23/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD I IE APPROPR	BE	(X5) COMPLETION DATE
	Resident #25 's Horder read "give a dose". According Resident #25 was R sliding scale insute 4:30 p.m. The facifollowing times: Breakfast= 7:45 a.r. Lunch= 12:00 p.m. Dinner= 5:15 p.m. According to the action of the selection o	les and Humulin R sliding scale on times do not correspond.  Jumulin R sliding scale insuling along with scheduled meal to the September 2016 MAR, scheduled to receive Humuling aling at 6:30 a.m., 11:30 a.m., lity served meals at the limin at 6:30 a.m., 11:30 a.m., lity served meals at the limin at 6:30 a.m., 11:30 a.m., lity served meals at the limin at 6:30 a.m., 11:30 a.m., liministration times for the cale insulin order and the not #25 was receiving the before he was scheduled to scheduled lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%". The lunch dose of an extra parameter "HOLD 5%" and the scheduled before the unclear if Resident #25's seing assessed prior to the extra parameter "HOLD 5%" and the scheduled before the unclear if Resident #25's seing assessed prior to the extra parameter "HOLD 5%" and the scheduled before the unclear if Resident #25's seing assessed prior to the extra parameter "HOLD 5%" and the scheduled the scheduled the scheduled for the schedul	F 2	81			
	following "71-90= ( the meal dose ". T sliding scale order is scheduled doses of meal times.	ng scale order included the ) units, subtract 1 unit from he " meal dose " in the s in reference to the Humulin R administered at				en transcription de constitution de l'entrance de la constitution de l	
6	a.m., 11:30 a.m., an	cale was administered at 6:30 de de 4:30 p.m. The Humulin Rere administered at 9:00 a.m.,		. ***		• •	

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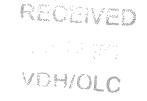
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	, cor	(X3) DATE SURVEY COMPLETED	
		495393	B. WING		ı	C /29/2016	
	PROVIDER OR SUPPLIER	ERANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1601 BROADROCK BLVD RICHMOND, VA 23224			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 281	scheduled Humulir Humulin R do not of insulin administere corresponding sche Because the sliding the scheduled Humtimes did not correparameters could rephysician order.  C. Insulin was not order.  C. Insulin was not order.  Sliding scale insulin sugar readings we September 2016 M  9/28/16 (11:30 a.m.  Licensed Practical nurse who complem MAR on 9/28/16 (1 MAR, LPN C meas gave 0 units of slid According to the slounits of insulin be scale order also in should have been the "meal dose meal dose of insulin one time a day.  According to the S scheduled Humulin administered. Instinsulin from the mean insulin from the mean dose of insuling t	30 p.m. The times of the R and the sliding scale correspond. Sliding scale d at 6:30 a.m. did not have a eduled meal dose of insulin. It is scale Humulin R insulin and mulin R insulin administration spond, the sliding scale not be implemented per administered per physician administration and blood re documented on the MAR as follows:  1.) 72, 0 units  Nurse C (LPN C) was the ted the documentation on the 1:30 a.m.). According to the sured a blood sugar of 72 and ling scale coverage. Iding scale coverage. Iding scale it was correct that a administered. But the sliding dicated that 1 unit of insulin subtracted from the meal dose, referred to the scheduled in, Humulin R inject 16 units  eptember 2016 MAR, the n R 16 units was not ead of subtracting 1 unit of eal dose (per sliding scale the 16 units of Humulin R	F 2				

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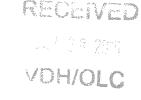
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
•					Add David Control (1994) (1994) (1994) (1994) (1994) (1994) (1994) (1994) (1994) (1994) (1994) (1994) (1994)		C	
		495393	B. WING				09/2	9/2016
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	ERANS CARE CENTER		160	REET ADDRESS, CITY, STATE, ZIP COE D1 BROADROCK BLVD CHMOND, VA 23224	)E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 281	She was asked to specifically "71-90=	ewed on 9/29/16 at 10:55 a.m. review the sliding scale order, = 0 units, subtract 1 unit the	F2	281			TOTALE . A SECTE TITALENAMENTA MINISTERIAL PROPERTY CONTACTOR	
	" meant. LPN C streferred to the breath of the breath of the breath of the series of the referred to the schedumulin R. She against the series of the series	h LPN C that the blood sugar measured at 11:30 a.m LPN " meal dose " at 11:30 a.m. eduled lunch time dose of gain stated that the "meal he breakfast meal. When d the scheduled dose of a.m., she stated she held the e felt the blood sugar was low.						
	guidance regarding physician is respontreatment. Nurses physicians orders are in error or would all orders must be at to be erroneous or from the physician.  On 9/29/16 at 11:15 scale order was rev. Nursing (DON). The LPN C was also rev. DON was notified the understand the Hurhad not implemented parameters during administration. It were also responses to the control of the contr	physicians 'orders, "The sible for directing medical are obligated to follow unless they believe the orders dharm the clients. Therefore assessed, and if one is found harmful, further clarification						

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		495393	B. WING		09	C /29/2016
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	ERANS CARE CENTER	#	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BROADROCK BLVD RICHMOND, VA 23224		[E3]EV 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 281	not have a corresponding agreed that the order The Administrator s	age 16 onding meal dose. The DON ler needed to be clarified. stated on 9/28/16 at about 2:30 erry" was their nursing	F 281	1		
	At the end of day morders were reviewed Administrator. No fiprovided.	neeting on 9/29/16, the insuling led with the DON and further information was CARE/SERVICES FOR EING	F 309	<b>)</b>		m mm - 1 de 1 l'extendiment monte et man 1 man man man me
	provide the necessa or maintain the high mental, and psychos accordance with the and plan of care.	e comprehensive assessment		F 309  1a. Resident # 13 MD was notifie 10/13/16. Orders were modified.  1b. Resident # 25 MD was notifie 10/14/16 and order was clarified.	d	
	by: Based on staff inter review, and clinical r failed to ensure the h	IT is not met as evidenced rview, facility documentation record review, the facility staff highest practicable well being sidents #13, #25, and #24) in 30 residents.		<ul><li>1c. Resident # 24 MD was notified</li><li>10/13/16 with no new orders.</li><li>2a. All residents have the potential</li><li>affected.</li></ul>		
	ensure multiple med per physician's order follows: Fluticasone calcium; multivitamin	, the facility staff failed to dications were administered r. The medications are as e; Gabapentin; Aspirin; n; effexor; fluticasone; lidocaine; loratidine; norvasc;			** Outstands for a common and many case case case case case case case case	

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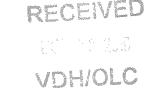
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495393	B. WING			C <b>09/29/2016</b>	
NAME OF PROVIDER OR SUPPLIER  SITTER AND BARFOOT VETER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 601 BROADROCK BLVD CICHMOND, VA 23224	, 03/2	20/2010
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
administer insulin per a #24's Clonidine per a Clonidine was administer trate was less at to physician orders.  The findings include  1. Resident #13, was 10-7-15. Diagnoses chronic obstructive partype II diabetes melli (CVA) cerebrovascu disorder.  Resident #13's most set) with an ARD (as 6-28-16 was coded a Resident #13 was coded a Resident #13 was codeficits and was able decisions. Resident needing extensive to member to perform  Review of Resident medication administing progress notes, and of Absence (LOA) Trevidence that he was following medication the reasoning given	the facility staff failed to er physician order. alled to administer Resident the physician orders. histered when Resident #24's han or equal to 60, contrary	F3	309	3a. Licensed nurses will be educated the following: following Physician of completing documentation following medication administration, care of diabetic resident (holding insulin, for parameters), clarifying orders, medication administration for residents on free LOA, and on following the six rights medication administration (right medication, right dose, right patient route, right time, right documentated.  3b. Unit Managers will review physorders written the previous day to orders are accurate and that vitals to be documented on the MAR if in Orders will be corrected if needed and nurse that entered the order will be educated as needed.  4a. The QA Nurse / designee will a four charts (MARs) of residents that receive insulin (scheduled and or siscale) a week for three months for of blood sugar monitoring and administration. Nurses will be educated if discrepancies are noted.	orders, a a collowing lication quent of t, right ion). sician ensure are able dicated. and the e udit t iding review	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. DOILDIN	And the state of t		С
		495393	B. WING_		I	/29/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (		72072010
				1601 BROADROCK BLVD		
SITTER	AND BARFOOT VETE	RANS CARE CENTER		RICHMOND, VA 23224		
(20.15	SI MAMADY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE	COMPLETION DATE
F 309	Continued From pa	ge 18	F 30	Ια	*** ***	
	•	ir (COPD) at 9:00 a.m., both	, 50	40. THE QA Hurse / designe		
		ison was given as "#9 See		four charts (MARs) a week f	or three	
		nursing note stated "being		months for review of missed		
	refilled by pharmac	у".		due to LOA to determine if	other	
	9-7-16 Gabapentin	(neuropathy) at 1:00 p.m., and		arrangements for medication	ons can be	
		n., both omitted and the s "#3 Absent from home".		made and discuss with MD	as needed.	
	There were no nurs	sing notes for this day, and the		4c. The QA nurse / designe	ee will audit	
	LOA tracking note did not show the Resident as			four charts (MARs) a week		at
	being signed out at	all for that day.		have parameters to review		
	9-13-16 Aspirin (lon	g term use), calcium		medication administration.		1
		vitamin (supplement), effexor		•	Marzez Mili pe	•
		fluticasone (seasonal		educated as needed.		
	rhinitis), hydrochloro	othiazide (hypertension),		i C		
		n), loratidine (seasonal		4b. Results of the audits w		
		ypertension), and vitamin D		to the QA committee for th	ree months to	
		n was to be administered only		determine if further action		
		according to physician's		determine in farther decion	10 1100 1100 110	
		There were no nursing notes sion for this day, and the LOA		5a. 11/9/2016		÷ -
		ed the Resident checked out		5a. 11/9/2016		
	<del>-</del>	gain at 12:00 noon. This				
		00 a.m. medications could				
		ered before the Resident left				
		en the Resident returned		*		
		een before he checked back				
	out at 12:00 noon.,	as these medications were				
	only given once per	day.				
	Alaa tha Daaidant a	lid not receive advoir (COPP)		1		
		lid not receive advair (COPD) (constipation) at 9:00 a.m.,				
		es) at 9:00 a.m., gabapentin				
		a.m., and situssin (cough) at				
		6, which were ordered				
		ay, however, could have been				
		5 a.m. before the Resident				The state of the s
	checked out.	Same Soloro tro Rosidoria				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED		
		495393	B. WING	;		I	C / <b>29/2016</b>
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		160	EET ADDRESS, CITY, STATE, ZIP CODE 1 BROADROCK BLVD SHMOND, VA 23224	1 00	23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	p.m., and gabapent There were no nurs omission for this day showed the Residen however does not in returned. The plaviday medication, and 9:00 p.m. medication Resident, and this madministered when 9-18-16 Plavix (cere p.m., There were not omission for this day showed the Resident replavix medication wand the record indications were and this medications were and this medication when the showed the Resident (mand gabapentin (new Nursing notes regarday revealed that the "returned after lunch showed the Resident however does not in Resident returned. Ordered to be given The Resident would medications again ubaclofen, and 5:00 p.	ebrovascular disease) at 5:00 in (neuropathy) at 5:00 p.m ing notes regarding the y, and the LOA tracking note at checked out at 1:00 p.m., adicate when the Resident in medication was a once per district that all inside were administered to this medication could have been the returned.  Bebrovascular disease) at 5:00 p.m. in the LOA tracking note in the checked out at 10:05 a.m., in turned at 7:45 p.m The in as a once per day medication, ated that all 9:00 p.m. in dministered to this Resident, could have been	. F:	309			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495393	B. WING		09	C 0 <b>/29/2016</b>	
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	ERANS CARE CENTER		STREET ADDRESS, CITY, STATE, 2 1601 BROADROCK BLVD RICHMOND, VA 23224		12312010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	9-24-16 Plavix (cer p.m., and gabapen Nursing notes rega day revealed that th p.m.". The LOA tra Resident checked was a once a day note been administered the facility.  A thorough review or record revealed no medications.  On 9-28-16 at 2:30 (DON) and Administrated they would be DON delivered a contracking record, an interviewed the DO medications could be one time per day must they would not be noted that was they would not be noted that would not be noted that they would not be noted t	rebrovascular disease) at 5:00 tin (neuropathy) at 5:00 p.m. arding the omissions for this he Resident "returned at 8:15 acking note showed the out at 1:05 p.m The plavix medication, and could have upon the Resident's return to of Resident #13's clinical evidence he refused the p.m., the Director of Nursing strator were interviewed, and book into the discrepancy. The pay of the E-MAR, LOA and nursing notes. When and strated that the once per day have been administered, and a called to ok administration of the stated to be given at a different a originally planned, so that missed, she stated "it is what it resing (DON) and Administrator or policy which stated "Verify the administered at the proper se, and by the correct route. The Administrator stated eir nursing standard.  In DON (director of nursing) are failure of the staff to ensure administered on numerous and the state of the staff to ensure administered on numerous.	F3	309			

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Event ID:0VCW11

Facility ID: VA0396

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		COMPLETED		
	,	495393	B. WING		09/29/2016		
NAME OF F	PROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP C		3/23/2010	
SITTER	AND BARFOOT VETE	RANS CARE CENTER		1601 BROADROCK BLVD RICHMOND, VA 23224			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 309	end of day debriefing.  2. For Resident #2 administer insulin president #25, an 8 facility on 2/1/16. It diabetes, chronic knypertension.  Resident #25's most assessment was a assessment reference ded with a Brief I score of 12 indicating impairment.  According to the cli September 2016 Mrecord (MAR), resphysician orders for 1. Lantus, inject 40 hold (9:00 a.m.)  2. Humulin R, inject 40 hold (9:00 a.m.)  3. Humulin R, inject 40 hold (9:00 a.m.)  5. Humulin R, inject (4:30 p.m.)  5. Humulin R, inject (4:30 p.m.)  5. Humulin R, inject (4:30 p.m.)  6. Humulin R, inject (4:30 p.m.)  71-90= 0 units, not 71-90= 0 units, see 91-150= 0 units, meal dose	2016, to Resident #13 at the figs on 9-28-16, and 9-29-16. 25, the facility staff failed to per physician order. 30 year old, was admitted to the dis diagnoses included idney disease and  St recent Minimum Data Set quarterly assessment with an ince date of 7/26/16. He was interview of Mental Status ing moderate cognitive  mical record and the edication Administration sident #25 had the following insulin administration: 30 units one time a day, do not ext 10 units one time a day, are is <25% (11:30 a.m.) and the edication sident #25 had the following insulin administration:  21 units one time a day, are is <25% (11:30 a.m.) are the following and the edication of the edication.	F3	09			
	meal dose 201-250= 4 units	, give along with scheduled					

RESERVED.

VANAGE

Facility ID: VA0396

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495393	B. WING		0:	9/29/2016	
	PROVIDER OR SUPPLIER	ERANS CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP COD 1601 BROADROCK BLVD RICHMOND, VA 23224	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	meal dose 251-300= 6 units meal dose 301+= 8 units, o greater than 400  Issues with the add orders included:  A. Actual meal timinsulin administrati  Resident #25 's H order read " give a dose ". According Resident #25 was R sliding scale insu 4:30 p.m. The fact following times: Breakfast= 7:45 a. Lunch= 12:00 p.m. Dinner= 5:15 p.m. According to the ad Humulin R sliding seale insuling meal times, Reside sliding scale insuling at his meals. The Humulin R include if lunch intake is <2 sliding scale Humul lunch service. It is lunch intake was b	ts, give along with scheduled call MD for blood glucose diministration of the insulin the sand Humulin R sliding scale tion times do not correspond. Humulin R sliding scale insulin along with scheduled meal g to the September 2016 MAR, scheduled to receive Humulin sulin at 6:30 a.m., 11:30 a.m., cility served meals at the .m.					
	scale did not corre doses of Humulin	times for Humulin R sliding espond with the scheduled R (per physician order). ding scale order included the					

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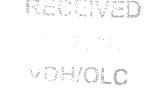
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILL				С
		495393	B. WING			09/	29/2016
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		16	REET ADDRESS, CITY, STATE, ZIP CODE 01 BROADROCK BLVD CHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 309	the meal dose ". T sliding scale order i scheduled doses of meal times.  Humulin R sliding sa.m., 11:30 a.m., ar scheduled doses we 11:30 a.m., and 4:30 scheduled Humulin Humulin R do not coinsulin administered corresponding sche Because the sliding the scheduled Hum times did not correspondents.	ge 23 0 units, subtract 1 unit from the "meal dose" in the s in reference to the Humulin R administered at cale was administered at 6:30 ad 4:30 p.m. The Humulin R ere administered at 9:00 a.m., 0 p.m. The times of the R and the sliding scale orrespond. Sliding scale at 6:30 a.m. did not have a duled meal dose of insulin. scale Humulin R insulin and ulin R insulin administration pond, the sliding scale of be implemented per	F	309			
	order.  Sliding scale insulin sugar readings were September 2016 M/  9/28/16 (11:30 a.m.) (millimeters/deciliter)  Licensed Practical Nurse who complete MAR on 9/28/16 (11 MAR, LPN C measure gave 0 units of slidir According to the slid 0 units of insulin be scale order also indi	) 72 blood glucose level r), 0 units  Nurse C (LPN C) was the ed the documentation on the :30 a.m.). According to the ured a blood sugar of 72 and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495393	B. WING			00	C 9/29/2016	
	PROVIDER OR SUPPLIER  AND BARFOOT VET	ERANS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1601 BROADROCK BLVD  RICHMOND, VA 23224					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		
F 309	The "meal dose '	age 24 ' referred to the scheduled lin, Humulin R inject 16 units	F3	<b>309</b>			or a series variety and the series of the se	
	scheduled Humuli administered. Inst insulin from the mo	september 2016 MAR, the n R 16 units was not tead of subtracting 1 unit of eal dose (per sliding scale of the 16 units of Humulin R 0 a.m.	• • • • • • • • • • • • • • • • • • •					
	She was asked to specifically "71-90" meal dose". LPN	ewed on 9/29/16 at 10:55 a.m. review the sliding scale order, = 0 units, subtract 1 unit the C was asked what " meal dose stated that the meal dose akfast dose.	TO ST. THEORY BOTH STATES IN S.	anguirectum annum manaman sanannaman san angu u c a a - Ap				
The second secon	reading of 72 was C was asked if the referred to the sche Humulin R. She ad dose" referred to the asked why she hell Humulin R at 11:30	th LPN C that the blood sugar measured at 11:30 a.m LPN "meal dose" at 11:30 a.m. eduled lunch time dose of gain stated that the "meal he breakfast meal. When d the scheduled dose of 0 a.m., she stated she held the e felt the blood sugar was low.		1 th e				
	scale order was rev Nursing (DON). The LPN C was also revenue DON was notified to understand the Humbad not implement parameters during administration. It was cale insulin to be a	5 a.m., Resident #25's sliding viewed with the Director of the interview conducted with viewed with the DON. The hat LPN C did not appear to mulin R sliding scale order and led the order per the the 9/28/16, 11:30 a.m. vas also reviewed that sliding administered at 6:30 a.m. did londing meal dose. The DON						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495393	B. WING	i			1	C <b>/29/2016</b>
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		16	TREET ADDRESS, CITY, STATE, ZIP CO 501 BROADROCK BLVD ICHMOND, VA 23224	DE	1 03.	12912010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 309	At the end of day m	ge 25 er needed to be clarified. eeting on 9/29/16, the insulined with the DON and urther information was	F	309	· .			
	#24's Clonidine per Clonidine was admi	failed to administer Resident the physician orders. nistered when Resident #24's than or equal to 60, contrary		a verillandinamentereverillamentation et e e e e e e e e e	en de la companya de La companya de la co			
* * * * * * * * * * * * * * * * * * *	lowers blood pressu certain chemicals in exactly as prescribe Resident #24 was at 12/16/14 and readm 6/22/15. His diagno	dmitted to the facility on itted after hospitalization on ses included hypertension, iflux disease, dementia,		THE CONTRACTOR WITH MALESTANDED BY 1 PM . I AMBREMENTANDED BY THE PARTY OF				
\$ 2 3 4 1 1	Set) with an ARD (As of 8/29/16 was code He was coded a BIM Status) score of 14, #24 was coded as reone staff member to	recent MDS (Minimum Data ssessment Reference Date) d as a quarterly assessment. IS (Brief Interview of Mental cognitively intact. Resident equiring limited assistance of perform his activities of daily tion of eating. For eating, he endent.		AND A SECTION AND THE ANALYSIS AND ADMINISTRATION OF THE SECTION O				
		eserved 9/29/16 at 8:30 a.m. e dining room and had just eakfast.		WHEN THE PARTY AND ADDRESS OF THE PARTY AND AD			e es	· ·
TO PORTIONAL VICE.	At 9/29/16 at 9:00 a.r	n. a review of Resident					f	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
,		495393	B. WING		n'	C 9/ <b>29/2016</b>		
	PROVIDER OR SUPPLIER	ERANS CARE CENTER		STREET ADDRESS, CITY, STATE, 2 1601 BROADROCK BLVD RICHMOND, VA 23224		1 00/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 309	revealed the follow  1. A care plan that a cardiac disease i monitoring related (CAD), Hypertensic Interventions inclue Pressure) medical ordered." The care 12/02/2015.  2. A current signe 6/23/15 read, "CLC Give 1 tablet by mo UNSPECIFIED HY (Systolic Blood Pre 100 or HR (heart ra  3. An August 2016 Administration Rec indicating the medi with heart rate/ pull following days and was < or equal to 6  "8/17/16 at 9 p.m. 8/28/16 at 9 p.m. 8/28/16 at 9 p.m. 6/31/16 at 9 p.m. 6/31	d was conducted. The review	F3	09				

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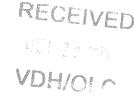
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495393	B. WING_		C 09/29/2016	
NAME OF PROVIDER		RANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BROADROCK BLVD RICHMOND, VA 23224	03/23/2010	
( ) ((m) 1)/( )	CH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		
per mir is for the Review policy radminis adminis medicatime, in route."  Guidan adminis and Pe p 336, medicator or harm  On 9/28 DON (Efailure of Resider 60 beat was professed for the policy of the	of the facility evealed a prostration, the stering the motion is being the prescribility and the prescribility and the staff to the sta	ON stated, "The expectation follow the physician's orders.  y's Medication Administration ocedure that read, "Prior to Nursing staff members redication shall verify the administered at the proper red dose, and by the correct redications is included in Potter mentals of Nursing 7th Edition, an is responsible for directing Nurses follow physician's relieve the orders are in error of p.m., the Administrator and pursing) were informed of the hold Clonidine when es were less than or equal to the No additional information	F 32	9  3 F 323  1a. Resident #10 received new a sleeves which were place d on re 9/29/16.  1b. Resident #16 had his chair a placed 9/28/16. Alarm intervent been reviewed by the falls preve committee and the chair alarm h been discontinued.	sident larm re- ions have ntion	

ADH/OFC

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CENTE	NO FOR MEDICARI	E & MEDICAID SERVICES			OMB NO. 0938-03
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	(X3) DATE SURVEY	
		The state of the s	A. BUILDIN	NG	COMPLETED
		495393	B. WING_		С
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE	09/29/2016
SITTER	AND BARFOOT VETE	RANS CARE CENTER		1601 BROADROCK BLVD	
				RICHMOND, VA 23224	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IDRE COMPLETION
I a a a a a a a a a a a a a a a a a a a	by: Based on observation interview, facility docrecord review, the fasafe environment for and Resident #16) in residents.  1. Resident #10 did sleeves) in place. 2. For Resident #16 apply a physician or alarm.  The findings included Resident #10 was add 12/29/15. Diagnoses but not limited to Parkand high blood pressed Minimum Data Set (alan Assessment Referencesident #10 with a Emental status) of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status) of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment. Data Set coded Resident #10 with a Emental status of "15" cognitive impairment with dressing and toiled with a Emental status of "15" cognitive impairment with a Emental status of "15" cogniti	on, resident and staff cumentation and clinical acility staff failed to provide a r two residents (Resident #10 n a survey sample of 30 not have his protective (gerico, the facility staff failed to dered fall preventive chair dered fall preventive of conson's Disease, dementia are. Resident #10's n assessment protocol) with ence Date of 9/20/16 coded del fall (brief interview of out of a possible 15, or no ln addition, the Minimum ent #10 requiring limited and extensive assistance eting.	F 32:		potential ed on use ide and in daily eves and in eded. ake week are in ught to
O	n 9/28/16 at 11:20 Aft oserved in his room w	M, Resident #10 was vith the private sitter. He			

was not wearing skin protectors on his arms.



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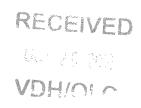
CENTE	NO FOR WEDICARE	E & MEDICAID SERVICES				OMB NO	<b>). 0938</b> -039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495393	B. WING			C		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD		/29/2016	
01 <b>77</b> 50					601 BROADROCK BLVD	<b>-</b>		
SHIER	AND BARFOOT VETE	RANS CARE CENTER			ICHMOND, VA 23224			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ž.	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	Continued From pa	ae 29	_,	200				
. 020		~	r.	323				
	my arms, I don't ge	d, "I like to wear the ones on t scratched."						
	On 9/28/16 at 2:00	PM, an interview was						
	conducted with CN	A (certified nursing assistant)						
		"Night staff dresses him, I						
	don't know about th	e skin protectors."						
	Review of the clinic	al record reveled a physician's	*					
	order dated 6/22/16	and signed on the POS					4	
	(physician order she	eet) dated 8/7/16 for "Geri						
	sleeves to forearms fragile skin."	at all times every shift for						
	an entry for "geri sle evidenced skin tears	plan dated 7/22/16 contained beves." The care plan is to right forearm on 3/7/16, ear to the left forearm.						
		nd of the day exit, the						
	notified of above fine							
		6, the facility staff failed to						
	apply a physician or alarm.	dered fall preventive chair						
	Resident #16 was a	dmitted to the facility 4-11-16.	;					
	Diagnoses included;	Head injury with brain tumor						
		res, anemia, depression, over					EAST-OFFICE CONTRACTOR	
	active bladder, benig	n prostatic hypertrophy						
	had a history of follo	communication deficit, and at home with major injury,						
	and falls at the facilit						Millelitenanooriskaasa	
	Resident #16's most	recent MDS (minimum data						
		sessment reference date) of						
	7-12-16 was coded a	as a quarterly assessment.					***************************************	
		oded as having short and						
	long term memory de	eficits and as being						

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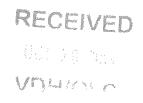
						1110 110.	0000 000 1	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495393	B. WING			İ	C <b>29/2016</b>	
	PROVIDER OR SUPPLIER	RANS CARE CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 801 BROADROCK BLVD ICHMOND, VA 23224			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	decisions. Resider needing extensive to staff members. Resident #16 was a bowel and always in Resident #16's room 8:45 a.m., an alarm the head board of the found in the Resider was not in the room Resident #16 was for 9-28-16 from 9:00 a Resident was sitting activity in the main anursing station designation designation of the Resident #16 was we cap, and pants. Resident #16 was we cap, and pants it was well as	d in making own daily life at #16 was also coded as to total assistance of one to for all activities of daily living. Toded frequently incontinent of incontinent of bladder.  In was inspected on 9-28-16 at box was noted hanging from the bed. No other alarms were not room, and the Resident incommon and observed on the amount and observed on the area of		323				

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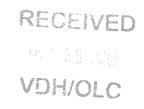
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495393	B. WING _		09/2	: 9/2016
	PROVIDER OR SUPPLIER	RANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BROADROCK BLVD RICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa		F 32	3		
	a comprehensive carecently reviewed a Review of the compinterventions for the to bed and chair, chauctioning every shadows.	#16's clinical record revealed are plan that had been most and revised on 6-26-16. The prehensive care plan revealed application of Sensor alarm the prehensive that the prehensive care plan revealed application of Sensor alarm the prehensive of falls, and the prehensive of falls at home and while in				
	progress notes and while in the facility of only minor injuries of A review of the nurs	al record revealed nurses the care plan indicating falls on 5-22-16, and 6-26-16, with of skin tears, and bruising. e's notes did not reveal any t #16, to wear the sensor			· · · · · · · · · · · · · · · · · · ·	
F 329 SS=D	Director of nursing ( informed of the facil physician orders for alarm for Resident # stated they had no f	oximately 4:30 p.m., the DON) and Administrator were ity staff's failure to follow the the application of the sensor #16, the facility administration urther information to provide. GIMEN IS FREE FROM RUGS	F 329	F 329		
	unnecessary drugs. drug when used in eduplicate therapy); owithout adequate meindications for its usadverse consequence	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate e; or in the presence of ces which indicate the dose or discontinued; or any reasons above.		<ul> <li>1a. Resident #7 attending physician notified 10/13/16. Order clarified of MAR to include space for monitoring pulse.</li> <li>1b. Resident #24 attending physician notified 10/13/16. No new orders given</li> </ul>	on the g of the	

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Event ID:0VCW11

Facility ID: VA0396

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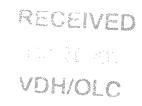
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495393	B. WING			C 09/29/2016		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
SITTER	AND BARFOOT VETE	ERANS CARE CENTER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) COMPLETION DATE		
F 329	resident, the facility who have not used given these drugs to therapy is necessar as diagnosed and crecord; and residen drugs receive gradubehavioral interventions.	ehensive 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	F 3	11 11 11 11 11 11 11 11 11 11 11 11 11	2a. All residents receiving blood pormedication have the potential to be affected.  3a. Licensed nurses will be educated the following: following Physician of a following review and following parameters), completing document following medication administration following the six rights of medicated ministration (right medication, right dose, right patient, right route, right right documentation).	ed on orders tation n and ation ght		
	by: Based on observat documentation reviet the facility staff faile and #24) of 30 resid ensure residents we medications.  1. For Resident #7, metoprolol (blood pi heart rate measured 2. For Resident #24 when Resident #24 equal to 60, contrary The finding included	4, Clonidine was administered s heart rate was less than or y to physician orders.		i 	3b. Nurses will be educated on homeone input an order into the EHR (electron health record) for a medication who parameters are given to include how to take the blood pressure and / or a constant of the color of the pressure medications the new ensure orders have been entered contact of the nurse needed.	onic en w often pulse. ers for kt day to	ı	
	heart rate prior to th					:		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
		495393	B. WING	***************************************			C <b>29/2016</b>	
	DER OR SUPPLIER	ERANS CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1601 BROADROCK BLVD  RICHMOND, VA 23224					
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
Resi adm inclu dysp His r was refer Brief indic requ daily Resi lnclu Meto mounthan The Reco read follow	ident #7, an 80 itted to the face ided hypertens of hagia and left most recent Mi an annual asserence date of 9 f Interview of Mi atting moderate ired extensive in living.  Ident #7 was of room on 9/28/1 ace.  Ident #7's clinicated was a phypoprolol. The or the two times a or equal to 60 ord (MAR) was ing and metop ws:  I6, 9:00 p.m., rinistered I6, 9:00 a.m., rinistered	tion when the heart rate as per physician order.  I year old, was most recently ility on 8/15/16. His diagnoses ion, dementia, anxiety, sided paralysis.  Inimum Data Set assessment essment with an assessment with an assessment b/12/16. He was coded with a fental Status score of 10 e cognitive impairment and assistance with activities of bserved eating breakfast in the 16. His assistive devices were cal record was reviewed.  I record was reviewed.	F3	329	4a. The QA nurse / designee wilfour charts a week for three more residents receiving blood pressumedication (with parameters) to the medication has been adminified accordingly.  4b. Results of the audits will be to the QA committee for three medication is need to accord to the second to the seco	ensure ensure stered or brought nonths to		

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CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				OMB N	<u>0. 0938-0391</u>
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED
		495393	B. WING	3		0	C 9/29/2016
NAME OF I	PROVIDER OR SUPPLIER		<del></del> ,	T	STREET ADDRESS, CITY, STATE, ZIP CO		VIAVI
			,		1601 BROADROCK BLVD		
SITTER A	AND BARFOOT VETE	ERANS CARE CENTER		1	RICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From pa	24	F	329	on '		
1 020	•	***	1 3	کدن	.9		
	9/12/16, 9:00 p.m., administered	, HR=54, medication					
		, no HR, medication					
	administered	The First Francisco					
	9/22/16, 9:00 p.m.,	, no HR, medication					
	administered	- <u>-</u>					
		, no HR, medication					
	administered	, no HR, medication					
	9/24/16, 9:00 p.m., administered	no nk, medication					
		, no HR, medication					
	administered						
	•	, no HR, medication					
	administered						
	without measuring t	the heart rate. On 3					
		olol was administered when it					
		held. There were no adverse nted on the above dates.					
		g Resident #7's Metoprolol parameters was reviewed with					
	the Director of Nurs	sing (DON) and Administrator					
	at the end of day m	neeting on 9/28/16.					
	On 9/29/16, the DO	ON provided Resident #7's					
		th included vital statistic					
		rates were not documented in or the dates in the above					
		information was provided.					
	2. For Resident #2	24, Clonidine was administered					
		4's heart rate was less than or					
	equal to 60, contrar	ry to physician orders.					
		to treat hypertension. It					
		sure by decreasing the levels of					
	exactly as prescribe	n your blood. Take Clonidine					
	exactly as prescribe	30 uruga.com					

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Resident #24 was admitted to the facility on

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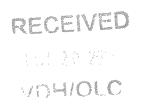
		TO THE STORES	<del></del>	·		, 14.00 1 4 O	. 0000 000
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		(X3) DATE SURVEY COMPLETED		
		495393	B. WING	i	1	C <b>29/2016</b>	
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		STI	REET ADDRESS, CITY, STATE, ZIP CODE D1 BROADROCK BLVD CHMOND, VA 23224	1 09/	29/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
F 329	G/22/15. His diagning gastroesophageal in diabetes, depression Resident #24's mosset) with an ARD (yof 8/29/16 was coded as It	mitted after hospitalization on oses included hypertension, reflux disease, dementia, on, and anxiety.  St recent MDS (Minimum Data Assessment Reference Date) ed as a quarterly assessment. MS (Brief Interview of Mental, cognitively intact. Resident requiring limited assistance of o perform his activities of daily eption of eating. For eating, he bendent.  Subserved 9/29/16 at 8:30 a.m. ne dining room and had just breakfast.	<b>F</b> :	329			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495393	B. WING		09/29/2016		
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP 1601 BROADROCK BLVD RICHMOND, VA 23224		112912010	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	indicating the med with heart rate/ pul following days and was < or equal to 6 "8/17/16 at 9 p.m. 8/28/16 at 9 p.m. 8/31/16 at 9 p.m. 6 On 9/29/16 at 10:4 Director of Nursing Resident #24's Cloadministered when equal to or below the parameters to hold reviewing Resident ADON said he counclonidine was held #24's pulses were per minute. The AD is for the nurses to Review of the facility policy revealed a pilot with the policy revealed a pilot following revealed a pilot followin	cord) revealed nurses' initials cation was administered daily ses documented. On the times Resident #24's pulse to beats per minute:  60 beats per minute beats per minute to beats per minute to beats per minute.  5 a.m., the ADON (Assistant) was interviewed about nidine that had been the measured pulses were not physician ordered the medication. After #24's clinical record, the did find no documentation on the days when Resident ess than or equal to 60 beats DON stated, "The expectation follow the physician's orders.	F 32				
	administering the medication is being time, in the prescrit route."  Guidance for nersin administration of mand Perry's, Fundar p 336, "The physic medical treatment.	Nursing staff members nedication shall verify the administered at the proper ped dose, and by the correct ag practice for the edications is included in Potter mentals of Nursing 7th Edition, ian is responsible for directing Nurses follow physician's believe the orders are in error					

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F 329 Continued From page 37 On 9/29/16 at 12:15 p.m., the Administrator and DON (Director of Nursing) were informed of the failure of the staff to hold Clonidine when Resident #24's pulses were less than or equal to 60 beats per minute. No additional information was provided.  F 333 483.25(m)(2) RESIDENTS FREE OF SS=D SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #7) of 30 residents in the survey sample to ensure resident was free from significant medication errors.  1. For Resident #7, facility staff failed to hold metoprolol (blood pressure medication) when the heart rate measured 60 or less per physician	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
SITTER AND BARFOOT VETERANS CARE CENTER    SITTER AND BARFOOT VETERANS CARE CENTER   1601 BROADROCK BLUP   160			495393	B. WING		1	
F 329 Continued From page 37 On 9/29/16 at 12:15 p.m., the Administrator and DON (Director of Nursing) were informed of the failure of the staff to hold Clonidine when Resident #24's pulses were less than or equal to 60 beats per minute. No additional information was provided.  F 333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #7) of 30 residents in the survey sample to ensure resident was free from significant medication errors.  1. For Resident #7, facility staff failed to hold metoprolol (blood pressure medication) when the heart rate measured 60 or less per physician					1601 BROADROCK BLVD	<del></del>	An W   Six w   N
On 9/29/16 at 12:15 p.m., the Administrator and DON (Director of Nursing) were informed of the failure of the staff to hold Clonidine when Resident #24's pulses were less than or equal to 60 beats per minute. No additional information was provided.  F 333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #7) of 30 residents in the survey sample to ensure resident was free from significant medication errors.  1. For Resident #7, facility staff failed to hold metoprolol (blood pressure medication) when the heart rate measured 60 or less per physician	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE O THE APPROPRIATE	COMPLETION
order.  The finding included:  Resident #7, an 80 year old, was most recently admitted to the facility on 8/15/16. His diagnoses included hypertension, dementia, anxiety, dysphagia and left sided paralysis.  His most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 9/12/16. He was coded with a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment and	F 333	On 9/29/16 at 12:18 DON (Director of N failure of the staff to Resident #24's puls 60 beats per minute was provided. 483.25(m)(2) RESII SIGNIFICANT MED The facility must en any significant med  This REQUIREMEN by: Based on observat record review the fa (Resident #7) of 30 sample to ensure re significant medication.  1. For Resident #7, metoprolol (blood put heart rate measured order.  The finding included Resident #7, an 80 admitted to the facil included hypertensic dysphagia and left s  His most recent Min was an annual asse reference date of 9/ Brief Interview of Me	Jursing) were informed of the to hold Clonidine when ses were less than or equal to the No additional information.  IDENTS FREE OF DERRORS  IDENTS FRE	F 33	1a. Resident # 7 attend notified 10/13/16. Order 2a. Residents that rece antihypertensive medical potential to be affected.  3a. Licensed nurses will the following: following (including review and following administration following administration and on for rights of medication, right dose, residents.)	er was clarified.  eive an ation has the .  If be educated on g Physician orders following pulse, completing g medication collowing the six ministration (right right patient, right	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, 2 3		С	
		495393	B. WING _		09/	29/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SITTED	NO BARFOOT VETE	RANS CARE CENTER		1601 BROADROCK BLVD		
SHIEKA	MD BARLOOT TELL	INANO OAKE OEMIEK		RICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 333	Continued From pa	ge 38	F 33	3 3b. Nurses will be educated on h	ow to	The state of the s
	required extensive assistance with activities of			input an order into the EHR (electro		\$ :
	daily living.			health record) for a medication wh		
	Danislant #7 woo ob	sanual acting brookfast in the		parameters are given to include ho		
		oserved eating breakfast in the 6. His assistive devices were		to take the blood pressure and / or		
	in place.			3c. Unit managers will review ord	ers for	
	Resident #7's clinical record was reviewed.			blood pressure medications the ne		· )
		sician order dated 8/31/16 for		ensure orders have been entered		
		der read Give 1 tablet by		Education will be given to the nurs		
mouth two times a day hold for heart rate less than or equal to 60.				needed.		
				necucu.		
		16 Medication Administration		4a. The QA nurse / designee will	audit	
		reviewed. Heart rate (HR)		four charts a week for three mont		
	reading and metopr follows:	olol were documented as				:
	ioliows.	:		residents receiving blood pressure		
	9/4/16, 9:00 a.m., H	R=60, medication		medication (with parameters) to e	nsure	
	administered			the medication has been administ	ered per	
	9/5/16, 9:00 a.m., H	R=59, medication		orders.		
:	administered	UD=54 medication				:
	9/12/16, 9:00 p.m., administered	nn-54, medication		4b. Results of the audits will be b	rought	
	adiffiliotoroa			to the QA committee for three mo	nths to	
		toprolol was administered		determine if further action is need	ed.	
		been held according to the				
;		ere were no adverse		5a. 11/9/2016	;	
	outcomes documen	ted on the above dates.			:	
	administration and p					
F 371	483.35(i) FOOD PR	•	F 37′	1	:	
		SERVE - SANITARY	. 01	•		
~~ m						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT CON	(X3) DATE SURVEY COMPLETED	
AND PLAN C	IF CURRECTION					C
		495393	B. WING			29/2016
	PROVIDER OR SUPPLIER	ERANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZI 1601 BROADROCK BLVD RICHMOND, VA 23224	P CODE	
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	A - A A A MERCHANIA TA T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	considered satisfa	om sources approved or ctory by Federal, State or local, distribute and serve food	F	F 371  1a. The hair restraints ha relocated to the entrance  1b. The food in the stear discarded and not used.	to the kitchen.	
			NO NO III	1c. The pots and pans we before use.		
	by: Based on observation rev	ENT is not met as evidenced ation, staff interview, and facility view, the facility staff failed to a food in a sanitary manner.		1d. The back-up process testing was implemented manufacturer came to ins 9/28/2016. The Eco Lab performed dish machine	<ol> <li>The spect the machin representative</li> </ol>	
	<ol> <li>Hair restraints of the kitchen, the prep tables.</li> </ol>	were not stored at the entrance y were stored above one of the		checks the morning of 9/  1e. The staff member was correct hand hygiene and	/28/16. as educated on	
	<ol><li>Prepped food turned on or cook</li></ol>	was stored in the steamer, not ing.	THE TAXABLE PROPERTY AND THE TAXABLE PROPERTY	policy.		- CONTROL OF THE CONT
	<ol><li>Nested wet se rack.</li></ol>	rving pans were on the storage		2a. All residents have the affected.	e potential to be	
	<ol> <li>The dishwashe manufacturer's te cycle.</li> </ol>	er was not reaching mperature during the rinse	TO THE REAL PROPERTY OF THE PR	3a. Dietary staff will be of following: keeping hair reentrance to the kitchen,	estraints at the	
	washed their hand	f the dining room kitchens ds and turned the faucet off with s opposed to a paper towel.		storage of food, how to t temperatures, use of the storage of food, cleaning	ake food steamer and	* * * * * * * * * * * * * * * * * * *
	The findings inclu	ded:		pots and pans, hand hygi temperature / function o	iene, and	•
	1 Hair restraints	were not stored at the entrance				

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CENTERS FOR MEDICARE	: & MEDICAID SERVICES			OND NO.	0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED  C 09/29/2016	
	495393	B. WING		1		
NAME OF PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CO	T ADDRESS, CITY, STATE, ZIP CODE  BROADROCK BLVD  MOND, VA 23224  PROVIDER'S PLAN OF CORRECTION (X5)		
SITTER AND BARFOOT VETE	RANS CARE CENTER		1601 BROADROCK BLVD RICHMOND, VA 23224			
PREELY (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION	
F 371 Continued From pa	age 40	F 3	71			
	were stored above one of the			ken on the		
prep tables.			<u>.</u>		TO THE PARTY OF TH	
The initial tour of th	e facility's kitchen began					
9/27/16 at 2:42 p.n manager, came to hair restraints were	Other D, the dietary		·			
	the door to the kitchen. As no					
	ated the hair restraints were	:				
always kept on the	top shelf of one of the prep		checks by the Eco Lab repres	entative.	\$ 5 6	
tables. The prep ta	ble was all the way into the		4a. The Dietitian / designee	will make		
KIICHEH and paralle	Other D stated the hair restraints were always stored on the top of the prep table and that as no food preparation was occurring, that should have been alright.		rounds in the kitchen weekly			
Other D stated the			months to observe for placer			
stored on the top of food preparation was			restraints, inspection of the s		±	
			regards to food storage, pots			
2 Proposed food w	as stored in the steamer, not		storage after washing, temper			
turned on or cooking			the dish machine.	-	C COORDINATES	
Approximately 2:51	p.m., the steamer was		4b. The Dietitian will report	to the QA		
	amer was turned off. In the teamer was observed two		committee for three months			
	oli in water with what		on rounds to determine if fu			
appeared to marga	rine or butter on the top. The		necessary.			
	d stated the broccoli was for ner would not be served until		•			
5:15-5:30 p.m.	iei wodia not be served drie		5a. 11/9/2016			
have already prepp the broccoli should uncooked. Other D should be put in the	r D said the supervisor must ed the broccoli for dinner and not have sitting in the steamer said the food to be cooked a steamer in preparation for d not be in the steamer more at the meal.					
I ocated in the botto	om half of the steamer was					

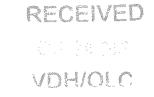
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observed: large pan of peas, large pan carrots,

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE	CONSTRUCTION		(X3) DATE SURVEY
AND PLAN	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	JING _			COMPLETED
		495393	B. WING	;			C <b>09/29/2016</b>
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	ERANS CARE CENTER	1	STF	REET ADDRESS, CITY, STATE, ZIP COD 11 BROADROCK BLVD CHMOND, VA 23224	E	03/23/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD I	BE COMPLETION
F 371	chicken breasts, pasoup, pan with ham vegetables, and pathe pans had plasti of the pans the plas water. While the psteamer was not to Other E, the super the broccoli and pustated one of the co (Other E) was busy meal prepared. Ot pans in the bottom from lunch. Other serving the tomato dinner meal. Other have the food in the on.  3. Nested wet services.  Located on the storpans for the steam pans were used for steam table. On the were observed four inch steam table pans to when separated from Other D stated the and should not have the dishwasher.	pan with gravy, pan with 2 an cream soup, pan tomato a cream soup, pan tomato a cream soup, pan of mixed an with ground turkey. All of its wrap over them and in some stic wrap was covered with ans felt a little warm, the arned on.  wisor, stated he had prepped at it in the steamer. Other E cooks had called in and he and trying to get the dinner ther E also stated all of the of the steamer had been left E stated he was planning on and cream soup with the ar E said he knew he should not be steamer that long, not turned wing pans were on the storage trage rack were the serving tables. Other D stated the ar cooking and serving on the ne top of the stacks of pans and three 4 inch half that were wet and dripping om the stack.  The pans had been used at lunch the been nested wet.		371			

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Facility ID: VA0396

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CENIE	<b>VOLOVI MITDIOVUT</b>	O MILDIOAID OFICAIOEO			01110114	<u> </u>		
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495393	B. WING	)	0:	C 9/29/2016		
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 1601 BROADROCK BLVD RICHMOND, VA 23224				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		4 SHOULD BE	(X5) COMPLETION DATE		
F 371	Continued From page 42  The dishwasher was observed at approximately 3:10 p.m. Three staff members were processing the dirty dishes. Upon approaching the dishwasher, the temperature gauges were observed with one gauge for the wash cycle and one for the rinse cycle. The next new load was observed with the rinse temperature gauge never going beyond 160 degrees Fahrenheit during the rinse cycle. Two more loads were observed with the rinse water temperature never going beyond 172 degrees Fahrenheit during the rinse cycle. Other F, the staff member removing the dishes after they left the dishwasher stated there was a sanitizer that also went into the rinse cycle. Other F pointed to the "rinse aid" container located on top of the machine.  Other D said she would have to get maintenance to check on the machine. Other D stated the dishwasher was a high temperature machine and			371				
	degrees Fahrenhei was posted above wash temperature Fahrenheit and the 180 degrees Fahre Other D turned the when the next load rose to 182 degree load with a test stri surface temperatur degrees. For that I was noted to be 18	ould get to at least 180 It during the rinse cycle. A sign Ithe gauges that indicated the Ishould be at least 160 degree Irinse temperature should be Inheit, I dishwasher off and on and I ran, the rinse temperature I Fahrenheit. Other D ran a I De that indicated the food I e of the plate was 160 I oad, the rinse temperature I degree Fahrenheit. I she used the strips to check. If I mperature of the plate was						

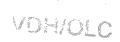
PRINTED: 10/11/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>או מואר</u>	). <del>0938-039</del> 1
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		TE SURVEY MPLETED
		495393	B. WING			09	)/29/2016
NAME OF F	PROVIDER OR SUPPLIER	Language and the second		Si	TREET ADDRESS, CITY, STATE, ZIP CODE		
SITTER	AND BARFOOT VETE	RANS CARE CENTER			601 BROADROCK BLVD CICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 43	F;	371			
	180 degrees Fahre the staff to rewash	nheit, the water had to get to nheit. Other D also directed the dishes during the time the did not get to 180 degree					
	observed washing loads that were rundid not change from The wash cycle wadegrees Fahrenheidishwasher off and loads that were run	5 a.m., the kitchen staff were breakfast dishes. The first two is, the rinse temperature gauge in 152 degrees Fahrenheit. Is noted to get to 160 and 164 it. Other D turned the on again and the next two revealed the rinse it 182 and 180 degrees					
	aid" was a sanitizer maintenance staff a the washing product dishwasher, stating	hen again indicated the "rinse product. Other D stated the and the company that provided the had checked the the problem was "lime g the gauge from reading					
	sheets) for the rins	ne MSDS (material safety data e aid, "Solid Brilliance." The e product was a rinse aid.	<u>.</u>				
	p.m. Other C, emp supplies the rinse a sanitizer and had n C stated the rinse a spotting and quicke	acted by phone 9/28/16 at 2:10 bloyee of the company that aid, stated rinse aid was not a consanitizing properties. Other aid assisted with preventing er drying. Other C also said gh temperature dishwasher tizer.					

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5. Staff on one of the dining room kitchens

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>). 0938-0391</u>
STATEMENT AND PLAN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY
		495393	B. WING			0:	C 9/29/2016
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER		1601	eet address, city, state, zip ( I <b>broadrock blyd</b> <b>HMOND, VA 23224</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	<b>N S</b> HOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	The dining room for unit was observed approximately 8:10 (Other B) came to the B was wearing plass the unit. Other B rewashed her hands, bare hand. Other B gloves.  Other B removed the temperatures of omelet, sausage, pmuffin, bacon. When pad to clean the the same pad for all the Other B removed hands, turning the foother B donned a reprepared several beremoved her gloves.	s and turned the faucet off with sed to a paper towel.  If the B/C hall on the Richmond 9/28/16 at 7:52 a.m. At p.m., the dietary staff member the unit, pushing a cart. Other stic gloves when she entered emoved her gloves and turning the water off with her a donned another pair of the plastic wrap from the tops serving pans. Other B took f all of the food, vegetable totatoes, oatmeal, fried egg, ile Other B used an alcohol ermometer, she used the		371			
		erve the Residents their r staff coming to the steam plates.					
	•	r B stated she should turn the per towel, not her bare hand,	İ				
	Review of the facilitingluded:	ty's policy "Hand Hygiene"					

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Facility ID: VA0396

PRINTED: 10/11/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495393	B. WING		0.0	C 9 <b>/29/2016</b>
		1		STREET ADDRESS, CITY, STATE		3/23/2010
	PROVIDER OR SUPPLIER AND BARFOOT VETE	ERANS CARE CENTER		1601 BROADROCK BLVD RICHMOND, VA 23224	, ZIP GODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 371	proteinaceous mater blood or other body resident with a spot Difficile-clostridium hygiene with either water or an antimic A. Turn on water to temperature.  B. Moisten hands a heavy lather.  C. Wash well under of 15 seconds, usin D. Rinse hands well.  E. Dry hands with paper towel to turn.  The administrator are of nursing) were into staff to ensure hair accessible prior to area, ensure food on to cooking or being temperature, ensure the at an appropriate to performed hand hyp.m.	isibly dirty or contaminated with erial, are visibly soiled with a fluids, and in the case of a re-forming organism (e.g., C. difficile), perform hand a non-antimicrobial soap and crobial soap and water.  In a comfortable warm  with soap and water and make the running water for a minimum and a rotary motion and friction.  Well under running water.  In a clean paper towel. Use the off the faucet, then discard."  I and ADON (assistant director formed of the failure of the restraints were readily entering the food preparation was not sitting in the steamer go held at an appropriate the pans were not wet and dishwasher was rinsing dishes emperature, and ensure staff giene correctly, 9/28/16 at 3:30				
F 431 SS=D		EUGS & BIOLOGICALS	F 4.	31		



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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495393	B. WING			09/2	: 29/2016
	PROVIDER OR SUPPLIER			S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 601 BROADROCK BLVD RICHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE :	(X5) COMPLETION DATE
F 431	The facility must e a licensed pharma of records of recei controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled.  Drugs and biologic labeled in accorda professional princi appropriate access instructions, and thapplicable.  In accordance with facility must store locked compartme controls, and permhave access to the The facility must ppermanently affixed controlled drugs list Comprehensive D Control Act of 197 abuse, except whe package drug distinance in order to a list of the package drug distinance in order to a list order to a li	mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an ation; and determines that drug er and that an account of all maintained and periodically cals used in the facility must be not with currently accepted ples, and include the sory and cautionary ne expiration date when all drugs and biologicals in ents under proper temperature nit only authorized personnel to be keys.  Tovide separately locked, and compartments for storage of ested in Schedule II of the rug Abuse Prevention and and other drugs subject to the facility uses single unit ribution systems in which the minimal and a missing dose can		131	1a. The thermometer was replace refrigerator and the temperature was degrees. The medication (Previousl of PPD) were discarded.  1b. Both vials of insulin on the Bacart were discarded.  1c. The vial of insulin on the Rich cart was discarded.  2a. All residents have the potential affected.  3a. Nurses will be educated on the labeling/dating/storage / expiration / discarding of refrigerated medical also include insulin).  3b. Licensed nurses will be educated checking refrigerator temps and completing a maintenance request the temperature is out of range (3d degrees).	was then har and hyside mond hal to be he on dates tions (to ted on form if	
	by: Based on observa documentation rev	ENT is not met as evidenced ation, staff interview, and facility view, the facility staff failed to a sand biologicals were stored			3c. The Unit manager will check to room refrigerator temperature log for any discrepancies. A maintena repair ticket will be completed if in Staff will be educated as needed.	weekly nce	

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPART	NENT OF HEALTH	& MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COM	E SURVEY MPLETED
		495393		***************************************		09/29/201	
	PROVIDER OR SUPPLIER	RANS CARE CENTER		16	REET ADDRESS, CITY, STATE, ZIP CODE 01 BROADROCK BLVD CHMOND, VA 23224		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 431	four units.  1. The medication Blue Ridge was observed 9/27/16 and erivative -tubercul syringes (pneumod refrigerator. The material recommendations at 36-46 degrees Foundation and one vial having been access Bayside C hall cart and the surface of	refrigerator temperature on served to be 28 degrees of PPD (purified protein in testing) and 4 Prevnar occal vaccine) were in the nanufacturer's were for both was to be stored ahrenheit; and oened, unaccessed Lantus of Novolog insulin dated as sed 8/23/16 were stored in the city.  Dened unaccessed vial of stored in the C/d hall the Richmond unit.  Dened unaccessed vial of stored in the C/d hall the Richmond unit.  Dened unaccessed vial of stored in the C/d hall the Richmond unit.  Dened unaccessed vial of stored in the Richmond unit.  Dened unaccessed vial of stored in the C/d hall the Richmond unit.  Dened unaccessed vial of stored in the Richmond unit.  Dened unaccessed vial of stored in the Richmond unit.  Dened unaccessed vial of stored in the vial of PPD and four		- Constitution of the cons	3d. The Unit manager / designer check med carts weekly for expiremedications for the labeling and of medications. Discrepancies we corrected immediately. Nurses we ducated as needed.  4a. The Pharmacy tech/designer check/audit one med room and coart per unit twice a month for the months.  4b. Results of the audits will be to the QA committee for three med the determine if further action is needed.	ed expiration ill be will be ee will one med hree brought nonths to	

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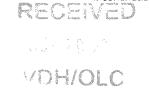
PRINTED: 10/11/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495393			1 '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		B. WING		09	C <b>09/29/2016</b>		
	PROVIDER OR SUPPLIE	R FERANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP O 1601 BROADROCK BLVD RICHMOND, VA 23224			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 431	Review of the mafor both biological should be stored.  RN (registered nuresponsible for chall medication refriged.  2. One vial of uninsulin and one vial having been accessed as a side Chall can accessed vial conference of the fabox. LPN K state vial was put in the thought it would have to the fabox. LPN K state vial was put in the thought it would have thought it would have dinsulin shountil opened for Review of the malantus insulin revision malantus insu	Inufacturer's recommendations are vealed the biologicals at 36 to 46 degrees Fahrenheit.  Inse) G stated the night shift was necking and logging the erator.  Inse opened, unaccessed Lantus al of Novolog insulin dated as essed 8/23/16 were stored in the rt.  Insertion cart was observed on 1/16 at 3:48 p.m. Located within art was noted one unopened of Lantus insulin. LPN (licensed at stated the vial had been excility 9/27/16 by the date on the date could not say when the emedication cart but she have been on 9/27/16. LPN K and the stored in the refrigerator	F 4	31			

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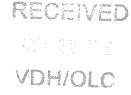
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
495393			B. WING		09	C 09/29/2016	
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	ERANS CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BROADROCK BLVD RICHMOND, VA 23224		The state of the s	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		IOULD BE	(X5) COMPLETION DATE	
F 431	Once the vial was rinsulin would only be dating, the staff wo insulin was not stor when the 28 day into the manufacturer's Novolog insulin at vial temperature 28 day in temperature 28 day in the manufacturer's linused temperature 28 day Review of the facilitinsulins included Laable to be administed No guidance was purefrigerated prior to 3. One vial of unop Novolog insulin was medication cart on the medication cart on the medication cart. delivered to the facilitation cart. delivered to the facilitation cart.	not refrigerated, the vial of the good for 28 days. Without hold have no idea of when the red in the refrigerator and sterval would be expired.  Is recommendations for swww.novolog.com:  I Not in use/unopened/room sys  use/unopened/ Refrigerated sexpiration date  opened Refrigerated/room sys  ty's guidance for storage of cantus and Novolog insulin were ered 28 days after opening. Trovided for insulins not accessing.	F 4	I31			
	be good for 28 days refrigerated.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER: A. BUI		A. BUILDING			COMPLETED
		495393	B. WING			·	2 <b>9/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SITTER AND BARFOOT VETERANS CARE CENTER			1		01 BROADROCK BLVD		
SHIER	AND BARFOOT VETE	NANO CARE CENTER	l	RI	ICHMOND, VA 2322#		**************************************
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 50	F4	131			
F 518 SS=D	of nursing) were inf staff to ensure the tarefrigerator was an storing Prevnar and staff stored insuling instructions, 9/28/16 483.75(m)(2) TRAII PROCEDURES/DF The facility must traprocedures when the periodically review staff; and carry out	6 at 3:30 p.m. N ALL STAFF-EMERGENCY	F 5	518	F 518  1a. The staff member was re-educemergency preparedness processe facility.	s for the	2.
	This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, 1 of 6 staff failed to verbalize understanding of Fire response strategies, and response to weather emergencies.  The findings included:  On 9-28-14 at 11:30 p.m., a telephone interview was conducted with the RN supervisor (RN A) who could not complete the interview independently.  After a short conversation about what the surveyor would be asking in the interview, the surveyor commenced with the formal questions. RN A was asked, if a fire was found in a Resident's room what would she do. RN A				2a. All residents have the potential affected.  3a. Staff will be re-educated on facility of the emergency preparedness processes. 3b. Staff will be educated on facility emergency preparedness processes orientation and annually thereafter. 4a. The QA Nurse/designee will reask four staff members a week for months questions related to emerge preparedness. Staff will be educated needed.  5a. 11/9/2016	acility s. ity s during r. andomly three	

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CENTE	13 FOR MEDICARE	& MEDICAID SERVICES				U	VID IVU.	0930-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495393	B. WING	j			1	C <b>29/2016</b>	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDR	RESS, CITY, STATE, ZIP	CODE			
				1601 BROADI					
SITTER	AND BARFOOT VETE	RANS CARE CENTER		RICHMOND					
				L					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EAC	ROVIDER'S PLAN OF CO CH CORRECTIVE ACTIO S-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE	
E 518	Continued From pa	aa 51	·	=40					
1 510	•	•	F:	518					
		ld get the resident out and try							
		She was asked if they used an							
	acronym to remind staff of the steps to take to								
	respond to a fire emergency, and she stated yes, it was PASS. She was asked what those letters								
	stood for, and she responded point and sweep at								
	the fire. She was asked if that was in reference								
	to the fire extinguisher, she stated yes. RN A was							000000000000000000000000000000000000000	
	then asked again what would she do if she found							anopamano.	
	a fire in a resident's room. RN A responded that								
	she would get the fire doors closed. When asked								
	if the fire doors closed on their own, she								
	responded yes. When asked how the rest of the								
	facility would know there was a fire, she stated								
		erhead and let every one							
	know. At no time, e	ven with cueing did she							
		e, Alarm, Contain, and	:						
		and seemed not to be able to							
		oxes must be initiated to							
		nd automatically close the fire							
		the Resident. When asked							
		o keep the residents safe						MOTOR	
	-	ters such as tornado							
	~ .	nes, RN A responded she							
	•	dent's safe, and that it							
		was a tornado in the parking							
		was asked what was she						· advantage	
		sidents safe, and she gave							
		noted that during the						and the same of th	
		active and strong thunder						e de la composition della comp	
	storms in the area. At this point, the RN supervisor was then asked to place a direct care staff member on the phone to complete the							недуменного	
								no no no no no no no no no no no no no n	
		i phone to complete the ied Nurse Aide (CNA-B)						Name of the last o	
		e and introduced herself							
		ter a short conversation about						December	
		ould be asking in the						аминания	
		is able to complete the						BERTHOOLIG	
	WO	io anie io collibiele (116						· ·	

interview with good knowledge of procedures

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<u> </u>	TO I OIL MEDIOTIVE	. G MILDIOAID SERVICES			ONIR M	J. 0938-039 <sup>1</sup>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				LE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495393	B. WING		no	C 9/29/2016	
	PROVIDER OR SUPPLIER  AND BARFOOT VETE	RANS CARE CENTER	1	STREET ADDRESS, CITY, STATE, ZIP COD 1601 BROADROCK BLVD RICHMOND, VA 23224	offension and a second and a second as a second as a second as a second as a second as a second as a second as	12012010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 518	Continued From pa	ge 52	F 518				
and the state of t	evidenced in the int						
	required training red this was evidenced was unable to verba policies.  On 9-29-16 at 10:00 conducted with the land Administrator, received training/info	cedure on fire and clearly and effectively the ceived by staff members, and by CNA B, however, RN A alize knowledge of the facility a.m., an interview was Director of Nursing (DON), They stated that all staff formation regarding facility's res at least annually.					
	day debrief at 11:00 DON were notified o (RN A) staff membe	a.m., and again at the end of a.m., the Administrator and of the 11:00 p.m. to 7:00 a.m. r's inability to show emergency procedures.					
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FORM CMS-2567(02-99) Previous Versions Obsolete

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