DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING .. C. 8 WING 495177 05/10/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER REVISED SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION. (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 000 E 000 Initial Comments This Plan of Correction is respectfully An unannounced Emergency Preparedness survey submitted as evidence of compliance. was conducted 5/08/18 through 05/10/18. The The submission is not an admission facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care that the deficiencies existed or that we Facilities. are in agreement with them. It is an F 000 INITIAL COMMENTS F 000 affirmation that corrections to the areas cited have been made and that An unannounced Medicare/Medicaid standard survey was conducted 5/8/18 through 5/10/18. the facility is in compliance with the Significant corrections are required for compliance requirements of participation. with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The Life Safety Code survey/report will follow. F 657 Care Plan Revision The census in this 140 certified bed facility was 94 at the time of the survey. The survey sample **Corrective Measure for Residents** consisted of twenty-one current resident reviews and two closed record reviews. Affected F 657 Care Plan Timing and Revision F 657 CFR(s): 483.21(b)(2)(l)-(iii) Resident # 36's care plan has been SS=E revised to reflect measurable goals and §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must bespecific interventions regarding (i) Developed within 7 days after completion of the contractures and the joints/extremities comprehensive assessment. (ii) Prepared by an interdisciplinary team, that involved. Non-pharmacological includes but is not limited tointerventions have been revised to (A) The attending physician. (B) A registered nurse with responsibility for the include specific approaches. Comfort resident. measures related to positioning have (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. been added. Interventions for (E) To the extent practicable, the participation of the regurgitation of oral intake and assistive resident and the resident's representative(s).

Any deficiency statement ending with an esterisk (*) 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 regulate to continued program participation.

TITLE

(X8) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
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F 657	medical record if the and their resident re practicable for the dicare plan. (F) Other appropriat disciplines as determas requested by the (iii)Reviewed and re team after each assocomprehensive and	t be included in a resident's participation of the resident presentative is determined not evelopment of the resident's e staff or professionals in nined by the resident's needs or	F	357	device have been discontinued are not appropriate at this time. Resident # 46 was discharged facility on 5/11/18 and the comprehensive care plan cited survey is no longer in use. He admitted on 5/17 and a new comprehensive care plan will developed based on his assess	from the d during was re-	
	Based on observation, staff interview and clinical record review, facility staff failed to review and revise a comprehensive care plan (CCP) for eight of 23 residents in the survey sample, Residents #36, #46, #72, #67, #5, #54, #25, and #73. 1. Resident #36's care plan did not have measurable interventions to address contractures, comfort measures, non-pharmacological interventions, assistive devices or her NPO (nothing by mouth) status. 2. Resident #46's care plan did not have measurable interventions to address non-pharmacological interventions, urinary status or verbalization of self harm. 3. Resident #72 's care plan did not have measurable interventions to address restorative therapy, comfort measures or non-pharmacological interventions. 4. Resident #67 did not have a care plan to				Resident # 72's care plan has be revised to address restorative interventions. Non-pharmacol interventions for pain and oth comfort measures now includ approaches. The care plan for resident # 67 revised to reflect the use of Pl for nutrition and hydration and pureed food and thickened liquid provided orally for pleasure. It reflects feeding assistance being provided by staff. The care plan for Resident # 5 reviewed and interventions for	therapy ogical er e specific has been G tube d the uids also ng	
		d not have a care plan to ercutaneuous endoscopic			prevention were present.	1 1011	
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F 657	puree diet, or that s feeding. 5. Resident #54 ca include measurable #54 has encountered indicating lack of successions. 6. The facility staff comprehensive care Resident # 5. 7. Facility staff fail of care with interver 8. Resident #73's include use of plast Findings included: 1. Resident #36 w facility on 03/04/20 with diagnoses included Hypertension, Sacr MRSA (methicillin r Dementia, Parkinson Dysphagia. The most recent Mannual assessment reference date) of cassessed as severe term memory and control Resident #36's CC.	tube feedings, the use of a the was total assistance for the was total assistance for the was not revised to interventions for falls. Resident and multiple unwitnessed falls pervision. If alled to review and revise the eplan (CCP) for falls for the eplan (CCP) for falls for the eplan for fall/injury prevention.		557	Other interventions are being chair/bed alarm to remind he get out of bed or wheelchair PT/OT evaluation to assess programmed for wheelchair adapt place personal items within recloser supervision and scheditoileting. Resident # 25 was assessed frontinued use of the reclining was discontinued based on the assessment. Additional interwill be implemented based of investigation and root cause. Additional interventions have will be added to Resident # 5 plan: increased supervision to family, tray for his wheelchair him to work on a "busy boar scheduled toileting, chair and with voice instruction not to without assistance, visual chair and the second of th	er not to unassisted ositioning rations, each, uled or g chair. It he ventions n fall analysis. e been or '4's care by staff and ir to allow d", d bed alar get up ecks every nd physicia of ns, and	d m

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F 657	without personalize goals: "Prevent t contracturesEvalu	d interventions or measurable further deterioration of late effectiveness of comfort	F	657	structured environment and Resident # 73 was provided r		
	measuresProvide	[Name] with non erventionsUtilize assistive			flatware on a trial basis and s	he was	
	devices for function	and independenceObserve			observed to be using them		
	for regurgitation with	n oral intake" These			appropriately. The use of pla	stic	
	statements were written as noted above. Nothing was personalized specific to Resident #36.				flatware was thus discontinu	ed.	
	Resident #36 had numerous contractures that were not listed on the CCP. No specific comfort measures or non-pharmacological interventions were listed. No specific assistive devices were listed. Resident #36 was NPO and received all nutrition and oral medications via a feeding tube in her abdomen. RN #3 (registered nurse) was interviewed on 05/10/18 at 10:50 a.m. regarding care plans. RN #3 stated, "Care plans are a joint effort. We are responsible."				Identification of Other Reside Potential To Be Affected Other residents with potential affected will be identified the review of physician's orders, and care plans. Any variance will be addressed.	al to be rough fall logs	
	were informed of the the survey team on p.m. No further informat team prior to the example of t	and DON (director of nursing) e above during a meeting with 05/10/18 at approximately 2:30 from was received by the survey tit conference on 05/10/18. The same of the facility on the same of the f			The care plan application for implemented in November if flexibility for individualizatio originally thought. In-service of nursing staff will be conduthis application and to reiter requirement that care plans based on post fall assessment resident centered care neces meet residents' needs.	the EM! nas more n than c/re-train ucted on rate the be upda	ing
	quarterly assessing	one man and the face of the first			meet residents needs.		

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F 657	reference date) of assessed as cogniscore of 15 out of Resident #46's CC 12:25 p.m. Include general, non-speciand goals. These with non-pharmace effectivenessAn prevent tension. tract infection], prosupport skin care, independence. Curinary retention/ocontinuous Foley. tubing per policy immediately" No specific non-plincluded on this refoley catheter was survey. There was verbalizations by behavior in his clin RN #3 (registered 05/10/18 at 11:00 CCP. RN #3 stal We are responsible nurse who do'd [ditaken it out of the someone checker recollection of him himself."	03/26/18. Resident #46 was itively intact with a total cognitive 15. CP was reviewed on 05/09/18 at ded in this resident's CCP were iffic, non measurable interventions included: "Provide [Name] ological intervention, evaluate chor drainage tube of Foley to Eval for symptoms of UTI [urinary pmote hydration, proper cleansing, catheter needs while promoting check for physician diagnosis of other medical justification forChange urinary catheter bag and .Address self injury verbalizations harmacological interventions were esident's CCP. Resident #46's self discontinued on 04/09/18. It is no mention of any Resident #46 of self injurious		357	Monitoring: The Director of Nursing or de will review care plans to ensare being updated/revised to fall prevention interventions appropriate interventions to resident needs. Monitoring implementation of care plantinterventions on a sample of will also be conducted. Variances identified during a be corrected and non-composite will be re-in-serviced, couns disciplined. Audits will be conducted we weeks. Findings will be reported for further or recommendations. Correction Date: 6/24/2018	ure they o reflect and other meet of staff f resident liant staff eled or eekly X 8 orted to to	is he

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: A, BUILDING _ C B. WING 05/10/2018 495177 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES Œ (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX OR LSC (DENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 657 F 657 | Continued From page 5 were informed of the above during a meeting with the survey team on 05/10/18 at approximately 2:30 p.m. No further information was received by the survey team prior to the exit conference on 05/10/18. 3. Resident #72 was originally admitted to the facility on 07/27/2004 and readmitted on 04/14/2018 | with diagnoses including, but not limited to: Anemia, Hypertension, Diabetes, Hemiparesis and Depression. The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 04/21/18. Resident #72 was assessed as severely impaired in her short and long term memory and daily decision making skills. Resident #72's CCP was reviewed on 05/09/18 at 9:30 a.m. The CCP included general, non-specific, non-measurable goals and interventions. These included: "...Functions at Optimal Level with ADLs [activities of daily living]...Provide assistance to support level of needs... Evaluate effectiveness of comfort measures...Provide [Name] with nonpharmacological Interventions..." This CCP was not Individualized to Resident #72's needs. There was no mention of her restorative nursing on the CCP. This resident was maximum assist with all ADL's. Also, no specific comfort measures or non-pharmacological interventions were stated on the CCP. RN #3 (registered nurse) was Interviewed on

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F 657	#3 stated, "Care places possible." The Administrator a were informed of the the survey team on p.m. No further information team prior to the extended to: Resident #67 w 03/27/2018. Her dimited to: Stage IV sepsis, dementia, a (adult). The most recent MI admission assessmere ence date) of 0 assessed as being short term memory, decision making skill to approximately 11:44 observed lying in he assistant) #4 was a Resident #67 a purpump was observed attached to a pole a Jevity 1.2 was hang from the pump was At approximately 1: hailway. This surve	m. regarding care plans. RN ans are a joint effort. We are not DON (director of nursing) above during a meeting with 05/10/18 at approximately 2:30 on was received by the survey it conference on 05/10/18. As admitted to the facility on iagnoses included but were not pressure ulcer of the sacrum, and body mass index 19.9 or less on the conference on 05/10/18. Resident #67 was impaired with both long and and severely impaired with daily		657			

PRINTED: 05/22/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING C B. WING 495177 05/10/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (MS) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) éréeix. TAG DEFICIENCY) F 657 F 657 | Continued From page 7 25 %. CNA #4 was asked if Resident #67 could feed herself at all. She stated, "No, we feed her at every meal." The clinical record was reviewed at approximately 2:30 p.m. Observed on the physician orders were orders for the administration of the tube feeding, cleaning of the PEG site, and a diet order for a modified diet, texture restricted with nectar thick liquids. The care plan was reviewed. A focus area for "LTC [long term care] Nutritional Status" was observed. There were no interventions listed for Resident #67's PEG tube, PEG tube care, tube feeding, her puree diet or that she needed assistance to be fed. The other focus areas were reviewed and did not contain the Interventions listed. The DON (director of nursing) was interviewed on 05/09/2018 at approximately 10:00 a.m., regarding the care plan for Resident #67. She looked at the care plan and stated, "I don't see them [interventions previously named]. The DON was asked if the interventions should be listed. She stated, "Yes." The above information was discussed during a meeting with the DON, the administrator and the unit manager on 05/10/2018 at approximately 2:30 p.m. No further information was provided prior to the exit conference on 05/10/2018. 5. Resident #5 was admitted to the facility 8/24/17 with diagnoses to include, but were not limited to: dementia, anxiety, depression, GERD, and high

blood pressure.

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F 657	Continued From page	ge 8	F	657			
	quarterly review data 5 assessed with seria total summary social summary social puring review of the (EMR), it was noted "IPOC (Individual placare) Falls (Initiated The EMR identified injury (GOAL); Des Nurse Reviewed." documented "Mors The items were ide 5/9/18. The care place to the consisted of check as "Goal Met." The specific problems, plan. LPN # 5 was asked plan. LPN # 5 stain the current softwother than to check LPN # 5 was asked off if there was not done. LPN # 5 did was then asked whistandard precaution actually a form that gives a numer This surveyor then	e electronic medical record If the care plan documented as Ian of care): LTC (long term I). Last updated on: 5/8/18" under "Outcomes: Free from cription of Fall activity LTC; MDS Under "Interventions was e fall risk standard precautions." ntified as "activated" and dated blan documentation in the EMR marks beside typed notes writter ere was no description located or goals, or interventions. p.m. LPN (licensed practical ded for assistance with the care ted there were no specific areas rare to include documentation off the area under the heading. If how an area could be checked documentation of what was to be d not have an answer. LPN # 5 nat was the "Morse fall risk in." LPN # 5 stated "I think it's it's filled out at the time of a fall ical score of the risk for falls." asked if there were any other ills included in the care plan.	n f				

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F 657	the care plan with the asked if she knew we precautions" were. know- I can find out the unit where Resistaff about the fall passessing and mon a fallat least, I thir (certified nursing as heard of that, I have that she had no ide precaution was, but stated, "The Morse intervention; it's a fall, it brings up a the score as you go numerical value. I assessment." During a meeting wat 2:30 p.m. with the several nursing state care plan for falls of falls. No additional informexit conference. 6. Resident #54 woriginally on 05/18/dementia. The most current for annual quarterly as Resident #54 was Resident #54 was	ge 9 a.m. this surveyor discussed the DON (director of nursing) and what the "Morse fall risk standard The DON stated "I don't "This surveyor then went to dent # 5 resided and interviewed trecautions as written on the I stated "Well, I think it's litoring anything that could cause ink that's what that is." CNA sistant) # 1 stated "I have never a no idea!" CNA # 2 also stated a what the Morse fall risk the could find out. LPN # 2 fall risk precaution isn't anorm that is to be filled out when fall. When it's activated if there's list of questions and tally's upon and then gives you the fall risk it's basically like a fall risk it's basically like a fall risk it's basically like a fall risk it'not include interventions for mation was provided prior to the was admitted to the facility "16, with diagnoses that included ADS (minimum data set) was an assessed with long and y loss and severe loss of cognitive loss and severe loss of cognitive		657			

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F 657	12:21 PM. During to verbalized that Resistems and Resident and tries to get out of Resident #54's sondoes were an alarm a shortage of staff with because the certifiers of much to do. On 05/09/18 3:30 p. within 10 feet of the Three staff member were unaware that if get out of the wheel continued for 15 min attempted to assist member observed the interacting with Resident #54 back interventions including asked, resulting the call light. The staff was the call light. The staff on 2/4/18. The intervention was dasight during risk hold documentation, Resident 2/4/16.	as conducted on 05/08/18 at he interview Resident #54's son dent #54 had fallen multiple #54 does not use the call bell of bed and out of the wheelchair. Verbalized that Resident #54 and has a fall mat, but felt that has the main reason for the falls dinursing assistants (CNA) have m. Resident #54 was observed nurses station by 2 surveyors. It were at the nurses station, but Resident #54 was attempting to chair. This observation nutes. No staff member Resident #54 until one staff he surveyors and then started ident #54, trying to get Resident #54 back in the wheelchair. Resident #54 back in the wheelchair. Resident #54 hack in the wheelchair. #54's care plan for fall led: Bed alarm, Chair alarm has, low bed with mat, remind to these interventions were all he most recent updated ted 5/9/18 and included, keep in urs. According to sident #54 had fallen a total of 7 is and 5/8/18.		657			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEPICIONNESS AND PLAN OF CORPORATION ASSURANCE CONSTRUCTION A SULLING CONTROL OF CONTR	CENTER	S FOR MEDICARE	& MEDICAID SERVICES						MB NO	<u>, 0938-0391</u>
NAME OF PROMOTER OR SUPPLIER COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SIMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SOUTH HILL, VA. 23870 PROFITE CHOPMICIPAL PROPERTY OR 155 CHEMICIPAL PROFITAL PROPERTY TAG FOR THE CHOPMICIPAL PROPERTY OR 155 CHEMICIPAL PROFITAL PROPERTY TAG FOR TO CONTINUE FROM PROFITAL PROFITAL PROPERTY TAG FOR THE CHOPMICIPAL PROFITAL PROPERTY TAG FOR THE CHOPMICIPAL PROPERTY TAG COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER FOR THE CHOPMICIPAL PROPERTY TAG	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	* ,						
COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SAMARY STATEMENT OF DEFICIENCES PRIETY TAG SAMARY STATEMENT OF DEFICIENCES PRIETY TAG CACH DEFICIENCY WILL RESULTATORY OR LSCIDENTPYNO INFORMATION) F 657 Continued From page 11 regarding Resident #54's care plan. RN #3 verticalized that Resident #54 was continuously brying to get out of the during that state doesn't know what else to do. This surveyor explained that some of Resident #54's interventions does not seem Individualized and specific, for example, frequent observations and keep in sight during risk hours. This surveyor asked RN #3'how often was frequent observation and when were the risk hours. RN #3' vertibalized that flose interventions were not specific to time because that would make the staff have to document when and how often Resident #54 was being observed. On 05/10/18 10.49 AM the director of nursing was informed of the concerns regarding revising the care plan to reflect more measurable interventions. No other information was provided prior to exit conference on 5/10/18. 7. Resident #25 was admitted to the facility on 5/33/17 with diagnoses that included Parkinson's disease, cerebiovascular accident (stroke), peripheral vascular disease, anemia and depression. The minimum data set (MDS) dated 2/28/18 assessed Resident #25 with severely impaired cognitive skills. Resident #25's clinical record documented a post fall evaluation note dated 6/4/19 stelling the resident fell from a recilingin chair in his room. The record documented no further details about the fall or any describtion of events leading up to or surrounding			495177	B. WING					1	_
F 657 Continued From page 11 regarding Resident #54's care plan. RN #3 verbalized that Resident #54 was continuously trying to get out of feet or out of the wheelchair, does not call for help, and has had multiple falls. RN #3 verbalized that the facility has tried to put Interventions into place, but short of putting Resident #54' on one to one, the staff doesn't know what else to do. This surveyor explained that some of Resident #54's interventions does not seem Individualized and specific, for example, frequent observations and keep in sight during risk hours. This surveyor asked RN #3 how often was frequent observation and when were the risk hours. RN #3 verbalized that those interventions were not specific to time because that would make the staff have to document when and how often Resident #54 was being observed. On 05/10/18 10:49 AM the director of nursing was Informed of the concerns regarding revising the care plan to reflect more measurable interventions. No other information was provided prior to exit conference on 5/10/18. 7. Resident #25 was admitted to the facility on 5/31/17 with diagnoses that included Parkinson's disease, carebrovascular accident (stroke), peripheral vascular disease, anemia and depression. The minimum data set (MDS) dated 2/28/18 assessed Resident #25 with severely impaired cognitive skills. Resident #25 clinical record documented a post fall evaluation note dated 6/4/18 stafting the resident felt from a reciliang potair in his room. The record documented no further details about the fall or any describit on of vertex leading up to or surrounding			PITAL HUNDLEY CENTER		12	5 BUENA VISTA CI	RCLE	DDE		
regarding Resident #54's care plan. RN #3 verbalized that Resident #54 was continuously trying to get out of bed or out of the wheelchair, does not call for help, and has had multiple falls. RN #3 verbalized that the facility has tried to put Interventions into place, but short of putiting Resident #54 on one to one, the staff doesn't know what else to do. This surveyor explained that some of Resident #54's interventions does not seem Individualized and specific, for example, frequent observations and keep in sight during risk hours. This surveyor asked RN #3 how often was frequent observation and when were the risk hours. RN #3 verbalized that those interventions were not specific to time because that would make the staff have to document when and how often Resident #54 was being observed. On 05/10/18 10:49 AM the director of nursing was informed of the concerns regarding revising the care plan to reflect more measurable interventions. No other information was provided prior to exit conference on 5/10/18. 7. Resident #25 was admitted to the facility on 5/31/17 with diagnoses that included Parkinson's disease, cerebrovascular accident (stroke), peripheral vascular disease, enemia and depression. The minimum data set (MDS) dated 2/28/18 assessed Resident #25 with severely impaired cognitive skills. Resident #25 sclinical record documented a post fell evaluation note dated 5/4/18 stating the resident felt from a reclining chair in his room. The record documented no further details about the fall or any description of events leading up to or surrounding	PREFIX	(EACH DEFICIENCY MUST	FBE PRECEDED BY FULL REGULATORY	PREFI		(EACH COF	RRECTIVE ACTIC ERENCED TO TH	N SHOULD E E APPROPRI		(X5) COMPLETION DATE
the incident. Interventions listed	F 657	regarding Resident verbalized that Resitrying to get out of bidoes not call for hel RN #3 verbalized the Interventions into place Resident #54 on on what else to do. Tiof Resident #54's in Individualized and sobservations and ket This surveyor asked observation and whore balized that those to time because that document when and being observed. On 05/10/18 10:49 Informed of the concare plan to reflect to No other information conference on 5/10 7. Resident #25 w 5/31/17 with diagnoral disease, cerebroval peripheral vascular depression. The m 2/28/18 assessed Fimpaired cognitive strength of the conference on first the resident #25's clinification and the resident #25's clinification and the resident #25's clinification and the resident #25's clinification of even description of even	#54's care plan. RN #3 Ident #54 was continuously led or out of the wheelchair, p, and has had multiple falls. In the facility has tried to put lace, but short of putting le to one, the staff doesn't know his surveyor explained that some literventions does not seem lipecific, for example, frequent leep in sight during risk hours. If RN #3 how often was frequent leep in sight during risk hours. If RN #3 how often was frequent leep were the risk hours. RN #3 le interventions were not specific lit would make the staff have to lid how often Resident #54 was AM the director of nursing was learns regarding revising the limore measurable interventions. In was provided prior to exit litial. It was admitted to the facility on lises that included Parkinson's liscular accident (stroke), lidisease, anemia and linimum data set (MDS) dated licesident #25 with severely liskills. It record documented a post lidated 5/4/18 stating the resident licesident in his room. The record lifter details about the fall or any lits leading up to or surrounding		357					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES				FORM OMB NO	05/22/2018 APPROVED 0938-0391
STATEMENT C	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		SURVEY MPLETED
		495177	e. WING			05/	10/2018
	ROVIDER OR SUPPLIER HTY MEMORIAL HÖSI	PITAL HUNDLEY CENTER		125	EET ADDRESS, CITY, STATE, ZIP CODE BUENA VISTA CIRCLE UTH HILL, VA 23970		
(X4) ID PREFIX TAG	(CACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES THE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAC	XI.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	reclining chair. Intervent further falls lighting, bed in low wheels locked, bed room. The resident's plan updated with any noprevention following interventions listed and location while fall risk standard probed or chair, evaluation following call bell action frequently, remove monitor as needed plan made no men use of a reclining of the control o	alls made no mention of the erventions documented to included adequate room position, non-slip footwear, alarm, floor mat and clutter free of care (revised 5/8/18) was not ew interventions for fall githe fall on 5/4/18. Care plan included were: note positioning out of bed in wheelchair, Morse recautions, sensory pad while in ate room for clutter, frequent cessible, low bed, monitor more from harmful objects and while in wheelchair. The care tion of the 5/4/18 fall or of any		657			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	05/22/2018 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPL/ER/CLIA IDENTIFICATION NUMBER:	• =	E CONSTRUCTION		SURVEY MPLETED
		495177	B. WNG		1	10/2018
NAME OF P	ROVIDER OR SUPPLIËR		8	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	NITY MEMORIAL HOSF	PITAL HUNDLEY CENTER		126 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	38 C	(X5) COMPLETION DATE
F 657	reviewed the circum On 5/10/18 at 10:31 Resident #25 was in reclining chair. LPN typically out of bed it #7 stated she was n a reclining chair. LI the care plan had be 5/4/18. On 5/10/18 at 12:05 care plan updates w #25's fall on 5/4/18. care plans when MD completed and that responsible for update between assessmer #25's care plan and revisions in responsions. These findings were and director of nursi at 2:30 p.m. 8. Resident #73 was 1/13/12 with a re-adfor Resident #73 inc pressure, cerebrova hemiplegia, dementi data set (MDS) date #73 with moderately. On 5/8/18 at 11:40 a	she had not investigated or stances surrounding the fall. a.m., LPN #7 caring for terviewed about use of the N #7 stated the resident was in a standard wheelchair. LPN of aware of Resident #25 using PN #7 stated she did not know if the updated following the fall on p.m., LPN #5 responsible for as interviewed about Resident LPN #5 stated she updated its assessments were the floor nurses were thing the care plan as needed its. LPN #5 reviewed Resident stated she did not see any is to the 5/4/18 fall. reviewed with the administratoring during a meeting on 5/10/18 is admitted to the facility on mission on 3/1/18. Diagnoses luded diabetes, high blood scular accident (stroke), a and anxiety. The minimum is d./23/18 assessed Resident impaired cognitive skills.	F 657			

PRINTED: 05/22/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION A. BUILDING _ C B. WING, 495177 05/10/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XB) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX OR LISC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 657 | Continued From page 14 F 657 On 5/9/18 at 9:18 a.m., Resident #73 was observed in her room eating a cup of applesauce using a plastic spoon. Resident #73 was interviewed at this time about the plastic utensils. Resident #73 stated she was always given plastic utensils but she dld not know why. Resident #73's plan of care (revised 5/9/18) made no mention of plastic eating utensils. On 5/9/18 at 9:20 a.m., the licensed practical nurse (LPN #8) caring for Resident #73 was interviewed about the plastic utensils. LPN #B stated she was aware the resident had plastic utensils and thought they were used due to a safety issue with the resident. On 5/9/18 at 9:25 a.m., LPN #2, working on Resident #73's living unit, was interviewed about the plastic utensils. LPN #2 stated the resident at one time hoarded the stainless silverware in her reclining chair and the utensils were sticking the resident causing a safety concern. LPN #2 stated the hoarding behavior started several months ago and the plastic utensils were used as a safety precaution. LPN #2 reviewed Resident #73's care plan and stated there was nothing on the care plan about the utensils or the hoarding behavior

utensils.

On 5/10/18 at 8:52 a.m., LPN #5, responsible for MDS assessments and care plans, was interviewed about the plastic utensils. LPN #5 stated she knew the resident used plastic eating utensils but did not see any updates to the care plan about the plastic

These findings were reviewed with the administrator

and director of nursing during a

PRINTED: 05/22/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER DATE OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER DATE OF PREFIX TAG (FACH DEFICIENCY MAY TE DIEN TO F DEFICIENCIES SOUTH HILL, VA 2 3970 DETINETING OR LISC DESTRIPTIVES INFORMATION) F 657 Continued From page 15 meeting on 5/10/18 at 2:30 p.m. F 689 F 689		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED				
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128 BUENA VISTA CIRCLE SOUTHILL, VA 23970 PREFIX SUMMARY STATEMENT OF DEFICIENCIES TAG PREFIX GRACH DEPICIENCY MUST BE PRECEDED BY FILL REQUATORY TAG F 657 Continued From page 15 meeting on 5/10/18 at 2:30 p.m. F 659 meeting on 5/10/18 at 2:30 p.m. F 659 SAS_25(d)(1)(17) The resident environment remains as free of accident Hazards/Supervision/Devices S483.25(d) Accidents. The facility must ensure that - \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and The brakes on Resident #34's bed are being locked. A bed rail assessment was conducted and the bilateral ½ rails were discontinued and are no longer in use. The top bilateral ½ rails continue to be used per physician order. A fall mattress has been added. There has been no additional fall at this time. Prefix the provide supervision and interventions to prevent falls/accidents for five of 22 residents, Resident #34. Resident #54. This is a complaint deficiency. 1. Facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 22 residents, Resident #34. Resident #54. This is a complaint deficiency. 1. Facility staff failed to provide supervision and interventions to her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident #6.	NAME OF PI	ROVIDER OR SUPPLIER							
Southfill Val 2397					125 BUENA VISTA CIRCLE				
F 657 Continued From page 15 meeting on 5/10/18 at 2:30 p.m. Free of Accident Hazards/Supervision/Devices SS=G SS=G SS=G SS=G SS=G SS=G SS=G SS=	COMMUN	IITY MEMORIAL HOSF	PITAL HUNDLEY CENTER		SOUTH HILL, VA 23970				
meeting on 5/10/18 at 2:30 p.m. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) (Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34, Resident #54. This is a complaint deficiency. 1. Facility staff failed to lock the brakes on Resident #34's bed, when providing personal care. Resident #34 was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident #5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stainwell door with a malfunctioning	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI				
Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34, Resident #54. Resident #54. Resident #54. Resident #54. Resident #54 have providing personal care. Resident #34 was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident #5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning	F 657	Continued From page	ge 15	F 657					
F 689 SS=G Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34, Resident #54. Resident #54. Resident #54. Resident #54. Resident #54 and Resident providing personal care. Resident #34 was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident #5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning F 689 Supervision; Devices Corrective Measure for Residents Affected The brakes on Resident # 34's bed are being locked. A bed rail assessment was conducted and the bilateral ½ rails continued to be used per physician order. A fall mattress has been added. There has been no additional fall at this time. The top bilateral ½ rails continue to be used per physician order. A fall mattress has been added. There has been no additional fall at this time. Additional fall prevention interventions will be added for Resident #5: a chair/bed alarm to remind her not to get out of bed or wheelchair unassisted, PT/OT evaluation to assess positioning or need for wheelchair adaptations, place personal items within reach, closer supervision and scheduled toileting. Because of her dementia, potential for falls from bed or toilet is also being a		meeting on 5/10/18	at 2:30 p.m.		F 689 Free From Accidents/Ha	azards;			
SS=G CFR(s): 483.25(d)(1)(2) §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34. Resident #34. Resident #34. Resident #34. Resident #34. Resident #34. Resident #34 resolution for repair. (Harm). 1. Facility staff failed to lock the brakes on Resident #34 was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #55. Resident #5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning	F 689			F 689	Supervision: Devices				
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The facility must ensure that - \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #25 and Resident #54. This is a complaint deficiency. 1. Facility staff failed to look the brakes on Resident #34's bed, when providing personal care. Resident #34's bed was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident #5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stainwell door with a malfunctioning		8483 25(d) Accidents		Corrective Measure for Resid	ents				
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supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34, Resident #55, Resident #57, Resident #54. This is a complaint deficiency. 1. Facility staff failed to lock the brakes on Resident #34's bed, when providing personal care. Resident #34's bed, when providing personal care. Resident #34's was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident # 5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning conducted and the bilateral ½ rails continue to be used per physician order. A fall mattress has been added. There has been no additional fall at this time. Additional fall prevention interventions will be added for Resident # 5: a chair/bed alarm to remind her not to get out of bed or wheelchair unassisted, PT/OT evaluation to assess positioning or need for wheelchair adaptations, place personal items within reach, closer supervision and scheduled toileting. Because of her dementia, potential for falls from bed or toilet is also being addressed. Post fall assessment now		8483 25(d)(2)Each i	resident receives adequate						
accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34, Resident #5, Resident #187, Resident #25 and Resident #54. This is a complaint deficiency. 1. Facility staff failed to lock the brakes on Resident #34's bed, when providing personal care. Resident #34's had a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning Continued and are no longer in use. The top bilateral ½ rails continue to be used per physician order. A fall mattress has been added. There has been no additional fall at this time. Additional fall prevention interventions will be added for Resident #5: a chair/bed alarm to remind her not to get out of bed or wheelchair unassisted, PT/OT evaluation to assess positioning or need for wheelchair adaptations, place personal items within reach, closer supervision and scheduled toileting. Because of her dementia, potential for falls from bed or toilet is also being addressed. Post fall assessment now		supervision and ass	istance devices to prevent		1	1			
Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide supervision and interventions to prevent falls/accidents for five of 23 residents, Resident #34, Resident #5, Resident #187, Resident #25 and Resident #54. This is a complaint deficiency. 1. Facility staff failed to lock the brakes on Resident #34's bed, when providing personal care. Resident #34's bed, when providing personal care. Resident #34 was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). 2. Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident # 5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning The top bilateral ½ rails continue to be used per physician order. A fall mattress has been added. There has been no additional fall at this time. Additional fall prevention interventions will be added for Resident # 5: a chair/bed alarm to remind her not to get out of bed or wheelchair unassisted, PT/OT evaluation to assess positioning or need for wheelchair adaptations, place personal items within reach, closer supervision and scheduled toileting. Because of her dementia, potential for falls from bed or toilet is also being addressed. Post fall assessment now									
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 Facility staff failed to lock the brakes on Resident #34's bed, when providing personal care. Resident #34 was rolled out of the bed, landed on her face and sustained a laceration. She was sent to the emergency room for repair. (Harm). Facility staff failed to provide supervision per physician order to prevent falls for Resident #5. Resident #5 had a fall from her wheelchair resulting in a fracture (Harm). Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning chair/bed alarm to remind her not to get out of bed or wheelchair unassisted, PT/OT evaluation to assess positioning or need for wheelchair adaptations, place personal items within reach, closer supervision and scheduled toileting. Because of her dementia, potential for falls from bed or toilet is also being addressed. Post fall assessment now 					· ·				
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physician order to prevent falls for Resident #5. Resident # 5 had a fall from her wheelchair resulting in a fracture (Harm). 3. Resident #187, with a wander prevention device in place, fell after exiting his living unit through a stairwell door with a malfunctioning closer supervision and scheduled toileting. Because of her dementia, potential for falls from bed or toilet is also being addressed. Post fall assessment now		2 Escility staff fails	nd to provide supervision per		place personal items within re	each,			
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in place, fell after exiting his living unit through a stairwell door with a malfunctioning addressed. Post fall assessment now		Resident # 5 had a	fall from her wheelchair resulting		·				
in place, fell after exiting his living unit through a stairwell door with a malfunctioning addressed. Post fall assessment now		3 Resident #187	with a wander prevention device		Because of her dementia, pot	ential for			
stairwell door with a malfunctioning addressed. Post fall assessment now		in place, fell after ex	citing his living unit through a		•	ļ .			
		stairwell door with a	malfunctioning			-			
the alternative management from make					includes assessment for pain	2116 11044			

Facility ID: VA0071

PRINTED: 05/22/2018 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			COM	PLETED
	495177	B. WING	.,		1	; 10/2018
ROVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		1	25 BUENA VISTA CIRCLE		
(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
locking system. Reground floor landing left upper arm as a reground floor landing left upper arm as a red. Resident #25, we reclining chair and ender his right eye. The reformation of the reclinity review and/or invest for use of the reclinity review and/or invest falls indicating lack of the following were: 1. Resident #34 was facility on 01/30/199 05/17/2017. Her discilling on 01/30/199 05/17/2017. Her discilling to: Spastic accident, contractured from the most recent ME quarterly assessment of the following state/no discernible cognitive status was resident #34 was a being named in a Fireceived at the State On 05/08/2018 during the following received at the state on 05/08/2018 during the following received at the state on 05/08/2018 during the following received at the state on 05/08/2018 during the following received at the state on 05/08/2018 during the following received at the state on 05/08/2018 during received at the state of the following received at the state on 05/08/2018 during received at the state of the following received at the state of the following received at the state on 05/08/2018 during received at the state of the following received at the state of the following received at the state of the following received received at the state of the following received receiv	esident #187 was found on the and diagnosed with a fractured result of the fall (Harm). ith a history of falls, fell from a experienced an abrasion above resident had not been assessed and chair. There was no prompt igation of the fall by facility staff. In the stained multiple unwitnessed of supervision. It is a originally admitted to the fand readmitted on agnoses included but were not ag		689	Elopement prevention interverse were implemented for Reside He was discharged home on 6 with no further incidents. Resident # 25 was assessed by rehabilitation therapy staff or and the use of recliner chair with discontinued per recommend. Additional fall prevention into for Resident # 54 have been of implemented: increased superstaff and family, tray for his with allow him to work on a "buscheduled toileting, chair and with voice instruction not to without assistance, visual cheduled to a demential chair and review for appropriateness of pharmacological intervention referral to a dementia unit with the structured environment and the light of the structured environment and th	y 5/10/17 y 5/10/17 y 5/10/11 vas lation. ervention or will be ervision be rvision be rv	8 ir d'', rm y ian
				1		
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENCY MUSTOR LSC IDE Continued From page locking system. Reground floor landing left upper arm as a reclining chair and endis right eye. Therefor use of the reclining review and/or invested falls indicating lack of the facility on 01/30/199 05/17/2017. Herefor limited to: Spastic accident, contractured from the form of the facility on 01/30/199 05/17/2017. Herefore ilmited to: Spastic accident, contractured from the facility on 01/30/199 05/17/2017. Herefore for the facility on 01/30/199 05/17/2017. Here	A95177 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 locking system. Resident #187 was found on the ground floor landing and diagnosed with a fractured left upper arm as a result of the fall (Harm). 4. Resident #25, with a history of falls, fell from a reclining chair and experienced an abrasion above his right eye. The resident had not been assessed for use of the reclining chair. There was no prompt review and/or investigation of the fall by facility staff. 5. Resident #54 sustained multiple unwitnessed falls indicating lack of supervision. Findings were: 1. Resident #34 was originally admitted to the facility on 01/30/1996 and readmitted on 05/17/2017. Her diagnoses included but were not limited to: Spastic Quadriplegia, Cerebral vascular accident, contractures, dysphagia and seizures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/09/2018. Section	A BUILD 495177 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 locking system. Resident #187 was found on the ground floor landing and diagnosed with a fractured left upper arm as a result of the fall (Harm). 4. Resident #25, with a history of falls, fell from a reclining chair and experienced an abrasion above his right eye. The resident had not been assessed for use of the reclining chair. There was no prompt review and/or investigation of the fall by facility staff. 5. Resident #54 sustained multiple unwitnessed falls indicating lack of supervision. Findings were: 1. Resident #34 was originally admitted to the facility on 01/30/1996 and readmitted on 05/17/2017. Her diagnoses included but were not limited to: Spastic Quadriplegia, Cerebral vascular accident, contractures, dysphagia and seizures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/09/2018. Section B. Hearing, Speech, and Vision assessed Resident #34 as being "Comatose Persistent vegetative state/no discernible consciousness"; therefore, no cognitive status was assessed. Resident #34 was added to the survey sample after being named in a FRI (facility reported incident) received at the State Agency in December 2017. On 05/08/2018 during initial tour of the facility	A BUILDING 495177 ROWIDER OR SUPPLIER ITY MEMORIAL HOSPITAL HUNDLEY CENTER ITY MEMORIAL HOSPITAL HUNDLEY CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 locking system. Resident #187 was found on the ground floor landing and diagnosed with a fractured left upper arm as a result of the fall (Harm). 4. Resident #25, with a history of falls, fell from a reclining chair and experienced an abrasion above his right eye. The resident had not been assessed for use of the reclining chair. There was no prompt review and/or investigation of the fall by facility staff. 5. Resident #54 sustained multiple unwitnessed falls indicating lack of supervision. Findings were: 1. Resident #34 was originally admitted to the facility on 01/30/1996 and readmitted on 05/17/2017. Her diagnoses included but were not limited to: Spastic Quadriplegia, Cerebral vascular accident, contractures, dysphagia and seizures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/09/2018. Section B - Hearing, Speech, and Vision assessed Resident #34 as being "Comatose Persistent vegetative state/no discernible consciousness"; therefore, no cognitive status was assessed. Resident #34 was added to the survey sample after being named in a FRI (facility reported incident) received at the State Agency in December 2017. On 05/08/2018 during initial tour of the facility	A BUILDING B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	A BUILDING 495177 A BUILDING B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970 SUMMARY STATUBERT OF DEPOSED SET SET PROCEDED BY FILL BEGULATORY OF LEG DENTFYING INFORMATION) CONTINUED From page 16 locking system. Resident #187 was found on the ground floor landing and diagnosed with a fractured left upper arm as a result of the fall (Harm). 4. Resident #25, with a history of falls, fell from a reclining chair and experienced an abrasion above his right eye. The resident had not been assessed for use of the reclining chair. There was no prompt review and/or investigation of the fall by facility staff. 5. Resident #54 sustained multiple unwitnessed falls indicating lack of supervision. Findings were: 1. Resident #34 was originally admitted to the facility on 01/30/1996 and readmitted on 05/17/2017. Her diagnoses included but were not limited to: Spastic Quadriplegia, Cerebral vascular accident, contractures, dysphagia and seizures. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/09/2018. Section B. Hearing, Speech, and Vision assessed Resident #34 was added to the survey sample after being named in a FRI (facility reported incident) received at the State Agency in December 2017. On 05/08/2018 during initial tour of the facility Resident #34 was observed lying in bed. Bilateral

Facility ID: VA0071

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE S	SURVEY IPLETED
						c	:
		495177	B. WING			05/1	0/2018
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	ITY MEMORIAL HOSE	PITAL HUNDLEY CENTER			25 BUENA VISTA CIRCLE		
0011111011					SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689			F	689		n order	
		s were in the up position on her lats were beside her bed.			review of fall logs and physicia	Į.	5
	The facility reported incident was reviewed on 05/09/2018 at approximately 10:00 a.m. Per the				for bed rails. Interventions fo	1	
			i		prevention will be developed	1	
	05/09/2018 at appro	at 3:05 a.m., CNA [certified			implemented as appropriate f	or those	
	FRI, "On 12/4/2017 at 3:05 a.m., CNA [certified nursing assistant] came to the nursing station and reported resident fell in the floor. CNA was changin resident, bed began rolling, and CNA was unable to grasp resident. The resident fell off the bed onto				identified with variances.		
					The brakes on all the beds we	re	
	grasp resident. The	e resident fell off the bed onto ce hitting the floor. Resident			inspected shortly after Reside	nt # 34'	,
	suffered a 4.5 cm st	ellate laceration to mid forehead			fall and none were found defe	ective.	
	was caused by a fai	ith two layers of ew with staff revealed the fall lure of staff to lock the brakes d. Based on the information			Measures to Prevent Recurre	nce	
		e this fall could have been			The fall investigation tool has	been re	-
	prevented."	•			designed to make it more effe	ctive in	
	Review of the clinical	al record included a final report	į		identifying root cause. The us	e of the	
	from the emergency	department where Resident			Morse fall investigation tool h	as been	
	#34 was treated. Int	formation included, but was not tient presents following a			discontinued as it is not appro	priate f	or
	fallrolled out of be	dThe character of symptoms			this setting. A policy and pro-	cedure f	or
	is swelling and lace Swelling, laceration	rationHead: On exam:			post fall assessment for pain i	s being	
	foreheadProcedur	re notes: 4.5 cm stellate			implemented. In-service to r	nursing	
		lead closed with 2 layers of g sterile technique"			staff will be conducted on the	_	
					changes and to reiterate the	need for	
	A copy of the facility	r's investigation of the incident received. The "Post Fall Huddle"			thorough and timely fall inves		
	form contained the	following: Contributing factors:			and implementation of appro		
	"Improper bed heigh	nt and bed unlocked." Witness			interventions to prevent recu	-	nd
	statements were rev	viewed. The CNA statement ving information: "While giving			harm. They will also be infor		
	contained the following information: "While giving daily care, I turned her over so I could reach the				deviation from standard or po		1 1
	back side while was	shing and changing she began to				SHOP WILL	
	come				result in disciplinary action.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE	SURVEY IPLETED
, , , , , , , , , , , , , , , , , , , ,			A. BUILDIN	NG			;
		495177	B. WING _		•	05/1	0/2018
	SUMMARY ST	PITAL HUNDLEY CENTER	ID	125 SO	EET ADDRESS, CITY, STATE, ZIP CODE BUENA VISTA CIRCLE UTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	ı=	(X5) COMPLETION
PRÉFIX TAG	(EACH DEFICIENCY MUST OR LSC IDE	F BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	PREFIX TAG	×	CROSS-REFERENCED TO THE APPROPRI	ATE	DATE
F 689	attempted to keep h weight I couldn't hol floor." A second wi the night shift nurse [name] came runnin [name] fell in the flo floor-large amount of forehead-turned res noted a 4 cm X 3 cm forehead and bleed to bed and body che notedfacial swellir and pressure dressi called and resident [treatment]the bed rail down and CNA and bed started rollir res slip [sic] off side The administrator w approximately 1:00 stated, "The CNA m nurse what happen locked, she rolled o head." The above informat a possible harm lev during a meeting wi and the administrate approximately 2:30 No further informati conference on 05/1 2. Resident #5 v 8/24/17 with diagnore	e started coming forward I er on her bed but with her d her up and she fell on the stress statement completed by contained the following: "CNA g to nursing station stating orfound lying face down in the of dark red blood noted from series and in laceration in center of ing from her mouthlifted back each done-no bruises or rednessing applied to laceration911 to ER for eval and tx if was up in the air with top side stated he was changing resident ing and he couldn't hold her and for bed" The same interviewed on 05/10/2018 at p.m. regarding the incident. She or longer works herehe told the ed, he didn't have the bed ut and got a laceration on her lied deficiency was discussed in the DON (director of nursing) or on 05/10/2018 at p.m	F	689	Monitoring: The Risk/QA nurse or designereview falls to ensure post fall investigations are properly coand care plans are being updated/revised to reflect apfall prevention interventions apain assessments are performed fall. Observations to determic compliance with physician or relative to bedrails or other interventions will also be confall prevention interventions sample of patients will also be monitored for staff compliance. Variances identified during at be corrected and non-complimitely will be re-in-serviced, counse disciplined. Audits and observations will a conducted daily X 10 days that times 8 weeks if audits show compliance. Findings will be to the QAPI Committee for further discussion or recommendation.	mpleted propriat and that and that and after ders ducted. for a e ce. udits will ant staff led or ce significa reported arther	e a nt
					Correction Date: 6/24/2018		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;			CONSTRUCTION	(X3) DATE : COM	SURVEY PLETED
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		495177	E. WING			05/1	0/2018
	ROVIDER OR SUPPLIER NITY MEMORIAL HOSP	ITAL HUNDLEY CENTER		13	NREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
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F 689	and high blood press The most recent MD quarterly review date 6 assessed with sev a total summary sco "Section G- Function "G0110'ActIvItles of E. Locomotion on ur between locations in same floor If in whe chair." This section Performance" as "7. twice." Under "Sup person physical assi unit- how resident m off-unit (activities, di self-sufficiency once coded under "Self P occurred once or twi coded as "2. One per The electronic media on 5/9/18 at 7:45 a.r. as follows: (It should times given for the e when the documenta computer system): 12/8/17: "New order shoulder due to extra 12/8/17: Informed M new order for xrays, transportation sllp. see If they are to be	i i	F	689	investigations are properly coand care plans are being updated/revised to reflect apfall prevention interventions apain assessments are performfall. Observations to determine compliance with physician or relative to bedrails or other interventions will also be converted and non-compliative during autobe corrected and non-compliative will be re-in-serviced, counsed disciplined. Audits and observations will be conducted daily X 10 days the times 8 weeks if audits show compliance. Findings will be to the QAPI Committee for furth discussion or recommendation. Correction Date: 6/24/2018	propriate and that hed afterne ducted. Idits will ant staffiled or he significate ported arther	e a Y nt

DEPARTM	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				MB NO. 0	PPROVED 938-0391
TATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SU COMP	JRVEY LETED
ND PLAN OF	CORRECTION	IDEM ILION TOMBER	A. BUILDI	NG		С	
		495177	B. WING			0 <u>5/10</u>	/2018
NAME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5 BUENA VISTA CIRCLE		
COMMUN	ITY MEMORIAL HOST	PITAL HUNDLEY CENTER			OUTH HILL, VA 23970		
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F 689	Continued From pa	ge 20	F	689			
	was asked about the 1st pain, and what I the resident had fall wheelchair, but did incurred any injury. documentation about nurses' notes. RN I told not to document the new program is documentation. Woff and entered; the usually if there's a documentation by something out of the make daily notes." RN # 1 was then a fall, a copy of the caphysician orders a copy of the care panded, but a revice of the investigation this surveyor. RN needed, but a revice onducted. The care plan, darreviewed. Under "Risk for injury: britalisrelated to de documented "Note interventions" increachKeep objectorwaar when output to the care plan.	a.m. RN (registered nurse) # 1 the documentation of Resident # the data ppear at the time to have This surveyor asked where the the fall was located in the # 1 stated "Well, we have been that any notes in the computer as the not set up for that type of We have forms that are checked are are some notes but those are significant eventwe do exception, so unless there's the ordinary we are told not to asked for the investigation of the care plan at the time of the fall, the time of the fall. p.m. RN # 1 gave this surveyor a lan in place at the time of the fall, administrator had told her a copy the was not allowed to be copied for the investigation could be ted as implemented 9/5/17 was "Problems" was documented the das implemented 9/5/17 was the das implemented 9/5/17 was fall related injuries" Cluded: "Call bell within easy acts in easy reachNon-skid at of bed." "If (name of resident each shift for 72 hours for pain,	7				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES				FORM / OMB <u>NO.</u>	05/22/2018 APPROVED 0938-0391			
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		ONSTRUCTION	(X3) DATE S	IPLEYED			
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	ROVIDER OR SUPPLIER HTY MEMORIAL HOSE	PITAL HUNDLEY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970							
(X4) ID PREFIX TAG	REACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 689	of the wheelchair. An xray report from documented "Clinic fallFindings:Pro a minimally impacte ER (emergency roothe xray report doctiliness: Pt. unable 5 days ago. The constant. Type of hip/shoulder. The "Diagnosis: Hip fraction from dated "Brief factual describeen observed lear looking into her dracting in the dracting into her	the hospital dated 12/8/17 al History: Pain after oximal left femur is suspicious for ed subcapital fracture" The om) physician notes attached to umented "History of Present to provide much history. Onset course/duration of symptoms is injury: fall. Location: left character of symptoms is pain" cture." ed a copy of an Incident form me of Resident # 5's fall. The I 11/30/17 revealed the following: iption: She'(Resident # 5) had ning forward in her wheelchair exerved a short time later to be on side. She had slipped out of the floor. Her wheelchair was for resident mobility. Call light lights on, personal items within decific incident Details" was ecaution: bed in low position, call		689						

DEPART	TMENT OF HEALTH	AND HUMAN SERVICES R MEDICAID SERVICES				FOI OMB N	ED: 05/22/2018 RM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• .		CONSTRUCTION		ATE SURVEY COMPLETED
		495177	B. WING				05/10/2018
	ROVIDER OR SUPPLIER NITY MEMORIAL HOS	PITAL HUNDLEY CENTER		125	REET ADDRESS, CITY, STATE, ZIP CODE BIBLENA VISTA CIRCLE DUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES THE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG	XI:	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	3 BE	(X5) COMPLETION DATE
F 689	fall. She stated "S we are unable to fir we could fell at the was a result of the The administrator on what was to be there was, and gay document entitled care." Under "Doc following: "After a report to help track facility can impleming the resident, and in events preceding the resident's reachest product at the resident's reachest product at the resident at the resid	hould there be one? Yes. But and it if it was done. From what time, it looked like the fracture fall from the wheelchair." vas asked if there was a policy done after a fall. She stated the this surveyor a copy of a stall management: Long term cumentation included the stall, complete a detailed incident frequent resident falls so your ent prevention measures for an include the fall occurred, how you found in what position. Include the he fall, the names of witnesses, tion to the fall, and a detailed resident's condition based on the the resident's statement of the surveyor a copy of the physician the time of the resident's fall. Eviewed and noted to include an antered, everyday supervised from the time to time to sit up on the time of the above order, and and DON stated there should be the order. The DON explained a time specified, like from 1 p.m. ever long she was to be in the field, and she should be supervise.		689			

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DEPARTI	MENT OF HEALTH	AND HUMAN SERVICES			·	OMB N	M APPROVED <u>), 0938-0391</u>	
TATEMENT O	S FOR MEDICARE F DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(· · / ·		NSTRUCTION	(X3) DA'I C	C SURVEY	
		495177	B. WING			0	5/10/ <u>201</u> 8	
	OVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		125	ET ADDRESS, CITY, STATE, 2IP CODE BUENA VISTA CIRCLE JTH HILL, VA 23970	CIRCLE A 23970		
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F 689	time we were switch system, and nurses came over and put be why it's like that clarification on the On 5/10/18 at 11:5 the incident form, I interviewed. She observed her; a Clifall to me; I don't re nowthat was a with administrator, several nursing stating findings during an beginning at 2:30 time of the potentic deficiency, and if the administrator state. No further information administrator state. No further information of the potentic of the potentic administrator state. Resident #187 was read chronic obstraining mum data set Resident #187 with skills.	in that way; I know that at that thing to the new computer is from the OB (obstetrics) unit. In a lot of the orders, so that may it. I can see if I can get order." O a.m. the nurse who filled out dentified as RN # 5, was stated "I am not the one who NA saw her and then reported the emember who the CNA was chille back." DON (director of nursing), and aff were made aware of the above meeting with facility staff 5/10/18 p.m. It was discussed at that all for harm associated with the chere were any questions or tion they could provide. The ed "No, I don't think so." ation was provided prior to the exit was admitted to the facility on dmitted on 3/13/18 and died in the Diagnoses for Resident #187 moor, atrial fibrillation, heart fallure uctive pulmonary disease. The time (MDS) dated 3/20/18 assessed the moderately impaired cognitive closed clinical record documented ated 6/7/17 at 1:30 p.m. stating, "I nother employee that the resident		689				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: (FORM A ON BMC. Q	PPROVED
STATEMENT (OF DEFICIÊNCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SU COMP	JRVEY LETED
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	ROVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE COUTH HILL, VA 23970	_	
(X4) ID PREFIX TAG	CACH DEFICIENCY MIJS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG	¥Χ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
F 689	When I arrived to the top of the stairs was still in place or sensory pad. He was the steptook his stretcher to be train room]" A note of "Report was called resident had an abdisplaced fracture abd. [abdominal] was the element of the state of the statesAssessmer [centimeter] skin to elbowAbrasion of fracture (avulsion) humerus - Suspectuall" The facility's Invested 6/8/17 documented (avulsion) humerus - Suspectuall" The facility's invested 6/8/17 documented for exity department for exity department for exity department for exity decumented, "Invested to the fire south stalrwell on the gradent left the fire south stalrwell exity and found the stalrwell exity stall well and found the stall well and the stal	ne scene his wheelchair was at a wandergaurd [Wanderguard] in his chair, and so was his was lying with his arm hanging off wital signs and placed him on a sported to the ER [emergency dated 6/7/17 at 11:30 p.m. stated, from the E.Rwas told that the rasion to his it [left] elbow, non of the left humerus, contusion of		689			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES MEDICAID SERVICES				FORM. OMB NO.	05/22/2018 APPROVED 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(XS) DATE (COM	IPLETED
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	ROYIDER OR SUPPLIER ITY MEMORIAL HOSI	PITAL HUNDLEY CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
(X4) ID PREFIX TAG	/FACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	9E ((X5) COMPLETION DATE
F 689	slipped or fellHis floor landingThe ractivated the alarm upon activationNi stated that she had stairwell door go of incident. She cheranything amissSo system's automatic functioning properly Resident #187's cliphysician's order disprised with functioning properly Resident #187's fa April 2017 and Junas a high risk for fawandering, inconting balance, health continuity the clinical record recent confusion polyne. In the floor by regarding this fall of "Investigation cound got out of bed to leave," falling to Resident #187's polynemented the rebruises, skin tears therapy and previous interventions lister	to the ground floor landing and wheelchair was found on the first resident's Wander guard bracelet system but the door did not lock urse assigned to the resident heard the alarm on the south f about 20 minutes before the cked the stainwell and did not find buth door Wander guard locking mechanism was not y" nical record documented a ated 5/1/17 for a Wanderguard oning to be checked weekly. If risk assessments completed in e 2017 documented the resident alls due to a history of falls, mence, unsteady gait, poor anditions and multiple medications documented a history of falls and for to the elopement incident on note on 6/2/17 documented the to get up without assistance and was found on 6/2/17 at 8:10 whis bed. A follow up note chated 6/5/17 documented, mpleted. Resident is confused unassisted, stated, "I was trying fall mat" Ian of care (June 2017) esident was at risk of injury for the south as at risk of injury for the south action of the care (June 2017) and the province of the care (June 2017) and the care of the		689			

DEPART	MENT OF HEALT	HAND HUMAN SERVICES					APPROVED 0938-0391
STATEMENT O	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S	SURVEY PLETED
		495177	B. WING			05/1	0/20 <u>18</u>
	KOVIDER OR SUPPLIER	SPITAL HUNDLEY CENTER		128	REET ADDRESS, CITY, STATE, ZIP CODE 5 BUENA YISTA CIRCLE DUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIES IST BE PRECEDED BY FULL REGULATORY DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFIGIENCY)	8E	(X&) COMPLETION DATE
F 689	interventions regaprevention or use There were no rethe fall on 6/2/17. The nurse assign director of nursing elopement/fall on interview as they On 5/9/18 at 2:00 interviewed about fall in the stainwell resident had a proposed to activate of the nurse stainwell, she wooknown the reside administrator stainwell, she wooknown the reside administrator stainwell, she wooknown the reside administrator stainwell. The assounded but the administrator stainwell. The assounded but the administrator stainwell, she wooknown the reside administrator stainwell. The assounded but the administrator stainwell admini	an had no problem, goals and/or ording wandering, elopement of the Wanderguard device. visions to the care plan following	1	689			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM AF	PROVED 938-0391
- STATEMENT C	S FOR MEDICARE (of DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495177	B, WING			05/10	/2018
	ROVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 26 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	/EACH DEFICIENCY MUST	ATEMBNT OF DEPICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-RÉFERENCED TO THE APPROPE DEFICIÉNCY)	ØE '	(X6) COMPLETION DATE
F 689	residents. On 5/9/19 at 5:10 p was interviewed ab malfunction found v 6/7/17. The maint was inspected after power supply failur stated the alarm so the magnet door for resident to get into director stated prior elopement/fall the proper function eved director stated the on 5/15/17 prior to The facility's policy (revised 9/8/17) stated the dependent of the consistency included in prevention, "Resimmediately. This When responding to the alarm panel been openedfind alarm before turning the activated door outside vicinity	intely check and account for .m., the maintenance director out the south hall door look when Resident #187 fell on enance director stated the door rethe incident and found with a e. The maintenance director bunded at the nursing station but ck did not activate allowing the the staliwell. The maintenance in to Resident #187's door locks were checked for ery 6 months. The maintenance door locks were lasted checked		689			
	and director of nu at 2:30 p.m.	rsing during a meeting on 5/10/18	3			:	

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DEPARTM	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED C		
		495177	B. WING			i i	10/2018
	OVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		125	ET ADDRESS, CITY, STATE, ZIP CODE BUENA VISTA CIRCLE UTH HILL, VA 23970		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREF TAG			LD RE	(X5) COMPLETION DATE
· F 68 9	Continued From page	nge 28	F	689			
	This was a compla						
	5/31/17 with diagnorms of the comments of the	as admitted to the facility on oses that included Parkinson's ascular accident (stroke), or disease, anemia and minimum data set (MDS) dated Resident #25 with severely skills. Inical record documented a post or dated 5/4/18 stating the resident growth or details about the fall or any of the fall or any of the fall and signs (temperature, blood ory rate, pulse rate). There was rinjuries on the post fall note.					
	indication for the The resident's plate interventions for it positioning and lowheelchair, Mors sensory pad while clutter, frequent robjects and month The care plan machair with Reside		or ıl r.				
	nurse (LPN #6) v	48 a.m., the licensed practical vorking on Resident #25's living wed about the fall on 5/4/18. LP sident had Parkinson's	N				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					M APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(XS) DA	(X3) DATE SURVEY COMPLETED	
		495177	B. WING			0	5/10/ <u>2018</u>	
	ROVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		125 Bi	FADDRESS, CITY, STATE, ZIP CODE JENA VISTA CIRCLE TH HJLL, VA 23970			
(X4) ID PREFIX TAG	#FACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ið PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEPICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 689	disease and tried to things frequently for stated when the recusually seated in a stated when Reside "fidgety" they some chair. LPN #6 statesident was in the On 5/10/18 at 10:1 responsible for que interviewed about reclining chair. Rinvestigated all fall implemented. RN staff members were report, get stateme perform neurologic stated her records previous falls on 1 #1 stated she had she had not invest circumstances sur asked for any associated fo	o get up and reached out for om the wheelchair. LPN #6 sident was more alert he was standard wheelchair. LPN #6 ent #25 was more restless and atimes placed him in a reclining ted she did not know why the reclining chair on 5/4/18. 2 a.m., the registered nurse ality assurance (RN #1) was Resident #25's fall from the N #1 stated she reviewed and as to ensure interventions were if #1 stated when a resident fell, we supposed to complete a fall ents from any witnesses and cal checks if needed. RN #1 indicated Resident #25 had /16/18, 2/19/18 and 2/24/18. RN no report of the fall on 5/4/18 so igated or reviewed the rounding the fall. RN #1 was essments regarding Resident	t	689				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C 05/10/2018 B. WING 495177 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 689 F 689 | Continued From page 30 These findings were reviewed with the administrator and director of nursing during a meeting on 5/10/18 at 2:30 p.m. 5. Resident #54 was admitted to the facility originally on 05/18/16, with diagnoses that included dementia. The most current MDS (minimum data set) was an annual quarterly assessment dated 04/6/18. Resident #54 was assessed with long and short-term memory loss and severe loss of cognitive status. A family interview was conducted on 05/08/18 at 12:21 PM. During the interview Resident #54's son verbalized that Resident #54 had fallen multiple times and Resident #54 does not use the call bell and tries to get out of bed and out of the wheelchair. Resident #54's son verbalized that Resident #54 does were an alarm and has a fall mat, but felt that a shortage of staff was the main reason for the falls because the certified nursing assistants (CNA) have so much to do. On 05/09/18 3:30 p.m. Resident #54 was observed within 10 feet of the nurses station by 2 surveyors. Three staff members were at the nurses station, but were unaware that Resident #54 was attempting to get out of the wheelchair. This observation continued for 15 minutes. No staff member attempted to assist Resident #54 until one staff member observed the surveyors and then started interacting with Resident #54, trying to get Resident #54 to scoot back in the wheelchair. Resident #54 did not want to slide back in the wheelchair after being asked, resulting in 2 CNA's physically moving Resident #54 back in the wheelchair.

PRINTED: 05/22/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ С B. WING 05/10/2018 495177 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 126 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 689 F 689 Continued From page 31 Review of Resident #54's care plan for fall interventions included: Bed alarm, Chair alarm frequent observations, low bed with mat, remind to use the call light. These interventions were all dated on 2/4/18. The most recent updated intervention was dated 5/9/18 and included, keep in sight during risk hours. According to documentation, Resident #54 had fallen a total of 7 times between 2/4/18 and 5/8/18. Review of Resident #54's post fall evaluation notes with a date range from 2/4/18 through 5/8/18 documented unwitnessed falls on 2/4/18, 2/20/18, 4/4/18, 4/11/18, 4/30/18, and 2 falls on 5/8/18. On 05/10/18 at 08:51 AM registered nurse (RN #3), was interviewed regarding Resident #54's frequent falls. RN #3 verbalized that Resident #54 is continuously trying to get out of bed or out of the wheelchair, does not call for help and has had multiple falls. RN #3 verbalized that the facility has tried to put interventions into place, and felt the Resident # 54 would benefit from more supervision. RN #3 verbalized that the facility does not provided one on one monitoring and has asked the family if they could have a sitter to come into the facility to be able to monitor Resident #54 more closely. RN #3 verbalized that the family was unable to provide a sitter. On 05/10/18 10:49 AM the director of nursing was Informed of the concerns regarding lack of supervision resulting in multiple falls. No other information was provided prior to exit conference on 5/10/18.

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CENTERS FOR MEDICARE & MEDICAID SERVICES BITATEMENT OF DERGIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		•		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 690	Continued From pag	ne 32	F	690			
F 690	Bowel/Bladder Inco	ntinence, Catheter, UTI	Ĭ.	690			
\$\$=D	CFR(s): 483.25(e)(1 §483.25(e) Incontine	·			F 690 Bowel Bladder Incontin	ience,	
	\$483.25(e)(1) The fa	acility must ensure that resident bladder and bowel on admission			Catheter Care		
	receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary				Corrective Measure for Resid Affected	ents	
					A physician order for the care	I	
	§483.25(e)(2)For a incontinence, based	resident with urinary I on the resident's			maintenance of Resident #36's Foley		
comprehensive assessment, the facility must				catheter has been obtained a	1	ire	
	ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the				plan was revised to reflect thi	ıs.	
	resident's clinical co	ondition demonstrates that			Identification of Other Reside	ents wit	h
	catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is				Potential To Be Affected		'
	assessed for remov	al of the catheter as soon as			Other residents with potentia	ıl to be	
	possible unless the	resident's clinical condition atheterization is necessary; and			affected will be identified thr		
	(iii) A resident who is incontinent of bladder receives				review of medical records. If		
	appropriate treatme	nt and services to prevent his and to restore continence to			Issues are identified, physicia		
	the extent possible.				care and maintenance of Fole	-	
	6483 25(a)(3) For a	resident with fecal incontinence,			will be obtained and care plan revised		
	based on the reside	nt's comprehensive			as appropriate.		
	assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal			. 1	Measures to Prevent Recurre	ence	
	bowel function as possible. This REQUIREMENT—is not met as evidenced by:				In-service to nursing staff will	l be	
					conducted to reiterate the po	to reiterate the policy and	
					procedure for maintenance a		l
					a Foley catheter.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICALD SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING _ 05/10/2018 B. WING 495177 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 126 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD SE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 690 F 690 | Continued From page 33 Based on observation, staff interview, and clinical record review, facility staff failed to obtain physician orders for the care and maintenance of a Foley Monitoring: catheter for one of 23 residents in the survey sample, Resident #36. The Director of Nursing (DON) or designee shall audit medical records of Findings included: residents with Foley catheter to ensure Resident #36 was originally admitted to the facility on 03/04/2011 and readmitted on 10/05/2016 with there is a physician order for their diagnoses including, but not limited to: maintenance and care. Variances Hypertension, Sacral Pressure Ulcer-Stage 3 with Identified during audits will be MRSA (methicillin resistant staphylococcus aureus), Dementia, Parkinson's Disease, Schizophrenia and corrected and non-compliant staff will Dysphagia. be re-in-serviced, counseled or The most recent MDS (minimum data set) was an disciplined. annual assessment with an ARD (assessment reference date) of 03/12/18. Resident #36 was Audits will be conducted weekly times assessed as severely impaired in her short and long term memory and daily decision making skills. 8 weeks. Findings will be reported to the QAPI Committee for further Resident #36 was observed on 05/08/18 at 3:00 p.m. lying in bed with her Foley catheter in a privacy discussion or recommendations. bag. A fall mat was in place at the bedside. Correction Date: 6/24/2018 Resident #36's clinical record was reviewed on 05/09/18 at 10:30 a.m. On the physician order sheet dated May 2018 was the following order: "...St 3/4 [Stage 3 - Stage 4] press [pressure] ulcer worse by incontinence, Foley cath [catheter] 18 Fr. [french] with 10 cc [cubic centimeter] bulb, Start: 02/07/18..." There were no other physician orders pertaining to Resident #36's Foley catheter care and maintenance. RN #3 (registered nurse) was interviewed on

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STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	LE CONSTRUCTION	co	(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	<u> </u>		
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F 690 F 691 SS≂D	reviewed Resident #36's physician ordithere are no specific maintenance of a Final The Administrator a were informed of the survey team on DON stated, "There change and care for No further informatite team prior to the extended and care for the facility must encotostomy, Urostom Such care consisted practice, the comproplant, and the resident practice, the comproplant and the resident practice and clinic failed to provide care deened skin area of 23 residents, Resident #28's ost across her abdomes.	ers. RN #3 stated, "I agree corders for care and oley catheter." Ind DON (director of nursing) e above during a meeting with 05/10/18 at 2:30 p.m. The should be specific orders to ra Foley catheter." Indicate the specific orders to ra Foley catheter." Indicate the specific orders to ra Foley catheter." Indicate the survey of the sur		F 691 Colostomy, Uros Ileostomy Care	or Residents ring care and dened skin are the resident's e is prone to so omy bag is emptied) sevent's preference monitor and as necessary and her ostomy ral rather than as taff complist. This prefer	kin eral ce. This bag	

FORM CMS-2587(02-99) Previous Versions Obsolete

Eyent ID: VSS211

Facility ID: VA0071

If continuation sheet Page 35 of 75



		AND HUMAN SERVICES				FORM	05/22/2018 APPROVED 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII			MPLETED			
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NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
COMMUN	NITY MEMORIAL HOSE	PITAL HUNDLEY CENTER	_		BUENA VISTA CIRCLE ITH HILL, VA 23970	,		
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F 691	Continued From page	ge 35	F	391				
	Findings were: Resident #28 was readmitted to the facility on 05/31/2017. Her diagnoses included, but were not limited to: Hypertension, Chronic kidney disease, Chrohn's disease with ileostomy placement, atrial fibrillation and chronic dehydration.				Identification of Other Residents with			
					Potential To Be Affected			
					Other residents with poten	entified through		
					affected will be identified t			
					review of medical records.			
	The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 03/05/2018. Resident #28 was assessed as being cognitively intact with a summary score of "15". A medication pass and pour observation was conducted on 05/09/2018 beginning at approximately 8:00 a.m., with LPN (licensed practical nurse) #4. Medications were administered to Resident #28. While in the room, this surveyor spoke with				ostomies will be provided s	kin care a	nd	
					treatment as appropriate.			
					Measures to Prevent Recu	rrence		
					in-service to nursing staff v			
					conducted to relterate the	ostomies and		
					procedure for care of ostor			
					prevention of skin breakdo	wn aroun	d	
	Resident #28. She	28. She pulled her gown up and			the stoma.			
	showed this surveyor her iteostomy. She stated, "It comes off all the time and leaksI've always had trouble with it." A one piece ostomy bag was				Monitoring:			
	observed laying ho	laying horizontally across her abdomen			The Director of Nursing (D	ON) or		
	with her brief over it. LPN #4 undid the side of				designee shall audit medic	medical records of		
	visualize the oston	Resident #28's brief so this surveyor could better visualize the ostomy bag and the surrounding area.			residents with ostomies to			
	The skin under the bag and on Resident #28's mid abdomen was reddened. Resident #28 was asked if her the skin on her abdomen bothered her. She stated, "It itches and burns all the time."				appropriate skin care and			
					prevent skin breakdown. \			
					identified during audits wi	ll be		
	When LPN #4 and	When LPN #4 and this surveyor left the room, LPN			corrected and non-compli		/i	
	#4 stated, "She plo think she even rea	ks at her bag all the timeI don't			be re-in-serviced, counsel	ed or		
•	fully sua avenues	nzoo eno la donig			disciplined.			

		AND HUMAN SERVICES & MEDICAID SERVICES			_	FORM	05/22/2018 APPROVED . 0938-0391
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
COMMU	NITY MEMORIAL HOSE	PITAL HUNDLEY CENTER			5 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
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F 691	itsometimes we had ay because it will a sometimes the hole big and that irritates. The care plan for Re. There were no interposerved regarding ostomy bag. On 05/10/2018 at an surveyor spoke with The reddened area that was observed the discussed. LPN #3 days we change it finasked what the facil "picking" and what with the was reddened. This surveyor and Ling room. LPN #3 spoke explained that she with bag. Resident #28 the bag needed to the "That's what happelemptied and then it change it." This surveyor and Ling resident #28 the bag needed to the "That's what happelemptied and then it change it." This surveyor and Ling the bag needed to the "That's what happelemptied and then it change it." This surveyor and Ling the bag needed to the "That's what happelemptied and then it change it." This surveyor are the bag needed to the "That's what happelemptied and then it change it." This surveyor are the bag needed to the	ave to change it several times a tart to leak, and I think around her stoma gets cut too		691	Audits will be conducted weeks. Findings will be rep QAPI Committee for furthe or recommendations. Correction Date: 6/24/2019	orted to ti discussio	he

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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	ROVIDER OR SUPFLIER NITY MEMORIAL HOSF	ITAL HUNDLEY CENTER		125 B	TADDRESS, CITY, STATE, ZIP CODE UENA VISTA CIRCLE I'H H)LL, VA 23970		
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F 691	feces. When the or the area on Residenthan when observed stated, "The bag she educate the nurse to and not across." Li and applied the new the reddened area of that it burned and its protectant over the riwas asked if she knowed that had helpe abdomen. She state for a while and that The above informatimeeting with the DC administrator on 05/10.	stomy bag was lifted by LPN #3, it #28's abdomen was less red ton 05/09/2018. LPN #3 buildn't be laying this way, we'll apply it so that it is going down PN #3 then removed the old bag. Resident #28 was asked how if her abdomen felt. She stated thed. LPN #3 applied skin reddened areas. Resident #28 we of anything that had been do the itching and burning on her id, "They used nystatin cream nelped." on was discussed during a link (director of nursing) and the 10/2018 at approximately 2:30 an was provided prior to the exit	F6	91	F 694 Parenteral/IV Fluids Corrective Measure for Resid Affected	lents	
F 694 SS=D	GFR(s): 483.25(h) § 483.25(h) Parente Parenteral fluids mu with professional state accordance with phy comprehensive pers resident's goals and This REQUIREMEN Based on observate document review, th	est be administered consistent andards of practice and in visician orders, the con-centered care plan, and the preferences. This not met as evidenced by: ion, staff interview and facility se facility staff failed to obtain the care of a PICC (peripherally	F 6	94	A physician order for flushing # 2's PICC line has been obtain appropriate amount of flushing is being administered pursual facility policy. Identification of Other Reside Potential To Be Affected Other residents with intravent will be identified through reviewed ical records. Physician of	ned and ng soluti nt to ents wit nous line iew of	on h

	OF DEFICIENCIÉS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PREFIX TAG		BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	her PICC line. Findings were: Resident #28 was re 05/31/2017. Her dia limited to: Hyperten Chrohn's disease wifibrillation and chroni The most recent MD quarterly assessmen reference date) of 03 assessed as being c summary score of "1 A medication pass at conducted on 05/09/2 approximately 8:00 a practical nurse) #4. administration to Resident preparation. Observas an IV (intravenoran empty bag of IV fl asked if Resident #21 "Yes, she gets them ileostomy and she ne asked how the fluids "She has a PICC line often the line was flus She was asked wher checked the electron	admitted to the facility on agnoses included, but were not ision, Chronic kidney disease, th lieostomy placement, atrial ic dehydration. S (minimum data set) was a at with an ARD (assessment Mo5/2018. Resident #28 was ognitively intact with a 5". Ind pour observation was 2018 beginning at a.m., with LPN (licensed Medications were prepared for sident #28. This surveyor #28's room during the wed beside Resident #28's bed us) pole with an IV pump and ulds on the pole. LPN #4 was a received IV fluids. She stated, every nightshe has an eds the fluids." LPN #4 was were administered. She stated, e." LPN #4 was asked how shed. She stated, every shift. In the next flush was due. She ic record and the medication if don't see an order for the	Fe	694	care and maintenance of the obtained as indicated and purfacility policy. Measures to Prevent Recurred in-service to nursing staff on a policy/protocol for care and maintenance of intravenous is be conducted. Monitoring: The Director of Nursing (DON designee shall audit medical in residents with intravenous line ensure staff compliance with order for flushing of the line. Identified during audits will be corrected and non-compliant be re-in-serviced, counseled of disciplined. Audits will be conducted wee weeks. Findings will be report QAPI Committee for further door recommendations.	rsuant to ence the ines will or records of tes to physician Variances e staff will or kly times 8 ted to the
					Correction Date: 6/24/2018	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BÜILDİ	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 694	won't do it today becknow we flush ports here about it." Medications were ac While in the room, L surveyor. The insert upper chest, one lur LPN #4 stated, "It's over here." The clinical record we 9:15 a.m., to recond to Resident #28. To flush Resident #2 was reviewed. A for Communication was intervention: "flush sallne every shift] if The unit manager, Finterviewed at approasked if there were PICC lines. She state orders." She was to flush Resident #2 electronic record an and we don't put the administration record that meant. She state needs to be done." nurse's knew that. RN #3 was asked if	e past. She stated, "Yes, but I cause I don't see an order		694			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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t		495177	B. WING_			05/1	10/2018
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F 694	At approximately 10 following: "Periphe	:30 a.m., RN #3 presented the rally inserted central catheter	F	594			
	Lippincott [clinical re procedureswe foll- we add Critical Note The policy was revie Notes" section was	locking." She stated, "We use eference book] for our ow what they recommend and es that personalize it to us." ewed. Under the "Critical the following information: "Flush all medications, blood draws use."					
	RN #3. She stated think we have figure so the nurse's can sprocedure provided documentation for the state of	policy this surveyor spoke with , "We should have an order, we do out a way to get it on the MAR see it." The difference in the and the care plan he amount of NS to be used for sed. She stated, "It should be		Total And The To	F 697 Pain Management Corrective Measure for Resid Affected	lents	
	meeting with the DC administrator on 05/ p.m.	ion was discussed during a DN (director of nursing) and the /10/2018 at approximately 2:30 on was provided prior to the exit 0/2018.		The state of the s	Resident # 5 is currently receive fective pain management. assessment is being conducted shift and documented. Appropriately interventions for pain is being	Pain ed every opriate	
F 697 SS=G	Pain Management CFR(s): 483.25(k)		F	697	Identification of Other Resid Potential To Be Affected		
	provided to resident consistent with prof	sure that pain management is ts who require such services, essional standards of practice, person-centered care plan, and	1997		A list of all residents who are pain medications will be revidents at risk. management will be reviewe effectiveness and adjusted if	ewed to Their pa d for	in

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495177	B. WING			0 <u>5/10/2018</u>
-	ST JWWARY ST	PITAL HUNDLEY CENTER	ID	125 SO	EET ADDRESS, CITY, STAYE, ZIP CODE BUENA VISTA CIRCLE UTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
PRÉFIX TAG	(EACH DEFICIENCY MUST OR LSC IDE	BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAYE DATE
F 697	This REQUIREMEN Based on staff inter the facility staff failer management was pour the cause of pain, four survey sample: Re Resident # 5 sustain 12/1/18 through 12, evaluate and manarelleved by a currer already in place for resident was sent of fracture of the hip. Findings include: Resident # 5 was a with diagnoses to indementia, anxiety, blood pressure. The most recent M quarterly review da 5 assessed with se a total summary so The electronic med on 5/9/18 at 7:45 a as follows: (It shoulds)	orview and clinical record review, and to ensure effective pain provided, and failed to determine or one of 23 residents in the esident # 5. Indeed a fall on 11/30/18, From (8/18), the facility staff failed to ge a complaint of leg pain, not as needed order for Tylenol back pain. On 12/8/18 the patrict for x-rays which determined a complaint of leg pain, not as needed order for Tylenol back pain. On 12/8/18 the patrict for x-rays which determined a complaint of leg pain, not as needed order for Tylenol back pain. On 12/8/18 the patrict for x-rays which determined a complaint of the facility 8/24/17 include, but were not limited to: depression, GERD, and high the patrict for of 03 out of 15. Sical record (EMR) was reviewed the moted here there was no		697	Measures to Prevent Recurs A policy and procedure that pain assessment in the 72-th monitoring will be implement and on pain management I be conducted. One- on-one and /or counseling will be a Staffs who failed to appropaddress Resident # 5's pain Monitoring: The Director of Nursing (December 1) designee shall audit medications to ensure the receiving effective pain matches are being completed.	t includes hour post fall ented. In- this policy n general will e in-services given to oriately n. ON) or al records of rder for pain y are anagement. Induct audits nest to ensure per policy.
times given for the events; just a time stamp for when the documentation was entered in the computer system): 12/1/17: "While receiving her nightly bath Res (resident) complained of pain in her right leg. CNA (certified nursing assistant) tried putting lotton on her feet, Res cried out in loud pain.				Interviews of a random sa residents will also be cond determine if the resident's managed effectively. The	lucted to s pain is being	

DEPARTMENT OF HEA	ALTH A	AND HUMAN SERVICES				FORM.	APPROVED 0938-0391
ENTERS FOR MEDIC ATEMENT OF DEFICIENCIES OPLAN OF CORRECTION	<u>A</u> RE <u>8</u>	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495177	B. WING				0/2018
(X4) ID SUM PREFIX (EACH DEPICIEN TAG Of	L HOSI MARY ST LCY MUS' R LSC IDE	PITAL HUNDLEY CENTER ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG	1 5	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA GIRCLE SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SMOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) HC	(XZ) COMPLETION DATE
to complain of 12/4/17: "Who complained or ubbing lotion in pain. Who continued to information of 12/8/17: "Reany care is produced by the second seco	Res 65 of pain nile res of pain n on th iter gan complete days esident provide arm ar ities of reposl elated side to of left so olding D and ew ord are to e formed for xray ion slip are to nce rad 3 at 11: I about	ge 42 0 mg of Tylenol. Res continued the rest of the night." was receiving her bed [sic], she in her left leg. CNA tried he same leg and the res cried out we res 650 mg of Tylenol, but res aln of pain. Writer passed along thift on 12/5/17." complains by hollering out when ad and siaff touches left side of orts resident complains of pain to had shoulder when giving care, if daily llving), applying toilons, to dementia, left hip and leg pain to side to change resident; to dementia, left hip and leg pain to side to change resident, shoulder pain, laying supine (on onto armInformed unit manage request xrays be done" IMD of pain/hollering out, obtained yes, created orders, and put in the complete the sent via 911 today or wait untit diology doubts they can fit her in the documentation of Resident # the documentation of Resident # the dhappened. RN	ft	697	cognitive level will be considered deciding whether monitorin thru interviews or observation. Variances identified during a be corrected and non-composite will be re-in-serviced, counsidisciplined. Audits will be conducted we weeks. Findings will be reported for further or recommendations. Correction Date: 6/24/201	g will be ons. audits will ant staff seled or eekly time orted to reiscussi	es 8

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					M APPROVED), 0938-0391	
TATEMENT C	S FOR MEDICARE (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	TIPLE CON	NSTRUCTION		E SURVEY DMPLETED	
		495177	B, WING		05	110/2018		
	ROVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		125 E	et address, city, state, zip code Buena vista circle Th Hill, va 23970			
(X4) ID PREFIX TAG	ZENOU DEDICIONOV MILIS	TATEMENT OF DEFICIENCIES THE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 697	her wheelchair, but have incurred any i where the documer in the nurses' notes been told not to do computer as the net type of documentation something out of it make daily notes." the notes entered 1 was also asked it Resident # 5 after about the resident of the care plan in also requested. I complain of that make the time of the make daily notes." RN # 1 which were writter noting it was documentation assessments at the time of the not complete. The care plan, da reviewed. Unde "Risk for injury: b fallsrelated to d documented "No "Interventions" in	lent had fallen on 11/30/17 out of it did not appear at the time to injury. This surveyor asked intation about the fall was located is. RN # 1 stated "Well, we have current any notes in the ew program is not set up for that tion. We have forms that are stered; there are some notes but if there's a significant eventwe by exception, so unless there's the ordinary we are told not to RN # 1 was then asked about about the resident's pain. RN # for pain assessments done for the fall, and any other notes is pain that were done. A copy of place at the time of the fall was RN # 1 stated "She really didn't much pain after she fell until much was referred to the above notes in the day after Resident # 5 fell, imment. RN # 1 stated she wouk asments copied, and the care plan p.m. RN # 1 provided a copy of so, notes, and the care plan in place at implemented 9/5/17 was in the day after Resident # 5 fell, imment. RN # 1 stated she wouk asments copied, and the care plan in place at the time of the fall was in pain. The pain assessments were sted as implemented 9/5/17 was in "Problems" was documented ruises, skin tears, scratches, tementia" Under "Goals" was fall related injuries" cluded: "If (name of resident) has shift for 72 hours for pain.	of diam.	697				

CENTER		AND HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLER/CLIA	(X2) MUL	TIPLE (FORM OMB NO. (K3) DATE 5	
	CORRECTION	IDENTIFICATION NUMBER:	•				IPLETED
		495177	B. WING			05/10/2018	
	ROVIDER OR SUPPLIER	PITAL HUNDLEY CENTER		12	REET AODRESS, CITY, STATE, ZIP CODE 5 BUENA VISTA CIRCLE DUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DÉFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY WIIFYING INFORMATION)	ID PREF TAG		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 697	injury" Per a fall incident re have fallen at 4:43 passessment sheets 11/30/17 through 12 assessed as having used, but no docum resident's pain level included an area who described for onset, occurs, what makes better and comment. There was one pain which was partially resident had pain in by movement. A "Resident Pain Persesses and pain in the pa	port, the resident was noted to o.m. on 11/30/17. Pain revealed from 5:00 p.m. on 1/4/17 the resident was pain; a pain scale of 0-10 was entation was located noting the . The assessment form also here the pain was to be duration, region, quality, when a pain worse, what makes pain its. All the area's were blank. Assessment dated 12/2/17 completed and documented the the leg which was brought on erception Note" dated 12/8/17	F	697	,		
·	understood: Usually be conducted: Yes. Perception" was do hurting was present FrequentlyVerbal Very severe, horribl An xray report from documented "Clinic Findings:Proxima minimally impacted (emergency room) xray report documented to provid ago. The course/or Type of injury"fall.	rating of pain over past 5 days:					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE	MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE S COM	SURVEY PLETED
		495177	B. WING			05/1	0/2018
*	SUMMARY STA (EACH DEFICIENCY MUST	PITAL HUNDLEY CENTER ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG	125 SO	EET ADDRESS, CITY, STATE, ZIP CODE BUENA VISTA CIRCLE UTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF	BE	(X5) COMPLETION DATE
F 697	the documentation of RN # 1 stated "Well, documented, I can so the administrator, E several nursing staff findings during a me beginning at 2:30 p. time of the potential deficiency, and If the additional informatic administrator stated	o.m. RN # 1 was asked about in the pain assessment sheets, it's not filled out or		\$97	F 700 Bed Rails Corrective Measure for Res	dents	
F 700 \$S⇒D	CFR(s): 483.25(n)(1 §483.25(n) Bed Rail The facility must atternatives prior to bed or side rall is us correct installation, rails, including but nelements. §483.25(n)(1) Assess entrapment from be §483.25(n)(2) Revieralls with the resider obtain informed con §483.25(n)(3) Ensur		F	700	The use of bilateral ½ side rabottom half of Resident # 34 been discontinued. Entrapm assessment was conducted awere no Issues identified. Identification of Other Residents and To Be Affected Residents with physician orderail use during care have the to be affected as well as the have bed rails attached to the	i's bed ha ent and there dents wit lers for be potentia se who	s h ed

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Facility ID; VA0071

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, PUILDING			(X3) DATE SURVEY COMPLETED	
		,	// EDIED			c	
		495177	B. WING			05/1	0/2018
	OVIDER OR SUPPLIER TY MEMORIAL HOSF	PITAL HUNDLEY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	8E	(X6) COMPLETION DATE
	recommendations a and maintaining bed This REQUIREMEN Based on observat document review an facility staff failed to the use of full bilater #34. Resident #34 was o padded side rails in the survey. There we the use or safety of Findings were: Resident #34 was o on 01/30/1998 and reduced the dead of the contracture accident, contracture accident, contracture The most recent ME quarterly assessme reference date) of OB - Hearing, Speech #34 as being "Coma state/no discernible cognitive status was On 05/08/2018 durin Resident #34 was o mattress; bilateral full	w the manufacturers' nd specifications for installing I rails. IT is not met as evidenced by: ion, staff Interview, facility id cilnical record review, the assess one of 23 residents for ral padded side rails, Resident bserved with full bilateral the upright position throughout as no assessment or order for the side rails. riginally admitted to the facility readmitted on 05/17/2017. Her but were not limited to: Spastic and vascular as, dysphagia and seizures. S (minimum data set) was a not with an ARD (assessment 3/09/2018. Section and Vision assessed Resident atose Persistent vegetative consciousness"; therefore, no assessed. In ginitial tour of the facility bserved lying on an air ull padded side rail were in the ed. Bilateral fall mats were		700	They will be identified throug of physician orders and actual inspection of beds. Issues ide be addressed. Measures to Prevent Recurred in-service to nursing staff will conducted to reiterate the purposedure for complying with orders for the use of side rail. Policy and procedure for asset for entrapment will be review the nursing staff and implemed beds will be inspected and may for risk of entrapment and isseidentified corrected. Monitoring: The Director of Nursing (DON designee shall audit medical residents with physician orderails to ensure staff compliant Random observations of staff made to determine if side ralbeing used properly.	ntified we ence I be olicy and n physicials. essing be wed with ented. All easured sues I) or records of er for side ace. If will be	ill ds I

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Facility ID: VA0071

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page 22.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/22/2018

FORM APPROVED

CENTER	S FOR MEDICARE	MEDICAID SERVICES				<u>)MB NO.</u>	<u>0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495177	B. WING			05/°	1 <u>0/2018</u>
NAME OF PR	ROVIDER OR SUPPLIER		L	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				12	5 BUENA VISTA CIRCLE		
COMMUN	IITY MEMORIAL HOSE	ITAL HUNDLEY CENTER		80	OUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES DE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	id PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFÉRENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 700	Continued From page On 05/09/2018 at application of the "2 1/2 side rails at his while resident is record was respect to the care plan was reported on 2/12 rail both sides of receiving care." A side rail assessment was a "Side Rail & Ecompeted on 2/15/2 distances of various mattress, or Reside included in the evaluation was a content of the content	ge 47 poroximately 10:00 a.m. the eviewed. The physician order following order dated 11/14/17: ead of bed to promote safety		700	Variances identified during at be corrected and non-complia will be re-in-serviced, counse disciplined. Audits will be conducted wee weeks. Findings will be report QAPI Committee for further correction Date: 6/24/2018	ant staff ed or kly time ted to t	s 8 ne
		00 p.m., the administrator heet regarding maintenance					

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Event ID: VSS211

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RIN (FD:	05/22/2018
FORM	APPROVED
OMB NO.	0936-0391

NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SUMMAY STATELENT OF DEPOSPORES CEACH DEPOSPORE (EACH DEPOSPORE) (EACH DEPOSPORE TAY OF THE PROCESS OF THAL REGULATORY TAY OR ISO IDENTIFYING INFORMATION) F 700 Continued From page 48 of beds at the facility. She stated, "I have someone from blomed coming to speak with you about the bedsthey did all of our measuringour rule is if we move a resident from room to room we move bed and all now to make sure it is appropriateif we change mattresses the nurses are going to start doing the measurements the tool we use is out for calibration and [name of bio med manager] said it is easy to do and he has a video to train the nurseswe will do that when the tool gets back" On 05/09/2018 at approximately 5:00 p.m., during a meeting with the DON (director of nursing), the administrator and other facility staff, the Facility Biomed Maintenance Manager, OS (other staff) #2, came to speak with this surveyor. He stated, "That spread sheet was done in 2017It is per bed. We look at the mattress to make sure it is the correct one for the bed. We are not responsible for the measurementsI can measure right now and make sure everything is okey and in two hours they can move somebody or add an air mattress and my measurements aren't valid told the administrator that I gave her a brand new tool to use and told her there was a video the nurse's could watchnursing is responsible for the measurements." He was asked when the decision was made for nursing to do the measurements. He stated, "February 2017 when the repairs listed on the state of the measurements." He was asked when the decision was made for nursing to do the measurements. He stated, "February 2017 when the repairs listed on the state of the measurements."		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	ŢIPLE CONSTRUCȚIÓN ING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM STATEMENT OF DEFICIENCIES TAG F 700 Continued From page 48 of beds at the facility. She stated, "I have someone from blomed coming to speak with you about the bedsthey did all of our measuringour rule is if we move a resident from promy to room we move bed and all now to make sure it is appropriateif we change mattresses the nurses are going to start doing the measurementsthe tool we use is out for calibration and [name of bio med manager] sald it is easy to do and he has a video to train the nurseswe will do that when the tool gets back" On 05/09/2018 at approximately 5:00 p.m., during a meeting with the DON (director of nursing), the administrator and other facility staff, the Facility Blomed Maintenance Manager, OS (other start) #2, came to speak with this surveyor. He stated, "That spread sheet was done in 2017 it is per bed. We look at the mattress to make sure it is the correct one for the bed. We are not responsible for the measurementsI can measure right now and make sure everything is okay and in two hours they can move somebody or add an air mattress and my measurements aren't valid It told the administrator that I gave her a brand new tool to use and told her there was a video the nurse's could watchnursing is responsible for the measurements. He was asked when the decision was made for nursing to do the measurements. He			A95177	B WING		۰		
F 700 Continued From page 48 of beds at the facility. She stated, "I have someone from blomed comling to speak with you about the bedsthey did all of our measuringour rule is if we move a resident from room to room we move bed and all now to make sure it is appropriateif we change mattresses the nurses are going to start doing the measurementsthe tool we use is out for calibration and [name of bio med manager] sald it is easy to do and he has a video to train the nurseswe will do that when the tool gets back" On 05/09/2018 at approximately 5:00 p.m., during a meeting with the DON (director of nursing), the administrator and other facility staff, the Fecility Blomed Maintenance Manager, OS (other start) #2, came to speak with this surveyor. He stated, "That spread sheet was done in 2017it is per bed. We look at the mattress to make sure it is the correct one for the bed. We are not responsible for the measurementsl can measure right now and make sure everything is okay and in two hours they can move somebody or add an air mattress and my measurements aren't valid! told the administrator that! gave her a brand new tool to use and told her there was a video the nurse's could watchursing is responsible for the measurements." He was asked when the decision was made for nursing to do the measurements. He					125 BUENA VISTA CIRCLE		<u>1</u> 70/2018	
of beds at the facility. She stated, "I have someone from blomed coming to speak with you about the bedsthey did all of our measuringour rule is if we move a resident from room to room we move bed and all now to make sure it is appropriateif we change mattresses the nurses are going to start doing the measurementsthe tool we use is out for calibration and [name of bio med manager] sald it is easy to do and he has a video to train the nurseswe will do that when the tool gets back" On 05/09/2018 at approximately 5:00 p.m., during a meeting with the DON (director of nursing), the administrator and other facility staff, the Facility Blomed Maintenance Manager, OS (other staff) #2, came to speak with this surveyor. He stated, "That spread sheet was done in 2017it is per bed. We look at the mattress to make sure it is the correct one for the bed. We are not responsible for the measurementsl can measure right now and make sure everything is okay and in two hours they can move somebody or add an air mattress and my measurements aren't validl told the administrator thatl gave her a brand new tool to use and told her there was a video the nurse's could watchnursing is responsible for the measurements." He was asked when the decision was made for nursing to do the measurements. He	PREFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREF	X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE	
that spreadsheet were completed." He was asked if that meant no bed measurements had been done since then. He stated, "Not by us [biomed]. The administrator was asked if she was aware of the information being provided by the Biomedical manager. She stated, "Yesblame it on my short term memory loss." This surveyor asked who measured the air mattresses with side rails observed on the unit.	F 700	of beds at the facility from blomed coming bedsthey did all of move a resident from and all now to make change mattresses the doing the measurem calibration and [nameasy to do and he had not been compared by the compare	A. She stated, "I have someone to speak with you about the our measuringour rule is if we need to room to room we move bed sure it is appropriateif we he nurses are going to start tentsthe tool we use is out for e of bio med manager] sald it is as a video to train the nat when the tool gets back" Approximately 5:00 p.m., during a N (director of nursing), the her facility staff, the Facility and Manager, OS (other staff) #2, this surveyor. He stated, "That one in 2017it is per bed. We to make sure it is the correct are not responsible for the measure right now and make tay and in two hours they can add an air mattress and my it validI told the administrator and new tool to use and told to the nurse's could sponsible for the was asked when the decision g to do the measurements. He 17 when the repairs listed on re completed." He was asked measurements had been done ed, "Not by us [biomed]. The sked if she was aware of the byided by the Biomedical it, "Yesblame it on my short This surveyor asked who attresses with side rails	F	700			

PRINTED: 05/22/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING _ Ĉ 495177 B. WING 05/10/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BLIENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 700 | Continued From page 49 F 700 OS #2 stated, "Nursing is responsible for that." On 05/10/2018 the DON came to the conference room and spoke with this surveyor. She stated, "We are only using the top rails now...we reassessed her and got a consent from the family to use them." The DON was asked if the measurements for entrapment had been done. She stated, "I don't think so." No further Information was obtained prior to the exit conference on 05/10/2018. F 725 F 725 | Sufficient Nursing Staff SS=E | CFR(s): 483.35(a)(1)(2) F 725 Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with Corrective Measure for Residents the appropriate competencies and skills sets to **Affected** provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial Resident # 73 was the only resident well-being of each resident, as determined by identified in the 2567 report under this resident assessments and individual plans of care and considering the number, aculty and diagnoses citation. A reassessment of her needs of the facility's resident population in accordance and functional level were conducted with the facility assessment required at §483.70(e). and the plan of care updated based on §483.35(a)(1) The facility must provide services by this assessment. The clinical sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing coordinator of the Unit where she care to all residents in accordance with resident resides will ensure staff compliance care plans: (i) Except when waived under paragraph (e) of this with interventions implemented. section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION ,	(XS) DATE SURVEY COMPLETED		
	495177		B, WING			C 05/10/2018	
	ROVIDER OR SUPPLIER	PITAL HUNDLEY CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 126 BUENA VISTA CIRCLE SOUTH HILL, VA 23970				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI OEFICIENCY)	E COMPLÉTION	
F 725	(e) of this section, the licensed nurse to set tour of duty. This REQUIREMEN Based on individual Group Interview, the sufficient staffing to maintain the resident mental, and psychos. The individual resident insufficient staff, as a to call bells. The findings were: During the Group Interview and the nine residents presponse was a prolicited waits of 15 to 2 to call bells. One minument of the nine residents presponse was a prolicited waits of 15 to 2 to call bells. One minument of the nurses Station, "he just sitting there talk (ringing). I asked the one of the nurses safelp." The nine residents as "A CNA (Certified Ninot show up for world in the second of the nurses safelp."	of when waived under paragraph the facility must designate a rive as a charge nurse on each This not met as evidenced by: I resident interviews and a the facility staff failed to ensure provide care and services to the highest practical physical, social well-being. The sand group complained of the well as the staff's slow response therefore at 3:00 p.m. on 5/8/18, the sent all agreed that call bell tolem. Several of the residents of minutes for staff to respond the resident cited and instance call bell but got no response for tes. There were four nurses the said. There were four nurses the said. There were four nurses the said and call bells were going off the metal they were doing, and the said of short staffing. The said of short staffing the said of the sai	F	725	Identification of Other Reside Potential To Be Affected All residents who are dependenceding assistance with ADL's potential to be affected. They Identified through review of the status per their most current Staff assignments and work flower be redesigned to maximize state coverage and meet resident in timely manner. Measures to Prevent Recurred A thorough analysis was compour resident population, acuit and the staffing ratios of our competitors. The data utilized analysis was obtained from Clastar Staffing Data (Payroll Bast Journal) Report. The analysis that our staffing ratios are meadequate to meet the needs of resident population and we have significantly higher direct liced staffing than our closest competition adjusted expected.	ent or have the will be helr ADL MDS. ows will aff heeds in a ence bleted of ty needs closest d in the MS Five ed verified ore than of our ave nsed nurse betitor and	
					patient day.		

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

Event ID:VSS211

Facility ID: VA0071

If continuation sheet Page 51 of 75

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	& MEDICAID SERVICES				<u>OMB NO.</u>	0938-0 <u>391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495177	B. WING			C 05/10/2018	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	I)TY MEMORIAL HOSE	PITAL HUNDLEY CENTER			25 BUENA VISTA CIRCLE COUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFI . TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X8) COMPLETION CATE
F 725	4:10 p.m. on 5/8/18, bell response and si said she frequently response. According up in the recliner (chishe has to wait 30 in back in the resident said she freshedoesn't believe in the facility. In another individual p.m. on 5/8/18, the inflimited staff on the sithe weekends. Some minutes for them (Chishe) and there will be said the said the said there will be said the	dent Interview, conducted at Resident # 73 spoke about call ufficient staffing. The resident experienced slow call belling to the resident, when she is halr) and her hip starts to hurt, ninutes to an hour to be put Resident # 73 went on to say call bell unless I have to." The aquently had long wait times and there are enough aldes (CNA's) I interview conducted at 3:50 resident reported there was second shift "especially during metimes it takes 30 to 45 NA's) to answer a call bell." terviewed at 10:00 a.m. on as not enough staffing, y one person on third shift. I've in hour for someone to come room or answer my call bell." ur of the facility at 11:30 a.m. on the second floor reported that on the second flo	F	725	On April 25, 2018 the organized implemented an "Incentivized program that allows addition premium pay on hours worked above the staff's regularly sets shift to encourage staff to plot additional hours to cover emistaffing issues. Additional measures: Staff will be re-in-serviced on Pass Zone" program The DON and clinical coordinates and responsibilities, and workflows that maximize efflor of time. Management staff will round throughout the day to ensure are answered promptly, staff their assigned halls and breat staggered to provide sufficie on the units.	d Shift" al ad over a neduled ak up ergency the "No ators wil ements, ad clent use a call ligh s are on ks are	ts

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·	FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	,,,,,				0938-0391
STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495177	B. WING			05/10/2018	
NAME OF PE	ROVIDER OR SUPPLIER			ŞT	REET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	IITY MEMORIAL HOSF	PITAL HUNDLEY CENTER	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I DROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	about call bell responsible resident sald, "I bathroom door now. help, but I do need a toilet. The first time bathroom, I sat there ringing the call bell filme get off the commithem leave me now when they put me or right there, I"II be do On 5/10/18, at the big (3:00 p.m.), a CNA a station was heard to leaving. It's just me (pointing from one e total of 20 rooms), because they were I the findings were dimeeting on 5/9/18, a conference on 5/10/10/	our, another resident was asked nse time. "Well, I can tell you," make them stay right beside the I don't need a great amount of a little help getting on and off the ethey helped me in the effor about 40 minutes after for someone to come and help node. That's why I don't let w. I don't take that long, so in the toilet I tell them to wait me in just a minute." eginning of the evening shift at the second floor nurses a say, "The state must be to tonight from there to there and of the hall to the other, a Last night we had plenty of help	F	725	Monitoring: The Director of Nursing (DON designee will review daily starsheets to assess adequacy of each shift. Actual staff worker from the previous 24 hours was provided to the DON daily by staffing coordinator. Call light response audits and with residents will be conducted staff. Variances identified during at the corrected. Non-compliant the re-in-serviced, counseled disciplined.	ffing staff on ed hours vill be the intervie ted by udits wil t staff wi	ws
F 756 SS=D	CFR(s): 483.45(c)(1 §483.45(c) Drug Re §483.45(c)(1) The d must be reviewed at licensed pharmacist §483.45(c)(2) This r the resident's medic	gimen Review. rug regimen of each resident t least once a month by a :. eview must include a review of	F	756	Audits will be conducted daily then weekly times 8 weeks. Will be reported to the QAPI of for further discussion or recommendations. Correction Date: 6/24/2018	Findings	

FORM CM8-2557(02-99) Previous Versions Obsolete

Event ID: VSS211

Facility ID: VA0071

If continuation sheet Page 53 of 75

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLÍA AND FLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED			
		495177	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	490177		TREET ADDRESS, CITY, STATE, ZIP CODE	05/10/2018	
	COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER			25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
(X4) ID PREFIX YAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SE COMPLETION IATE DATE	
F 756 Continued From [ge 53	Ė 756			
irregularities to the attending physician and the facility's medical director and director of nursing,				F 756 Drug Regimen Review		
	and these reports m	iust be acted upon. lude, but are not limited to, any		Corrective Measure for Resid	lents	
	drug that meets the	criteria set forth in paragraph r an unnecessary drug.		Affected		
	(II) Any irregularities	noted by the pharmacist during		The order for prn Lorazepam	for	
		documented on a separate, sent to the attending physician		Resident # 46 has been chang		
		dical director and director of		it stops after 14 days. A new o	order will	
		a minimum, the resident's drug, and the Irregularity the d.		be obtained if indicated.		
	(iii) The attending pl	nysician must document in the		The attending physician does	not want	
		ecord that the identified r reviewed and what, If any,		dose reduction for Resident #	43's	
	action has been take no change in the me	to address it. If there is to be ication, the attending		Effexor at this time.	`	
	physician should do the resident's medic	cument his or her rationale in		Identification of Other Resid	ents with	
		acilify must develop and		Potential To Be Affected		
	maintain policies an	d procedures for the monthly		Other residents with potentia	l to be	
		v that include, but are not limited the different steps in the process		affected will be identified thr		
	and steps the pharn	nacist must take when he or she		review of physician orders for		
	identifies an irregulatory for the desired the reside	arity that requires urgent action and action are in the contraction		psychoactive medications. Co	. 1	
		IT is not met as evidenced by:		will be made as appropriate,	.	
		,		the facility's revised policy an		
	Based on staff inte	rview, facility document review,		procedure for the use of prin		
:	and clinical record re	eview, facility staff failed to		psychoactive medications.		
		ponse to a pharmacy two of 23 residents in the				
	survey sample, Res			Pharmacy recommendations		
pharmacy recor		physician failed to respond to a Indation dated 02/27/18 hthuation of Lorazepam	_	reviewed to identify resident	s who may	

		(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MULTIPL	E CONSTRUCTION	(XS) DATE SURVEY
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
					C
		495177	B. WING		05/10/2018
NAME OF P	ROVIDER OR SUPPLIER		ì	STREET ADDRESS, CITY, STATE, ZIP CODE	
COMMUN	ITY MEMORIAL HOSP	ITAL HUNDLEY CENTER	1	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	
	OLILALIA DIVET	ATRIACUT OF DEFICIENCIES		FROVIDER'S PLAN OF CORRE	CTION PGS)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATÉMENT OF DEFICIENCIES BE PRÉCEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
F 756	Continued From pag	e 54	F 756	5	
	(Ativan).			be affected by the lack of	physician
				response to pharmacy co	nsultant
 Resident #43 had a pharmacy recommendation to determine if a GDR (gradual dose reduction) for Effexor XR would be acceptable on 3/20/2018; the facility falled to act upon this in a timely manner. Findings included: Resident #46 was admitted to the facility on 12/21/17 with diagnoses including, but not limited to: Diabetes, Alzheimer's, BPH (benign prostatic 			recommendations. Corre	ctions will be	
			made pursuant to the fac	cility's revised	
			policy and procedure for	1 1	
			Medication Regimen Rev	iew.	
			Measures to Prevent Rec	currence	
		oma, Diverticulitis, and Mild		A memorandum and a co	ppy of the
	Intellectual Disability	<i>/</i> .		regulations and revised p	oolicy and
		S (minimum data set) was a		procedure addressing pri	n psychoactive
	quarterly assessment reference date) of 0	nt with an ARD (assessment 3/26/16. Resident #46 was		medications and monthly	/ medication
	assessed as cognitive	vely intact with a total cognitive		regimen review will be se	ent again to
	score of 15 out of 15	ō.		practitioners serving the	facility's
	Resident #46's clinic 05/09/18 at 12:25 p.	cal record was reviewed on min. A "30 Day Medication		residents/patients.	
	Regimen Review No	ote" dated 02/27/18 and signed		The Director of Nursing a	and licensed
	by the pharmacist in documentation: "	Lorazepam 0.5 MG TAB, PO		nursing staff will be in-se	1 1
	every 6 hours, PRN:	: AnxietyRecommendations		changes.	
-	to Physician: Other	r: Please consider to lack of use (11 doses in past		Ŭ	
	60 days)" No phy	sician response was located in		Monitoring:	
	the clinical record.			The Director of Nursing (חלאוו מר
		dent's physician order sheet			·
		s an order that stated, "Start		designee shall audit med	1
	Date: 12/26/17 Lorazepam 0.5 mg [milligrams], HiGH ALERT med [medication], Tab [tablet], PO [by mouth], every 6 hours, PRN [as needed] Anxiety, initial therapy, X [tlmes] 120 Doses			residents with orders for	Pilt

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ((2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ C B. WING 05/10/2018 495177 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX DATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCYS F 756 Continued From page 55 F 756 (Times), Give first dose: Routine, Start: psychoactive medications, Audits will 12/28/17..." be conducted weekly times 8 weeks. RN #3 (registered nurse) was interviewed on Findings will be reported to the QAPI 05/10/18 at 10:40 a.m. re: pharmacy Committee for further discussion or recommendations to the physician. RN #3 stated, "The DON (director of nursing) gets all those recommendations. recommendations. She then may ask us to get in touch with the doctor." The Director of Nursing (DON) or designee shall audit pharmacy LPN #2 (licensed practical nurse) was interviewed on 05/10/18 at 10:50 a.m. re: pharmacy recommendations for practitioner recommendations. LPN #2 stated, "That was response. Audits will be conducted taken from the charge nurses and given back to the DON in September 2017." monthly for 3 months. During a meeting with the survey team on 05/10/18 Variances Identified during audits will at 2:45 p.m., the DON stated, "Pharmacy Recommendations are put into (Name of Computer) be corrected and names of non-System] and the recommendations go to me, compliant providers will be provided to physician and the medical director. I check to see if the recommendations have been addressed. the VP of Patlent Services and/or The doctor will either write on the recommendation Medical Quality Committee. or write an order in [Name of Computer System]. If I don't see anything in either place, then we call the physician's office. This one must have slipped Findings will be reported to the QAPI through." Committee for further discussion or recommendations. No further information was received by the survey team prior to the exit conference on 05/10/18. 2. Resident #43 was admitted to the facility Correction Date: 6/24/2018 6/30/14, with a readmission on 4/26/16 with diagnoses that included dementia, depression, hematuria, hypocholesteremia, mental retardation, osteoporosis, seizure disorder, congestive heart failure, constipation and hypertension. The minimum data set (MDS) dated 3/22/18 assessed Resident #43 as moderately impaired for daily decision making.

		AND HUMAN SERVICES				FO	RM APPROVED NO. 0938-0391
	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:					COMPLETED
		495177	B. WING			C 05/10/2018	
NAME OF P	ROVIDER OR SUPPLIER			ŝ	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	IITY MEMORIAL HOSE	PITAL HUNDLEY CENTER		1	25 BUENA VISTA CIRCLE BOUTH HILL, VA 23970		·
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEPED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
F 756	Continued From pag	ge 56	F	75 6		•	
	5/10/2018 revealed dated 12/13/2017, a Venlafaxine (generic 150 mg, Cap-SR, to depression. During the resident's resident's pharmacy reviewed. A pharm 3/20/2018 documen for depression. Reviadjustment. Please determine if a GDR	cian' Order Form dated the following medication order, and carried forward monthly: c form of Effexor XR 150 mg) be given by mouth daily for s clinical record review, the recommendations were eacy recommendation dated ted, "Effexor XR 150 mg, daily lew behaviors, consider dosage review resident's condition to (Effexor XR 75 mg daily for the acceptable at this time."					
	The physician saw t 5/2/2018 and there v	he resident on 3/28/2018 and was no mention of a GDR for imented in the progress notes					
	(DON) was interview was notified about the during Medication R stated the pharmacy in the facility's electr medication regimen	5 p.m., the director of nursing wed regarding how the physician he pharmacy recommendations tegimen Reviews. The DON y recommendations were noted ronic medical record. The review report is sent to the ON after the review Is complete.					
		as made aware of the above asked for the Medication Illoy.				,	
		l Medication Regimen Review /15/2018) documented "the					

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1	FORM AF	PROVED
CENTER	RS FOR MEDICARE	MEDICAID SERVICES				MB NO. 09	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495177	B. WING			05/10/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	ITY MEMORIAL HOSE	PITAL HUNDLEY CENTER		1	25 BUENA VISTA CIRCLE		
			1	S	OUTH HILL, VA 23970		
(X4) ID PREPIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XB) COMPLETION DATE
F 756	attending physician medical record that been reviewed and taken to address it. not want to act upon attending physician in the resident's medicumentation must receipt of the pharm Nursing shall track pharmacy reports, made to the physician physician response director of nursing s Services if physiciar of the follow-up photon.	must document in the resident's the identified irregularity has what, if any, action has been if the attending physician does the identified irregularity(s), the shall document his/her rationale dical record. This the performed within 15 days of acist's report. The Director of physician response to the A follow-up phone call shall be an's office if there is no within 15 days of the report. The hall notify the VP of Patient a does not respond within 7 days no call.	F	756			
SS=E	CFR(s): 483.45(c)(3) §483.45(e) Psychotology affects brain activities processes and behave not limited to, dr (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (Iv) Hypnotic	ropic Drugs. chotropic drug Is any drug that es associated with mental evior. These drugs include, but ugs in the following categories:	F .	758	F 758 Free From Unnecessar Psychotropic Drugs Corrective Measure for Resid Affected The order for prn Lorazepam Resident # 46 has been chang it stops after 14 days. A new of be obtained if indicated. Identification of Other Residential To Be Affected Other residents with potential	for ged so that order will ents with	t
					affected will be identified thr	ough	

FORM CMS-2587(02-99) Previous Versions Obsolele

Event ID: VSS211

Facility ID: VA0071

If continuation sheet Page 58 of 75

PRINTED: 05/22/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES. (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ С 495177 B. WING 05/10/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DESIGNACIES ID PREFIX (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) Continued From page 58 F 758 \$483,45(e)(1) Residents who have not used review of physician orders for prin psychotropic drugs are not given these drugs unless psychoactive medications. Corrections the medication is necessary to treat a specific condition as diagnosed and documented in the will be made as appropriate, pursuant clinical record; to the facility's revised policy and procedure for the use of prn §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and psychoactive medications. behavioral interventions, unless clinically contraindicated, in an effort to discontinue these Measures to Prevent Recurrence drugs; §483.45(e)(3) Residents do not receive The administrator and DON were both psychotropic drugs pursuant to a PRN order unless aware of the new regulation limiting that medication is necessary to treat a diagnosed specific condition that is documented in the clinical the use of prn psychoactive medications record; and to fourteen days. This knowledge was §483.45(e)(4) PRN orders for psychotropic drugs shared with the pharmacy consultant are limited to 14 days. Except as provided in and practitioners serving facility §483.45(e)(5), if the attending physician or prescribing practitioner believes that It is appropriate residents in November, 2017. The for the PRN order to be extended beyond 14 days, facility's policy for the use of prn he or she should document their rationals in the resident's medical record and Indicate the duration psychoactive medications has been for the PRN order. revised to include built in automatic stop order, weekly review by pharmaty §483,45(e)(5) PRN orders for anti-psychotic drugs are Ilmited to 14 days and cannot be renewed: consultant, and steps to be taken when unless the attending physician or prescribing practitioner evaluates the resident for the practitioners are non-compliant. appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Practitioners, pharmacy consultant and Licensed nursing staff will be made Based on staff interview, and clinical record review. aware of these changes. facility staff failed to discontinue an order for prn (as

Resident #46.
FORM CMS-2587(02-99) Previous Versions Obsolete

needed) Lorazepam (Ativan) greater than 14 days for one of 23 residents in the survey sample,

Event ID; VSS211

Facility ID; VA0071

If continuation sheet Page 69 of 75

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

_CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	,	495177	B. WING_			i	C 10/2018
NAME OF P	ROVIDER OR SUPPLIER	l <u> </u>		Si	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	10/2018
COMMUN	NITY MEMORIAL HOSE	PITAL HUNDLEY CENTER		12	25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES PE PRECEDED BY FULL REGULATORY INTEYING INFORMATION)	IO PREFI TAG	c	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPA DEFICIENCY)	BE	(X5) COMPLETION DATE
	for prn Ativan since Findings Included: Resident #46 was ar 12/21/17 with diagnote: Diabetes, Alzhe hypertrophy), Glauce Intellectual Disability The most recent MD quarterly assessmer reference date) of 03 assessed as cognitiv score of 15 out of 15 Resident #46's clinic 05/09/18 at 12:25 p. physician order shee that stated, "Start to 0.5 mg [milligrams], Tab [tablet], PO [by a needed] Anxiety, init (Times), Give first do 12/28/17" The Administrator ar were informed of the during a meeting with approximately 2:30 p this meeting if they w regulation that this m order for fourteen da No further informatio	ad a continuous physician order December 28, 2017 to present. dmitted to the facility on oses including, but not limited imer's, BPH (benign prostatic oma, Diverticulitis, and Mild of the facility of the f	F 7	758	Monitoring: The Director of Nursing (DON designee shall audit medical residents with orders for propsychoactive medications. Validentified during audits will be corrected and name of non-coproviders will be submitted to Patient Services and/or Medic Committee for further action. Audits will be conducted wee weeks. Findings will be report QAPI Committee for further dor recommendations. Correction Date: 6/24/2018	records of ariances e omplian o the VP cal Quali s. kly time ted to th	t of ty s 8 ne

PRINTED: 05/18/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
					c		
		495177	B. WING				
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
COMMU	NITY MEMORIAL HOS	SPITAL HUNDLEY CENTER		125 BUENA VISTA CIRCLE			
0011110101			 Ĺ	SOUTH HILL, VA 23970	CTICLI	l ne	
(X4) 1D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN DF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 808	Therapeutic Diet P	rescribed by Physician	F8	.08			
SS=D	1			F 808 Therapeutic Prescrib	ed by		
	 §483.60(e) Therap	eutic Diets		Physician			
	§483.60(e)(1) Ther	rapeutic diets must be					
	prescribed by the a	attending physician.		Corrective Measure for Re	sidents		
	 8483 60(e)(2)	attending physician may		Affected	•		
	delogate to a regis	tered or licensed dietitian the		A physician order for the p	uree diet for	'	
,	task of prescribing	a resident's diet, including a the extent allowed by State		Resident # 67 has been ob			
	law.						
This REQUIREMENT is not met as evidenced			Identification of Other Res	idents with			
	by: Based on observation, staff interview, and clinical			Potential To Be Affected			
	record review, one	of 23 residents, did not have cific therapoutic diet, Resident		Other residents who had c	hanges and		
	#67.	Mile the poster and treatment		or additions to their diet h	ave the		
	ם .:	esé bour produce for a purae diet		potential to be affected. V	ariances		
	Resident #67 dia n	not have orders for a puree diet.		Identified will be corrected	1.		
	Findings were:						
	Pacidoni #67 was	admitted to the facility on		Measures to Prevent Recu	irrence	-	
-	03/27/2018. Her d	liagnoses included but were not	:	The policy and process for			
	limited to: Stage I'	V pressure ulcer of the sacrum,		communicating dietary ch			
	sepsis, dementia, less (adult).	and body mass index 19.9 or		Dietary have been revised	-	1	
				Dietary Is aware of the cha			
	The most recent N	MDS (minimum data set) was		revised policy also reflects	-		
	(assessment refer	essment with an ARD rence date) of 04/03/2018.		recommendations by Spee	•	1	
	Resident #67 was	assessed as being impaired		or other staff will take effe	ct only after		
	with both long and	with both long and short term memory, and		a physician order for the c			
severely impaired with daily decision making skills.		with daily decision making		been obtained. In-service			
			therapist and nursing and	•	5		
	at approximately 1	our of the facility on 05/08/2018 11:45 a.m., Resident #67 was her bed. CNA (certified nursing			•		

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Food and Nutrition Service director or designee shall audit dietary orders and

tray tickets. Variances identified during

compliant staff will be re-in-serviced,

Audits will be conducted weekly times 8

weeks. Findings will be reported to the

OAPI Committee for further discussion

audits will be corrected and non-

counseled or disciplined.

or recommendations.

Correction Date: 6/24/2018

PRINTED: 05/18/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLÍA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ CB. WING 05/10/2018 495177 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 808 F 808 | Continued From page 61 assistant) # 4 was sitting beside the bed feeding on the policy and process changes will Resident #67 a puree diet for lunch. A tube feeding pump was observed beside the bed. The be conducted. pump was attached to a pole and not turned on; a container of Jevity 1.2 was hanging above the Monitoring: pump. The tubing from the pump was capped and secured to the pole.

At approximately 1:00 p.m., CNA #4 was in the hallway. This surveyor asked her how much lunch Resident #67 had consumed. She stated, about 25 %, CNA #4 was asked If Resident #67 could feed herself at all. She stated, "No, we feed her at every meal."

The clinical record was reviewed at approximately 2:30 p.m. Observed on the physician orders was an order dated 04/13/2018: "Modified diet Textured Restricted (must add a modifier), Nectar thick liquid, Start: 04/13/18...Nursing instructions: pleasure tray."

On 05/09/2018 at approximately 9:00 a.m., the unit manager, RN [registered nurse] #3 was interviewed regarding the diet order for Resident #67. She was asked what a textured restricted dlet meant. She stated, "She is on nectar thick. "textured restricted diet" did the physician want since there was no modifier added to the order, did that mean mechanical soft, ground meat, puree, etc. She stated, "Oh, I see...that wasn't added...l'il see what she is getting." RN #3 was informed that this surveyor had observed a puree diet being served at two different meal observations. RN #3 stated, "I'll check on that."

The above information was discussed during an

Ilquids." RN #3 was asked to clarify what type of

end of the day meeting on 05/09/2018 at FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:V8\$211

Facility ID: VA0071

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			C C	
	495177		6. WING			05/10/2018	
	PROVIDER OR SUPPLIER VITY MEMORIAL HOS	SPITAL HUNDLEY CENTER		125	REET ADDRESS, CITY, STATE, ZIP CODE BUENA VISTA CIRCLE UTH HILL, VA 23970		
(X4) ID PREFIX TAG	(FACH DEF)CIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEPICIENCY)	DBE [(X5) COMPLETION DATE
F 808	approximately 4:40 administrative team On 05/10/2018 at a #3 came to speak "When she came it tube put in, the ord didn't add the mod she was on previous a note from the presented a "The date "3/28, 3/29/18 comments: "Total thick nonverbal therapist was attact following: "This is SLP [speech languate came here on and was considered consistencies, give order, but it was the now." RN #3 was clarified the diet of	approximately 11:00 a.m., RN with this surveyor. She stated, which this surveyor. She stated, wack after having her feeding for was put into the system. We offier so dietary resumed what usly which was the pureehere speech therapist." RN #3 erapy Data Collection Form" that contained the following A [assist]puree/nectar" A "Sticky note" from the ched, which contained the the screen I found by the prioruage pathologist]. Looks like puree/NTL [nectar thick liquids] and to be appropriate on those en total feed A [assistance]." The didn't add the modifier to the peright dietwe will add that asked if dietary should have reder prior to resuming the puree diet. She stated, "Yes,		808			-
F 842 \$S≒F	exit conference of Resident Records CFR(s): 483.20(f) §483.20(f)(5) Res (i) A facility may n	- Identifiable Information (5), 483.70(i)(1)-(5) ident-identifiable Information. ot release information that Is	F	842	F 842 Resident Records Corrective Measure for Reside Affected There was no specific resident		
	resident-identifiab (ii) The facility ma resident-identifiab	le to the public. y release information that is le to an agent only in			the 2567 report as having bee affected by this citation.		

STATEMENT	OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМЕ	(X3) DATE SURVEY COMPLETED	
		495177	B. WING		05/1	: (0/201 <mark>8</mark>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COU 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	DÉ		
(X4) ID PREFIX TAG	(FACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
F 842	accordance with a agrees not to use except to the exter to do so. §483.70(i) Medical §483.70(i)(1) In according to the exter to do so. §483.70(i)(1) In according to the exterior of the exterior of the exterior of the exterior of the except with the exc	contract under which the agent or disclose the information of the facility itself is permitted. I records. Scordance with accepted ards and practices, the facility dical records on each resident umented; sible; and rorganized facility must keep confidential stained in the resident's records, form or storage method of the hen release isal, or their resident ere permitted by applicable law; aw; payment, or health care mitted by and in compliance 506; alth activities, reporting of abuse, stic violence, health oversight and administrative proceedings, purposes, organ donation on purposes, or to coroners, and to aven to health or safety as permitted in each of the safety as permitted in against loss, destruction, or	r	Identification of Other Res Potential To Be Affected All residents have the pote affected. Enhancements to electronic medical record application has more flexible individualization and docu the EMR, including treatm interventions, is readily accessible accessible accessible accessible accessible application has more flexible individualization and docu the EMR, including treatm interventions, is readily accessed to Prevent Recultations are provided folder with step by step in how to access each section. These instructions will be reflect the changes/enhant have been made. Selected be trained to access and unview so that they can be made assisting the surveyors of EMR. Certain sections of the record can only be printed medical records staff and for printing will be accompany to the section and the printing will be accompany to the section after the changes and the section and the printing will be accompany to the section after the changes.	ential to be to the system (EMR) information plan pility for mentation in ents and cessible. Irrence ed with a structions on of the EMR. revised to cements that I staff will also se surveyor nore effective navigate the che medical by the any request		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIET/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(
	_	495177	B. WING	_		05/	0/2018
	PROVIDER OR SUPPLIER NITY MEMORIAL HO	SPITAL HUNDLEY CENTER		1.	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE COUTH HILL, VA 23970		•
(X4) ID PREFIX TAG	(EACH DEE)CIENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .BC IDENTIFYING INFORMATION)	JD PRÉF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	(X5) CONPLETION DATE
F 842	§483.70(i)(4) Meditor- (i) The period of tir (ii) Five years from there is no require (iii) For a minor, 3 legal age under St §483.70(i)(5) The (i) Sufficient inform (ii) A record of the (iii) The comprehations of the comprehations co (v) The results of and resident reviet determinations co (v) Physician's, nuprofessional's pro- (vi) Laboratory, raservices reports a This REQUIREMED by: Based on staff in review, the facility medical records vertically accessible survey team had within the comput for 26 of 26 records had confilinformation for reunable to locate in without assistance. The findings including the entrangement of the contrangement of the co	cai records must be retained me required by State law; or if the date of discharge when ment in State law; or years after a resident reaches ate law. medical record must contain- nation to Identify the resident; resident's assessments; ansive plan of care and services any preadmission screening w evaluations and inducted by the State; irse's, and other licensed gress notes; and diology and other diagnostic is required under §483.50. ENT is not met as evidenced terview and clinical record staff falled to ensure resident vere complete, accurate and didring the current survey. The difficulty locating information erized medical record system dis reviewed. The computerized icting resident health sident weights. Surveyors were information within the record of from staff. ide:		842	timely manner. This informal included in the instructions a surveyors will also be inform during entrance conference. Appropriate nursing and diet will be re-educated in the poweights — that weights obtain hospital are not to be used. are to be obtained by assigne pursuant to facility policy and in Cerner on the correct encomposition. Monitoring: The Director of Nursing or destaff shall review surveyor in every three months for accust test surveyor view to ensure information from all sections. EMR are easily accessible. Validentified will be corrected. Findings will be reported to Committee for further discust recommendations. Correction Date: 6/24/2018	and ed of this ed of this elicy for ned at the Weights ed staff d recorded ounter. esignated estructions racy and data and sof the eriances en erianc	
	transitioned to a	dministrator stated the facility new health record software in					

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		SURVEY PLETED
		495177	B. WING		·	05/	10/2018
	PROVIDER OR SUPPLIER NITY MEMORIAL HOS	SPITAL HUNDLEY CENTER	<u></u>	12	REET ADDRESS, CITY, STATE, ZIP CODE 15 BUENA VISTA CIRCLE OUTH HILL, VA 23970	1 30,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION (DATE
F 842	November 2017. T software was hospi system used by the administrator stated with transitioning to would be provided a process. After sign on names provided to the sundifficulty locating nuprogress notes, car medication/treatme computerized healt requested from facilocating the records. On 5/9/18 at 8:15 at technology (IT) man help in locating phyhealth record. The not familiar with the provided for the surstated she did not sonotes in the record abreast of that view. On 5/9/18 at 10:45 the only other accest to write and enter domanager stated the surveyors were not software used by the The survey team had notes and treatment approximately 1:30 manager (RN #3) was administration of the surveyors was an approximately 1:30 manager (RN #3) was administration of the surveyors was an approximately 1:30 manager (RN #3) was administration of the surveyors was an approximately 1:30 manager (RN #3) was administration of the surveyors was an approximately 1:30 manager (RN #3) was administration of the surveyors was a surveyor the surveyo	The administrator stated the tal based and identical to the lar partnered hospital. The id there had been challenges the system and assistance as needed for the survey. Is and passwords were vey team, all surveyors had arsing notes, physician orders and not records in the facility's in records. Assistance was lity administration concerning is. Im., the facility's information mager attempted to provide sician progress notes in a IT manager stated she was escreen view that was veyors. The IT manager see any physician progress reviewed and stated, "I'm not progress in a little and stated, "I'm not progress reviewed and stated and progress reviewed and stated and progress re		342			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		495177	в. WING		To a second seco		C 10/2018
	PROVIDER OR SUPPLIER NITY MEMORIAL HO	OSPITAL HUNDLEY CENTER		125	REET ADDRESS, CITY, STATE, ZIP CODE BUENA VISTA CIRCLE OUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENT	l'ATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRE PREPIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)		JLD BE	(X5) COMPLETION DATE
F 842	notes/progress not stated, "There are love to show them been instructed not there are forms things there are isn't a form then y believe me we' On 05/09/2018 at where treatment a were located in the "We don't have a communications." RN #3 stated, "If o something the nut check off for it." Swhether or not ite alarms, etc. were #3 stated, "The not tracked on a TAR we don't do it." The body weights resident health resurveyor requestered dietitian resident's weight health record. Or stated the weights record were not the Care Tracker health record weights. The entered into the C they were actual the aides. The R	asked where the nurses' ates were located. RN #3 and progress notes. We would a to you but the nurses have but to do notes in this system that we complete for most a few exceptions and if there you can write a clinical note would love to show you notes." 1:35 p.m., RN #3 was asked administration records (TAR) e clinical record. She stated,	1	342			

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Event ID: VSS211

Facility ID: VA0071

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION	СОМІ	(X3) DATE SURVEY COMPLETED	
		495177	B. WING		1	C 10/2018	
	PROVIDER OR SUPPLIER	SPITAL, HUNDLEY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X6) COMPLETION DATE	
F 842	actual but estimate purposes only. The informed regarding weights or the local interview with the Financian strains of the survey team we records as requested to print out the MAF record); the comput doesn't allow us to the system was to this new comput OB [obstetric] unit a helped put in a lot of the system was new Several nurses and assist surveyors will throughout the surveyors will throughout the surveyors will the surveyor will the surveyor will the system was new security of the surveyor will the surveyor	d for pharmacy dosage a survey team had not been the displayed calculated from of actual weights until this tip. as not able to get printouts of ed. On 5/9/18 at 2:45 p.m. the ursing) and RN (registered ked for a copy of a resident's stration record (MAR). A few N # 5 came to the conference the surveyor, "We aren't able R's (medication adminstration ter software we are using now print that." 5 a.m., a surveyor asked the of a physician's order. The order and stated, "I'm not sure put in that way; when we went er program nurses from the fat the hospital came over and of the orders and forms since w to us." I unit managers attempted to the locating information vey. The nurses had difficulty ation in the health record not familiar with the screen he surveyors. The nurses vided to the surveyors did not seed on the floor.		342			
	needed by surveyo inability of the surv	uested to print any information rs for review due to the ey team to locate needed ter system even after					

AND DUAN OF CORDECTION DESCRIPTION AND THE STREET		, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	,	4951 77	B, WING			05/1	0 10/2018
NAME OF F	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		10,2010
	destarchionial tipe	SELECT THE PROPERTY OF SELECTION		12	5 BUENA VISTA CIRCLE		
COMMU	NITY MEMORIAL HOS	PITAL HUNDLEY CENTER		S	OUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DÉFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DBE	(X5) COMPLETION DATE
·					DEFICIENCY)		
F 842	Continued From pa	ge 68	F 8	34 2			
	survey proceeded v as requested from t	ility staff members. The vith staff printing documents he computerized system.			·		
F 908 SS=D		nt, Safe Operating Condition 2)		806			
	and patient care eq condition. This REQUIREMEN	tain all mechanical, electrical, uipment in safe operating NT is not met as evidenced	,				
	review, clinic record investigation, the fa	rview, facility document I review and complaint cility staff falled to ensure			Past noncompliance: no plan of correction required.		.,
	locking system on on the facility. Resider	of the Wanderguard door one of five alarmed doors in nt #187, with a wander n place, fell after exiting his					
'	living unit through the a malfunctioning loot living unit into the file.	ne South stairwell door due to cking system. After exiting his rst floor stairwell, Resident			•		
,	ground floor landing diagnosed with a fra elbow laceration an	the bottom of the steps on the g. The resident was actured left upper arm, left d an abdominal contusion as					
	a result of the fall. The findings include	э;	AND THE PARTY OF T				
	Resident #187 was 4/20/17, was re-adr the facility on 4/15// #187 included rena failure and chronic disease. The minim	admitted to the facility on mitted on 3/13/18 and died in 18. Diagnoses for Resident i cancer, atrial fibrillation, heart obstructive pulmonary num data set (MDS) dated Resident #187 with moderately			·		
				1			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, -	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495177	B. WING _		(C 10/2018	
	PROVIDER OR SUPPLIER	SPITAL HUNDLEY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(XS) COMPLETION DATE	
F 908	nursing note dated was alerted by anot resident had fallen and arrived to the scer top of the stairs, was still in place on sensory pad. He woff the steptook hon a stretcher to be [emergency room] 11:30 p.m. stated, "E.Rwas told that to his It [left] elbow, left humerus, contuit wall" The emergency rood documented, "wa his wheelchair like to opened the door to flights of stairsAscom [centimeter] skilled elbowAbrasion of fracture (avulsion) of humerus - Suspectivall" The facility's investing agency dated 6/8/1 found at Ground Left from first Floor Door ED [emergency depreturned to facility, fracture of left hume investigation stated	nical record documented a 6/7/17 at 1:30 p.m. stating, "I ther employee that the down South hall stairs. When he his wheelchair was at the undergaurd [Wanderguard] his chair, and so was his as lying with his arm hanging is vital signs and placed him transported to the ER" A note dated 6/7/17 at Report was called from the the resident had an abrasion non displaced fracture of the sion of abd. [abdominal] om report dated 6/7/17 s rolling down the hallway in the normally does, and he the stairwell and fell down two sessmentapproximately 7 in tear noted to L [left] elbow - Left, Nondisplaced of lateral epicondyle of left ed, Contusion of abdominal gation report to the state 7 documented, "Resident ovel Landing having exited or (south exit). Transferred to cartment] for evaluation and Finding of nonDisplaced	F 90	08			
		on the ground at the stairwell landing. This report					

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Event ID: VSS211

Facility ID: VA0071

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		OP DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION ·	(X3) DATE SURVEY COMPLETED	
			495177	B. WING	·		C 05/10/2018	
		PROVIDER OR SUPPLIER NITY MEMORIAL HO	SPITAL HUNDLEY CENTER		12	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
	(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
-	F 908	documented, "Inversident left the first south stairwell exit wheelchair and by the steps. He got slipped or fellHis first floor landing bracelet activated did not lock upon a the resident stated on the south stairwell and dld not door Wander guarmechanism was not 5/9/18 at 2:00 jinterviewed about	estigation revealed that the stifloor unit and went out of the door. He then got up from his using the handrall, went down to the ground floor landing and wheelchair was found on the The resident's Wander guard the alarm system but the door activationNurse assigned to that she had heard the alarm vell door go off about 20 incident. She checked the off find anything amissSouth disystem's automatic locking of functioning properly"	F	908			
		the resident had a Wanderguard as in elopement/fall on 6 stated the Wander to activate the doo prevent the resident The administrator the door did not loomaintenance chect and found a defect On 5/9/19 at 5:10 was interviewed at malfunction found 6/7/17. The maint was inspected after power supply failur stated the alarm subut the magnet do	well. The administrator stated pressure seat alarm and interventions prior to the 6/7/17. The administrator guard bracelet was supposed in alarm and the door lock to intervention from going into the stairwell, stated the alarm sounded but ock. The administrator stated ked the door after the incident tive part. p.m., the maintenance director could the South hall door lock when Resident #187 fell on enance director stated the door er the incident and found with a re. The maintenance director ounded at the nursing station or lock did not activate allowing into the stairwell. The					

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		TIPLE CONSTRUCTION ING	(X3) DATE COM	(X3) DATE SURVEY COMPLETED	
		495177	B, WING		i	0/2018	
	PROVIDER OR SUPPLIER NITY MEMORIAL HOS	SPITAL HUNDLEY CENTER		STREET ADDRESS, CITY, STATE, ZIF 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 909 SS=F	#187's elopement/fichecked for proper maintenance direct lasted checked on The facility implement regarding the malfu 6/7/17. The plan of following: South hamalfunction was reand elevators with were checked for pwith sporadic issue with a Wanderguard proper function of the education was provided and elevators was changed actions listed were During the current wanderguard door and completed dail issues with the Wallarms had been no further facility since 7/27/11. This deficiency was non-compliance. This was a complain Resident Bed CFR(s): 483.90(d)(d)	for stated prior to Resident all the door locks were function every 6 months. The for stated the door locks were 5/15/17 prior to the fall. ented a plan of correction unctioning door lock system on f correction included the all door identified with paired on 6/9/17. All doors Wanderguard alarm system proper function and those found is were repaired. All residents disparded to all staff regarding erm, alarms and locks. The sing the function of the door I to daily. The corrective completed on 7/27/17. survey, the daily checks of the is and alarms were ongoing y as indicated. Any defective inderguard door locks and epaired when found. There is elipement issues in the 7. sicited as a past intideficiency.		F 909 Resident Beds Corrective Measure for Affected There was no specific the 2567 report as have by this citation. Identification of Other Potential To Be Affected All residents have the affected. Engineering all beds to ensure all be mattresses and bed rain and areas of possible of identified and corrected.	resident cited in ving been affecte r Residents with ed potential to be staff will inspect ped frames, wils are compatible entrapment are		

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Event ID:VSS211

Facility ID: VA0071 ·

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PENIE	A LOK MEDIOVILE	& MEDICHID SEKAICES				1	0000-000
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
							1
		495177	B, WING			05/1	10/2 018
	PROVIDER OR SUPPLIER NITY MEMORIAL HOS	SPITAL HUNDLEY CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE		
				5	OUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 909	bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify			909	Measures to Prevent Recurren	ce	
:	and mattresses are	ossible entrapment. When bed rails esses are used and purchased from the bed frame, the facility must			The policy and procedure for re inspection of all beds and subse	_	
		l rails, mattress, and bed			inspections when necessary have		
	This REQUIREMEN	NT is not met as evidenced			revised to provide clear delinea		
	by: Based on observa	tion, staff interview, and facility			responsibility between Enginee		1
	document review, t	he facility staff falled to	l .		Nursing staff. In-service to Eng		i i
		pection of facility beds for			and Nursing staffs on this revise	- 1	
	potential entrapme	nt in the facility.			and procedure will be conducted	ed.	
	Findings were:				Monitoring:		
	administrator provious maintenance of bethave someone from with you about the measuringour rul room to room we maure it is appropriate the nurses are goir measurementsth calibration and [nat is easy to do and hourseswe will do	e tool we use is out for me of bio med manager] said it e has a video to train the that when the tool gets back."	*		The QA/Risk Management Nursidesignee shall inspect a set nurbeds weekly to determine comwith the policy. Variances identiduring inspections will be correimmediately. Non-compliant stible re-in-serviced, counseled or disciplined. Audits will be conducted weekly weeks then per schedule.	nber of pliance difled acted aff will	
	a meeting with the	approximately 5:00 p.m., during DON (director of nursing), the other facility staff, the Facility			be reported to the QAPI Comm	ittee for	
	Biomed Maintenan	ce Manager, OS (other staff) with this surveyor. He stated,			further discussion or recomme	ndations	
	"That spread sheet bed. We look at the the correct one for	t was done in 2017it is per the mattress to make sure it is the bed." The spreadsheet ontained room numbers, bed			Correction Date: 6/24/2018		

PRINTED: 05/18/2018 FORM APPROVED OMB NO. 0938-0391

SYATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		495177	B. WING_		l	C 10/2018
	PROVIDER OR SUPPLIER NITY MEMORIAL HO	SPITAL HUNDLEY CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	lÓ PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 909	numbers, mainten safety. OS #2 was been done specific ensure the bed/maif the side rails on stated, "We are not measurementsI make sure everyth they can move so and my measuremadministrator that, use and told her the could watchnurs measurements." decision was mad measurements. He the repairs listed of completed." He was measurements has stated, "Not by us be responsible for administrator was information being manager. She staterm memory loss of DON] an email that was done in Jurveyor asked which with side rails obs "Nursing is responsible for administrator was formation being manager. She staterm memory loss of DON] an email that was done in Jurveyor asked which side rails obs "Nursing is responsible for on 05/10/2018 at DON presented a pages) from OS # inspections conduction of the beds and all corrected.	ance issues, and electrical asked if measurements had to to resident's height/weight to attress used was appropriate or the beds were correct. He of responsible for the can measure right now and hing is okay and in two hours mebody or add an air mattress ments aren't valid! told the! gave her a brand new tool to here was a video the nurse's ing is responsible for the He was asked when the e for nursing to do the e stated, "February 2017 when on that spreadsheet were has asked if that meant no bed do been done since then. He [biomed]we are not going to thatit is up to nursing." The asked If she was aware of the provided by the Biomedical ted, "Yesblame it on my short." OS #2 stated, "I sent [name with all my work order history anuary of this year." This no measured the air mattresses erved on the unit. OS #2 stated,	F 90	09		

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PRINTED: 05/18/2018 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES DELAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495177	B. WING	;		05/1	0 10/2018
	PROVIDER OR SUPPLIER NITY MEMORIAL HO	R DSPITAL HUNDLEY CENTER		1:	TREET ADDRESS, CITY, STATE, ZIP CODE 25 BUENA VISTA CIRCLE OUTH HILL, VA 23970		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREF TAG	XI,	PROVIDER'S PLAN OF CORRECTIC (EAGH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 909	about the informa stated that a chec beds annually but measurements. He checklist. He presented the 11:15 a.m. He state aren't used over he The checklist condimited to: "Verify appropriate for the excessive gaps at the bed and mattrest would be determeasurements. He we look at the mattressthat's with the right mattress what difference if incorrect. He state risk but we (bior to be responsible up to nursing."	tion on the work orders. He klist was used to inspect the it did not Include le was asked for a copy of the checklist at approximately ted, "The first things on there arethey are at the hospital." tained the following, but not mattress (foam or air) is a bed installed. Verify no re noted between the framing of ess" OS #2 was asked how ermined if he was not doing the stated, "What we do here is ttress to make sure it fits the aed needs an 84 inch that we are doing, making sure is on the bed." He was asked made if the mattress was ed, "It can be an entrapment med/maintenance) are not going for the measurements. That is		909			

FORM CMS-2587(02-99) Provious Versions Obsolete

Event ID: VSS211

Facility ID: VA0071

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FORM APPROVED State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495177 B. WING 05/10/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 000 Initial Comments F 000 This Plan of Correction (POC) for the An unannounced biennial State Licensure Virginia Rules and Regulations cited Inspection survey was conducted 5/8/18 through during the Licensure Survey conducted 5/10/18. The facility was not in compliance with the Virginia Rules and Regulations for the on 5/8/18 through 5/10/18 is Licensure of Nursing Facilities. One complaint respectfully submitted as evidence of was investigated during the survey. compliance. The census in this 140 bed facility was ninety-four at the time of the survey. The survey sample consisted of twenty-one current resident reviews and two closed record reviews. 12-VAC-371-250(C) and (F) F 001 Non Compliance F 001 Please cross reference to POC for F6\$7 The facility was out of compliance with the 12-VAC-371-220(A) following state licensure requirements: This RULE: is not met as evidenced by: Please cross reference to POC for F689. The facility was not in compliance with the following Virginia Rules and Regulations for the 12-VAC-371-220(C,3) Licensure of Nursing Facilities: Please cross reference to POC for F690 12VAC-371-250(C) and (F). Please cross reference to F657 12-VAC-371-220(C) and (D) 12VAC-371-220(A). Please cross reference to F689. Please cross reference to POC for F691 12VAC-371-220(C,3). 12-VAC-371-220(D) Please cross reference to F690. Please cross reference to POC for F694 12VAC-371-220(C) and (D). Please cross reference F691. 12-VAC-371-220(A) 12VAC-371-220(D). Please cross reference to F694. Please cross reference to POC for F700.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Williams

12VAC-371-220(A).

Please cross reference F700.

administrator

PRINTED: 05/29/2018 FORM APPROVED

State of Virginia (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING ___ B. WNG 05/10/2018 495177 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 BUENA VISTA CIRCLE COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER SOUTH HILL, VA 23970 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE , DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 001 Continued From Page 1 F 001 12-VAC-371-210(B) 12VAC-371-210(B). Please cross reference to F725. Please cross reference to POC for F725 12VAC-371-300(H). 12-VAC-371-300(H) Please cross reference to F756. Please cross reference to POC for F756 12VAC-371-300(B). Please cross reference to F758. 12-VAC-371-300(B) 12VAC-371-340(J). Please cross reference to F808. Please cross reference to POC for F758 12VAC-371-360(A) and (E). 12-VAC-371-340(J) Please cross reference to F842. Please cross reference to POC for F808 12VAC-371-370 (A) and (B). Please cross reference to F908. 12-VAC-371-360(A) and (E) 12VAC-371-370(A) and (B). Please cross reference to F909. Please cross reference to POC for F842 12-VAC-370(A) and (B) Please cross reference to POC for F908 12-VAC-371-370(A) and (B) Please cross reference to POC for F909