8000 Iliff Dr. Dunn Loring, VA 22027 Tel 703-560-1000

May 12, 2016

Ms. Elaine Cacciatore, Long Term Care Supervisor Office of Licensure and Certification Division of Long Term Care Services 9960 Mayland Drive, Suite 401 Richmond, Virginia 23233

Dear Ms. Cacciatore,

Please find the enclosed response to the deficiencies the staff from the Virginia Department of Health's Office of Licensure and Certification identified during the unannounced standard survey ending April 28, 2016.

Iliff Nursing and Rehabilitation Center respectfully requests that this plan of correction and the compliance dates contained herein be considered as the facility's credible allegation of compliance.

If you should have any further questions please feel free to contact me at 703-560-1002.

Sincerely,

Kathy Delimba Administrator RECEIVED

VDH/OLG

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State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_\_\_

		495205		B. WING		04/28/2016
	PROVIDER OR SUPPLIER RSING HOME AND RE	нав с	STREET ADD 8000 ILIFF DUNN LOI	DRIVE	STATE, ZIP CODE 22027	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIE MUST BE PRECEDED BY C IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMP
F 000	Initial Comments			F 000		
***	An unannounced Me survey and biennial was conducted 4/26. Significant correction corrections are requirements and Vi for the Licensure of I Compliance deficien F323.  The Life Safety Cod The census in this 13 103 at the time of the consisted of 18 currer (Residents #1 throug (Residents # 19 throug residents # 19 through residents	State licensure insp /16 through 4/28/16 is were required ar ired for compliance al Long Term Care rginia Rules and Re Nursing Facilities. A cy was cited at a ha e Survey/Report will 80 certified bed faci e survey. The surve ent Resident reviews th #18), and 5 close	pection and with 42 egulations a Past-Non arm level at li follow. lity was ey sample s			
F 001	Non Compliance			F 001	A CENTO	
	The facility was out o following state licens	f compliance with thure requirements:	he		1.7 33 208	
	This RULE: is not me	et as evidenced by:			VDH/OLC	
	12 VAC 5-371-200 (E	, F.1)			COV 12 VAC 5-371-200 (E, F.1)	
	Based on staff intervireview, and employed staff failed to ensure (certified nursing assiwith DHP (Department of a survey sample of employees.  Emp. #24 was hired of verification was obtain.	e record review, the verification of one C stant) Emp. #24) co nt of Health Profess 22 certified/license on 10/9/15 and no li ned from DHP until	e facility CNA ertification sions) out ed		<ol> <li>Corrective Action         The license verification with the Department of Health Profession employee # 24 was done on April 2016 and no residents were affect by this deficient practice.     </li> <li>Other Potential Residents All residents have the potential to affected by this deficient practice.</li> </ol>	27, ted
ORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENT	TATIVE'S SIGNA	ATURE	TITLE	(X6) DATE
	h. Ahlad /	////			1 2111 2	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495205 B. WING 04/28/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ILIFF NURSING HOME AND REHAB C 8000 ILIFF DRIVE **DUNN LORING, VA 22027** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** (X5) COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From Page 1 F 001 F 001 3. New Measures/Systems Change Emp. #24, a CNA was hired by the facility 10/9/15. The Administrator will re-educate the Upon hire, she was determined to have just business office staff on the importance graduated from a CNA program. A thorough of having all employee licenses review of Emp. #24's employee file revealed no verified with the Department of certification had been obtained through DHP as of **Health Professions.** 4/27/16. The facility Business Office Manger audited 100% of all current licensed Other A, the human resources manager stated 4/27/16 at 3:17 p.m. at she would review the issue employee files and found all licenses and check to see if certification verification for were verified with the Department of Emp. #24 was in another file. Health Professionals. This audited was completed May 5, 2016. A certification verification through DHP was presented 4/27/16 at 4:10 p.m. and Other A stated 4. Monitoring she was unable to find the certification had been The facility Business Office Manager verified prior to 4/27/16. will audit 100% of all newly hired employees over the course of the next Review of the policy entitled, "VA (Virginia) Abuse three months to ensure all the newly Prohibition-State of Virginia" included: hired employees have their license "The Center will screen potential employees for a verified through the Department of history of abuse, neglect, or mistreating residents **Health Professionals. The Business** including checking with appropriate licensing Office Manager will present her boards and registries. findings of these audits monthly to the Administrator and the COI 2.1 The Center will not employ individuals who: Committee. 2.1.1 Have been found guilty by a court of law of abusing, neglecting, or mistreating others; or 2.1.2 had a finding entered into the state nurse aid registry concerning abuse, neglect, 5. Completion Date mistreatment of others or misappropriation of June 11, 2016. property..." The administrator, DON (director of nursing), and RECEIVED corporate consultant were informed of the failure of the staff to verify certification with DHP for Emp. #24, 4/28/16 at 1:15 p.m. The facility was not in compliance with the VDH/OLC following Virginia Rules and Regulations for the Licensure of Nursing Facilities:

State of Virginia

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLI IDENTIFICATION NU	MBER:				) DATE SURVEY COMPLETED	
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F 001	Continued From Pa	ge 2		F 001	,			
	Resident Assessment and Care Plan 12 VAC 5-371-250 (B.2) Cross-Reference F-274  Nurse Staffing 12 VAC 5-371-210 (E, F.1)				Resident Assessment and Ca 12 VAC 5-371-250 (B.2) S for F-274 on pages 3 & 4 of	See response		
	12 VAC 5-371-210 ( Nursing Services 12 VAC 5-371-220 (I F-329 12 VAC 5-371-220 (I F-309  Pharmaceutical Serv 12 VAC 5-371-300 (I F-425 and F431  Dietary and Food Se 12 VAC 5-371-340 (J F-367  Clinical Records 12 VAC 5-371-360 (E F-514	B) Cross-Reference C) Cross-Reference rices B) Cross-Reference rvice Program C) Cross-Reference	ce to		Nurse Services 12 VAC 5-371-220 (B) —See for F-329 on pages 16, 17, & 12VAC 5-371-220 (C) -See F-309 on pages 5 & 6 0f 40.  Pharmaceutical Services 12 VAC 5-371-300 (B) —See for F-425 on page 32 of 40 a pages 35 & 36 of 40.  Dietary and Food Services P. 12 VAC 5-371-340 (J) — See for F-367 on pages 23 & 24 of Clinical Records 12 VAC 5-371-360 (E) —See for F-514 on pages 37 & 38 of Clinical Records	response for 40.		
ATE EODNA						-		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		495205	B. WING_			C 4/28/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 8000 ILIFF DRIVE DUNN LORING, VA 220	ATE, ZIP CODE	+/20/2010
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F 000	INITIAL COMMEN		F 00	0		
SS=C	survey was condu Significant corrections are req CFR Part 483 Federequirements. A Federiciency was cite Life Safety Code S The census in this 103 at the time of the consisted of 18 cur (Residents #1 through (Residents #19 through 483.10(g)(1) RIGHT READILY ACCESS A resident has the resident or State surportection in effect was accessible to resident availability.  This REQUIREMENT This REQUIREMENT This REQUIREMENT This REQUIREMENT This REQUIREMENT TO STATE STATE STATE TO STATE STATE TO STATE STATE TO STATE STATE TO STAT	ight to examine the results of vey of the facility conducted by rveyors and any plan of with respect to the facility.  ake the results available for ust post in a place readily ents and must post a notice of on, facility documentation erview, the facility staff failed vas available to indicate the	F 167	1. Corrective Act On April 27, 2016 posted stating the current survey re location of the pro results. No reside this deficient prace 2. Other Potentia All residents had affected by this de 3. New Measures, New signage was plocation of the mo results and the loc	o new signage was a location of the most sults and the evious survey ents were affected by etice.  Il Residents the potential to be eficient practice.  /Systems Change posted stating the st current survey	
BORATORY D	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are 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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495205	B. WING	i		1	C
	PROVIDER OR SUPPLIER URSING AND REHAB	CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 ILIFF DRIVE DUNN LORING, VA 22027	1 04	/28/2016
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F 167	The findings included buring general observed 4/27/stated:  "This center has repand complaint investing three years available upon request. Pleasinquire."  The sign was in a holobby. A binder was along with a number the survey results. Aname of the new ow	_	F 1	167	4. Monitoring The Administrator or designee wisually observe to ensure the nesign posted stating the location of current and previous survey restremains in place. These observation will occur a minimum of five day week over the next three months a report of the findings will be prepared and presented monthly the CQI Committee.  5. Completion Date June 11, 2016.	w  of  ults  tions  os per  and	
F 274 SS=D	have the location of the 4/27/16 at end of day. The administrator, Discorporate consultant of the facility to have location of previous selection of previous selection of the facility to have location of previous selection of the facility must conduct assessment of a residual facility determines, or that there has been as	ON (director of nursing), and were informed of the failure signage indicating the surveys, 4/28/16 at 1:20 p.m. PREHENSIVE ASSESS T CHANGE  et a comprehensive dent within 14 days after the should have determined, significant change in the	F 27	74			
	purpose of this section	mental condition. (For n, a significant change			VDH/QLC	A delivery property	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
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	PROVIDER OR SUPPLIER  FRANCE AND REHAB	CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 ILIFF DRIVE DUNN LORING, VA 22027	1 047.	20/2010
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	means a major decresident's status that itself without further implementing stand interventions, that hone area of the resirequires interdiscipl care plan, or both.)  This REQUIREMENT by: Based on Family in clinical record review, the facility so (significant change 14 days after determ for 1 Resident (Resin the resident surversession the Resident for a staffer the Resident's transferring, ambulate toileting changed from completely dependent staff members for the (ADL's).  The findings include Resident #7 was origon 6-9-15, and reading 3-8-16. Diagnostic	line or improvement in the at will not normally resolve intervention by staff or by lard disease-related clinical las an impact on more than dent's health status, and inary review or revision of the last of the	F 2	274	1. Corrective Action Residents #7 suffered no ill effection this deficient practice.  2. Other Potential Residents All residents have the potential affected by this deficient practice.  3. New Measures/Systems Charthe Administrator will re-educated Clinical Reimbursement Coordinators (MDS Coordinators) who are responsible for complet significant change in status assessment on the need to complete assessment even on residents show an improvement in status.  The Administrator will educate Department Managers and staff present during the monthly Administrators staff meeting on importance of notifying the Clinical Reimbursement Coordinators (MC Coordinators) if they feel a resid has had a significant change in status assessment.	to be ce.  age ate the ors) ting a lete s who all the ical MDS ent tatus a	
	Resident #7's most r	ecent Minimum Data Set					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
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F 274	(MDS) assessmen with an Assessmen 4-5-16. The Reside interview for mentapoints scored in a psevere cognitive im required limited asstransferring, ambul Resident was also assistance of staff.  The Most recent For comparison, was a Assessment completed just prior assessment mentic experienced by Resident required by Resident required of transferring, and dependant on staff toileting.  4-5-16 Quarterly as required limited asstransferring, ambula Resident was also cassistance of staff of Review of these dochanges in transferring hygiene, and toileting assessments, withou assessment being controlled to the resident was also cassistance of staff of Review of these dochanges in transferring hygiene, and toileting assessments, without assessment being controlled to the resident was also cassistance of staff of Review of these dochanges in transferring hygiene, and toileting assessments, without assessments being controlled to the resident was also cassistance of staff of Review of these dochanges in transferring hygiene, and toileting assessments being controlled to the resident was also cassistance of staff of Review of these dochanges in transferring hygiene, and toileting assessments being controlled to the resident was also cassistance of staff of Review of these dochanges in transferring hygiene, and toileting assessments being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting assessment being controlled to the received hygiene, and toileting the received hygiene, and toileting the receiv	t was a quarterly assessment at Reference Date (ARD) of ent was coded with a Brief all status (BIMS) score of 3 possible 15 points, indicating apairment. The Resident sistance of staff for ation, and hygiene. The coded as requiring extensive for dressing, and toileting.  Ill MDS assessment used for Significant change eted on 1-4-16, and was into the most recent quarterly ened above. The changes sident #7 between these two in below:  Change assessment = The extensive assistance of staff if ambulation, and was totally for dressing, hygiene, and  sessment = The Resident istance of staff for ation, and hygiene. The coded as requiring extensive or dressing, and toileting.  cuments reveals significant ring, ambulation, dressing, and between the two completed out a significant change completed as of the time of 23 days after the quarterly	F 2'	Significant change in state added to the agenda of the morning meetings twice the next 3 months. The tridentify any resident the meet the criteria for a significant change in status assessment will be completed to meet the criteria assessment was completed identified residents meeting and present these finding Committee monthly for the months.  5. Completion Date June 11, 2016	he daily team weekly over team will y feel may gnificant ent. If eria an leted. The ee will verify ge in status ed on all ing criteria g to the CQI	

Facility ID: VA0127

1 Continuation sheet Page 4 of 40



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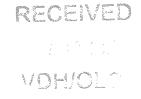
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F 309 SS=D	On 4-27-16, and 4-debrief the Director Administrator were significant change at that no further docupresented. 483.25 PROVIDE OF HIGHEST WELL BEACH resident must provide the necessor maintain the high mental, and psychological provide with the and plan of care.  This REQUIREMENT by: Based on staff intereview, the facility so (Resident #5) of 23 sample to provide of services.  Resident #5 was accorded antianxiety attempting non-phate 4/14/16, 4/22/16 and The findings included Resident #5 was accorded to the provide of services.	28-16, at the end of day of Nursing and the made aware of the need for a assessment, and they stated amentation was available to be CARE/SERVICES FOR EING areceive and the facility must ary care and services to attain nest practicable physical, asocial well-being, in a comprehensive assessment with a comprehensive assessment and the facility and clinical record traff failed for one resident residents in the survey dementia related care and administered the PRN (as a medication Ativan, without reacological interventions on day 26/16.	F 2		ng PRN eations ed by nange Clinical rvisors licensed ical

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 5 of 40



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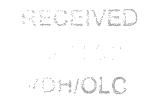
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 8000 ILIFF DRIVE DUNN LORING, VA 22027		
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	significant change and Assessment Refere The MDS coded Recognitive impairments and verbal behaviors and verbal behaviors of ther behaviors of the behaviors of	inimum Data Set (MDS) was a assessment with an ence Date (ARD) of 3/31/16. esident #5 with severe nt; required assistance from s of daily living; had physical rs directed toward others and ot directed toward others.  a.m., Resident #5 was adependently in her room. She ered questions with rambling rs were observed at the time anked the surveyor for visiting.  #5's clinical record, 15, revealed physician's ed:  1) Tablet 0.5 MG (milligrams) at hevery 8 hours as needed in inistration Record (MAR) for ewed and revealed the Ativan of 4/1/16 x 2, 4/5/16, 4/8/16, 22/16 and 4/26/16. Behaviors or pical approaches (i.e. that activity) were documented and on the Behavior ventions sheet prior to edication on 4/1/16, 4/5, 4/8, er there were no documented ations found in the clinical avior sheet for 4/14/16,	F 309	The RN Clinical Coordina Supervisors will audit 25% behavioral sheets for all genesidents receiving PRN amedications weekly to ensipharmacological invention attempted prior to admini PRN antianxiety medicatica audit allows for 100% of the residents receiving PRN amedication to be audited a medication to be audited and the color of the results of audits will be shared with Director of Nursing who we the findings monthly over three months with the Admand the CQI Committee.  5. Completion Date June 11, 2016.	of the eriatric eriatric eriatric entianxiety erias been estering a eriatric entianxiety enouthly to egical erior to enxiety eritese erill share ethe erial eric entites eritese erite eritese	

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

Event ID: L40611

Facility ID: VA0127

If continuation sheet Page 6 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	(X3) D	ATE SURVEY OMPLETED
		495205	B. WING			C <b>94/28/2016</b>
	PROVIDER OR SUPPLIER  JRSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 ILIFF DRIVE DUNN LORING, VA 22027		
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F 309	anxiety and audito interventions that i ordered by MD (Mout what's bothering changes as needed calm voice and calmoving and down hallwagitation with intervesident time to vertical and reduce exposion of 4/27/16 at 3:55 conducted with the (Employee-A). What the nurses to do proving Employee-A stated patient." "Have to when you see behall of the province of the prov	ry hallucinations with neluded: Administer meds as edical Doctor); attempt to find g the resident and make d; speak to the resident in a liner by name. behavior: pacing and shouting ay, delusional thinking, and ventions that included: Allow at feelings/needs; Assess and eds such as: pain, toileting, pocument interventions and e; Identify behavior triggers are to triggers.  p.m. an interview was Director of Nursing en asked what he expected for to administering Ativan, it's "Individualized for each manage behaviors first of all, evior start might give it then."	F 30	9		
TO SECONDARY AND ADMINISTRATION OF THE PARTY	was "No document	p.m., Employee-A stated there ation for 4/14, 4/22 or 4/26 alogical) approaches."				
SS=G	staff. 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain		F 323	3		

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 7 of 40

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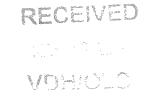
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495205	B. WING			C <b>4/28/2016</b>	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP C 8000 ILIFF DRIVE DUNN LORING, VA 22027		+/20/2016	
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F 323		ion and assistance devices to	F 32	3			
	by: Based on observation documentation review in the course of a confacility failed to safe (Resident #19) of 2 sample, causing infacility identified, conserviced staff corprevented no furthed deficiency was cited a harm level, thus inneeded.  1. Resident #19 sullegs during a transf	NT is not met as evidenced ation, staff interview, facility iew, clinical record review and complaint investigation the ely transfer one resident 23 residents in the survey jury resulting in harm. The prected/implemented and incerning the incident, which er incidents to occur. The d at a Past Non-compliance at no further plan of correction is ustained lacerations to both fer from wheelchair to bed rgency room visit and sutures		Past noncompliance: no picorrection required.	lan of		
and Administration of the Control of	facility on 2/4/15 an hospitalization on 3 but not limited to, co peripheral vascular kidney disease-stag toes, and diabetes i	ed: as originally admitted to the d readmitted after a /18/15 with the diagnoses of, ongestive heart failure (CHF), disease (PVD), chronic ge IV, osteomyelitis of left mellitus type 2. Resident was a facility on 4/20/15, therefore					

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Event ID: L40611

Facility ID: VA0127

If continuation sheet Page 8 of 40



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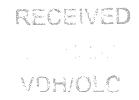
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F 323	a closed record revenue The most recent M Significant Change Assessment Reference The MDS coded Recognition; required staff members for a not walk in room or staff for locomotion extensive assistance, personal hygic coded Resident #11 weakness on both to stabilize with state surface-to-surface and chair or wheeld On 4/28/16 Resider reviewed. The reviewed. The reviewed. The reviewed with min-mod sliding board is des www.myshepherdor equipment that can able to use their leg between surfaces of safe to perform. The solid "bridge" between surfaces of 3/12/15 at 20:51 (8:	view was conducted.  linimum Data Set (MDS) was a assessment with an ence Date (ARD) of 3/25/15. esident #19 with intact extensive assistance from 2 ped mobility and transfers; did corridor; was dependent on a on and off the unit; required be of staff for dressing, toilet ene and bathing. The MDS 9 with lower extremity sides and not steady, only able of assistance during transfer (transfer between bed chair).  Int #19's clinical record was ew revealed the following ich read:  9:33 a.m.) "Interdisciplinary associal Worker included: cilled care, she is alert and didenttransfers with sliding that assist, non ambulatory" A	F 32			

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

Event ID: L40611

Facility ID: VA0127

If continuation sheet Page 9 of 40



PRINTED: 05/05/2016 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	
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F 323	bleeding from both writer went to room bilateral lower extre fresh bright red bloskin tear to right low lower leg during tradry dressing with programmer was admitted on 2/lower leg, has a + 4/lower	legs during pivot transfer, to assess observe resident emity with large amount of od on floor, resident sustain a wer leg and laceration to left insfer from wheel chair to bed, ressure applied. pt (patient) 4/15 with laceration to left is edema to bilateral lower is to bilateral armspatient kin, edema and is on bumex if pill) and coumadin 4mg (and thinner)MD (Dr. Name) insfer resident via 911 to for further evaluation"  a.m.) "Resident arrived at cher accompanied by 2 inter. dressing in place on both in p.m.) "Skin/Wound Note" is essed resident's lacerations ties. Dr (Name) and daughter laceration on L leg lateral intimeters) with 11 stitches wer leg 8 x 8.5 x x 0.6 cm. In the bilateral lower is eatly and the before"  #19's care plan included, but	F	323			

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

Event ID: L4O611

Facility ID: VA0127

RECEIVE 10 of 40



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PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

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	recent hospitalization treatment for a chroboth PT and OT (PI Therapy) and shown non ambulatory at the 02/23/2015." "Goal She will improde ADL's and begin work (sic) this review. Date 102/23/2015Revision of 102/23/2015Revision of 102/203/03/2015."  On 4/28/16 at 11:00 Therapy (PT) notes notes contained the "Physical Therapy Pincluded an "Initial A "Functional Deficits. LECurrent Level-5 Transfers, Bed/Chaid (1-25%)" "Functional Deficit Codifficulty with static some of transfer is some aware."  02/27/2015 PT Therefore the patient is abled the patient is abled to th	on and prolonged medical onic problem. She is receiving hysical and Occupational ing progress. She remains his time. Date Initiated:  Ove current level of function in orking with parallel bars durig ate Initiated:  ON ON 03/03/2015."  INSFER: She requires 1-2 staff using sliding board.  3/2015Revision on:  a.m. a review of the Physical was conducted. The PT following:  Ilan Of Care" initiated 2/5/15 ssessment" Weight bearing Status, Left 0% weight bearing  rminimal assistance  Other Due to increased tanding d/t (due to) pain, sliding board. NSG (nursing)  apist Progress note "Current"	F 32	23		

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 11 of 40 RECEIVED



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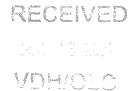
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F 323	The patient is able wheelchair requiring assist)squat pivot On 4/28/16 at 11:50 conducted with the (Other-B) and Physother-C was identified worked with Reside and goals were revolved transfer status was #19, Other-C read to for transfer is sliding When asked how the what the appropriat Other-C stated we off the floor and teastated we "Would estiding board until coway." The PT squawas discussed. Otherember I did not transfer (Resident from the best of the should have been untransfers." The intervals and investigation report Employee-A) was rinvestigation report Employee-A include "CNA-C (Name) wa called CNA-B (Name)	unction" "Minimal assistance to safely transfer from bed < > g minimal assistance (1-25% transfer."  Dia.m. an interview was Rehab Department Manager ical Therapist (Other-C). It ied as the primary PT who ent #19. The PT assessments is ewed. When asked what the for Resident he initial assessment "mode board. NSG made aware." In enursing staff were taught in enursing staff were taught in enursing to use the expect nursing staff to pivot transfer from 3/6/15 in er-C stated "As far as I train nursing staff to pivot expect nur	F 32	23			

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 12 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

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F 323	Both C.N.A's had of the resident." "Resident." "Resident and really During pivot and the resident's right leg called for help and room. (Name) who (Name) the superv (Name) entering the noticed to be bleed. "Both (Name), C.N. that the cut was net that injury occurred laceration and skin indications of new "Both CNA-C and (happen because the body, they are how injury was as a residence of the commented in Physical Therapist, document in progrechange of transfer documented then in #19) wasn't cleared staff)." Other-C state documented if we in the room."  A telephone interviewith the Director of CNA-B stated she #19 acquired the with stated she knew Resident in the	gait belts during the transfer of sident stated hands were could not help with the transfer. ansfer, C.N.A's noticed was bleeding. CNA-C (Name) the charge nurse came into a was the charge nurse called risor to the room. Prior to be room, the left leg was ding also."  A-B, CNA-C & (Name) agreed by, the blood was fresh and during the transfer as the a tear on assessment were	F 323			
ann avenuer 1775 en		ted when the resident came bital (after the injuries) rehab	VALADA VAR & BALLOOPPRARE		E & home book	

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 13 of 40



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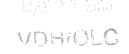
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F 323	taught staff to use the stated when they stated when they stated in one legal remember her legal asked how the CNA resident (transfer stated to contact the voice message was return call received on 4/28/16 at approasked if the kardex Nursing stated "The The Administrator a informed of the hand to the transfer. Administrator asked where it was board beside the restated it was on the interdisciplinary not Administrator stated I investigated the incoordinator put the The Director of Nur MDS put in sliding to the facility provided after the survey:	the sliding board. CNA-B tood her up she began to then the other but did not nitting the wheelchair. When A's know how to transfer a status) CNA-B stated at the ard (Kardex) on the back of the elinformation) but now the elinformation) but now the elinformation) but now the elinformation was found, the Director of ere is no kardex in the record." and Director of Nursing were may level deficient practice due ministration was questioned all determine to use a standide board. The Administrator documented to use the slide hab notes; the surveyor care plan and in an el. At 2:30 p.m., the difference of Employee-A) and cident fully. The MDS sliding board in the care plan." sing then stated I "Believe the board in error."	F 32			

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

Event ID: L4O611

Facility ID: VA0127

RECIficantinuation sheet Page 14 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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F 323	two person transfer Following this incide other residents had transferred, however future.  The Director of Nursupervisors re-eductransferring resider 13, 2015.  The Director of Nurworked together to to alert all staff to the individualized plans ambulation, weight NPO status, and/or newly developed to and adopted by the 2015 Quality Impromed The Director of Nurstaff on this new togethed on May 12, 20. The Director of Nurresident unusual of were related to imp The facility maintain compliance by June 19 for the director of Nurresident unusual of the promote of the process of the proce	on March 12, 2015 during a r. lent it was determined that no d been injured while being er others may possibly in the rsing and the RN nursing cated the nursing staff on the with fragile skin on March rsing and Director of Rehab develop a new tool and policy he rehab department 's so for resident transfers, a bearing status, diet, liquids, or special instruction. This cool and policy was presented a facility during the April 24, overment Committee Meeting, rsing educated the nursing colduring his monthly meeting continued reviewing all courrences and found none proper resident transfers. In that it was back in e 1, 2015.	F 323	3		
F 329 SS=E	Complaint Deficience 483.25(I) DRUG RE	EGIMEN IS FREE FROM	F 329	9		
The second secon	unnecessary drugs.	ng regimen must be free from  a. An unnecessary drug is any excessive dose (including				

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 15 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

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F 329	duplicate therapy); without adequate n indications for its u adverse consequer should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs utherapy is necessar as diagnosed and crecord; and resident drugs receive gradubehavioral interventions.	or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 32	1. Corrective Action Residents #14, #7, #16, and suffered no ill effects due to deficient practice.  2. Other Potential Resident All geriatric residents have potential to be affected by the deficient practice.  3. New Measures/Systems C The RN Clinical Coordinate RN Nursing Supervisors will inservice the geriatric licens on the need for each drug rebe free of unnecessary drugs the six rights of medication administration.	this s the his Change or and/or ll re- ed nurses egimen to	
	by: Based on observat documentation reviet the facility staff faile (Residents' #14, #7 sample of 23 Resident unnecessary medic  1. For Resident #14 nurse) A administer mg (milligram) table ordered one tablet;  2. For Resident #7,			The nurse who made the me error involving resident #14 re-inserviced the need for earegimen to be free of unnecedrugs and on the six rights of medication administration a counseled for her error.	will be ach drug assary af	

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C If continuation sheet Page 16 of 40

PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

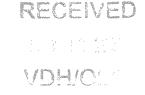
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F 329	antihypertensive norder; 3. For Resident # amlodipine and medications) as in ordered paramete 4. For Resident # diltiazem (blood prindicated in the photo The findings included in the photo Th	the facility staff failed to hold etoprolol (blood pressure indicated in the physician ers.  44 the facility staff failed to hold ressure medication) as invision ordered parameters.  46 the facility staff failed to hold ressure medication) as invision ordered parameters.  46 the facility staff failed to hold ressure medication) as invision ordered parameters.  46 the facility staff failed to hold ressure medication) as invision ordered parameters.  46 the facility staff failed to hold ressure medication) as invision ordered parameters.  47 the facility staff failed to hold ressure medication) as invision ordered parameters.  48 the facility staff failed to hold ressure medication) as invision ordered parameters.  49 the facility staff failed to hold ressure medication) as invision ordered parameters.  49 the facility staff failed to hold ressure medication) as invision ordered parameters.  40 the facility staff failed to hold ressure medication) as invision ordered parameters.  40 the facility staff failed to hold ressure medication) as invision ordered parameters.  40 the facility staff failed to hold ressure medication) as invision ordered parameters.  41 the facility staff failed to hold ressure medication) as invision ordered parameters.  42 the facility staff failed to hold ressure medication) as invision ordered parameters.  42 the facility staff failed to hold ressure medication) as invision ordered parameters.  43 the facility staff failed to hold ressure medication) as invision ordered parameters.  44 the facility staff failed to hold ressure medication) as invision ordered parameters.  45 the facility staff failed to hold ressure medication) as invision ordered parameters.  46 the facility staff failed to hold ressure medication) as invision ordered parameters.  47 the facility staff failed to hold ressure medication) as invision ordered parameters.  47 the facility staff failed to hold ressure medication) as invision ordered parameters.	F 329	The RN Clinical Coordinator a Nursing Supervisor will audit the Medication Administration Records for all geriatric reside receiving blood pressure medication because the blood pressure medications and allows for 100% of the geriatric residents receiving blood pressure medications to be audited mon The results of these audits will shared with the Director of Nuwho will share the findings mo over the next three months with Administrator and the CQI Committee.  The Geriatric RN Clinical Coordinator or the RN Nursing Supervisor will make random to observations of the medication administration pass of the nursimade the medication error to eather correct dosages are administration three times weekly the course of three months. The results of these observations will present them to the Administrator and the CQI Committee monthly.	25% of nents cations to ication of the it ic sure thly. be rsing nthly h the general see who ensure stered. Ations over ne ill be		

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 17 of 40



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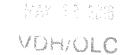
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	Omega 3 1000 mg cup. LPN entered administered the m 4/26/16 at 4:15 p.m Upon reconciliation administered with the following order was "3/15/16 Acetamine 8 hours as needed allowed=4 grms (grmost recently signed "4/1/16." Review of the clinic physician's order for to be administered RN (registered nurs 4/27/16 at 10:24 autility and the following administered to Re LPN A stated 4/27/17 realized after administered to Re LPN A stated 4/27/17 realized after administered the Review of the facility "Medication:Administered the Review of the facility "Medication:Administered the followed. Medication another patien Guidance for nursing administration of m "Fundamentals of Netter-Perry, p. 705 such as the America	in 500 mg, along with an capsule, into a medication Resident #14's bedroom and redications to Resident #14 at in.  If of the medications he physician's orders, the shoted: ophen 500 mg by mouth every for pain maximum daily dose rams)." The order was on the red physician's orders dated all record revealed now two Acetaminophen 500 mg for pain for Resident #16. See) B, the unit manager, stated m. she did not see any order hen 500 mg to be sident #14 for pain.  If at 4:28 p.m., she had histering the medication that error by administering two of mg instead of the physician's A stated she was nervous and the medication in error. The sy's policy entitled, stration: General" included: Med Tech, or medication aide, so, will administer medications all ations will not be borrowed ont."  If ye standards for the edication is provided by	F 329	5. Completion Date June 11, 2016.		

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 18 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

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F 329	administration. To follow the six rights medication errors can inconsistency in medication adminismedication adminismedication adminismedication adminismedication adminismedication adminismedication adminismedication adminismedication adminismedication administrator, It for right down administrator, It corporate consultant of the staff to administrator of the staff to administering twice and corporate consultant of the staff to administering twice administering twice Acetaminophen 500.  2. For Resident #7, not obtained prior to antihypertensive metorder.  Resident #7 was ori on 6-9-15, and read on 3-8-16. Diagnos renal insufficiency, resizure disorder, as deficiency.  Resident #7's most (MDS) assessment with an Assessment 4-5-16. The Resider	oly to the activity of medication prevent medication errors, of medications. Many an be linked, in some way, to adhering to the six rights of tration. The six rights of tration include the following: edication see ent atte to the cumentation."  DON (director of nursing, and at were informed of the failure dister Acetaminophen 500 mg are to Resident #14, 4/27/16 at the ce. The administrator, DON, cultant were informed of LPN A the amount of the mount of the mount of the administration of an edication per physician's ginally admitted to the facility mitted after a hospitalization es included; Hypertension, hypothyroidism, dementia,	F3	329			

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

Event ID: L40611

Facility ID: VA0127

If continuation sheet Page 19 of 40



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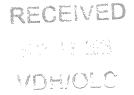
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F 329	points scored in a severe cognitive in required limited as transferring, ambut Resident was also assistance of staff.  On 4-26-16 a reviered record was begund physician's order stablet 10 mg (millig bedtime related to for SBP (systolic bound This order was data given at 8:00 p.m. The MAR (Medical was reviewed since effect. This medication blood pressure on 3-15-16, 3-16-13-17-16, no blood documented for the medication. This runaware if the Residel below 110 millimet medication may haphysician's order, when the blood predocumented. The Vital signs recommedical record, and clinical paper chart blood pressures to anti-hypertensive of documented in the On 4-27-16 at 3:00 conducted with the stated "I guess we	possible 15 points, indicating inpairment. The Resident issistance of staff for a lation, and hygiene. The coded as requiring extensive for dressing, and toileting.  Bew of Resident #7's clinical in the record revealed a signed stating "Amlodipine Besylate gram) one tablet by mouth at Essential hypertension - hold lood pressure) less than 110." and 3-12-16, and was to be ston Administration Record) the time the order went into ation was administered, and a was taken and documented 6, and 3-17-16, however, after pressures had been taken or the 8:00 p.m. blood pressure eveals that the staff was sident's blood pressure was ers/Mercury, and the are been unnecessary per the ap until 4-21-16 (34 days), the essures were again begun, and the are reviewed, and bedtime to taken before giving the larg, were not completed nor	F	329			

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 20 of 40



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED C	
		495205	B. WING		04	4/28/2016	
	PROVIDER OR SUPPLIER	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  8000 ILIFF DRIVE  DUNN LORING, VA 22027				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	Facility policy "Adm reviewed and it stat administered accordudance for nursing physician's orders where Perry, Fundary physician is responsive treatment. Nurses unless they believe harm clients."	inistering Medications" was ed "Medications must be ding to the orders" ag practice for following was included in Lippincott, and amentals of Nursing, "The sible for directing medical follow physician's orders the orders are in error or was informed of findings on . No further information was acility.	F3	329			
	amlodipine and met medications) as ind ordered parameters Resident #16, a 92 facility on 11/26/08. hypertension, depre had a pacemaker.	year old, was admitted to the Her diagnoses included ession, and dementia. She					
	assessment was a assessment referer coded with a Brief lascore of 7 indicating	at recent Minimum Data Set quarterly assessment with an ace date of 4/18/16. She was neterview of Mental Status as severe cognitive impairment, sive assistance with her ng.		VDH/O			

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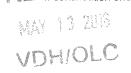
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	` ′сом	E SURVEY PLETED
		495205	B. WING _		1	C <b>28/2016</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8000 ILIFF DRIVE DUNN LORING, VA 22027		and the second s
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	medications to trea orders read:  1. Amlodipine 2.5 mouth one time a pressure less than 2. Metoprolol 25 ntwo times per day less than 120. Ordes than 120. Ord	physician orders for two at her hypertension. These milligram, give 1 tablet by day hold for systolic blood 120. Ordered 12/12/12 milligram, give 1 tablet by mouth hold for systolic blood pressure dered 3/28/16.  Til 2016 Medication cord (MAR) was reviewed. On ssure was documented as 6, blood pressure was 2/76. On both of these dates, pressure was less than 120. Were administered on these hould have been held.  Eviewed with the Administrator ring at the end of day meeting 4 the facility staff failed to hold essure medication) as ysician ordered parameters.  Every old, was admitted to the Her diagnoses included 1 fibrillation, depression, and the recent Minimum Data Set a quarterly assessment with an ence date of 2/10/16. She was Interview of Mental Status ing no cognitive impairment. Insive assistance with her	F 32	29		

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

Event ID:L4O611

Facility ID: VA0127

R = 4f continuation sheet Page 22 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

CLIVIE	COT OIL MEDICA	T TOTAL DELIVIORS			The second secon	
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405305	B. WING		C 04/20/204.5	
		495205			04/28/2016	
	PROVIDER OR SUPPLIER  RSING AND REHAB	CENTER	8	ETREET ADDRESS, CITY, STATE, ZIP CODE 1000 ILIFF DRIVE DUNN LORING, VA 22027		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 329	The order dated 8/3 milligram by mouth	physician order for Diltiazem. 8/15 read Diltiazem 180 one time a day Hold for	F 329			
F 367 SS=D	than 60.  Resident #4's April Administration Received the Diltiazem entry been recorded but been recorded.  The issue was review Nursing (DON) and day meeting on 4/2 DON stated that ducomputer system, to the been entered as dropped off. The hobtained prior to adswitch to the new statement of the switch to the new statement of the switch to the new statement of the switch to the switch to the new statement of the switch the	ord (MAR) was reviewed. On line, daily blood pressures had the daily heart rate had not ewed with the Director of Administrator at the end of 7/16. The following day, the ring the switch to the new he heart rate parameter had a part of the order and was eart rate had not been ministration. He stated the system took place on 3/15/16. EUTIC DIET PRESCRIBED	F 367	F – 367  1. Corrective Action Resident's #7and #20 suffered n effects from this deficient praction  2. Other Potential Residents All geriatric residents who are ordered to receive a therapeutic have the potential to be affected this deficient practice.	ce.	

Event ID: L40611

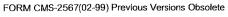
Facility ID: VA0127

If continuation sheet Page 23 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

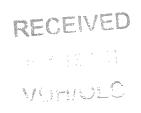
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
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* ** ***	PROVIDER OR SUPPLIER  JRSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 ILIFF DRIVE DUNN LORING, VA 22027	1 04/	720/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 367	1. For Resident #7, order for a "Dyspha Foods diet." Also of to assist while eating was observed eating assistance.  2. For Resident #20 discharged from the dysphagia diet, with secondary to a stroughous upon admission to received a regular of the findings included.  1. Resident #7 was facility on 6-9-15, and hospitalization on 3 Hypertension, renal dementia, seizure of the dementia, seizure of the dementia of	the Resident had a physician agia advanced/mechanical Soft one staff member was required ag for safety. The Resident ag a regular diet, with no an operation of the Resident was a hospital on a pureed an ectar thick liquids ke and aspiration pneumonia. The facility the Resident diet.  The resident was a hospital on a pureed an ectar thick liquids ke and aspiration pneumonia. The received after a second with a diet.  The recent Minimum Data Set was a quarterly assessment and received	F 36	3. New Measures/Systems Ch The RN Clinical Coordinator the RN Nursing Supervisors w inservice the geriatric licensed on the importance of ensuring orders coming from the hospit carried over to the facility and the importance of communica diet orders to the dietary depa  4. Monitoring The RN Clinical Coordinator the RN Nursing Supervisor wi 100% of new admissions to en diet orders coming from the h are carried over to the facility the course of three months. T results of these audits will be communicated to the Director Nursing who will report the fir to the Administrator and the C Committee monthly.  The Director of Dietary Servic compare 100% of the diet orde what the kitchen staff have as every other week over the cour three months. The Director of Dietary will report his finding monthly to the Administrator Committee over the course of months.  5. Completion Date June 11, 2016.	and/or rill re- nurses diet al are the of ting all rtment.  and/or ll audit sure the ospital over he of ndings CQI es will ers with ordered rse of	



Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 24 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495205	B. WING			С	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, 2 8000 ILIFF DRIVE DUNN LORING, VA 22027	ZIP CODE	04/28/2016	
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	a mechanically alta Significant Changa Resident was cod assistance of one mechanically alter Resident #7's breat 4-28-16 at 9:00 a.m. "Regular/Liberalize 4-28-16". All foods No Mechanical sofincluded whole to a was extremely hap foods she liked. No the Resident was equickly, taking larg little before swallow. The Resident cougsurveyor left the roothe hallway outside to return to the rooremove the tray. Cand asked if the Reeting. CNA A repl that the Resident for needed only to ope Resident, and then herself. CNA A was special diet, and she Resident ate a reguconsumed 100% of coughing intermitte removed by CNA A	ered diet. On the previous e assessment dated 1-4-16, the ed as requiring Extensive staff member for eating, and no ed diet.  akfast meal was observed on m. The meal tray ticket read ed Breakfast Thursday son the tray were regular diet. It foods were on the tray, which est. Resident #7 stated that she expy that he was allowed to eat on staff were in the room, and eating independently, and very the bites, and seemingly chewing ving, while continuing to talk, when the Resident's door for staff end of the Resident that the CNA end items like the milk for the end of the Resident could eat as asked if this Resident had a de replied "No." That the end end end end end end end end end en	F3	67			
1 1000	Director of Nursing of the most recent SResident #7. The D	al record was reviewed. The (DON) was asked for a copy Speech Therapy Evaluation for DON delivered a Speech Justion, dated 3-10-16. This					

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

Event ID: L40611

Facility ID: VA0127

RECIficantinuation sheet Page 25 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

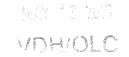
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495205	B. WING		04	C <b>4/28/2016</b>	
	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 ILIFF DRIVE DUNN LORING, VA 22027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	in the clinical reco "Assessment Sum (ST) documented "Swallowing impai "Recommendations (mechanical) Soft bites when eating. evaluation on 3-20 these recommend instituted as medic of treatment, as we physician signature transcribed and se  On 4-27-16 the Dir asked to provide th #7. Staff provided ticket. The meal tr "Regular/Liberalized On 4-27-16 the Dir asked how the num communicate diet of stated that they she the order change. also supposed to fi Order change" and When asked when communicated to d soon as possible."	ent Speech Therapy evaluation rd. Under the heading amary" the Speech Therapist her findings, which read; red" and under the heading of as" the ST documented of "Dysphagia Advanced/Mech Foods", and "small sips and "The physician had signed the 1-16, certifying the need for ations, and ordering them to be cally necessary under the planes documented on the line. This order was never ant to dining services.  In Services Manager was a copy of the 4-27-16 meal ay ticket read	F 367				
	being able to breatl pineapple chunks,	and began to complain of not n, the Resident was eating and they were removed from				- Constitution of the Cons	

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

Event ID: L4O611

Facility ID: VA0127

REOf continuation sheet Page 26 of 40



STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DA	(X3) DATE SURVEY COMPLETED	
		495205	B. WING		0.	C <b>I/28/2016</b>	
	A. BUILDING  495205  B. WING  OF PROVIDER OR SUPPLIER  NURSING AND REHAB CENTER  DESCRIPTION OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  IDENTIFICATION NUMBER:  A. BUILDING  B. WING  STREET ADDRESS, CITY, 8000 ILIFF DRIVE DUNN LORING, VA 2:  PROVIDER'S FORMATION OF DEFICIENCIES (EACH CORRECT CROSS-REFERENCE)  TAG CROSS-REFERENCE  DESCRIPTION OF DEFICIENCY OF DEF	STREET ADDRESS, CITY, STATE, ZIP CO 8000 ILIFF DRIVE DUNN LORING, VA 22027					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	order was received monitored by staff speech evaluation On 4-11-16 a social plan meeting with the revealed that the Rof fruit the previous note was a statement that the Resident would requested that mean the Resident would requested that mean therapist stated in a Barium Swallow of the previous of Barium Swallow on.  Review of the previous on the previous of the p	I that the Resident must be when eating, and that a would be completed on 4-4-16. If work note regarding a care he Resident's daughter resident had choked on a piece weekend. Included in the ent from the Speech Therapist ad food stuck in her chest, not Resident's daughter stated that do this at home as well, and ats be cut up. The Speech the note that an Endoscopy or study was possible. After the ng note nothing further ing to the DON, no endoscopy was ordered, or followed up to be a stated as the presence or absence of ight monthly, record and a daily."  I an dated 3-10-16 had no enstituted, and stated under the wing care plan "Resident eating." In the recapitulated Physician's interventions were current on the recapitulated Physician's order on 3-30-16. Diet. The Resident never	F 36	57			

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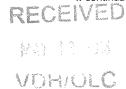
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495205	B. WING	successor control cont	gametro ser mojo meni menini minis 11 s. Artoroppor tujoji pop jemi akai ministraturatja 11 cempa promo mani	1	/28/2016	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE  8000 ILIFF DRIVE  DUNN LORING, VA 22027					
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F 367	the Resident whi meeting on 4-27-	page 27 tuted, and staff not monitoring le she ate, at the end of day -16. No further information was rovided according to the	F:	367				
	discharged from dysphagia diet, w secondary to a s Upon admission received a regula			And the second s				
	6-9-15, and disch day stay. Diagno dementia, dysph	as admitted to the facility on harged on 7-28-15, equaling a 49 oses included; Advanced agia, stroke, aspiration ression, Alzheimer's disease, and		And Andrewson an				
	assessment was an assessment r Resident #20 wa impaired" cogniti	nost recent Minimum Data Set an Admission assessment with eference date of 6-16-15. s coded with a "severely ve status, and required extensive e on one to two staff members daily living.		AND THE PROPERTY OF THE PARTY O				
	Resident #20 wa	s a closed record review, and so were possible.						
	Speech Therapy care, dated 6-10 required a puree	linical record was reviewed. The Initial Evaluation and plan of -15, indicated the Resident d diet with nectar thickened s in agreement with hospital		***************************************				

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

Event ID:L40611

Facility ID: VA0127

If continuation sheet Page 28 of 40



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		495205	B. WING_		0,	C <b>4/28/2016</b>
	PROVIDER OR SUPPLIER  JRSING AND REHAB	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8000 ILIFF DRIVE DUNN LORING, VA 22027		HZJIZO TO
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
200 mmmmm 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	discharge instruction there who stated the had signed the facing certifying the need and ordering them necessary under the documented on the order was never traservices.  On 4-27-16 the Dinasked to provide the #20. Staff was unan Resident's meal tick of the order change also supposed to fill Order change also supposed to fill Order change and When asked when communicated to dissoon as possible."  Review of the nursing revealed that on 6-9 it was documented receiving a pureed of liquids. On 7-8-15 (note for the Resider revealed that Speeds of food trials, and discussed and explathick liquids with the of the Resident. The director of nursing was documented to the Resident. The director of nursing was documented to the Resident. The director of nursing was documented to the Resident. The director of nursing was documented to the Resident. The director of nursing was documented to the Resident. The director of nursing was documented to the Resident.	ons from the Speech Therapist his diet as well. The physician lity evaluation on 6-23-15, for these recommendations, to be instituted as medically e plan of treatment, as was a physician signature line. This inscribed and sent to dining him services Manager was e diet information for Resident ble to provide a copy of the kets.  Sector of Nursing (DON) was sing staff were supposed to orders to the kitchen. He hald call and tell dietary about a addition, the nurses were led out the form called a "Diet take it down to the kitchen.	F 36			

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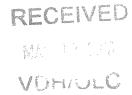
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 8000 ILIFF DRIVE DUNN LORING, VA 22027		2012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 367	medication that the and since it could it be changed to a lichad been receiving regular diet.  Review of the reca (signed 7-1-15) review of the reca (signed 7-1-15) review of the reca (signed 7-1-15) review of the gular Diet, Regular Diet,	e Resident had been receiving, not be crushed, it would have to quid, indicating the Resident g whole medications and a pitulated Physician's orders realed an order on 6-9-15 for a ular texture/Nectar consistency e Resident never received the resordered by Speech anscribed and communicated resupplements three times per not was losing weight, and this The physician seemed that the Resident had not diet, as on 7-17-15 the to discontinue the pureed diet phagia Advanced diet	F3	67			
	described that the land described that the land described that the land described had advanced by the orders for Regular physician's ordered had described had described had described by the land described had des	ess note dated 7-20-15 Resident was receiving sed diet (mechanical nectar thick liquids", however, alar diet still appeared on the lers sheet.  cation and Treatment ords (MAR/TAR), revealed the ng the Diet of a Resident was f the June, and July receiving a Pureed diet when					
PROPERTIES SOLICES IN AL	he left the hospital	6-9-15, due to a stroke, and					

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 30 of 40



PRINTED: 05/05/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495205	B. WING			l	C <b>28/2016</b>
	PROVIDER OR SUPPLIER	CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 ILIFF DRIVE DUNN LORING, VA 22027	Section 1997 - Sectio	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 367	facility on 6-9-15, a then down graded t on 7-17-15.  A telephone intervie Legal guardian, and separately, and beg	age 30 lar diet on admission to the gainst physician's orders, and to a Mechanical chopped diet ew was conducted with the diet the Complainant on 4-26-16, ginning at 3:40 p.m. According at never received the pureed	F3	367			
	dysphagia care plar on 6-23-15, had the instituted; "Diet as Monitor weights, lat No diet was specific to give guidance to The Administrator, I Corporate Nurse we never being institute on 4-27-16. No furt	tient at risk for weight loss" n dated 6-19-15, and revised e following interventions ordered, Hydration list, os, skin, intake as needed." ed or revised in the care plan nursing as to the correct diet.  Director of Nursing and ere notified of the diet order ed, at the end of day meeting ther information was available ording to the Administrator.					
	The facility must prodrugs and biologica them under an agre §483.75(h) of this p.	RMACEUTICAL SVC - EDURES, RPH  Divide routine and emergency Is to its residents, or obtain mement described in mart. The facility may permit mel to administer drugs if State ment y under the general	F4	25			

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

Event ID: L40611

Facility ID: VA0127

If continuation sheet Page 31 of 40



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	Property on a control	495205	B. WING			04/	4/28/2016	
	PROVIDER OR SUPPLIE			8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 ILIFF DRIVE DUNN LORING, VA 22027			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 425	A facility must pro (including procedu acquiring, receivin administering of a the needs of each)  The facility must ea licensed pharma	vide pharmaceutical services ares that assure the accurate g, dispensing, and ll drugs and biologicals) to meet resident.  If the services of acist who provides consultation are provision of pharmacy	F	425	<ol> <li>F – 425</li> <li>Corrective Action Resident #14 suffered no ill effection this deficient practice.</li> <li>Other Potential Residents All geriatric residents have the potential to be affected by this deficient practice.</li> </ol>	red no ill effects practice. Residents nts have the		
	by: Based on observatory documentation revithe facility staff fail accounting was markesident (Resident Residents.  For Resident #14, three Acetaminoph The findings included Resident #14, a ferthe facility 8/22/14 hospitalization 1/2/schizophrenia, atriareflux disease, must bladder, seizures, redisorder, extra pyrasepsis, dementia, a Resident #14's most revision revisio	ed: male, was initially admitted to and readmitted after a 16. Her diagnoses included al fibrillation, gastroesophageal scle weakness, over active renal tubular interstitial amidal symptoms, syncope, and hypothyroidism. st recent MDS (minimum data			3. New Measures/Systems Change The RN Clinical Coordinators and Nursing Supervisors will re-educate the geriatric licensed nursing staff the six rights of medication administration.  4. Monitoring The facility's pharmacy, Omnicate will audit 100% of the facility Medication Administration Recommon geriatrics to ensure medication administered are accurately accounted for. This audit will occur over the course of 90 days and the results of the audit will be present to the Director of Nursing and the Administrator who will present the findings to the CQI Committee.  5. Completion Date	re, rds secur		
THE PARTY AND A SECURITY OF TH	set) with an ARD (a	as a quarterly assessment.		1	5. Completion Date June 11, 2016.			

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION  DING	(X3) DA	TE SURVEY MPLETED	
		495205	B. WING		n/	C 1/29/2046	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 8000 ILIFF DRIVE DUNN LORING, VA 22027	O4/28/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 425	Resident #14 was deficits and was at decisions. She was assistance of one activities of daily like Licensed Practical during medication administering med 4/26/16 beginning assessed Resident #14 requireviewing the eMA administration reconstruction administration reconstruction administered the material with the following order was "3/15/16 at 4:15 p.m. Upon reconciliation administered with the following order was "3/15/16 Acetamine 8 hours as needed allowed=4 grms (grmost recently signed 4/1/16."  On 4/27/16 the pill observed and five the card. On the pic card had been sent on 4/21/16. When one dose of Acetam administered to Rethat was the dose of pour and pass on 4 administered in error observation. Registered Nurse (	coded as having no memory ble to make her own daily life is coded as needing extensive staff member to perform her ring.  Nurse (LPN) A was observed, pour and pass observation, factions to Resident #14 on at 4:10 p.m. LPN A had it #14 for pain and determined red pain medication. After R (electronic medication and), LPN A popped two 0 mg, along with an Omega 3 into a medication cup. LPN into a medication sto Resident #14 at into the medications to Resident #14 at into the physician's orders, the standard physician's orders, the standard for Acetaminophen was ablets had been removed from a lacet of the physician's orders dated card for Acetaminophen was ablets had been removed from a lacet of the pharmacy to the facility the eMAR was reviewed, only ninophen had been sident #14 after 4/21/16, and observed during medication and the physician is tablets had been or by LPN A during that	F	125			

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		ISTRUCTION	(X3) DATE SURVEY COMPLETED				
		495205	B. WING			م ا	C 4/28/2016
	PROVIDER OR SUPPLIER	CENTER		8000 IL	raddress, city, state, zip code .iff drive Loring, va 22027	1 0-	#Z0/Z0   0
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	4/27/16 at 10:24 a. The DON (director investigate where the Acetaminophen 500 conference. The Dot to borrow medication another Resident. As of the end of day further information of missing Acetaminophen 500 stated he was happened to the through The administrator, It consultant were information to ensure Acetamin Resident #14, 4/28/483.60(b), (d), (e) ELABEL/STORE DROTTHE facility must emalicensed pharmacof records of receipic controlled drugs in accurate reconciliate records are in order controlled drugs is reconciled.  Drugs and biological abeled in accordance professional principle appropriate accessor instructions, and the applicable.	ave to investigate the issue, m. of nursing) stated he would he three missing tablets of 0 mg, 4/27/16 at end of day ON stated the staff were not ons from one Resident for y conference 4/28/16, no was provided regarding then 500 mg tablets. The unable to determine what the etablets of Acetaminophen. DON, and corporate formed of the failure of the staff tophen was accounted for for 16 at 1:15 p.m. DRUG RECORDS, UGS & BIOLOGICALS and disposition of all sufficient detail to enable and ion; and determines that drug and that an account of all maintained and periodically alls used in the facility must be the ce with currently accepted les, and include the ory and cautionary expiration date when the staff of the facility must be considered the ory and cautionary expiration date when the state and Federal laws, the state and Federal laws, the	F 4				
:	facility must store al	l drugs and biologicals in		100 mg 10			

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

Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 34 of 40

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495205	B. WING	ì			C / <b>28/2016</b>
	(EACH DEFICIENC		ID PREF TAG	8 D X	TREET ADDRESS, CITY, STATE, ZIP CODE  000 ILIFF DRIVE  DUNN LORING, VA 22027  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	N ) BE	(X5) COMPLETION DATE
	controls, and perminave access to the The facility must premanently affixed controlled drugs list Comprehensive Dructontrol Act of 1976 abuse, except where package drug distrited quantity stored is must be readily detected.  This REQUIREMENT by:  Based on observation documentation reviet the medication keys unlocked refrigerator was behind a locked on 1 of 3 nursing until the medication keys unlocked the medication keys unlocked refrigerator was behind a locked on 1 of 3 nursing until the medication keys opened the medication keys opened the medication keys opened the medication keys opened the medication keys observed inserted in lock. No facility staff keys.  The findings include on 4/27/16 at 9:10 are frigerator on the permanent perm	ints under proper temperature it only authorized personnel to keys.  It ovide separately locked, a compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can of the facility failed to ensure were not inserted in the repad lock (the refrigerator in the nursing station its.  Is on the pediatric unit, which ion refrigerator, the narcotic fack up medications), were the unlocked refrigerator pad if were within sight of the discussion.  It is not met as evidenced in the redication in the nursing station its.	F	131	1. Corrective Action No pediatric residents suffered i effects from this deficient practic  2. Other Potential Residents All pediatric residents have the potential to be affected by this deficient practice.  3. New Measures/Systems Chan All pediatric licensed nurses will re-educated on the importance o keeping the medication keys in the possession at all times and on the importance of keeping the medicatric locked at times when they are not in direct contact with the medication cart refrigerator. This re-education when the done by the RN Pediatric Clin Coordinator and/or the RN Nurs Supervisors.	ge be f heir ation all and vill	
On 4/27/16 at 9:10 a.m., the medication refrigerator on the pediatric unit was observed to be unlocked with the keys inserted into the pad lock. The refrigerator was in the nursing station behind a locked door.			THE TAXABLE PROPERTY OF THE PR		i		



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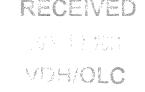
	The state of the s	TO MEDIONAL OLIVIOLO	-			. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION  IG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		495205	B. WING_		1	C <b>/28/2016</b>	
	PROVIDER OR SUPPLIER  IRSING AND REHAB (	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 8000 ILIFF DRIVE DUNN LORING, VA 22027	DE	20/2010	
(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 BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE	
	the presence of a set Approximately 30 be were stored in the relocked boxes affixed. They were locked, were at the nursing nursing station at the On 4/27/16 at 9:25 at A) entered the nursing surveyors "Do you has he was informed the medication keys the surveyors observative pad lock on the result of the nursing staff should be in possess the refrigerator, the doubt the refrigerator, the doubt the refrigerator and the medications).  RN A was asked when the stated medication carts, and the drawer of the middle. The facility policy title General" included the stated in the stated i	refrigerator were reviewed in econd surveyor. Ottles of liquid medication efrigerator. There were two do to the refrigerator door. No nurses or any facility staff station or within sight of the is time.  a.m., Registered Nurse A (RN any station. She asked the ave the medication keys?" and the surveyors did not have. She was also informed that wed the medication keys in refrigerator.  was ok that the refrigerator that he keys inserted in the don. When asked who sion of the keys, RN A stated and be in possession of the ed which items the keys ed that the keys unlocked the ole locked narcotic boxes in the pixis (back up  ere the keys are supposed to that there are three do the keys are kept in the top cart.  and "Medication Administration as section titled "Practice ection read "1. Maintain	F 43	The visually observations to the medication carts and reare locked when a licensed person is not present will be on rounds by the RN Pedia Clinical Coordinator or the of the Pediatric unit a minifive times per week and by nursing supervisors on the night and weekend shifts. To f these audits will be presed Director of the Pediatric unwill present the findings mothe Administrator and the Committee monthly over the three months.  5. Completion Date June 11, 2016.	efrigerators staff e done. done daily tric e Director mum of the RN evening, The results ented to the pit and she conthly to CQI		

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Event ID: L4O611

Facility ID: VA0127

If continuation sheet Page 36 of 40



PRINTED: 05/05/2016 FORM APPROVED OIMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED C	
		495205	B. WING_		1	/28/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8000 ILIFF DRIVE DUNN LORING, VA 22027		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 514 SS=D	At the end of day of Administrator and notified that the munattended in the refrigerator pad low 483.75(I)(1) RES RECORDS-COMFLE  The facility must make resident in accordate standards and practically orgate accurately docume systematically orgate and progress notes are provided; preadmission scream progress notes are provided and progress notes are provi	meeting on 4/27/16, the Director of Nursing were edication keys were left unlocked medication ck.  PLETE/ACCURATE/ACCESSIB  maintain clinical records on each ance with accepted professional ctices that are complete; ented; readily accessible; and anized.  must contain sufficient tify the resident; a record of the ments; the plan of care and the results of any ening conducted by the State; s.  NT is not met as evidenced  tion, staff interview and clinical facility staff failed for one #11) of 23 residents in the maintain an accurate record.  the facility staff failed to ent the times a wrist brace was ed. ed:	F 43		ers for e nge nd the taff on splint the rd to	
		admitted to the facility on agnoses of, but not limited to,				

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Event ID: L40611

Facility ID: VA0127

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		S INESIGNUS OFFICES		-	91	IVILLY INC.	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495205	B. WING			}	C <b>28/2016</b>
	PROVIDER OR SUPPLIER	CENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE 000 ILIFF DRIVE DUNN LORING, VA 22027		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	The most recent Mi quarterly assessme Reference Date (AF coded Resident #11 extensive assistance activities of daily livilimitation on the upp On 4/26/16 at 8:20 a observed lying in be answered questions Resident #11's clinic 4/27/16. The review which read: "RIGHT WORN AT DAY TIM FOR BADL (basic at TASKS." The origin Review of the Februand Treatment (TAR revealed the wrist brokens and times. The 2016 Material Resident Material Resident Resi	e, CVA (cerebrovascular d osteoporosis.  nimum Data Set (MDS) was a nt with an Assessment RD) of 1/20/16. The MDS with intact cognition; e required from staff for all ng; and had range of motion	F 5	514	4. Monitoring The RN Clinical Coordinator an Nursing Supervisors will audit 50 the geriatric residents who have orders for brace/splint application ensure that the correct time has recorded for application and rem. This audit will be done weekly the will result in 100% of the geriatric residents with orders for brace/spapplication and removal to be au every two weeks. The results of the audits will be shared with the Director of Nursing who will shart the findings monthly over three months with the Administrator at the CQI Committee.  5. Completion Date June 11, 2016.	on to been noval. us ic plint dited these	
	revealed a "Visual/B included directives o ambulate, eat, dress was to be performed directives and other Devices" section rea	devices. The "Other d: "Right Wrist Brace to be time. On at 8am & off at			RECEIVED		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
		495205	B. WING_		) 	C <b>4/28/2016</b>
	PROVIDER OR SUPPLIER  JRSING AND REHAB			STREET ADDRESS, CITY, STATE, ZIP C 8000 ILIFF DRIVE DUNN LORING, VA 22027		¥/20/20 16
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 514	On 4/27/16 at 10:59 conducted with the Nursing-Registered asked why the brace and not after, RN-B from one computer 2016 and "In the property of the brace, It is stated "You'll see the When asked who we take off the brace, It." The Restorative reviewed and revea and removing the brace and removing the brace and removing to the ordocumented as on a p.m., 4/15/16-on at p.m., 4/16/16-on at p.m., etc. Per RN-B, the document The concern that the applying the brace discussed. There we motion or contracture the interview with RN-B the order for the removal was observed in her whom member with the riguitable of the wrist brace documented on the documented on the	Assistant Director of Nurse B (RN-B). When was on the February TAR explained the facility switched system to another in March ocess of moving the orders to how on MAR or TAR." She is break in (the) system." As supposed to put on and RN-B stated "Restorative does in nursing documentation was led that the times of applying race varied and were not lers. 4/14/16 was at 1:04 p.m. and off at 1:04 11:39 a.m. and off at 2:25 11:25 a.m. and off at 2:12 mentation "Depends on the are the times that are there." ere is no documentation of ce at the ordered times was as no decline in range of the wrist brace application and	F 51	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495205		B. WING		C <b>04/28/2016</b>		
NAME OF PROVIDER OR SUPPLIER  ILIFF NURSING AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 8000 ILIFF DRIVE DUNN LORING, VA 22027		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION	
F 514	4/28/16 at 8:30 a.m showed that it was times it was done." documentation erro	rsing (Other-A) stated on that the "Documentation put on and taken off, not the It was determined it was a or. Inot present any further	F 514			
700				RECEIVED		