PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495079	B. WING _			C <b>01/06/2017</b>	
	ROVIDER OR SUPPLIER	PRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	<b>!</b> E	01700/2017	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE		
F 000	An unannounced Me survey was conducter Corrections are requirements. The Lisurvey/report will follow investigated during the The census in this 2000 at the time of the consisted of 27 currer (Residents #1 through reviews (Residents #1 through rev	dicare/Medicaid standard dd 1/4/17 through 1/6/17. red for compliance with 42 al Long Term Care ife Safety Code ow. One complaint was a survey.  16 certified bed facility was survey. The survey sample ent Resident reviews in #27) and 4 closed record 28 through #31).  ORT VIDUALS (4)(c)(1)-(4)  must- erwise engage individuals  quilty of abuse, neglect, opriation of property, or ourt of law; g entered into the State oncerning abuse, neglect, ment of residents or neir property; or one of the state	F 0	DEFICIENCY)	APPROPRIA	2/7/17	
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	  E	TITLE		(X6) DATE	

Electronically Signed 01/24/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495079	B. WING		C 01/06/2017	
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F 225	(4) Report to the Stalicensing authorities actions by a court of which would indicate nurse aide or other forms are aide or other aides after the allegation is cause the allegation is cause the allegation serious bodily injury, the events that cause abuse and do not reter the administrator of forms accordance with Staprocedures.  (2) Have evidence the thoroughly investigation is in procedures.  (3) Prevent further prexploitation, or mistrinvestigation is in procedures.	te nurse aide registry or any knowledge it has of law against an employee, a unfitness for service as a acility staff.  egations of abuse, neglect, eatment, the facility must:  leged violations involving potation or mistreatment, unknown source and resident property, are y, but not later than 2 hours is made, if the events that involve abuse or result in or not later than 24 hours if the the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and the state Survey Agency and the state Survey Agency and the state law provides geterm care facilities) in the law through established that all alleged violations are seed.  In the state of all investigations to the sories.	F 22	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C 01/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		7170072017	
				6800 LUCY CORR BLVD			
HEALTH C	CARE CENTER LUCY CO	ORR		CHESTERFIELD, VA 23832			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	Continued From page	e 2	F 22	25			
	if the alleged violation corrective action must This REQUIREMENT by: Based on observation documentation review the facility staff failed unknown origin to the Resident (Resident #Residents.  Resident #18 was not left ring finger on 11/2 diagnosed as being freported to the SA at Certification.  The findings included	is verified appropriate at be taken.  It is not met as evidenced and, staff interview, facility and clinical record review, to report an injury of a state agency (SA) for one at 18) in a survey sample of 31 atted to have a bruise to her 24/16 that was subsequently ractured. The injury was not the Office of Licensure and ale, was admitted to the		F 225 Corrective Action(s): Resident # 18 s bruise and fra her left ring finger noted on Nov 2016 have resolved. Resident # attending Physician and her res party was notified that the facilit report an injury of unknown orig state agency. A Facility reporte was completed and submitted t required state agencies.  Identification of Deficient Practi Corrective Action(s): All residents with injury of unknown ay have potentially been affect 100% review of all Risk manager.	vember 24, #18 s sponsible ty failed to gin to the d incident to the  ce &  own origin cted. A		
	constipation, unspect behavioral disturbant dysphagia, periphera anemia, hyperlipidem infarction, and celiac Resident #18's most set) with an ARD (ass 11/16/16 was coded as he memory deficits and with making daily life coded as requiring exof one staff member daily living. Resident	fied dementia with ces, atrial fibrillation, I vascular disease, seizures, nia, hypertension, cerebral disease.  recent MDS (minimum data sessment reference date) of as a quarterly assessment. aving short and long term required total assistance decisions. She was also kensive to total assistance to perform her activities of at #18 was coded as having ag self injurious behaviors		Incident and Accident Reports for previous 30 days will be review identify residents at risk. Any/al findings of reportable occurrence identified will result in a report to agency and an internal investig the outcomes reported to the all State agencies, attending physic responsible parties.  Systemic Change(s):  The facility Policy and Procedure been reviewed. No revisions and warranted at this time. The Adn and Nursing staff will be educated Administrator and/or designed Abuse Reporting Policy, includic completion of Incident/Accident	for the ed to I negative ces o the State ation with ppropriate ician and re has e ninistrative ted by the on the ng		

F 225 Continued From page 3 Resident #18 was observed 1/5/17 at 9:55 p.m. She was sitting in her wheelchair in the dining room. A personal alarm was in place on the back of her wheelchair. She was appropriately dressed. She was sitting at the dining table with her hands resting on the table.  Review of Resident #18's clinical record revealed on 11/24/16 while the CNA (certified nursing assistant) was assisting her with dressing, the CNA noticed Resident #18's "left ring finger" was bruised and discolored. The CNA notified the nurse "immediately."  The physician and responsible Party were notified on 11/24/16. Resident #18 left the facility with her family on 11/24/16 (Thanksgiving day) and according to the nursing notes had no complaint			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HEALTH CARE CENTER LUCY CORR  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG			495079	B. WING				
F 225 Continued From page 3 Resident #18 was observed 1/5/17 at 9:55 p.m. She was sitting in her wheelchair in the dining room. A personal alarm was in place on the back of her wheelchair. She was appropriately dressed. She was sitting at the dining table with her hands resting on the table.  Review of Resident #18's clinical record revealed on 11/24/16 while the CNA (certified nursing assistant) was assisting her with dressing, the CNA noticed Resident #18's "left ring finger" was bruised and discolored. The CNA notified the nurse "immediately."  PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 225  Investigations and timely submission to the appropriate state agencies.  Monitoring: The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The QA Audit will be conduct weekly by the DON and/or designee for completion of investigations and proper reporting. All negative findings will result in an internal investigation with the outcomes reported to the appropriate State agencies, attending physician and responsible Party were notified on 11/24/16. Resident #18 left the facility with her family on 11/24/16 (Thanksgiving day) and according to the nursing notes had no complaint			PRR		6800 LUCY CORR BLVD			
Resident #18 was observed 1/5/17 at 9:55 p.m. She was sitting in her wheelchair in the dining room. A personal alarm was in place on the back of her wheelchair. She was appropriately dressed. She was sitting at the dining table with her hands resting on the table.  Review of Resident #18's clinical record revealed on 11/24/16 while the CNA (certified nursing assistant) was assisting her with dressing, the CNA noticed Resident #18's "left ring finger" was bruised and discolored. The CNA notified the nurse "immediately."  The Administrator is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The QA Audit will be conduct weekly by the DON and/or designee for completion of investigations and proper reporting. All negative findings will result in an internal investigation with the outcomes reported to the appropriate State agencies.  Monitoring:  The Administrator is responsible for maintaining compliance. The QA Audit will be conduct weekly by the DON and/or designee for completion of investigations and proper reporting. All negative findings will result in an internal investigation with the outcomes reported to the appropriate State agencies.	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERT	D BE	COMPLETION	
of the finger at that time.  By 11/25/16 at 11:28 a.m., the physician was informed of Resident #18's discoloration of her left ring finger and the physician ordered an xray and doppler study to be performed. The x-ray was obtained and revealed:  "12/25/16 There is age-determinated fracture through the shaft of the proximal phalanx of the 5th finger. There are mild degenerative changes and osteopenia. Slight soft tissue swelling is seen."  The physician was notified and an order was written to send Resident #18 to the ER for evaluation of her fractured finger.  Review of the clinical record including nursing notes, MDS, and other interdisciplinary notes	F 225	Resident #18 was ob She was sitting in her room. A personal ala of her wheelchair. St dressed. She was sither hands resting on Review of Resident # on 11/24/16 while the assistant) was assistic CNA noticed Resider bruised and discolore nurse "immediately."  The physician and recon 11/24/16. Resider family on 11/24/16. Resider family on 11/24/16 (Taccording to the nurs of the finger at that tir By 11/25/16 at 11:28 informed of Resident left ring finger and the and doppler study to was obtained and rev "12/25/16 There is at through the shaft of the 5th finger. There are and osteopenia. Slig seen."  The physician was now written to send Residevaluation of her fractive Review of the clinical	served 1/5/17 at 9:55 p.m.  wheelchair in the dining rm was in place on the back he was appropriately ting at the dining table with the table.  18's clinical record revealed CNA (certified nursing ng her with dressing, the htt #18's "left ring finger" was hd. The CNA notified the  sponsible Party were notified htt #18 left the facility with her hanksgiving day) and hing notes had no complaint he.  a.m., the physician was #18's discoloration of her he physician ordered an xray he performed. The x-ray he performed fracture he proximal phalanx of the mild degenerative changes ht soft tissue swelling is  otified and an order was hent #18 to the ER for tured finger.  record including nursing	F 22	investigations and timely submission the appropriate state agencies.  Monitoring: The Administrator is responsible for maintaining compliance. The QA Proincludes audit tool for monitoring compliance. The QA Audit will be coweekly by the DON and/or designed completion of investigations and proreporting. All negative findings will rin an internal investigation with the outcomes reported to the appropriat State agencies, attending physician responsible parties. Aggregate finding these audits will be provided to the CAssurance Committee for review, analysis, and recommendations for change in facility policy, procedure, practice.	ogram  nduct for per esult e and ngs of Quality  and/or		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495079	B. WING _		_		C 06/2017
	ROVIDER OR SUPPLIER	RR		6800 LUCY CORR BLVD	STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
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F 225	fractured finger.  Review of the facility's statement was obtain identified the bruising. The statement was dobtained at some poin statement included "T with her hands. She touching just about ar was no indication as to obtained on 11/24/16, were dated as having Review of the "Incider indicated the writer fe was due to "Resident.  When interviewed reg facility staff to report a (fractured left finger) to stated 1/5/17 at 4:55	se investigation revealed a ed from the CNA that initially to Resident #18's finger. ated as having been in time on 11/24/16. The the resident is very active is usually grabbing, pulling, bything at her reach." There is when the statement was the rest of the statements been obtained 11/25/16. In the Accident Report the bruise to her finger is restless."  Jarding the failure of the an injury of unknown origin to the SA, the administrator p.m., the investigation as caused by Resident #18 a her table and other	F2	225	EFICIENCT)		
	her hands, the adminidetermined during the administrator stated the observed her banging interviewed after the bound.  Review of the facility's	e investigation. The ne staff stated they had					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
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F 225	Continued From page		F	225		
	that all alleged violati exploitation or mistre unknown source and property, are reported than 2 hours after the events that cause the result in serious bodil hours if the events th not involve abuse and injury, to the administ her designee, and to the State Survey Age services where state in long-term care faci State law through est	maintain systems to ensure ons involving abuse, neglect, eatment, including injuries of misappropriation of resident d immediately, but not later eallegation is made, if the eallegation involve abuse or y injury, or not later than 24 at cause the allegation do d do not result serious bodily rator of the facility, or his or other officials (including to ncy and adult protective law provides for jurisdiction lities) in accordance with ablished procedures				
F 241 SS=D	alleged violations invincluding injuries of u mistreatment and/or in property, by anyone of the provider, to the designee of the facility. The administrator and of nursing) were inforstaff to report an injur SA, 1/6/16 at 11:42 a DIGNITY AND RESP CFR(s): 483.10(a)(1) (a)(1) A facility must the resident in a manner promotes maintenance.	misappropriation of resident furnishing services on behalf administrator or his or her y."  d ADON (assistant director med of the failure of the y of unknown origin to the .m.  ECT OF INDIVIDUALITY  reat and care for each and in an environment that the or enhancement of his originizing each resident's lity must protect and	F 2	241		2/7/17

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY
			71. 501251	_		(	c
		495079	B. WING				06/2017
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	A DE OENTED I 110V 00	<b></b>		68	300 LUCY CORR BLVD		
HEALIH	CARE CENTER LUCY CO	JRR		С	HESTERFIELD, VA 23832		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  I SO IDENTIFYING INFORMATION	ID PREFI	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	
F 241	Continued From page	e 6	F:	241			
		「 is not met as evidenced					
	by:						
		riew and clinical record			F 241		
	review, the facility sta	aff failed to provide a			Corrective Action(s):		
	dignified living experience for one Resident				Resident #1 □s Responsible party was		
	(Resident #1) in a sui	rvey sample of 31			notified that a physician referred to her		
	Residents.				use of incontinence products as Diape	rs	
					in the written record. The physician wh		
		term "diapers" was utilized in			authored the progress note and order v		
		s and progress notes instead			notified of the failure to provide a dignif	ied	
	of "incontinent brief."				living experience.		
	The findings included	l:			Identification of Deficient Practice &		
	D				Corrective Action(s):		
		e, was admitted to the facility			All other residents who utilize		
	9/15/14. Her diagnos				incontinence products for their	II. <i>i</i>	
		cancer of colon, chronic			incontinence needs may have potentia been affected. The DON and/or design	-	
	obstructive pulmonar	y disease, a, enuresis, dysphagia,			will do a 100% review of all current	iee	
		oody, cellulitis, Vitamin D			physician orders to verify all residents	with	
		laucoma, hypertension,			orders related to continence products	741(11	
		ovascular disease, and			have no inappropriate verbiage that wo	uld	
	muscle weakness.	vaccular discuss, and			be negative to their dignity.	dia	
	Resident #1's most re	ecent MDS (minimum data			Systemic Change(s):		
	,	sessment reference date) of			The facility Policy and Procedure has		
		as a quarterly assessment.			been reviewed. No revisions are		
		ed as having short and long			warranted at this time. The Administrat		
	term memory deficits				and/or Medical Director will educate the		
		ng daily life decisions. She			Attending physicians on the policy and		
	was coded as requiring	_			procedure regarding resident rights and	מ	
	assistance of one to t				dignity. The DON and/or designee will		
		of daily living with the			educate all staff on the policy and	J	
		For eating, she was coded			procedure regarding resident rights and	ı	
	as needing standby b	by assistance.			dignity. The interdisciplinary team will		
	Povious of Posidont #	t1's clinical record revealed			review clinical documentation for all	ort	
		n abrasion to her left lip.			residents on an ongoing basis and repo		
		n abrasion to her left lip. ed Resident #1 and entered			any verbiage that would be negative to resident ☐s dignity to the Administrator.		
	ニーロモ いけいいはけ ほううどううと		1	- 1	reagent a dignivio de Administrator.		1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 246 SS=D	hip due to being thin a diapers. Start barrier  One of the nursing stathat included: "12/6/1 prevent irritation from  When interviewed 1/6 conference, the admit the staff, both floor staterm "diapers" to refer incontinent briefs.  "Fundamentals of Nur Potter-Perry, p. 475," sense of dignity includes elf-regard, an ability strength from one's or valued by others, and caregivers. Nurses pesteem and dignity by whole person with fee and passions indeper experienceWhen cafunctions, show patient after the client become.  The administrator and of nursing) were infort staff to ensure the use	a "small abrasion on L (left) A rubbing from adult cream."  aff created a verbal order 6 Barrier cream to hips to diapers daily."  aff and clinician, utilizing the r to Resident #1's use of  rsing, 7 th Edition, provides guidance, "A des a person's positive to invest in and gain wn meaning in life, feeling how one is treated by romote a client's self r respecting him or her as a elings, accomplishments, adent of the illness uring for a client's bodily nce and respect, especially es dependent."  I ADON (assistant director med of the failure of the e of Resident #1's e documented in a dignified a.m. DMMODATION OF	F 24	Monitoring: The DON is responsible for maintain compliance. The QA Program include audit tool for monitoring compliance. DON and/or designee will complete to audit tool weekly coinciding with the MDS/CP calendar. Any/all negative findings from the audit will be reported the Risk management Committee for review Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, a practice.  Completion Date: February 7, 2017	es The he d to	
	CFR(s): 483.10(e)(3) 483.10(e) Respect an	d Dignity. The resident has				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	<b>'</b>	01/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)  TAG  PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
F 246	Continued From page a right to be treated vincluding:  (e)(3) The right to rest the facility with reaso resident needs and p do so would endange resident or other resident from the resident or other resident or other resident or other resident or other resident resident (Resident #4 resident (Resident #4 residents, to ensure the reach.  For Resident #4, the that her food was with the food was with the findings included Resident #4 was an admitted to the facility diagnoses included Coperessive Disorder, Disease, and Dyspharman.	e 8 with respect and dignity, side and receive services in mable accommodation of references except when to er the health or safety of the dents. T is not met as evidenced on, resident interview, staff ord review and facility w, facility staff failed, for one e) of the survey sample of 31 that her food was within facility staff failed to ensure hin reach. d: 36 year old who was y on 3/23/16. Resident #4's Deteoporosis, Major Gastroesophageal Reflux asia.	F 2	DEFICIENCY)	arty and r food was 7 at 9:05 ing with hat day on ng with cice & ed and setup ected. The	
	Assessment with an A of 12/30/16, coded R Interview of Mental S no cognitive impairments	set, which was a Quarterly Assessment Reference Date esident #4 as having a Brief tatus Score of 15, indicating ent. In addition, Resident #4 on to set up her meals within		have reasonable accommodate meals. Any/all findings that mathe needs of the resident will be and a facility Incident and Accident mill be completed.  Systemic Change(s):	ions during by not meet be corrected	
	On 1/5/17 at 9:05 A.N conducted of Reside	M. an observation was nt #4 in her room. Her bed tion close to the floor.		The facility Policy and Procedu been reviewed. No revisions a warranted at this time. The DO designee will educate all staff of	re N and/or	

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NAME OF P	ROVIDER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, ZIP COI	DE	01/00/2017	
HEALTH (	ARE CENTER LUCY CO	NRR		6800 LUCY CORR BLVD			
HEALING	ARE CENTER LUCT CC			CHESTERFIELD, VA 23832			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 246	Continued From page	e 9	F 24	46			
	Resident #4 was sitting with her legs hanging not touching the floor position, causing her tray table was at her near her waist level. It serve my breakfast latthey'll be right back to wash me. Resident # brought up at about 8.  Resident #4's breakfad During the time the stacility staff still had in #4's food within her reobserve any staff prehallway.  On 1/5/17 a review with #4's clinical record. He stable for the previous contained the following not touch to the stable for the previous contained the following not touch touch the stable for the previous contained the following not touch touch the stable for the previous contained the following not touch to the stable for the previous contained the following not touch to the stable for the previous contained the following not touch the stable for the previous contained the following not touch the stable for the previous contained the following not touch the stable for the previous contained the following not touch the stable for the previous contained the following not touch the stable for the previous contained the following not touch the stable for the previous contained the following not touch the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the following not the stable for the previous contained the stable for the stable for the stable for the stable for	ng on the side of her bed over the side of the bed, but . Her tray table was in a high food to be out of reach. The eye level, instead of being Resident #4 stated, "They tte. They come in and say o help with my food and 4 stated that breakfast was		policy and procedure regardi rights and accommodation of interdisciplinary team will revidocumentation for all resider ongoing basis and report any needs or preferences related service.  Monitoring: The DON is responsible for recompliance. The QA Programa audit tool for monitoring com DON and/or designee will conclude tool weekly coinciding with MDS/CP calendar. Any/all infindings from the audit will be the Risk management Commerciew. Aggregate findings owill be provided to the Quality Committee for review, analyst recommendations for change policy, procedure, and/or pragarding to the provided to the quality commendations for change policy, procedure, and/or pragarding the service of the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy, procedure, and/or pragarding the provided to the quality commendations for change policy.	f needs. The riew clinical lats on an y changes in I to meal maintaining mincludes pliance. The mplete the with the egative exported to nittee for f these audits y Assurance sis, and exin facility actice.		
F 280 SS=D	the staff. They assisted today. Her tray will be to eat in bed. Her leg the staff were trained RIGHT TO PARTICIF CARE-REVISE CP CFR(s): 483.10(c)(2):	cility Administrator ne stated, "We inserviced ed her out of bed to eat e adjusted when she prefers s will not hang over the bed, in safety."	F 28	Completion Date: February	7, 2017	2/7/17	

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495079	B. WING			1	06/2017
	ROVIDER OR SUPPLIER	PRR	ı	6	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 017	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	(i) The right to participate including the right to it be included in the plan request meetings and revisions to the person (ii) The right to participate and the person (iii) The right to participate described goals and of amount, frequency, and other factors related the plan of care.  (iv) The right to receivant included in the plan of care.  (v) The right to see the right to sign after sign of care.  (c)(3) The facility shall right to participate in Its shall support the reside planning process must be planning pr	of his or her person-centered g but not limited to:  Date in the planning process, dentify individuals or roles to nning process, the right to it the right to request en-centered plan of care.  Date in establishing the nutcomes of care, the type, and duration of care, and any to the effectiveness of the effectiveness of the error of the nutcomes of care, the type, and duration of care, and any to the effectiveness of the effectiveness of the error of the nutcomes of care.  Description of the resident of the nutcome the plan efficient changes to the plan efficient in this right. The effectiveness of the effectiveness of the effectiveness of the effectiveness of the plan efficient of the resident and/or efficient in this right. The efficient of the resident and/or effectiveness of the efficient of the resident and/or efficient efficient efficient and/or efficient ef	F	280			

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495079	B. WING			l	06/ <b>2017</b>
	ROVIDER OR SUPPLIER	RR	,	6	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE
F 280	Continued From page	e 11	F:	280			
	(2) A comprehensive	care plan must be-					
	(i) Developed within 7 days after completion of the comprehensive assessment.						
	(ii) Prepared by an infincludes but is not lim	terdisciplinary team, that ited to					
	(A) The attending phy	vsician.					
	(B) A registered nurse resident.	e with responsibility for the					
	(C) A nurse aide with resident.	responsibility for the					
	(D) A member of food	I and nutrition services staff.					
	the resident and the r An explanation must medical record if the	eticable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the					
		staff or professionals in ined by the resident's needs e resident.					
	team after each asses comprehensive and of assessments. This REQUIREMENT by: Based on observation	is not met as evidenced n, staff interview, and clinical			F280		
	record review, the fac	cility staff failed to review and			Corrective Action(s):		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C 01/06/2017	
NAME OF P	ROVIDER OR SUPPLIER	1.00.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO		1/06/2017	
INAME OF T	TOVIDER OR OUT FEILIN				<i>,</i> DL		
HEALTH C	ARE CENTER LUCY CO	ORR		6800 LUCY CORR BLVD			
			CHESTERFIELD, VA 23832				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 280	Continued From page	e 12	F 28	30			
		nsive plan of care for one 1) in a survey sample of 31		Resident # 1 was re-evaluat not require the use of a bed alarm. The orders reflect this and care plan.	and chair		
		facility staff failed to revise they were discontinued.		Identification of Deficient Pra Corrective Action(s): All residents with safety alar been potentially affected. A	ms may have 100% review		
	Resident #1, a female, was admitted to the facility 9/15/14. Her diagnoses included major depressive disorder, cancer of colon, chronic obstructive pulmonary disease, hypercholesterolemia, enuresis, dysphagia, dementia with Lewy body, cellulitis, Vitamin D deficiency, anxiety, glaucoma, hypertension, arteriosclerotic cardiovascular disease, and muscle weakness.  Resident #1's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/21/16 was coded as a quarterly assessment. Resident #1 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. She was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living with the exception of eating. For eating, she was coded			of current care plans will be the DON and/or designee to each resident has a compre plan with specific and measure and appropriate intervention resident in sindividual medical Any/all negative findings will to the DON for corrective ac	ensure that hensive care urable goals s to meet the al needs. be reported		
				Systemic Change(s): The facility Policy and Procedure been reviewed. No revisions warranted at this time. The approcess will continue to be understand the developing of the process.	s are assessment		
				primary tool for developing comprehensive care plans. coordinators and Interdiscipl planning team will be educated policy and procedure for carthe DON.	linary care ted on the		
	coded as having had assessment.  Resident #1 was obs Two staff members tr to her wheelchair with alarm was noted und	erved 1/4/17 at 3:06 p.m. ransferred her from her bed h a mechanical lift. No bed er Resident #1 at the time of a chair alarm in place once		Monitoring: The DON, MDS coordinators interdisciplinary Team will be for verifying the resident spendans. The QA program incluted for monitoring compliant Audit tool, Care plan audit we to conduct a random 10% at	e responsible ecific care udes an audit ce. The QA vill be utilized		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495079	B. WING		0.	C I/ <b>06/2017</b>	
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832			
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F 280	her wheelchair, 1/5/1 8:24 a.m. She was sa half tray table in plata alarm was noted attated any of the observation.  Review of Resident she had been assess risk for falls with a can Documentation reveathistory of previous fateam had developed injury from falls that infunction" and "Chair achair or bed alarm was attached to Resident alert the staff if Residunassisted.  Review of Resident shoop hysician's order to chair alarm to be utiliate.  LPN (licensed praction manager, observed fam. She stated she personal alarm and we record. LPN D did steither bed or chair, we Resident #1, a physician's order to chair alarms had been discand a physician's order to chair a	to her wheelchair.  observed out of bed and in 7 at 8:30 a.m. and 1/6/16 at itting in the dining room with ace over her lap. No chair ched to the wheelchair at ins.  Et clinical record revealed sed and determined to be at re plan revised 9/7/16. aled Resident #1 had a lls, and the interdisciplinary a plan 9/28/16 to prevent included "Bed Alarm check function." A included "Bed Alarm check function." A included "Bed or chair that would lent #1 attempted to rise included for a bed or included for a bed o	F 28	care plans weekly for twelve we verify that the comprehensive of are completed timely, accuratel resident specific. Any/all finding reported to the DON and the Miccoordinator will make correction time of discovery. Aggregate fire these audits will be provided to Assurance Committee for review analysis, and recommendations change in facility policy, proced practice.  Completion Date: February 7,	are plans y, and are gs will be DS ns at the ndings of the Quality w, s for lure, and/or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ORR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		1 01/06/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 280	Continued From pag	ge 14	F 2	30			
		e care plan interventions are plan 9/28/16 when they ed 9/16/16.					
		ated the MDS staff were ting and revising the care					
	care plan is provided	eation of an individualized d by "Fundamentals of Potter-Perry, p. 268:					
	for providing a writte The plan of care sor formsIn hospitals a settings, the client of than one nurse, phy professional. A writt possible the coordin subspecialty consult diagnostic testsYo direct clinical nursing risk of incomplete, in As the client's probled does the plan. A nu guideline for coordin continuity of care, ar be used in evaluatio communicates nursi health care professie enhances the contin specific nursing inter	etting a nurse is responsible in plan of care for all clients. Inetimes takes several and community-based ften receives care from more sician, or allied health en nursing care plan makes ation of nursing care, ations, and scheduling of u design a written plan to g care and to decrease the accorrect, or inaccurate care. It is a written ating nursing care, promoting and listing outcome criteria to in. The written plan ing care priorities to other conals. The nursing care by listing reventions needed to achieve ill nurses who care for a given					
	client will then carry interventions through client's length of stay	out these nursing nout a given day during a y. A correctly formulated akes it easier to continue					

, ,		IDENTIFICATION NUMBED:		IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		495079	B. WING _		01/06/2017
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
F 280		d ADON (assistant director	F 2	280	
F 281 SS=E	staff to review and re of care for Resident # were discontinued, 1/	ED MEET PROFESSIONAL	F2	281	2/7/17
	-	e Care Plans  d or arranged by the facility, mprehensive care plan,			
	by: Based on staff interventies, clinical record a complaint investigate follow the professionaregarding medication Residents (# 14, # 28)	standards of quality.  is not met as evidenced  iew, facility documentation I review and in the course of tion, the facility staff failed to al standards of nursing s and treatments for 8 s, # 16, # 18, # 9, # 7, # 6 sample of 31 residents.		F281 Corrective Action(s): The attending physician and responding for Residents # 14, 28, 17, 6 and #19 have been notified of omission of documentation for meand/or treatment administration. An Incident and Accident report form	6, 18, 9, If the edication A facility
	ensure the medicatio documented as havir  2. For Resident # 28 clarify an order to ren Inserted Central Cath completed on 11/25/2	the facility staff failed to nove the PICC (Peripherally leter) line after Antibiotic 2015.		Identification of Deficient Practice Corrective Action(s): All other residents receiving medical may have been potentially affecte DON and/or designee will do a 10 review all resident medication and treatment records to ensure all orderenscribed correctly and medication	& cations ed. The 100% dd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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					800 LUCY CORR BLVD			
HEALTH C	CARE CENTER LUCY CO	DRR			HESTERFIELD, VA 23832			
(X4) ID PREFIX TAG			ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 281	Continued From page	e 16	F 2	281				
	documented as havin	ng been administered;			treatment supplies are available. Any/negative findings will be communicated			
	4. For Resident #18, ensure medications a	the facility staff failed to			the DON for corrective action.			
	documented as having been administered;				Systemic Change(s): The facility Policy and Procedure has			
		ne facility staff failed to			been reviewed. No revisions are			
	assure that multiple medications were administered and documented as having been				warranted at this time. Licensed Nursir	•		
					staff will be educated by the DON and			
	given.				designee on the policy and procedure			
	6 For Posidont #7 th	as facility staff failed to			the proper administration and delivery medications and treatments.	OΤ		
	6. For Resident #7, the facility staff failed to assure that multiple medications and treatments				medications and treatments.			
	1	nd charted as having been			Monitoring:			
	given.	.a charted ac harmig zeen			The DON is responsible for maintaining	a		
					compliance. The QA Program includes	-		
	7. For Resident #6, th	ne facility staff failed to			audit tool for monitoring compliance. T			
	document the admin	istration of medications and			DON and/or designee will conduct			
	I .	l occasions during August,			random weekly medication pass and			
	2016 through Novem	ber, 2016.			treatment observations audits to monit			
					compliance. Any/all negative findings v			
		the facility staff failed to			be corrected immediately and appropri	ate		
		istration of medications and			disciplinary action will be taken as	_		
	2016 through Novem	l occasions during August,			necessary. Aggregate findings of these audits will be provided to the Quality	;		
	2010 tillough Novelli	bei, 2010.			Assurance Committee for review,			
					analysis, and recommendations for			
	Findings included:				change in facility policy, procedure, an	d/or		
	· ··································				practice.			
	1. For Resident # 14,	the facility staff failed to			•			
	ensure the medication	ns and treatments were			Completion Date: February 7, 2017			
	documented as havin	ng been administered.						
	facility 6/23/16. Her of not limited to: Diabete	ale, was admitted to the diagnoses included but were es, Hypertension, Spinal dism, Dry Eye Syndrome, s, Arthopathy and						
	Atherosclerotic Heart							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '			COMPLETED	
	495079	B. WING			C <b>01/06/2017</b>	
			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	<u> </u>	01/00/2017	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE	
Continued From pag	e 17	F 2	81			
set) with an ARD (as 7/10/15 was coded a Resident #14 was coshort term memory of her own daily life dealso coded as needing assistance of one state activities of daily living Review of Resident and evidence the following treatments were admorders:  Aspirin 81 milligrams Atherosclerotic heart AM  Ibuprofen 800 milligrams Atherosclerotic heart AM  Ibuprofen 800 milligrams Apply to Right hip to at 9 PM , 10/17/2016 Lisinopril 2.5 mg 1 ta hypertension: 8/6/18  Lyrica 150 milligrams (pain): 10/17/2016 at Metformin 500 milligrams	sessment reference date) of as a Quarterly assessment. Oded as having no long and deficits and was able to make cisions. Resident #14 was ang supervision to total aff member to perform her ang.  #16's clinical record revealed awing medications or an inistered per physician's  1 tablet by mouth daily for a disease: 10/28/2016 at 9  ams 1 tablet by mouth at Pain Syndrome: 10/3/2016 at 9  Strength Ointment 7.6-29% pically at bedtime: 10/3/2016 at 9 PM  ablet every 12 hours for 5 at 10 a.m.  1 capsule every night at 9 PM  arams give 1.5 tablets by					
	ROVIDER OR SUPPLIER  SUMMARY S' (EACH DEFICIENC REGULATORY OR  Continued From page  Resident #14's most set) with an ARD (as 7/10/15 was coded a Resident #14 was conshort term memory of the own daily life dealso coded as needing assistance of one standard activities of daily living Review of Resident in the oevidence the following treatments were admorders:  Aspirin 81 milligrams Atherosclerotic heart AM  Ibuprofen 800 milligrams Atherosclerotic heart AM  Ibuprofen 800 milligrams Atherosclerotic heart AM  Lyrica 150 milligrams (pain): 10/17/2016 at Metformin 500 milligrams (pain): 10/17/2016 at Metformin 500 milligrams (pain): 10/17/2016 at Metformin 500 milligrams (pain): 500 mil	AP\$079  ROVIDER OR SUPPLIER  SARE CENTER LUCY CORR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 17  Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/10/15 was coded as a Quarterly assessment. Resident #14 was coded as having no long and short term memory deficits and was able to make her own daily life decisions. Resident #14 was also coded as needing supervision to total assistance of one staff member to perform her activities of daily living.  Review of Resident #16's clinical record revealed no evidence the following medications or treatments were administered per physician's orders:  Aspirin 81 milligrams 1 tablet by mouth daily for Atherosclerotic heart disease: 10/28/2016 at 9 AM  Ibuprofen 800 milligrams 1 tablet by mouth at bedtime for Chronic Pain Syndrome: 10/3/2016 at	A BUILDIN 495079  B. WING	ROWIDER OR SUPPLIER  CARE CENTER LUCY CORR  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH OFFICIENCY MUST BE PRECEDED BY FULL (EACH OFFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION BH CROSS REFERENCED TO THE APP  DEFICIENCY)  Continued From page 17  Resident #14's most recent MDS (minimum data set) with an ARD (assessment reference date) of 7/10/15 was coded as a Quarterly assessment. Resident #14 was coded as having no long and short term memory deficits and was able to make her own daily life decisions. Resident #14 was also coded as needing supervision to total assistance of one staff member to perform her activities of daily living.  Review of Resident #16's clinical record revealed no evidence the following medications or treatments were administered per physician's orders:  Aspirin 81 milligrams 1 tablet by mouth daily for Atherosclerotic heart disease: 10/28/2016 at 9 AM  Ibuprofen 800 milligrams 1 tablet by mouth at bedtime for Chronic Pain Syndrome: 10/3/2016 at 9 PM  Icy Hot Balm Extra Strength Ointment 7.6-29% Apply to Right hip topically at bedtime: 10/3/2016 at 9 PM, 10/17/2016 at 9 PM  Metformin 500 milligrams 1 capsule every night (pain): 10/17/2016 at 9 PM  Metformin 500 milligrams give 1.5 tablets by mouth daily for Diabetes: 10/28/2016 at 7:30 AM  Norvasc 5 milligrams 1 tablet by mouth daily for	A BUILDING  495079  ROYJOER OR SUPPLIER  ARE CENTER LUCY CORR  SUMMARY STATEMENT OF DEPOISONES (EACH DEPOISONES) (EACH DEPOISONE) (EACH DEPOISONES) (EACH DE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	COMPLETED	
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	ROVIDER OR SUPPLIER	ORR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 0.100.201.
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 281		grams 1 tablet by mouth at clerotic Heart Disease:	F 28	31	
		rams 1 tablet by mouth daily			
	, ,	oth 500 milligrams 1 tablet by r pain: 10/3/2016 at 9 PM ,			
	I .	S 2 capsules (Multiple 1 capsule by mouth two times			
	eyes four times a da 10/3/2016 at 9 PM,	ion 1.4 % instill 1 drop in both by for Dry Eye Syndrome: 10/17/2016 at 9 PM, , 10/28/2016 at 12 PM			
	Review of the Octob Administration Reco documentation of:				
	Saline, Apply Xerord Kling, and secure w	o left forearm with Normal orm, dry dressing, wrap with ith tape daily until healed: 016 and 10/28/2016.(all on			
		teral arms: 10/4/2016 at 9 9 AM, 10/28/2016 at 9 AM			
	documentation was #14 either refused the	ess notes revealed no available to indicate Resident ne medications and ot present at the facility for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NUMBER:  A. BUILDING			(X3) DATE COMP	SURVEY LETED			
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		495079	B. WING			01/	06/2017
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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IILALIII	ARE CENTER EOCT CO			(	CHESTERFIELD, VA 23832		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF		(EACH CORRECTIVE ACTION SHOULD B		COMPLETION DATE
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE.	DAIL
			+		,		
F 281	Continued From page	<u>.</u> 10		281			
. 20.			'	201			
		dicated. Valid physicians' or the medications and					
		nented as having been					
	administered.	ichted as having been					
	adminiotoroa.						
	The Administrator, Ad	cting DON, and Chief					
		e informed of the failure of					
	the staff to ensure me	edications and treatments					
		having been administered					
	-	debriefing on 1/5/2017 at					
		istrator stated Lippincott as					
	-	ing standard followed by the					
		rator stated the expectation					
	medications at the tim	cument the administration of					
	medications at the till	le of administration.					
	The facility policy enti	itled Medication					
	Administration Gener						
	Administration of Me	dications, Effective June					
	2014 on Page 2 of 3 i						
		e medication administered					
		ministration Record. If the					
		mediation, he/she indicates					
	Nurses' Notes and inc	ter on the MAR and in the					
	Nuises Notes and inc	ciudes reason.					
	Guidance given from	Potter and Perry					
	_	sing, Eighth Edition, page					
		low health care providers'					
		elieve the orders are in error					
	or harm patients. The	erefore you need to assess					
		one to be erroneous or					
	'	cation from the health care					
	1 -	"." Page 584 read: "To					
		rrors, follow the six rights of					
		ation consistently every time					
		ations. Many medication					
	errors can be linked, i						
	inconsistency in adhe	ering to these rights:					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495079	B. WING		C 01/06/2017
	ROVIDER OR SUPPLIER	ORR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 01/00/2017
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 281	Continued From page 1. The right medica 2. The right dose 3. The right patient 4. The right route 5. The right docume 6. The right docume	tion	F 28	1	
	No further information	on was provided.			
	2. For Resident # 28, the facility staff failed to clarify an order to remove the PICC (Peripherally Inserted Central Catheter) line after Antibiotic completed on 11/25/2015.				
	originally on 11/11/2 4/16/2015, 11/18/20 diagnoses to include Alzheimer's Disease Fibrillation, Kidney F	admitted to the facility 014 and readmitted on 15 and 12/22/2015 with be but not limited to: c, Dementia, Glaucoma, Atrial Failure, Hypertension, Anxiety, ry Retention, Bacteremia and			
	Assessment Reference 12/29/2015. The MI moderate cognitive required extensive to two staff persons will Resident # 28 was compared.				
		d clinical record for Resident on 1/6/2017 at 9:30 AM.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION  NG	(X:	(X3) DATE SURVEY COMPLETED		
		495079	B. WING_			C <b>01/06/2017</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	ODE	01/00/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 281	11/18/2015 revealed line after antibiotic colline after antibiotic colline after antibiotic colline after antibiotic colline after antibiotic Orders shot for Indication: Urosep The orders were for "Pull PICC Line at the and "May send patie for line evaluation or There were 4 options physician regarding to two options not checular pull PICC line at end through:  "Send patient to Interemoval at end of conform Under Antibiotic gram IV (intravenous 11/25/2015."  Review of the Admission the facility on 11/1 handwritten on a Phy 11/18/15-11/30/15.	al Discharge Note dated orders to "remove the PICC ompleted 11/25"  Dus Disease Outpatient owed orders for the PICC line osis Proteus Bacteremia.  2. weekly labs; 7. PICC line: e end of IV antibiotic course" into Interventional Radiology replacement as needed".  Is for orders from the one option was "Do not of therapy and maintain." The other option was reventional Radiology for line of the PICC line on the option was reventional Radiology for line of the option was reventional Radiology for line of the option was reventional Radiology for line of the option orders for Readmission (1948) every 8 hours through	F2	281			
	the second box read milliliters of normal so line, Stop date 11/25 of page 3, the area w (Intravenous) ABT (A diagnosis of Uroseps	Antibiotic Therapy) for sis with a stop date of dmission orders were signed					
	On 1/6/2017 at 11:25	5 AM, an interview was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495079	B. WING			C 01/06/2017
	ROVIDER OR SUPPLIER	PRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	A) who stated the fact discontinue the PICC physician but also be being followed by Infe facility wanted to be so by Infectious Disease line. The Administrat removed on 12/2/201 cleared.  On 1/6/2017 at 1:30 I (Admin A) stated she an order to remove the was the nurse who re Administrator (Admin Nursing of the facility was in the facility. At Admin A presented a dated 12/2/2015 at 4 "Residents PICC line without difficulty." Ac of the orders from Infe which ordered to "Pu antibiotic course" and Interventional Radiological replacement as need written "Cefepime 1 of 8 hours through 11/2.  During the end of day facility Administrator, and Chief Executive findings.  No further information 3. For Resident #16,	cility Administrator (Admin illity had an order to line by the attending cause the resident was ectious Disease doctors, the sure the resident was cleared before removing the PICC or stated the PICC line was 5 after the resident was  PM, the Administrator was positive that there was ne PICC line because she smoved the PICC line. The A) was the Director of at the time Resident # 28 approximately 1:45 PM, copy of the Nurses Note 10 PM which stated discontinued by writer lmin A also presented a copy ectious Disease physicians II PICC Line at the end of IV I "May send patient to opy for line evaluation or ed". Under Antibiotics was gram IV (intravenously) every 5/2015."  If debriefing on 1/6/2017, the Acting Director of Nursing Officer were informed of the	F 28	31		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		IPLE CONSTRUCTION  NG		COMPLETED	
		495079	B. WING _			C <b>01/06/2017</b>	
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIF 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	CODE	01100/2011	
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN C ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIA	DATE	
F 281	the facility 3/15/05. I vascular dementia, we fracture, Bell's palsy. Parkinson's disease, dysphagia, and hyper Resident #16's most set) with an ARD (as 10/18/16 was coded She was coded as homeomy deficits and with making daily life was coded as needing one staff member to living with the except was coded as needing was coded as needing Review of Resident in o evidence the follow documented as having Nystatin Powder appendially until area healer 10/29/16 8 a.m., 11/2 a.m., 12/6/16 5 p.m.  Apply protective barrand peri area for proday shift, 10/22/16 d. 10/23/16 evening shift, 12/2/16 evening shift, 12/12/16 evening shift,	ale, was initially admitted to der diagnoses included ertebral compression dysthrymic disorder, arthropathy, osteoporosis, ertension.  Trecent MDS (minimum data sessment reference date) of as a quarterly assessment. aving short and long term required total assistance decisions. Resident #16 ag extensive assistance of perform her activities of daily tion of eating. For eating she ag setup assistance only.  #16's clinical record revealed wing treatments were ag been administered:  Ity under both breasts twice d: 10/28/16 at 8 a.m., 11/20/16 8  Fier (zinc) cream to buttocks tection every shift: 10/16/16 ay shift, 10/24/16 night shift, 10/29/16 day shift, 11/20/16 whit shift, 12/5/16 night shift, 12/8/16 evening shift, ift, 12/8/16 evening shift, ift, 12/17/16 evening shift, ift, 12/17/16 evening shift,	F 2	281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495079	B. WING		C 01/06/2017	
	ROVIDER OR SUPPLIER	ORR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	01/00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION	
F 281	10/24/16 night shift, day shift, 11/20/16 of 12/5/16 night shift, evening shift, 12/12 evening shift, 12/23.  Chair alarm check purchashift: 10/16/16 day 10/23/16 day shift, 11/9/16 day shift, 11/9/16 day shift, 11/9/16 day shift; 10/16/16 day 10/23/16 day shift, 10/24/16 night shift, day shift, 11/20/16 of 12/5/16 night shift, day shift, 11/20/16 of 12/5/16 night shift, evening shift, 12/12 evening shift, 12/23.  Encourage non skidday shift: 10/16/16 day 10/23/16 day shift.  Skin prep right foot shift: 10/16/16 day 10/23/16 day shift, 11/20/16 of 12/5/16 night shift, day shift; 11/20/16 of 12/5/16 night shift; day shift; 11/20/16	10/23/16 evening shift, 10/28/16 day shift, 10/29/16 day shift, 12/2/16 night shift, 12/6/16 evening shift, 12/17/16 /16 evening shift, 12/17/16 /16 evening shift  blacement and function ever shift, 10/22/16 day shift, 10/23/16 evening shift, 10/28/16 day shift, 10/29/16 day shift ir (a device to prevent slipping from her chair) every shift, 10/22/16 day shift, 10/23/16 evening shift, 10/23/16 evening shift, 10/28/16 day shift, 10/29/16 day shift, 12/2/16 night shift, 12/6/16 evening shift, 12/8/16 /16 evening shift, 12/17/16	F 28	1		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G	· /	(X3) DATE SURVEY COMPLETED	
		495079	B. WING _		٠,	C 1/06/2017
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 0	1100/2017
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	Resident #16's clinic evidence she was not refused the treatment. Review of the facility Guidelines For The A Medications" include.  "10. Nurse record the on the Medication Acresident refuses the the failure to administ administration record and includes reason.  Guidance for nursing administration of merprovided by "Fundant Edition, Potter-Perry standards, such as the Association's Nursing Nursing Practice (20 medication administrerrors, follow the six medication errors cate an inconsistency in a medication administremedication	on. Additionally, review of al record revealed no of at the facility nor that she its in question.  I's policy entitled "General administration Of decent administration Of decent administration Record. If the medication, he/she indicates iter on the MAR (medication and in the Nurses' Notes "  I standards for the dication and treatments was mentals of Nursing, 7th p. 705: Professional me American Nurses gerscope and Standards of (04) apply to the activity of action. To prevent medication rights of medications. Many in be linked, in some way, to adhering to the six rights of action. The six rights of action include the following: dication include the following: dication."	F 2	81		
	of nursing) were info	d ADON (assistant director rmed of the failure of the nents were documented as				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495079	B. WING _			1	C 06/2017
	ROVIDER OR SUPPLIER	RR		68	TREET ADDRESS, CITY, STATE, ZIP CODE 300 LUCY CORR BLVD HESTERFIELD, VA 23832	1 011	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From page	e 26	F	281			
	1/6/17 at 11 a.m. The expectation was for n medications as ordered document when the n are administered.  4. For Resident #18, ensure treatments we been administered.	ered for Resident #16, e administrator stated the ursing staff to administer ed by the physician and to nedications and treatments  the facility staff failed to ere documented as having  le, was admitted to the					
	facility 8/10/16. Her constipation, unspeci- behavioral disturbance dysphagia, peripheral	liagnoses included fied dementia with es, atrial fibrillation, vascular disease, seizures, ia, hypertension, cerebral					
	set) with an ARD (ass 11/16/16 was coded a She was coded as ha memory deficits and r with making daily life coded as requiring ex	recent MDS (minimum data sessment reference date) of as a quarterly assessment. ving short and long term required total assistance decisions. She was also tensive to total assistance o perform her activities of					
	Review of Resident # no evidence the follow administered:	18's clinical record revealed ving treatments were					
	Dycem to wheelchair, placement: 12/23/16						
		d check placement every ft, 12/23/16 night shift					

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ITIEICATION NI IMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C 01/06/2017	
	ROVIDER OR SUPPLIER	l		6	STREET ADDRESS, CITY, STATE, ZIP CODE 8800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 017	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	shift: 12/3/16 day shift: 12/3/16 day shift: 12/6/16  Apply protective barribilateral buttocks eve 12/23/16 night shift: 12/3/16 day shift: 12/3/1	check placement every ft, 12/23/16 night shift  shin with normal saline, e and cover with dry with paper tape every day  er cream with zinc to ry shift: 12/3/16 day shift,  cement and function every ft, 12/23/16 night shift  acement and function every ft, 12/23/16 night shift  Resident #18's clinical vidence she was not at the ad refused the treatments in risician's order was in place question.  d ADON were informed of to ensure treatment were g been administered for at 11 a.m.  ne facility staff failed to nedications were cumented as having been  ar old female, was admitted 2011 and readmitted on noses included Alzheimer's, yroidism, depression, cognitive communication	F	281			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495079	B. WING		C 01/06/2017
	ROVIDER OR SUPPLIER	ORR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	01/00/2017
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 281	Set) with an ARD (A of 11/23/2016 was cassessment. She had Mental Status) score severe cognitive defassistance of one poliving, and was code of bowel and occasia. A review of the clinical 1/5/2017 at 10:30 Al medications not docadministered on the Acetaminophen Tab tablet oral at bedtimal 1/22/2016 9:00 PM Donepezil 10 mg Tabedtime-11/10/2016 PM, 11/25/2016 9:00 PM Donepezil 10 mg Tabedtime-11/10/2016 PM, 11/25/2016 9:00 PM Melatonin Tablet 3 na 11/10/2016 9:00 PM Magnesium Hydroxiat bedtime 11/10/20 PM, 11/25/2016 9:00 PM Magnesium Hydroxiat bedtime 11/10/20 PM, 11/25/2016 9:00 PM Namenda 10 mg ora 6:00 PM. An interview was co AM with Administrations.	recent MDS (Minimum Data ssessment Reference Date) oded as a 14 day ad a BIMS (Brief Interview of e of 6/15 which indicated ect. She required moderate erson for her activities of daily as being always continent onally incontinent of bladder. cal record was conducted on M and it revealed multiple umented as having been times and dates as follows: let 500 mg (milligram) one e-11/10/2016 9:00 PM, , 11/25/2016 9:00 PM, l. blet one tablet oral at 9:00 PM, 12/6/2016 9:00 PM. Im Tablet 88 mcg olet oral daily-11/17/2016 6:00 D AM, 11/26/2016 6:00 AM,	F 28		

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495079	B. WING				C 06/2017
	ROVIDER OR SUPPLIER	DRR		6	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD CHESTERFIELD, VA 23832		<b>V V V V V V V V V V</b>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	Guidelines for the Ad stated "Nurse records administered on the Mecord. The facility saccurate medication residents." Guidance for nursing administration of med "Fundamentals of Nurses Assand Standards of Nurses Assand Standards of Nurses and Sta	thments are given per charted accordingly. It document, "General ministration of Medications" is the medication Medication Administration staff will provide safe and administration to the standards for the dication is provided by irsing, 7th Edition, Potter and onal standards such as the sociation, Nursing: Scope raing Practice (2004) apply ication administration. To rrors, follow the six rights of ation. Many medication in some way, to an ering to the six rights of ation. The six rights of ation include the following:  ation  entation "PM the administration was	F	281			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495079	B. WING _			C 01/06/2017
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP COD 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		0110012011
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 281	Continued From pag	e 30	F 2	281		
	disease, cognitive de stroke, hypokalemia, Resident #7's most n Set) with an ARD (As of 12/3/2016 was coon She was rated as ha impairment via staff a extensive assistance activities of daily livin incontinent of bowel A review of the clinical 1/4/2017 at 2:15 PM medications and treat having been administated for a set of the staff of the sta	efficit, diabetes, psychosis, and edema.  ecent MDS (Minimum Data issessment Reference Date) ded a quarterly assessment. Ving moderate cognitive assessment. She required of 2+ persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and was always and bladder. The persons for her g and bladder. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
		495079	B. WING_			C <b>01/06/2017</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	ı	01/00/2017
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	daily-10/28/2016 8:0 Zoloft 25 mg oral dai Quetiapine 25 mg ½ daily-10/28/2016 8:0 An interview was cor AM with Administrative who stated that the emedication and treat physician orders and A review of the facilitic Guidelines for the Activated "Nurse record administered on the Record. The facility accurate medication residents." Guidance for nursing physicians' orders was Perry-"Fundamentals 336", which stated "I for directing medical physicians' orders under in error or harm of the finding of the finding of the finding of the finding treatments on severa 2016 through Novem Resident #6 was an admitted to the facility diagnoses included in Neuropathies, Pain, and Gastroesophage.  The Minimum Data States of The Min	10 MEQ (milleqivalant) oral D AM ly-10/28/2016 8:00 AM tablet oral 2x D AM inducted 1/6/2017 at 11:00 on A, Facility Administrator expectation is that all ments are given per charted accordingly. In y document "General liministration of Medications" is the medication Medication Administration staff will provide safe and administration to the practice for following as included in Potter and a of Nursing 7th Edition page the physician is responsible treatment. Nurses follow alless they believe the orders clients." PM the administration was alless they administration was alless they believe the orders clients." PM the administration was alless they believe the orders clients. The facility staff failed to distration of medications and all occasions during August, aber, 2016.  88 year old who was yon 12/10/15. Resident #6's Hereditary and Idiopathic Constipation, Hypothyroidism and Reflux Disease.	F 2	81		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	495079	B. WING_			C 1/06/2017
NAME OF PROVIDER OR SUPPLIER  HEALTH CARE CENTER LUCY CORR			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 0	1/00/2017
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281 Continued From page 32 of 11/25/16, coded Reside Interview of Mental Status severe cognitive impairme On 1/7/17 a review was co #6's clinical record, reveal medications and treatmen documented as having be signed physician orders:  1. Ensure Plus 10 ml by m for prophylaxis 8/6/16 at  2. Fall mat for safety chec 9/6/16 - 9/9/16 at evening  3. Levothroid Tablet 50 M0 once daily 11/17/16 and for Hypothyroidism  Resident #6's care plan re for falls related to confusio problems, history of fall. A as ordered."  8. For Resident #19, the fa document the administrat treatments on several occ 2016 through November, 3 Resident #19 was an 81 y admitted to the facility on diagnoses included Osteo with pain, Major Depressiv Unspecified.	score of 5, indicating nt.  Inducted of Resident ing the following its that were not en administered per south three times daily 9 P.M.  It placement every shift shift.  Inducted of Resident ing the following its that were not en administered per south three times daily 9 P.M.  It placement every shift shift.  Inducted of Resident en administer daily 9 P.M.  Inducted of Resident end ing the following its mouth end inguity 9 P.M.  Inducted of Resident end inguity 9 P.M.  Inducted of R	F 2	81		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495079	B. WING			C 01/06/2017	
	ROVIDER OR SUPPLIER	PRR		6	STREET ADDRESS, CITY, STATE, ZIP CODE 1800 LUCY CORR BLVD CHESTERFIELD, VA 23832		0.2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	signed physician order.  1. Clonidine HCI Tabl by mouth three times Depressive Disorder.  12/23/16 a 2:00 P.M.  2. Gabapentin Capsulat bedtime for neurop P.M.  Resident #19's care predication therapy rehas diagnosis of oste Aortic Aneurysm with medications as order.  On 1/7/17 a review with documentation, reveator the Administration 2014. It read, "Nurse administered on the Necord (MAR). If the medication, he/she in administer on the MA and includes reason."  On 1/6/17 at 11:20 A. the Administrator (Ad of the findings. The Aabout the facility's expected to be administrator stated to the medication to be a significant to the signific	ing the following tments that were not g been administered per ers:  et 0.3 mg. Give 1 tablet daily a day related to Major 12/22/16 at 9:00 P.M.  le. Give 200 mg. by mouth eathy pain. 12/22/16 at 9:00  clan read, "8/9/16. Pain elated to disease process coarthritis with joint pains and pain. Administer ed."  as conducted of facility eling the General Guidelines of Medications dated June records the medication Medication Administration resident refuses the dicates the failure to R and in the Nurse's Notes  M. in the conference room ministration A) was notified dministrator was asked	F	281			

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495079	B. WING				C 06/2017
	ROVIDER OR SUPPLIER	PRR	•	68	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 281	Continued From page should document it or with the physician for	n the MAR and follow-up	F	281			
F 309 SS=D	COMPLAINT DEFICI PROVIDE CARE/SEF WELL BEING CFR(s): 483.24, 483.	RVICES FOR HIGHEST	F	309			2/7/17
	applies to all care and residents. Each residents facility must provide the services to attain or in practicable physical, well-being, consistent	mental, and psychosocial					
	applies to all treatment facility residents. Bas assessment of a resident residents receive accordance with profesoractice, the comprehense	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered sidents' choices, including					
	provided to residents consistent with profes	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan, als and preferences.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED
		495079	B. WING			C <b>01/06/2017</b>
	ROVIDER OR SUPPLIER	PRR	•	STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		I SHOULD BE	(X5) COMPLETION DATE
F 309	services, consistent of practice, the comp care plan, and the respreserences.  This REQUIREMENT by:  Based on observation documentation review in the course of a confacility staff failed to pachieve the highest presidents (#7, #18, #18, #18) sample of 31 resident 1. For Resident #7, the obtain blood glucose if needed per physicia 2. For Resident #18, administer Keppra (aphysician's order.  3. For Resident #14, ensure the medication were administered as 4. For Resident # 28, remove the PICC line course of antibiotics of the Physician.  Findings included:  1. For Resident #7, the course of Resident #7, the course Resident Re	e dialysis receive such with professional standards rehensive person-centered sidents' goals and  is not met as evidenced on, staff interview, facility on, clinical record review, and implaint investigation the provide care and services to possible well-being for 4 and #28) in a survey its.  The facility staff failed to levels and administer insuling an's order.  The facility staff failed to seizure medication) per  The facility staff failed to ins Lisinopril and Norvasc is ordered by the physician.  The facility staff failed to ins after completion of a con 11/25/2015 as ordered by the levels and administer insuling	F 3	DEFICIENCY)	responsible ve been cumentation vels and the cility Incident oleted for responsible ave been cumentation ent and apleted for responsible ave been cumentation ent and apleted for responsible ave been cumentation	
	Resident #7, a 90 year to the facility on 8/26/included dementia, disease, cognitive de stroke, hypokalemia a Resident #7's most re Set) with an ARD (As	ar old female, was admitted /2016. Her diagnoses epression, coronary artery ficit, diabetes, psychosis,		incident.  Resident #28 is no longer a refacility. The PICC had been on December 2, 2015.	esident in the	

OLIVILIV	O T OIT MEDIO, TILE &	WILDIO/ WID CLITTIOLO				<del></del>	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495079	B. WING				06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
	A DE OENTED I 110V 00	NDD.	6800 LUCY CORR BLVD		800 LUCY CORR BLVD		
HEALIH	CARE CENTER LUCY CO	JRK		С	HESTERFIELD, VA 23832		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 309	Continued From page	e 36	F	309			
	· ·	ving moderate cognitive	'	000	Identification of Deficient Practice &		
		issessment. She required			Corrective Action(s):		
	extensive assistance				All other residents receiving insulin and	•	
	activities of daily living	•			have physician orders to obtain blood		
	incontinent of bowel a	-			glucose levels may have been potentia	lly	
	A review of the clinical	al record was conducted on			affected. All other residents receiving	-	
	1/4/2017 at 2:15 PM	revealed a physician order			medications may have been potentially	,	
	dated 9/24/2016 stati	•			affected. All other residents who have a	а	
	` •	glucose checks) AC (before			PICC line may have been potentially		
	meals) and QHS (at bedtime). Notify MD if blood				affected. The DON and/or designee wil		
		ucose < (less than) 60 or > (greater than) 350" lilligrams per deciliter).			do a 100% review all resident medicati		
		er). (Medication Administration			and treatment records to ensure all ord are transcribed correctly and medication		
		2016 revealed multiple			and treatment supplies are available.	113	
		od glucose checks were not			Any/all negative findings will be		
		der on the following dates			communicated to the DON for corrective	⁄e	
	and times:	ŭ			action.		
	10/15/2016 9:00 PM,	10/16/2016 11:00 AM,					
	10/28/2016 7:30 AM,	10/28/2016 11:00 AM			Systemic Change(s):		
		ducted 1/6/2016 at 11:00			The facility Policy and Procedure has		
		on A, Facility Administrator			been reviewed. No revisions are		
	who stated that the e				warranted at this time. Licensed Nursin		
	medication and treatr	- ·			staff will be educated by the DON and/		
	physician orders and A review of the facility	- ·			designee on the policy and procedure following physician orders including ob		
		ministration of Medications"			blood glucose levels, proper	laiii	
	stated "Nurse records				administration and delivery of medication	ons	
		Medication Administration			and treatments and discontinuing PICC		
		staff will provide safe and			lines.		
	accurate medication					ĺ	
	residents."						
	Guidance for nursing				Monitoring:		
		s included in Potter and			The DON is responsible for maintaining	-	
	_	of Nursing 7th Edition page			compliance. The QA Program includes		
		e physician is responsible for			audit tool for monitoring compliance. The	те	
		tment. Nurses follow			DON and/or designee will conduct	ĺ	
		less they believe the orders			random weekly medication pass and		
	are in error or harm o				treatment observations audits to monito		
	On 1/6/2017 at 3:00 f	PM the administration was			compliance. Any/all negative findings w	/111	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C <b>01/06/2017</b>	
	ROVIDER OR SUPPLIER	ORR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	ensure Keppra (a se administered per phy administered per phy Resident #18, a fem facility 8/10/16. Her constipation, unspect behavioral disturband dysphagia, periphera anemia, hyperlipider infarction, and celiace Resident #18's most set) with an ARD (as 11/16/16 was coded She was coded as homeory deficits and with making daily life coded as requiring e of one staff member daily living. Resident obehaviors including the look back.  Resident #18 was of She was sitting in her oom. A personal all of her wheelchair. So dressed.  Review of Resident: an entry in the eMAF and nursing notes the 500 mg (milligram) 1 seizures" was not ac p.m. A "9" was entereferred the reader to the resident to the second of the seco	ngs. In the facility staff failed to eizure medication) was sysician's order.  ale, was admitted to the diagnoses included eified dementia with ces, atrial fibrillation, al vascular disease, seizures, mia, hypertension, cerebral eidisease.  Trecent MDS (minimum data esessment reference date) of as a quarterly assessment, aving short and long term required total assistance eidecisions. She was also extensive to total assistance to perform her activities of at #18 was coded as having ang self injurious behaviors	F 30	be corrected immediately and disciplinary action will be take necessary. Aggregate findings audits will be provided to the C Assurance Committee for revi analysis, and recommendation change in facility policy, procespractice.  Completion Date: February 7	n as s of these Quality ew, ns for dure, and/or		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495079	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	, CODE	01/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	
F 309	indicated Keppra 500 administration. A vale vident for Keppra 500 Resident #18 twice of Keppra is a medication disorder. Keppra was Levetiracetam. Guid of Keppra/Levetiracetam is use medications to treat of adults and children wis in a class of medicanticonvulsants. It we excitement in the brash How should this medications to treat (long-acting) tablet, a suspension (a tablet mouth. The solution, and tablet for suspension (a tablet mouth. The solution, and tablet for suspension (a tablet mouth. The solution, and tablet for suspension (a tablet mouth). The solution, and tablet for suspension (a tablet mouth) aday, once in the moor without food. The usually taken once do to take levetiracetam every day. Follow the prescription label carpharmacist to explain understand. Take levedirected. Do not take more often than pressure the prescription of the suspension of the prescription of take more often than pressure the prescription of the suspension of the prescription of the prescription of the prescription of take more often than pressure the prescription of the prescription of take more often than pressure the prescription of the pr	try in the nursing notes of mg was not available for id physician's order was of mg to be administered to aily. on utilized to treat seizure s the brand name for ance for the administration tam was provided at v: ed in combination with other certain types of seizures in vith epilepsy. Levetiracetam ations called orks by decreasing abnormal in. licine be used? as a solution (liquid), an ablet, an extended-release and as a tablet for to take with liquid) to take by immediate-release tablet, asion are usually taken twice orning and once at night, with extended-release tablets are aily with or without food. Try at around the same time(s)	F	309		
	well. Do not stop taki talking to your doctor effects such as unus	ng levetiracetam without , even if you experience side ual changes in behavior or y stop taking levetiracetam,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495079	B. WING		0	C 1/06/2017	
	ROVIDER OR SUPPLIER	PRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 309	will probably decreas Review of the emerge at the facility revealed was available for the When interviewed, th at 4:55 p.m. Keppra/I in the emergency sup was unaware of why the medication 12/18 The administrator and of nursing) were infor staff to administer Ke #18 on 12/18/16 at 5 3. For Resident # 14 ensure the medicatio were administered as  Resident #14, a female facility 6/23/16. Her on to limited to: Diabete Stenosis, Hypothyroid Seborrheic Dermatitis Atherosclerotic Heart  Resident #14's most set) with an ARD (ass 7/10/16 was coded at Resident #14 was co short term memory de her own daily life dec also coded as needin assistance of one sta activities of daily livin  Review of Resident #	ecome worse. Your doctor e your dose gradually." ency supply of medications d that Levetiracetam 500 mg staff to administer. e administrator stated 1/5/16 Levetiracetam was available oply of medications and she the staff did not administer /16 at 5 p.m. d ADON (assistant director med of the failure of the ppra 500 mg to Resident p.m., 1/6/17 , the facility staff failed to ns Lisinopril and Norvasc ordered by the physician.  alle, was admitted to the diagnoses included but were es, Hypertension, Spinal dism, Dry Eye Syndrome, s, Arthopathy and Disease.  recent MDS (minimum data sessment reference date) of a Quarterly assessment. ded as having no long and eficits and was able to make disions. Resident #14 was g supervision to total ff members to perform her g. e16's clinical record revealed wing medications were	F 30				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				OMPLETED
		495079	B. WING			C 01/06/2017
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	<b>'</b>	01/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	Continued From pag Review of the Octob		F 30	09		
	Administration Record documentation of the initials for two medical Lisinopril 20 milligrar one time a day for Hy 9 AM and 10/31/2016	rd (MAR) revealed e number 9 and a nurse's ations: ns give 1 tablet by mouth ypertension on 10/27/2016 at 6 at 9 AM				
	Norvasc 5 milligrams 1 tablet by mouth daily for hypertension:on 10/27/2016 at 9 AM and 10/31/2016 at 9 AM					
	the number 9= Other Review of the Progred documentation of "T	ype: Orders-Administration Available. 10/27/2016 at				
	Box (Emergency Druwere available in the given. Among the me	ations available in the STAT ugs) revealed the medications facility but still were not edications available in the nopril 10 milligrams and ums.				
	facility Administrator	y debriefing on 1/5/2017, the stated the facility used sional Nursing Guidance.				
	305 read: "Nurses fo orders unless they be or harm patients. Th all orders; if you find	rsing, Eighth Edition, page Illow health care providers' elieve the orders are in error herefore you need to assess one to be erroneous or fication from the health care				

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495079	B. WING		C 01/06/2017		
	ROVIDER OR SUPPLIER	CORR		STREET ADDRESS, CITY, STATE, ZIP CODE 8800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 01100/2011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 309	remove the PICC lir course of antibiotics the Physician.  Resident # 28 was a originally on 11/11/2 4/16/2015, 11/18/20 diagnoses to include Alzheimer's Disease Fibrillation, Kidney I Heart Failure, Urina Pain.  The most recent Mi Significant Change Assessment Refere 12/29/2015. The M moderate cognitive required extensive to staff persons with Resident # 28 was a bowel and an indiventance.	B, the facility staff failed to the after completion of a son 11/25/2015 as ordered by admitted to the facility 2014 and readmitted on 2015 and 12/22/2015 with the but not limited to: 2015 e., Dementia, Glaucoma, Atrial Failure, Hypertension, Anxiety, rry Retention, Bacteremia and 2015 minum Data Set (MDS) was a Assessment with an	F 309				
	Review of the Hosp 11/18/2015 revealed line after antibiotic of Review of the Infect Antibiotic Orders sh for Indication: Urose The orders were fo "Pull PICC Line at the and "May send paties"	ital Discharge Note dated dorders to "remove the PICC completed 11/25."  cious Disease Outpatient owed orders for the PICC line epsis Proteus Bacteremia.  r 2. weekly labs; 7. PICC line: ne end of IV antibiotic course" ent to Interventional Radiology r replacement as needed".					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495079	B. WING _				C / <b>06/2017</b>	
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832			00/2017	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
F 309	There were 4 options physician regarding to two options not chec pull PICC line at end through:  "Send patient to Interemoval at end of conform Under Antibiotic gram IV (intravenous 11/25/2015."  Review of the Admission to the facility on 11/1 handwritten on a Phy 11/18/15-11/30/15. Ohandwritten medicati the second box readmilliliters of normal soline, Stop date 11/25 of page 3, the area we (Intravenous) ABT (Adiagnosis of Uroseps	s for orders from the the PICC line. There were ked: one option was "Do not of therapy and maintain." The other option was reventional Radiology for line urse." On the bottom of the s was written "Cefepime 1 sly) every 8 hours through sion orders for Readmission 8/2015 revealed orders visician's order sheet for on Page 2 under the list of ons, the medication order in Cefepime 1 gram in 100 caline every 8 hours via PICC via Control of the right hand side via checked for IV antibiotic Therapy) for sis with a stop date of dmission orders were signed	FS	809				
	conducted with the fact A) who stated the fact discontinue the PICC physician but also be being followed by Inffacility wanted to be by Infectious Disease line. The Administrative removed on 12/2/2010 cleared.	AM, an interview was acility Administrator (Administrator (Administrator) (Adm						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		495079	B. WING			C 01/06/2017
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE 6800 LUCY CORR BLVD CHESTERFIELD, VA 2383		1 01/06/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI' CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BI ED TO THE APPROPRIA FICIENCY)	
F 309	an order to remove the was the nurse who re Administrator (Admin Nursing of the facility was in the facility. At Admin A presented a dated 12/2/2015 at 4 "Residents PICC line without difficulty." Ac of the orders from Inf which ordered to "Pu antibiotic course" and Interventional Radiolor replacement as need written "Cefepime 1 of 8 hours through 11/2.  During the end of day facility Administrator, and Chief Executive findings.  Guidance given from Fundamentals of Nur 305 read: "Nurses fol orders unless they be or harm patients. The all orders; if you find harmful, further clarific provider is necessary No further information.  Review of the Hospita 11/18/2015 revealed line after antibiotic con Review of the Infection.	was positive that there was the PICC line because she amoved the PICC line. The A) was the Director of at the time Resident # 28 approximately 1:45 PM, copy of the Nurses Note 10 PM which stated discontinued by writer almin A also presented a copy ectious Disease physicians II PIC Line at the end of IV II may send patient to bogy for line evaluation or ed". Under Antibiotics was gram IV (intravenously) every 5/2015."  If debriefing on 1/6/2017, the Acting Director of Nursing Officer were informed of the Potter and Perry, sing, Eighth Edition, page low health care providers' elieve the orders are in error erefore you need to assess one to be erroneous or cation from the health care of the provided of the III care in was provided.  In was provided.	F3	309		

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495079	B. WING				06/ <b>2017</b>
	ROVIDER OR SUPPLIER	DRR	•	68	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD HESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	The orders were for "Pull PICC Line at the and "May send patier for line evaluation or There were 4 options physician regarding to two options not check pull PICC line at end through:	asis Proteus Bacteremia.  2. weekly labs; 7. PICC line: e end of IV antibiotic course" int to Interventional Radiology replacement as needed". If or orders from the the PICC line. There were ked: one option was "Do not of therapy and maintain Interventional Radiology for line arse. Is written "Cefepime 1 gram tery 8 hours through  AM, an interview was acility Administrator (Adminisity had an order to line by the attending cause the resident was tectious Disease doctors, the sure the resident was cleared to before removing the PICC or stated the PICC line was for after the resident was for the resident was the PICC line because she the picc line because she the picc line because she the picc line Resident # 28 approximately 1:45 PM, copy of the Nurses Note	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		l .	C
		495079	B. WING			01/	06/2017
	ROVIDER OR SUPPLIER	PRR		68	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	which ordered to "Pul antibiotic course" and Interventional Radiolo replacement as need	ectious Disease physicians II PICC Line at the end of IV I "May send patient to ogy for line evaluation or ed". Under Antibiotics was gram IV (intravenously) every	F	309			
F 323 SS=D	COMPLAINT DEFICI FREE OF ACCIDENT HAZARDS/SUPERVI CFR(s): 483.25(d)(1)(d) Accidents.	「 SION/DEVICES	F	323			2/7/17
	from accident hazard  (2) Each resident recorded assistance device  (n) - Bed Rails. The fappropriate alternative bed rail. If a bed or semust ensure correct is maintenance of bed resident and the seminary of the seminary	ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents.  facility must attempt to use es prior to installing a side or ide rail is used, the facility nstallation, use, and ails, including but not limited					
	from bed rails prior to (2) Review the risks a	nt for risk of entrapment installation.  and benefits of bed rails with nt representative and obtain or to installation.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C 01/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		1700/2011	
				6800 LUCY CORR BLVD			
HEALTH C	CARE CENTER LUCY CO	ORR		CHESTERFIELD, VA 23832			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 323	Continued From page	e 46	F 32	23			
	This REQUIREMENT by:	sident's size and weight.  is not met as evidenced  on, staff interview and clinical		F323			
		cility staff failed to ensure a		Corrective Action(s):			
		1 resident (Resident #15) of		The caddy was removed from	the hedside		
	31 residents in the su	,		of Resident # 15. The attendi			
				and responsible party for Res			
	For Resident #15 the	facility staff failed to remove		were notified of the incident.			
	a caddy containing la	incets and a sharps		was completed of the facility	to ensure a		
	container from the be	edside table and failed to		safe environment.			
	ensure a chair alarm	was applied to the wheel					
	chair.			The attending physician and			
				party for Resident # 15 were			
	The findings included	<b>!</b> :		she did not have a chair alarr	n in place.		
		ear old, was admitted to the		Identification of Deficient Practice	ctice &		
		Her diagnoses included		Corrective Action(s):			
		dementia, dysphagia,		All residents have been poter			
		ed lipids and osteoporosis.		affected by an unsafe enviror 100% audit was completed of	f the facility		
		mum Data Set assessment		to ensure a safe environment	••		
		sment with an assessment					
		1/16. She was coded with a		All residents who utilize a bed			
	severe cognitive impa	•		chair alarm as a fall interventi	•		
	extensive assistance	with activities of daily living.		been potentially affected. The			
	A) Langota/ sharps or	ontainer		designee will do a 100% revier residents who utilize a bed ar			
	A) Lancets/ sharps co	ontainei		alarm as a fall intervention to			
	During the initial tour	of the facility on 1/4/17 at		orders are transcribed correct			
	_	stic caddy containing a		supplies are available. Any/al	•		
		ed lancets in a cup and a		findings will be communicated			
		er containing used lancets		for corrective action.			
		bserved on Resident #15's					
		sidents were in the room at					
		e no residents or staff in the		Systemic Change(s):			
	vicinity of the room.			The facility Policy and Proced	lure has		
				been reviewed. No revisions	are		
	Shortly after the obse	ervation, the Administrator		warranted at this time. The D	ON and/or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495079	B. WING _				C 06/2017	
	ROVIDER OR SUPPLIER	PRR		68	TREET ADDRESS, CITY, STATE, ZIP CODE 300 LUCY CORR BLVD HESTERFIELD, VA 23832	1 017	00/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	observe the caddy on Administrator stated to in the room. She remarkable.  B) Chair alarm  Resident #15 had a harcent fall on 12/31/10 care, a bed alarm was #15 was in bed and a when she was in the second fall on the second fall on the second fall on the second fall on the second fall of the secon	the unit and was asked to a the bedside table. The shat the caddy should not be noved it from the bedside  distory of falls, with her most 6. According to the plan of so to be used when Resident a chair alarm was to be used wheel chair.  Served on 1/5/17 at 8:40 do in her wheel chair at a som waiting for breakfast. Harm attached to the wheel chair, Licensed Practical Nurse ager, was asked to identify sident 15's bed. There was at this time. LPN D stated ttached to the wheel chair.	F	323	designee will educate all staff on Safety hazards in resident care areas includin safe handling of supply caddies. The Dand/or designee will educate the Nursin staff on the use of fall interventions.  Monitoring: The DON is responsible for maintaining compliance. The QA Program includes audit tool for monitoring compliance. The DON and/or designee will complete QA Audit- Safety hazards and QA Audit- Fainterventions weekly for twelve weeks the monitor for compliance. Any/all negative findings will be corrected immediately a reported to the DON for corrective action and appropriate disciplinary action. Aggregate findings of these audits will provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.  Completion Date: February 7, 2017	g ON ng ne A all ove and on be		
		errad flot been attached. ere attaching the monitor						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495079	B. WING		C 01/06/2017	
	ROVIDER OR SUPPLIER	RR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 323			F 323	3		
F 333 SS=D	without a chair alarm. caddy containing land was observed on the	It was also reviewed that a cets and a sharps container bedside table.  OF SIGNIFICANT MED	F 333	3	2/7/17	
	by: Based on observation record review the factoresident (Resident #1 survey sample was fromedication error.  For Resident #10 the administer Coumading The findings included Resident #10, a 93 ye facility on 3/1/16. He dementia, anxiety, dia and hypothyroidism.  Resident #10's most assessment was a 5	ee of any significant  is not met as evidenced  n, staff interview and clinical lity staff failed to ensure 1 0) of 31 residents in the ee from a significant  facility staff failed to (blood thinner) on 1/3/17.		F333 Corrective Action(s): The attending physician and responsib parties for Residents□ # 10 have been notified of the omission of documentati for medication administration. A facility Incident and Accident report form was completed for these incidents.  Identification of Deficient Practice & Corrective Action(s): All other residents receiving medication may have been potentially affected. The DON and/or designee will do a 100% review all resident medication and treatment records to ensure all orders transcribed correctly and medications at treatment supplies are available. Any/or	on ns ne are and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495079	B. WING _			01/0	) 06/2017	
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP CO 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	ODE			
(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 (  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO TION  DEFICIENCY	ION SHOULD BE HE APPROPRIAT		(X5) COMPLETION DATE	
F 333	score of 8 indicating impairment. She rec with activities of daily Resident #10 was di thrombosis (blood clitherapy was initiated A telephone order readministration dated clinical record. The normalized ratio) (1/2 per day) 80/0.8 ml (r Coumadin Tues + W 1/04. Recheck INR T According to the Jan Administration Recondinistered on 1/3/with the Administrator pr "Medication Error Remissed Coumadin act as a medication error documented the data report read "Coumadin act as a medication error documented the data report read "Coumadin act as a medication error documented the data report read "Coumadin act as a medication error documented the data report read "Coumadin act as a medication error documented the data report read "Coumadin act as a medication error documented the data report read "Coumadin act as a medication error documented the data report read "Coumadin act as a medication error documented the data report read "Coumadin and a new Coumadin The following informations accessed on 1/2 website https://www."Coumadin (warfarin thinner). Warfarin red	terview of Mental Status moderate cognitive quired extensive assistance vilving.  agnosed with a deep vein obty on 12/16/16. Coumadin by the physician.  garding Coumadin 1/3/17 was included in the order read "INR (international 2/17) Lovenox BID (two times nilliliter) injection and ed 3.0 mg (milligram) 1/03, Thurs 1/05."  uary 2017 Medication red (MAR), Coumadin was not 17. The issue was reviewed or covided a copy of a eport" and stated that the diministration was written up	F3	negative findings will be corthe DON for corrective actions.  Systemic Change(s): The facility Policy and Procedure reviewed. No revisions warranted at this time. Licer staff will be educated by the designee on the policy and the proper administration are medications and treatments.  Monitoring: The DON is responsible for compliance. The QA Program audit tool for monitoring component of the proper administration and treatment observations and compliance. Any/all negative be corrected immediately and disciplinary action will be tall necessary. Aggregate finding audits will be provided to the Assurance Committee for reanalysis, and recommendate change in facility policy, propractice.  Completion Date: February	edure has as are nsed Nursing DON and/o procedure for nd delivery or s.  maintaining am includes ampliance. The conduct pass and lits to monitor findings wind appropriation as a ngs of these to Quality eview, tions for ocedure, and	g or or of e e r ill ate		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495079	B. WING		C <b>01/06/2017</b>	
	ROVIDER OR SUPPLIER	RR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	31100/2011	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 354 SS=F	risk of stroke, heart at conditions." "Take Coumadin exact doctor. Follow all dire label. Your doctor ma dose to make sure yo not take Coumadin in or for longer than you Coumadin at the sam take a double dose of The Coumadin medic with the Administrator the end of day meetin COMPLAINT DEFICH WAIVER-RN 8 HRS 7 DON CFR(s): 483.35(b)(1)-(1) Except when waiv (f) of this section, the services of a registered consecutive hours a consecutive hours a consecutive hours a consecutive for the services of a registered consecutive hours a consecutive hours a consecutive hours and the registered nurse to senursing on a full time (3) The director of nurnurse only when the foccupancy of 60 or fereigned and the conditions of the conditions	es, which can reduce the tack, or other serious  It yas prescribed by your ctions on your prescription y occasionally change your u get the best results. Do larger or smaller amounts reductor tells you to. Take the time every day. Never this medicine."  ation error was reviewed and Director of Nursing at g on 1/6/17.  ENCY  DAYS/WK, FULL-TIME  (3)  ed under paragraph (e) or facility must use the ed nurse for at least 8 day, 7 days a week.  ed under paragraph (e) or facility must designate a erve as the director of basis.  Tring may serve as a charge acility has an average daily wer residents.  It is not met as evidenced	F 354		2/7/17	
	documentation review	v the facility staff failed to N (director of nursing) was		Corrective Action(s): Tyler Harrell, RN, BSN was designated	as	

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C 01/06/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	•	01/00/2017	
				6800 LUCY CORR BLVD			
HEALTH C	CARE CENTER LUCY CO	DRR		CHESTERFIELD, VA 23832			
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F 354	Continued From page	e 51	F 35	54			
	functioning at the fac	ility.		the Director of Nursing on De	ecember 2,		
		s also functioning as a unit ON (assistant director of		2016. On January 23, 2017, Moody LPN was named intermanager for the Clover Hill ustaff/residents were given not this change.	im Unit nit and		
	12 noon, the current ADM C was functioni ADM A stated she (A and sometime during had become the intel SA (state agency) ha	entry to the facility 1/4/17 at approximately on, the current administrator, ADM A stated C was functioning as the interim DON. A stated she (ADM C) had been the DON ometime during December 2016, ADM C ecome the interim DON. ADM A stated the ate agency) had been informed and the was currently recruiting for the position.		Identification of Deficient Pra Corrective Action(s): All residents could have beer affected. Active recruitment fo of Nursing is proceeding. Upo DON status will be communic resident council and staff as o occur.	n potentially or a Director dates for cated to the		
	ADM C was still function and unit manager for ADM C was interview ADM C stated she had DON during Decemb was still functioning a also the Clover Hill u she had been the unityears. ADM C stated manager for Clover H was a separate unit runits and the as work that.  ADM C stated she had duties" with ADM A (to	s worked staffing revealed tioning as the facility ADON the Clover Hill unit.  yed 1/5/17 at 10:28 a.m. ad been appointed interim er, 2016. ADM C stated she as the facility's ADON and nit manager. ADM C stated it manager for a number of d there was no other unit dill unit. She stated there manager for all of the other c daily staffing confirmed  ad "split some of the DON he facility administrator).		Systemic Change(s): The facility Policy and Proced been reviewed. No revisions warranted at this time. Effect immediately an Interim unit Manager/ADON has been de oversee the Clover Hill neigh Staff have been provided a wof the change.  Monitoring: The DON is responsible for no compliance. Aggregate finding audits will be provided to the Assurance Committee for revanalysis, and recommendation change in facility policy, procepractice.  Completion Date: February	are ive esignated to borhood. rritten notice naintaining ags of these Quality riew, ons for edure, and/or		
	1/5/17 at 11:10 p.m.	visor (RN J) was interviewed RN J stated she had been lity for approximately three		Completion Date: February	7, 2017		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY
		495079	B. WING			C 06/2017
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	<u> </u>	06/2017
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 354	J stated she would conthere was any allegat mistreatment as part policy. RN J stated s (the administrator) as ADM A was functioning administrator. RN J stated s (the administrator. RN J stated should be administrator. RN J stated sho	ontact the facility DON if ion of abuse, neglect, or of implementing the abuse he would contact ADM A her understanding was that ag as the DON and stated ADM C was the unit ill and functioned as the er for the 500 rooms was 10:52 a.m. LPN D stated dministrator." ADM C was the interim DON. Dought ADM C misspoke ated she was the interim t manager. ADM A stated ion was to coordinate and intire facility. ADM A stated ing that duty by also being	F 35	54		
F 367 SS=D	were informed of the ensure a full time DO	failure of the facility to N was in place and me DON, 1/6/17 at 11 a.m. PRESCRIBED BY	F 36	67		2/7/17
	(e) Therapeutic Diets (e)(1) Therapeutic die the attending physicia	ets must be prescribed by an.				

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		IPLETED
	495079	B. WING			
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	onsible been entation er cups. A ort form s.  **A	1/06/2017
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
Continued From pag	e 53	F 36	57		
registered or licensed prescribing a resident therapeutic diet, to the law.  This REQUIREMENT by: Based on observation record review, the factone Resident (Resident of 31 Residents, recent therapeutic diet.  Resident #16 was not butter cups" as a weiter	d dietitian the task of t's diet, including a e extent allowed by State  is not met as evidenced on, staff interview, and clinical cility staff failed to ensure ent #16) in a survey sample eived a physician ordered  t administered "peanut ght gain supplement per		parties for Residents□ # 16 have notified of the omission of docum for administration of Peanut Butte facility Incident and Accident repo	been entation er cups. A ort form	
Resident #16, a femathe facility 3/15/05. It vascular dementia, v fracture, Bell's palsy, Parkinson's disease, dysphagia, and hype Resident #16's most set) with an ARD (as 10/18/16 was coded She was coded as hamemory deficits and with making daily life was coded as needing one staff member to living with the except was coded as needing Resident #16 was coded.	ale, was initially admitted to der diagnoses included ertebral compression dysthrymic disorder, arthropathy, osteoporosis, rtension.  recent MDS (minimum data sessment reference date) of as a quarterly assessment. aving short and long term required total assistance decisions. Resident #16 ag extensive assistance of perform her activities of daily ion of eating. For eating she ig setup assistance only, ded as being 63 inches tall		Corrective Action(s): All other residents receiving dieta supplements may have been pote affected. The DON and/or design do a 100% review all resident me and treatment records to ensure a for dietary supplements are trans correctly and dietary supplements available. Any/all negative finding communicated to the DON for coaction.  Systemic Change(s): The facility Policy and Procedure been reviewed. No revisions are warranted at this time. Licensed I staff will be educated by the DON designee on the policy and proce the proper administration and delivered.	entially ee will edication all orders cribed s are gs will be rrective  has  Nursing I and/or dure for	
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENCY REGULATORY OR  Continued From page  (e)(2) The attending registered or licensed prescribing a residen therapeutic diet, to the law.  This REQUIREMENT by: Based on observation record review, the fact one Resident (Reside of 31 Residents, recent therapeutic diet.  Resident #16 was not butter cups" as a weit physician's orders as  The findings included Resident #16, a femat the facility 3/15/05. In vascular dementia, we fracture, Bell's palsy, Parkinson's disease, dysphagia, and hype  Resident #16's most set) with an ARD (assident #16's most set) with the scoded as needing was coded as needing one staff member to living with the except was coded as needing Resident #16 was coded Resident #16 was coded as needing Resident #16 was coded Resident #	A95079  ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 53  (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, and clinical record review, the facility staff failed to ensure one Resident (Resident #16) in a survey sample of 31 Residents, received a physician ordered	A BUILDING  495079  ROVIDER OR SUPPLIER  CARE CENTER LUCY CORR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 53  F 36  (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, and clinical record review, the facility staff failed to ensure one Resident (Resident #16) in a survey sample of 31 Residents, received a physician ordered therapeutic diet.  Resident #16 was not administered "peanut butter cups" as a weight gain supplement per physician's orders as they were "not available."  The findings included:  Resident #16, a female, was initially admitted to the facility 3/15/05. Her diagnoses included vascular dementia, vertebral compression fracture, Bell's palsy, dysthrymic disorder, Parkinson's disease, arthropathy, osteoporosis, dysphagia, and hypertension.  Resident #16's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/18/16 was coded as a quarterly assessment. She was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #16 was coded as needing extensive assistance of one staff member to perform her activities of daily living with the exception of eating. For eating she was coded as needing setup assistance only. Resident #16 was coded as being 63 inches tall	ROVIDER OR SUPPLIER  CARE CENTER LUCY CORR  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHE (EACH C	A BUILDING  A STREET ADDRESS, CITY, STATE, ZP CODE  SOD LUCY CORR BLVD  CHASTER FIELD, VA 23832  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MUST SE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 53  Continued From page 53  Continued From page 53  F 367  Continued Fr

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C 01/06/2017	
	ROVIDER OR SUPPLIER	) PRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		01/00/2017	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 367	she had experienced interdisciplinary team developed a plan to getwice daily as a nutrit physician's order for 'daily for supplement"  An accompanying er (electronic medication Nurses' initials were electronic medication Nurses' initials were electronic of 10/29/16 p.m. and 1/2/16 at 8 are MAR indicating the administered and references and references were not administered and references were not administration to Respeanut butter cups. The cupunits, labeled with the administrator stated speanut butter cups were not administrator to Respense.  Documentation was ended experienced a slettle peanut butter cup.	216's clinical record revealed some weight loss and the , including the dietitian give her peanut butter cups ional supplement. A signed '1 peanut butter cup twice was obtained on 5/12/16.  Atry was placed on the eMAR in administration record). Evident that the peanut buttered twice daily with the states peanut butter cup was not erred the reader to the iffication. Documentation in icated the peanut butter stered as they were "not experienced as they were "not be Resident's name. The she did not know how the ere not available for ident #16, 1/5/16 at 4:55  Evident that Resident #16 ow steady weight gain since is were administered.  It ADON were informed of to ensure physician ordered	F 36	Monitoring: The DON is responsible for mai compliance. The QA Program in audit tool for monitoring compliad DON and/or designee will conditate random weekly medication pass treatment and to verify the suppare available audits to monitor compliance. Any/all negative finds the corrected immediately and addisciplinary action will be taken necessary. Aggregate findings audits will be provided to the Quantity and recommendations change in facility policy, proced practice.  Completion Date: February 7,	ncludes ance. The uct s and blements adings will appropriate as of these uality w, s for lure, and/or		

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495079	B. WING				C <b>06/2017</b>
NAME OF PI	ROVIDER OR SUPPLIER	100010	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	06/2017
HEALTH C	CARE CENTER LUCY CO	PRR			800 LUCY CORR BLVD HESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 367 F 386 SS=D	PHYSICIAN VISITS - CARE/NOTES/ORDE CFR(s): 483.30(b)(1):  (b) Physician Visits The physician must (1) Review the reside including medications visit required by parage (2) Write, sign, and divisit; and  (3) Sign and date all dinfluenza and pneumobe administered per policy after an assess This REQUIREMENT by:  Based on staff interview the facility staff (Residents# 23 and 2 survey sample to ensuand dated orders at each staff in the control of the contr	ident #16, 1/6/17 at 11 a.m. REVIEW ERS -(3)  Int's total program of care, and treatments, at each graph (c) of this section; Interpretation of the exception of		386	F 386 Corrective Action(s): The Attending physicians for Resident and 26 did not sign and date orders at each visit. Resident #23 and 26 have current orders signed.  Identification of Deficient Practice & Corrective Action(s):	#23	2/7/17
	ensure the physician 10/7/16.  The findings included	the facility staff failed to			All residents may have been potentially affected. A 100% audit of all residents clinical records will be completed to identify residents at risk. All negative findings will be addressed at the time o discovery. To include notification to the attending Physicians of the residents whave orders not dated and signed.	of .	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495079	B. WING			C <b>1/06/2017</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	1700/2017	
				6800 LUCY CORR BLVD			
HEALTH (	CARE CENTER LUCY	CORR		CHESTERFIELD, VA 23832			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 386	Continued From pa	age 56	F 38	36			
	facility on 7/1/16. anxiety, reflux, and dementia, diabetes hypothyroidism.  Resident #23's mo assessment was a assessment refere coded with a Brief score of 9 indicatir impairment. She ractivities of daily like the control of the cliphysician order shand 11/17/16 were they were not sign. At the end of day ractivitied regarding the facility 8/1/16. Resident #26, a fe facility 8/1/16. Her failure with hypoxiad disease, hypothyrohyperlipidemia, hyf failure, cerebral information Resident #26's mo	dical record was reviewed. The diphysician order sheet nical record was dated 8/24/16. Heets dated 10/1/16, 10/31/16 available on the record but ed.  Ineeting on 1/6/17, the Director of Nursing were the physician orders. No was provided. 26, the facility staff failed to an signed all orders after male, was admitted to the diagnoses included respiratory a, anemia of chronic kidney bidism, type II diabetes mellitus, pertension, congestive heart farction, and right hemiplegia.		Systemic Change(s): The facility Policy and Procobeen reviewed. No revision warranted at this time. All a Physicians groups have be and issued a copy of the St Federal guidelines for Physimonitoring the resident mercare. Any physician identific compliance will be notified phone. The DON and/or deeducate licensed nursing st State and Federal guideline visits and the monitoring of plan of care.  Monitoring: The Administrator is responmaintaining compliance. Thincludes audit tool for monit compliance. The QA Audit, audit will be completed by the Administrator and/or designensure timely physician visits Any/all negative findings with to the administrator for corrowing Aggregate findings of these provided to the Quality Asson Committee for review, analytecommendations for changing policy, procedure, and/or procedure, and/or procedure.	as are attending en informed cate and dical plan of ed to be out of by fax and esignee will taff on the es for Physician the medical  asible for ne QA Program toring physician Visit he nee weekly to it compliance. Il be reported ective action. e audits will be urance ysis, and ge in facility ractice.		
		st recent MDS (minimum data assessment reference date) of					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		OATE SURVEY OMPLETED
		495079	B. WING _			C 01/06/2017
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP CODE 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832	<u> </u>	01/00/2017
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 386	She was coded as hawas able to make he Resident #26 was cototal assistance of or perform her activities exception of eating. as needing stand by Review of Resident # no signed "Physician since 10/7/16. The " a cumulative and cur comprehensive plan the physician's signal facility as a review arcare.  Physician's notes we had been in and assefollowing days after 12/19/16, 12/21/16, 12/21/16, 13 RN (registered nurse 1/6/16 at 10:15 a.m., the order summary, tourrent clinical record see that the order su after 10/7/16.  The administrator and of nursing) were inforstaff to ensure Resid summary was signed.	s a quarterly assessment. aving no memory deficits and r own daily life decisions. ded as requiring extensive to the to two staff members to of daily living with the For eating, she was coded assistance.  #26's clinical record revealed 's Order Summary Report" Order Summary Report" was	F3	86		
F 387		ELINESS OF PHYSICIAN	F3	87		2/7/17

OLIVIEIV	OT OIL MEDIO TILE G	MEDIO/ ND OLIVIOLO				011110	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILD	_			c
		495079	B. WING				06/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UEALTU (	CARE CENTER LUCY CO			68	800 LUCY CORR BLVD		
HEALIH	DARE CENTER LUCT CO			С	HESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 387	Continued From page	e 58	F	387			
SS=D	VISIT						
	CFR(s): 483.30(c)(1)	(2)					
	( ) 5						
	(c) Frequency of Phy	sician visits					
	(1) The residents mus	st be seen by a physician at					
	least once every 30 d	lays for the first 90 days after					
	admission, and at lea	st once every 60 thereafter.					
	(2) A physician visit is	s considered timely if it					
	1	10 days after the date the					
	visit was required.						
	This REQUIREMENT	is not met as evidenced					
	by:						
		riew, facility documentation			F 387		
		cord review, the facility staff			Corrective Action(s):	00	
		ne (Resident #22) of 31 ey same, physician visits			The Attending physician for Resident #. did not complete the monthly visit in a	22	
	were timely.	ey same, physician visits			timely manner. Resident # 22 physiciar	1	
	word uniony.				visits are current and in compliance with		
	Resident #22's last pl	hysician's visit was 6/8/16			requirements.		
	which was over 6 mo	nths from the required					
	physician visit time.				Identification of Deficient Practice &		
	The findings included				Corrective Action(s):		
	The findings included				All residents may have been potentially affected. A 100% audit of all residents		
	Resident #22 was ad	mitted to the facility on			clinical records will be completed to	1	
		noses of, but not limited to,			identify residents at risk. All negative		
	dementia, diabetes m				findings will be addressed at the time o	f	
	hypertension.				discovery. To include notification to the		
					attending Physicians of the tardiness w	ith	
		mum Data Set (MDS) was a			the residents visit for completion		
		t with an Assessment			Systemic Change(s):		
		D) of 10/11/16. The MDS with intact cognition; required			Systemic Change(s): The facility Policy and Procedure has		
		m staff for bed mobility,			been reviewed. No revisions are		
		, toileting and hygiene; and			warranted at this time. All attending		
		from staff for dressing and			Physicians have been in- serviced and		
	bathing.	3 - 3			issued a copy of the State and Federal		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR MC	). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		PLETED
		495079	B. WING				C 0 <b>6/2017</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				68	800 LUCY CORR BLVD		
HEALIH	CARE CENTER LUCY CO	PKK		С	HESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 387	Continued From page On 1/6/17 at 8:45 a.m record was reviewed. last physician's progr There were no progre record dated after 3/2 conducted with the U Practical Nurse-F (LF review. LPN-F stated doesn't come here. The doctor's office." S staff call the doctor's daughter communica facility. When asked regulatory requirement stated "I'll have to cal was seen." She state visit." On 1/6/17 at 9:40 a.m conducted with the Ac Surveyor informed Ac documented physicia stated "Doctor (name the family takes them stated "We don't have required but we are con	n. Resident #22's clinical The review revealed the ess note was dated 3/26/15. ess notes in the clinical 26/15. An interview was nit Manager, Licensed PN-F) at the time of the d "The doctor normally The daughter takes her to She explained that the facility office when needed or the tes with the office and how she knows if the ints are being met, LPN-F I the office to see when she ed "We can get a fax of the in. an interview was dministrator (Admin-A).		3387		f of and are.	
	6/8/16, 6/22/15 and p	cian progress notes dated rior visits. There was no led that Resident #22 was n after 6/8/16.			recommendations for change in facility policy, procedure, and/or practice.  Completion Date: February 7, 2017		
	Nursing and CEO wit were informed of the	m. the acting Director of h Admin-A in attendance, late physician's visits. A ectation of timely physician					

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495079	B. WING			l	C 06/2017
	ROVIDER OR SUPPLIER	RR	•	6	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD HESTERFIELD, VA 23832	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 387	Telephone in the contract of t	e 60 n., when asked how often d occur, Admin-A stated the	F	387			
	physician "Should see and review their meds No further information staff.	e Resident every 60 days s and careplan." n was provided by the facility					
F 441 SS=D	INFECTION CONTROLLINENS CFR(s): 483.80(a)(1)(	OL, PREVENT SPREAD, (2)(4)(e)(f)	F ·	441			2/7/17
	The facility must esta	on and control program.  blish an infection prevention (IPCP) that must include, at ving elements:					
	investigating, and cor communicable diseas volunteers, visitors, a providing services un arrangement based u conducted according	der a contractual pon the facility assessment to §483.70(e) and following ndards (facility assessment					
	• •	, policies, and procedures h must include, but are not					
	possible communicati	lance designed to identify ble diseases or infections ad to other persons in the					
		m possible incidents of se or infections should be					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED	
		495079	B. WING _			C 01/06/2017	
	ROVIDER OR SUPPLIER	DRR		STREET ADDRESS, CITY, STATE, ZIP COI 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		711703/2017	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	(iv) When and how is resident; including but (A) The type and during depending upon the involved, and (B) A requirement that least restrictive possicircumstances.  (v) The circumstance must prohibit employ disease or infected secontact with residents contact will transmit to (vi) The hand hygient by staff involved in different facility's IP actions taken by the second of infection.  (f) Annual review. The annual review of its II program, as necessal	nsmission-based precautions vent spread of infections; solation should be used for a at not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct so or their food, if direct the disease; and eprocedures to be followed rect resident contact.  Inding incidents identified CP and the corrective facility.  In must handle, store, and limited the most as to prevent the me facility will conduct an PCP and update their ary.	F 4	41			
	by: Based on observation	on, staff interview and facility w. the infection control		F441 Corrective Action(s):			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		TE SURVEY MPLETED
		495079	B. WING				C
NAME OF D		493079	B. WING _	0.	TDEET ADDRESS OFTY STATE 7/D SODE	0	1/06/2017
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HEALTH (	CARE CENTER LUCY	CORR			800 LUCY CORR BLVD		
				С	HESTERFIELD, VA 23832		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From p	age 62	F.	441			
	1	ensure an effective infection			The nurse that failed to ensure an		
	control program w				effective infection control was educate	ad he	
	Control program w	as implemented.			on sanitation of the glucometer and	, .	
		tion administration observation, Nurse-B (LPN-B) failed to			carrier/caddie.		
		ter (hand held device to test			Identification of Deficient Practice &		
	_	) and carry caddy were			Corrective Action(s):		
	_	. Also, the carry caddy did not			All residents requiring blood glucose		
		erneath it when placed on the			monitoring may have been potentially		
		then brought back to the			affected. The DON and/or designee w		
	medication counte	r top.			complete a clinical record review of		
					current resident to identify residents w	/ho	
					require blood glucose monitoring.		
	The findings include	led:					
					Systemic Change(s):		
		p.m. a medication pass			The facility Policy and Procedure has		
		onducted with LPN-B. LPN-B			been reviewed. No revisions are		
		stic carry caddy which			warranted at this time. The DON and/	or	
		neter and testing supplies			designee will educate the Healthcare		
		cets, testing strips and gauze) s room. LPN-B placed a paper			center staff on Infection Control policy	anu	
		ed table which was positioned			procedures, including maintaining an effective infection control program. T	ho	
		26's bed then placed the			DON and/or designee will educate	. IC	
		paper towel. LPN-B placed			licensed nurses on the Blood Glucose	<u> </u>	
	-	lirectly on the overbed table			monitoring policy, including the cleani		
		arrier underneath. LPN-B			procedures of the glucometer and	9	
	_	d obtained Resident #26's			equipment caddie.		
	_	ing strip and glucometer					
		posed of the gloves properly.			Monitoring:		
					The DON is responsible for maintaining	ıg	
	LPN-B exited the r	esident's room, placed the			compliance. The QA Program include		
	-	irry basket on top of the			audit tool for monitoring compliance.		
		thout cleaning them. LPN-B			QA Audit, Infection control- Blood glud		
	-	e gloves, removed a Clorox			will be completed weekly by the DON		
		nd wiped the opening of the			and/or designee to monitor for		
		e the testing strip is inserted)			compliance. Any/all negative findings	will	
		ole machine. She then placed			be reported to the DON for corrective		
		ck in the carry caddy, removed			action. Aggregate findings of these au		
	the caddy from the	top of the medication cart and			will be provided to the Quality Assurar	ıce	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495079	B. WING _				C 06/2017
	ROVIDER OR SUPPLIER	DRR		68	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 01/	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 441	Continued From page brought it into the me placed the caddy on countertop. LPN-B d glucose test to perfor administer after the till Resident #26, a fema facility 8/1/16. Her dilimited to, type II diab heart failure, cerebrathemiplegia.  Resident #26's most set) with an ARD (ass 11/7/16 was coded as She was coded as She was coded as he was able to make her Resident #26 was co total assistance of on perform her activities exception of eating. as needing stand by a condiscussed the observe with LPN-B was condiscussed the observe with LPN-B, she repli	dication room. LPN-B the medication room id not have another blood m or other medications to me of observation.  Ale, was admitted to the agnoses included, but not betes mellitus, congestive l infarction, and right  recent MDS (minimum data sessment reference date) of a quarterly assessment. Aving no memory deficits and or own daily life decisions. ded as requiring extensive to the to two staff members to of daily living with the For eating, she was coded		441			
	discussed that the calbarrier underneath ar room to the cart and On 1/5/17 at 4:35 p.n Nursing, Administrate the infection control comedication administrate	vel under supplies." It was rry caddy did not have a and it went from the resident's into the medication room.  n. the acting Director of or and CEO were informed of concern during the ation observation. No ided by the facility staff at the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	1, ,	TE SURVEY MPLETED
	495079	B. WING			C 01/06/2017
NAME OF PROVIDER OR SUPPLIER  HEALTH CARE CENTER LUCY CO	PRR	•	STREET ADDRESS, CITY, STATE, ZIF 6800 LUCY CORR BLVD CHESTERFIELD, VA 23832		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
Program" policy was a Control Preventionist, Nursing (Admin-C). T "To provide a safe, a environment and to in prevent infections in t  On 1/6/17 at 11:30 a.u Administrator) and Adexpectation of bringin the rooms and the blorequested. No inform administration at the total Admin-A provided the stated on 1/6/17 at 2: expectation to bring a facility policy titled "BI PROCEDURE (FING) and included: "Procedure:9. Clefacility approved disin No further information staff.  F 514 RES RECORDS-COMPLE LE CFR(s): 483.70(i)(1)(5)	on was informed.  In the "Infection Control reviewed with the Infection of the acting Director of The policy included: sanitary, comfortable expestigate, control and help the facility."  In Admin-A (the dimin-C were asked what the of the carry case (caddy) into food glucose policy was nation was given by time.  It blood glucose policy and for p.m. "There is no for caddy into the room." The LOOD GLUCOSE TEST ERSTICK)" was reviewed free and the machine with the effecting wipe."  In was provided by the facility of the cacepted professional		514		2/7/17

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	
		495079	B. WING			01/	06/2017
	ROVIDER OR SUPPLIER	RR	1	6	TREET ADDRESS, CITY, STATE, ZIP CODE 800 LUCY CORR BLVD CHESTERFIELD, VA 23832	1 017	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	Continued From page	e 65	F	514			
	(i) Complete;						
	(ii) Accurately docume	ented;					
	(iii) Readily accessible	e; and					
	(iv) Systematically org	ganized					
	(5) The medical recor						
		on to identify the resident;					
	(ii) A record of the res	ident's assessments;					
	(iii) The comprehensing provided;	ve plan of care and services					
	(iv) The results of any and resident review e determinations condu						
	(v) Physician's, nurse professional's progres	's, and other licensed ss notes; and					
	services reports as re	ogy and other diagnostic quired under §483.50.					
	Based on staff interv review and clinical re- failed to ensure, for o	iew, facility documentation cord review, the facility staff ne (Resident #22) of 31 y sample, a complete			F514 Corrective Action(s): The medical record for Resident #22 w corrected at the time of discovery to accurately reflect all physician progress notes.		
		e facility staff failed to ensure otes were available for record.			Identification of Deficient Practice & Corrective Action(s):		

OLIVILIV	OT OIL MEDIO, ILL G	· · · · · · · · · · · · · · · · · · ·				<del></del>	<del>2. 0000 000 1</del>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILD			١ ,	С
		495079	B. WING				06/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	00/2011
				68	800 LUCY CORR BLVD		
HEALTH C	CARE CENTER LUCY CO	DRR		С	HESTERFIELD, VA 23832		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 514	Continued From page	e 66	F	514			
	The findings included		'	017	All residents may have been potentially	,	
	The infamigs included				affected. A 100% audit resident medica		
	Resident #22 was ad	mitted to the facility on			records have been conducted by the D		
		noses of, but not limited to,			and /or designee to identify residents a		
	dementia, diabetes m				risk. Any/all negative findings will be		
	hypertension.				corrected on discovery and reported to	the	
					DON for corrective action.		
		mum Data Set (MDS) was a					
	quarterly assessment				Systemic Change(s):		
		D) of 10/11/16. The MDS			The facility Policy and Procedure has		
		with intact cognition; required m staff for bed mobility,			been reviewed. No revisions are warranted at this time. The DON and/o	r	
		, toileting and hygiene; and			designee will be educate the Unit	1	
		from staff for dressing and			secretaries, neighborhood care manag	ers	
	bathing.				and Licensed nurses on maintaining a	0.0	
	J				complete medical record including		
	On 1/6/17 at 8:45 a.m	n. Resident #22's clinical			physician progress notes and clinical		
	record was reviewed.	The review revealed the			documentation standards per the		
		ess note was dated 3/26/15.			facility□s policy and procedure. The		
		ess notes in the clinical			training will include the procedure for		
		26/15. An interview was			receiving and reviewing all physician		
		nit Manager, Licensed			progress notes after an office visit.		
		PN-F) at the time of the doctor normally			Monitoring:		
		The doctor normally  The daughter takes her to			The DON is responsible for maintaining	n	
		She explained that the facility			compliance. The QA Program includes	-	
		office when needed or the			audit tool for monitoring compliance. The		
		tes with the office and			QA Audit tool, Physician progress note		
	facility. When asked				audit will be completed weekly for mon		
	regulatory requirement	nts are being met, LPN-F			for compliance. Any/all negative finding	-	
	· ·	Ill the office to see when she			will be reported to the DON and attend	•	
		ed, "We can get a fax of the			physician for corrective action. Aggrega		
	visit."				findings of these audits will be provided	d to	
	On 1/6/17 at 9:40 a.n	a an intonvious was			the Quality Assurance Committee for	c	
					review, analysis, and recommendation		
	Surveyor informed Ac	dministrator (Admin-A).			for change in facility policy, procedure, and/or practice.		
	· ·	n's visit of 3/26/15. Admin-A			and/of practice.		
		e) is her attending (doctor),			Completion Date: February 3, 2017		

				ATE SURVEY DMPLETED			
		495079	B. WING _			1	C ( <b>06/2017</b>
	ROVIDER OR SUPPLIER	RR		6800 LI	T ADDRESS, CITY, STATE, ZIP CODE UCY CORR BLVD TERFIELD, VA 23832	<u>,                                    </u>	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 514	the family takes them stated "We don't have required but we are c On 1/6/17 at 10:15 a. faxed copies of physic 6/8/16, 6/22/15 and p documentation provid seen by her physiciar On 1/6/17 at 11:35 a. Nursing, CEO (Chief Administrator were in notes not being in the	on a whim." Admin-A e the documentation that's hecking with the office."  m., Admin-A presented cian progress notes dated rior visits. There was no led that Resident #22 was	F	514			