| CENTERS FOR MEDICARE | AND HUMAN SER' & MEDICAID SER' | VICES VICES | | | Printed: 04/05/ FORM APPRO |
|---|--|--|-----------------------------|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLII IDENTIFICATION NO | ER/CLIA IMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | OMB NO. 0938- (X3) DATE SURVEY COMPLETED |
| | 495166 | 3 | B. WING | | C |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | 508 RIS | RESS, CITY, STA | r | 03/24/2016 |
| LUCLIY (CHOU DELICIENCA WIRST | ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION) | ES | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A | EUNITROS COMPLÉT |
| F 000 INITIAL COMMENT | S | | F 000 | DEFICIENCY) | |
| An unannounced Me survey was conducted 03/24/16. One compliance with 42 of Term Care requirements survey/report will follow the time of the survey/reports the time of the survey/reports of 12 currents (Residents 1 through reviews (Residents 13) | ed 03/22/16 through plaint was investigated one are required for CFR Part 483 Federal Parts. The Life Safet ow. I certified bed facility yey. The survey san at Resident reviews 12) and 4 closed reviews | ed during al Long y Code / was 52 nple | | This plan of correction written allegation of cothe deficiencies cited. Submission of this plan is not an admission the exists or that one was This plan of correction meet requirements estate and Federal law. | compliance for However, n of correction at a deficiency cited correctly. is submitted to |
| F 226 483.13(c) DEVELOP/ SS=E ABUSE/NEGLECT, E | IMPLMENT | | F 226 | | |
| The facility must developed policies and procedure mistreatment, neglect, and misappropriation of | es that prohibit and abuse of reside | ente | | | |
| This Requirement is not based on staff interview and facility document rethat the facility staff failed and procedures to probe The facility staff failed to background checks, chareferences for 11 of 20 the past 12 months. The Findings Included: On March 24, 2016 at 2 reviewed the facility polity "Resident Abuse." The pin part "Policy: This facility will resident Abuse." | w, employee record eview it was determined to implement politication obtain criminal eck for licenses and Employees hired will p.m. the surveyor cy and procedures toolicy and procedures | review ined icies I check thin | | | |

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

| 200 | EPAR | RTMENT OF HEALTH ERS FOR MEDICARE | AND HUMAN SERV | /ICES | | | Printed: 04/05/2016 FORM APPROVED | | | | |
|-----|-----------------|--|--|-----------------------|---------------------------------------|--|--|--|--|--|--|
| 37 | TATEME | INT OF DEFICIENCIES NOF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED | | | | |
| | | | 495166 | | B. WING | | C 03/24/2016 | | | | |
| | | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | 00/24/2010 | | | | |
| S | TRATI | FORD HEALTHCARE | CENTER | 508 RIS | ON STREE | r | | | | | |
| | (4) ID | SUMMARY STA | TEMENT OF DEFICIENCE | e . | · · · · · · · · · · · · · · · · · · · | ······································ | | | | | |
| 7 | REFIX TAG | OR LSC IDEA | BE PRECEDED BY FULL I NTIFYING INFORMATION) | REGULATORY! | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | #nec COMPLETION | | | | |
| | F 226 | Continued From pa | | | F 226 | | | | | | |
| | | residents or Misappr property by anyone. It is the policy to und | Procedure: 1). S ertake background | creening checks of | | F226 | | | | | |
| | | all employees and to | retain on file applic | able | | Employees that did not ha | | | | | |
| | | records of current en checks. a. The Facil | inployees regarding : | such | | background checks have h | ive | | | | |
| | | to hiring a new emplo | ovee: i Generally at | ng prior | | hackground shocks nave t | 180 | | | | |
| | | obtain references fro | m prior employers for | n an Tan | | background checks comple | eted. All | | | | |
| | | applicant; il. Check w | <i>i</i> ith applicable nurse | | | potential new hires will have | | | | | |
| | | assistant registry, and | d any other nurse as | sistant | | reference checks complete | ed. The | | | | |
| | | registries that the Fac | cility has reason to b | elieve | | Occupational Therapist him | ed on | | | | |
| | | contain information of | n the individual, prio | r to | | 12/21/15 has had their lice | nsure | | | | |
| | | using the individual as Check with all applica | s a nurse assistant; | iii. | | verified. | | | | | |
| | | certification status to | ible liberising and ensure that the own | in | | Allomatoria | | | | | |
| | | hold the requisite licer | onsure mat me emp ose/and/or certificati | on etate | | All employee files will be re | viewed to | | | | |
| | 1 | to perform their job fu | nctions: iv. Conduct | criminal | | assure that background che | ecks, | | | | |
| | | background check in : | accordance with Sta | t law | | licensure verification, and n | eference | | | | |
| | í | and facility policy;" | (sic) | | | checks completed. | | | | | |
| | (| On March 24, 2016 at | 2:10 p.m. the surve | yor | | All potential and the same | | | | | |
| | Į E | eviewed 20 employee | records with the He | ıman | | All potential new hires will h | nave | | | | |
| | t. | Resources Director Hi he following observati | ND). The surveyor i | nade | | reference checks completed | l. The | | | | |
| | | . A Housekeening e | ons. Employee hired on 1 | 2/1/16 | | Administrator will conduct a | in audit | | | | |
| | d | id not have reference | checks. | 2/1/13 | | monthly for three months of | f all new | | | | |
| | 2 | A Dietary employee | e hired on 11/11/15 | did not | | hires to assure they have con | mpeted | | | | |
| | n | ave reference checks | i. | | | reference checks, backgroun | d checks. | | | | |
| | 3 | . An Occupational T | herapist hired on 4/ | 1/15 | | and licensure verification. | | | | | |
| | Oi | ld not have a Criminal r reference checks. | Background Check | (CBD) | | | | | | | |
| | | | tmo bland as alaten | | | The results of the audits will | be | | | | |
| | ha ha | An Activities emplo ave reference checks. | yee Hileu ON 2/9/16 | aia not | | reviewed at the monthly Qua | ility | | | | |
| | | A Dietary employee | | not | | Assurance Committee Meetin | ng. | | | | |
| | ne | ive reference checks. | | | | | | | | | |
| | 6. | An Admission Coor | dinator employee hi | red on | | Completion Date: 5/2/16 | | | | | |
| | 5/ | 15/15 did not have ref | ference checks. | | | | | | | | |
| | 7. | An Occupational Th | erapist hired on 12/ | 21/15 | | | | | | | |
| | ch | d not have Licensure vecks. | | | | | | | | | |
| | _; 8. | A Physical Therapis | t hired on 4/16/15 d | ld not | | | | | | | |

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | Printed: 04/05/2016 FORM APPROVED | | |
|--|--|-------------------------|-----------------------------|---------------------------|---|--------------------------------------|----------------------------|--|
| #TAT | EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SU | . 0938-0391 JRVEY | | |
| | | 49516 | 6 | B. WING | | | C N/2016 | |
| | NAME OF PROVIDER OR SUPPLIER STREET AD | | | DRESS, CITY, STA | TE ZIP CODE | 03/24 | WZU10 | |
| SIR | ATFORD HEALTHCARE | | 508 RI | SON STREET LLE, VA 245 | r | | | |
| (X4) PREF TAC | G OR LSC IDE | MINEYING INFORMATION | DEMINISTRATIONS. | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | 18 U BE | (X6) COMPLETION DATE | |
| F | 226 Continued From pa | ige 2 | | F 000 | OCTIOENCT) | | | |
| | have reference chec | rks | | F 226 | | | | |
| | 9. A dietary employ | vee hired on 7/20/4 | E 4141 | | | | | |
| | nave reference chec | cks. | | | | | j | |
| | 10. A Certified Nursi | ing Assistant (C.N. | \ did not | | | | | |
| | have reference chec | oks. | n/ ala riot | | | | | |
| | 11. An Other Admiss | sion employee hire | d on | | | | | |
| | 0/23/15 did not have | reference checks | | | | | ļ | |
| | The surveyor pointed | dout to the HRM th | at the | | | | } | |
| | employee records we | ere missina License | 4 | | | | - | |
| | Verifications, CBC ar | nd References. The | e HRM | | | | | |
| | acknowledged that sl | he had not obtained | the | | | | 1 | |
| | reference checks. The | he HRM stated that | one of | | | | 1 | |
| | the employees was tr | he roomen about it | ster | | | | - | |
| | facility and that was the CBC. The survey | or potified the LIDA | ot have | | | | | |
| | she, the HRD, should | have the CBC on t | ithat | | | | | |
| | additional information | Have the CDC Off I | He. No | | | | ľ | |
| | HRD failed to impleme | ent the policy and r | wity the | | | | | |
| | to pronibit abuse. | | | | | | | |
| | On March 24, 2016 at | 3:05 p.m. the surv | evor | | | | l | |
| | notified the Administra | itor (Adm) that the I | HRD | | | | | |
| | talled to obtain license | • Verification CRC a | nd | | | | | |
| | reference checks on 1 | 1 of 20 employees | hired | | | | | |
| | within the past 12 mon | oths. | | | | | | |
| F 244 | 483.15(c)(6) LISTEN/A | ACT ON GROUP | | E 044 | | | | |
| SS=E | GRIEVANCE/RECOM | MENDATION | | F 244 | | | ĺ | |
| | When a resident or fan | nilv aroup exists th | e facility | | | | | |
| | must listen to the views | s and act upon the | • | | | | 1 | |
| | grievances and recomm | mendations of resid | lents | | | | - 1 | |
| | and families concerning | g proposed policy a | nd | | | | ļ | |
| | operational decisions a life in the facility. | mecting resident ca | re and | | F244 | | 1 | |
| | me in the racinty. | | | | | | | |
| | This Requirement is no Based on resident coun | Cii aroup interview | etoff | | The Facility has and will con have regular Resident Cou meetings. Minutes are tak | ıncil | | |
| | "" relaten aug Lesigeut C | Olincii aroun minut | 36 | | the meeting for follow up | hy the | | |
| | review it was determined follow up and communic | d the facility staff fa | iled to | | appropriate staff member. | oy tile | | |
| | | rara a reshouse 10 | | | | | | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | ICES | | | Printed: 04/05/2016 FORM APPROVED OMB NO. 0938-0391 | |
|---|--|---|---------------------------------------|--|---|--|
| AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA MBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | 495166 | | B. WING | | C 03/24/2016 | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | ATE ZIP CODE | VV/X-1/2010 | |
| STRATFORD HEALTHCARE | CENTER | 508 RIS | ON STREET | T | | |
| | | | LE, VA 245 | | | |
| (X4) ID SUMMARY STA | TEMENT OF DEFICIENCIE | e | · · · · · · · · · · · · · · · · · · · | | | |
| TAG OR LSC IDEN | BE PRECEDED BY FULL F ITIFYING INFORMATION) | EGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | INRE COMPLETION | |
| F 244 Continued From page | ge 3 | *************************************** | F 244 | | | |
| resident council grie | vances during subse | auent | | Administrator attend | ance will be | |
| meetings of the cour | noil. | • | | recorded in the minu | | |
| "We _ purs to | | | | | | |
| The Findings Include On March 23, 3016 a | at 10:30 a.m. the sur | veyor | | All residents are at ris | sk. | |
| reviewed the Resider | nt Group Council mi | nutes, | | The Administrator wi | Il continue to | |
| The surveyor reviews Council minutes from | ed the Resident Gro | πb | | attend Resident Coun | icil meeting with | |
| February 2016. The | yquinistrator (A4m) Yquinistrator (A4m) | rougn | | the invitation of the P | | |
| leaning over the nurs | es' station and watch | was hina the | | council's invitation or | ilv. The | |
| surveyor review the F | Resident Group Cour | ncil | | Administrator will rev | • | |
| minutes. The survey | or did not see Resid | enf | | concerns or grievance | • 1 | |
| Council Group minute | s for January 2016. | The | | appropriate Departme | | |
| surveyor did not see a | attendance/sign in s | heets for | | taken will be reviewed | | |
| September, October, 2015. The surveyor a | November or Decer | nder follow | | following Resident Co | | |
| up from Resident Cou | incii Groun concern | The | | | | |
| Resident Council Grou | up minutes read in n | art | | The Administrator will | · - · · · - · · · · · · · · · · · · · · | |
| A Resident Council | il Group meeting wa | is held | | track Resident Council | | |
| on 2/25/16. The notes | read in part | | | minutes and concerns | | |
| "Administration: Goo | od job, no concerns. | | | monthly for three mor | iths. | |
| Nursing: No concerns (Resident name withho | at this time. Dietary: eld) wants wheat hre | : Bad | | The minutes will be re- | viewed at the | |
| Housekeeping: Comin | g in when sleepina i | n | | monthly Quality Assura | ance | |
| mornings or trying to a | et ready, Laundry: F | ew | | Committee Meeting. | | |
| things missing (Reside | int name withheld) p | ink | | | | |
| gown missing. Mainten member name withheld | lance: Good job (sta | ıff | | Completion Date: 5/2/ | 16 | |
| living room too hot. So | u) is doing a great jo | D, | | | | |
| concerns. Activities: Gi | ad (name of staff m | ember | | | | |
| withheld) is back. Reha | ib: (name of residen | t | | | Í | |
| withheld): Doctor said s | tart therapy? Great | iob. | | | | |
| Business Office: no cor | ncerns. New Busines | 22 | | | ** | |
| More music programs, | Laster Activities pla | nned." | | | | |
| A Resident Council on 2/1/16. The minutes | Group meeting was | s held | | | | |
| "Administration: No co | neau I/i part | h | | | | |
| name withheld) great jo | h. Nursing Complet | ner | | | | |
| about changing guidelin | Not wanting certs | in | | | | |
| staff members. Dietary: | (name of resident | ••• | | | *** | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | ICES | *************************************** | | FOR | d: 04/05/201 M APPROVEI O. 0938-039 |
|---|---|----------------|---|--|----------------------|---|
| TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | (X2) MULTIPLI A. BUILDING _ | CONSTRUCTION | (X3) DATE : COMPL | SURVEY LETED |
| | 495166 | | B. WING | | 03/ | C 24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADDRE | SS, CITY, STA | TE, ZIP C O DE | | |
| STRATFORD HEALTHCARE | CENTER | | N STREET | | | |
| | | | E, VA 245 | 4 1 | | |
| PREFIX (EACH DEFICIENCY MUST TAG OR LSC IDEI | NTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 244 Continued From pa | ge 4 | | F 244 | | | |
| | with) (name of staff | mamhar | 1 277 | | | |
| withheld) Running o | ut of PB (peanut but | member ter) | | | | |
| mustard w/ (with) ha | mburgers + hot dog | s Tired | | | | |
| of wings. Housekee | ping: (name of staff | member | | | | |
| withheld) good job, r | ooms w/ soap in bat | throom | | | | |
| fitted sheets to fit be | ds, green spreads to | oo bia. | | | | |
| Laundry: (name of re | esident withheld)-mi | ssina | | | | |
| purple jacket, washo | cloths too small, (nar | ne of | | | | |
| resident withheld) re | quested dry cleaning | service. | | | • | |
| Maintenance: Heatin | ng +air conditioning r | not | | | | |
| working. Activities: C | coloring pages, shop | ping, | | | | |
| bingo. Rehab: (name | es of 2 residents with | nheld) | | | | l |
| more rehab. Other: | Residents missing ti | nings, | | | | |
| other residents roam | ing. New Business: | | | | | |
| Residents request fo | r weekly meal menu | i." | | | | |
| Multiple concern note | 9s were written in the | e margin | | | | 1 |
| of the document rega | arding tood choices, | | | | | |
| housekeeping and no | ursing. •••• ∩ | | | | | |
| A Resident Coun on 12/17/15. The no | ton and in a set in | as held | | | | |
| Services: No concern | res reau in part S | ociai | | | | } |
| New Business: (name | e of rapidant withhal | icems. av | | | | |
| missing gown. Gown | ?Red full length nig | u) htaawa 2 | | | | |
| -3 weeks ago. Dietan | v- fin newton hare r | ingown z | | | | |
| The surveyor reviews | ed the Resident Cou | ncil | | | | |
| Group minutes with the | he Adm. The survey | incii Inr | | | | |
| pointed out that no fo | llow up to the Group | Council | | | | 1 |
| Group was provided. | The Adm stated the | at when | | | | |
| residents made grieva | ances/concerns in the | ie | | | | f |
| Resident Council Gro | up meeting the indiv | ridual | | | | |
| resident was directed | to go to the Social \ | Vorker | | | | |
| (SW) to make an indi | vidual grievance/cor | cern | | | | l |
| report. The surveyor | asked why the resid | ents' | | | | |
| had to go through an | additional step/proce | ess to | | | | |
| make a grievance/cor | cern. The surveyor | also | | | | |
| asked why there was | no follow up to the F | Resident | | | | |
| Council Group when g | | | | | | |
| made. The Admistate | ad that anno the Dan | ident | | | | i |

made an individual grievance/concern to the SW, the SW would then follow up with the resident

| DEPAR CENTE | RTMENT OF HEALTH ERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | /ICES | | | Printed: 04/05/2010 FORM APPROVED OMB NO. 0938-0391 |
|--------------------------|--|--|--|------------------------|--|---|
| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | 1 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495166 | | B. WING | | 03/24/2016 |
| | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | |
| STRAT | FORD HEALTHCARE | CENTER | | ON STREE LLE, VA 24 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TON SHOULD BE COMPLETION THE APPROPRIATE DATE |
| | conducted the Residuith 15 alert and oringurveyor asked what Resident Council Grand grievances/concerns group stated that the in on the Resident Council Grand grievances/concerns directed to go to the individual grievance/residents stated that not read or write and to voice a grievance/spoke up and stated why the facility made extra step to voice a Resident Council Grand group grievances/council Grand | at 1 p.m. the survey dent Council Group is ented Resident's. To the process of th | meeting he e i. The AD) sat ng and were te an e of the nts could de it hard desident derstand rough an The acility g voiced ey team ON), d the e o (AT) eed rough failed | F 244 | | |
| F 252 SS=E | 483.15(h)(1) SAFE/CLEAN/COMF ENVIRONMENT | ORTABLE/HOMELI | KE | F 252 | | |
| | The facility must prov comfortable and hom the resident to use his | elike environment, a | allowing longings | | | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | /ICES | | | Printed: 04/05/2016 FORM APPROVED | |
|--|---|---|-----------------------|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | R/CLIA MBER: | | PLE CONSTRUCTION G | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED | |
| *************************************** | 495166 | | B. WING | | C 03/24/2016 | |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, S | TATE, ZIP CODE | 1 | |
| STRATFORD HEALTHCARE | | 508 RIS DANVII | ON STREI LE, VA 24 | ET | , | |
| PREFIX (EACH DEFICIENCY MUST TAG OR LSC IDEN | ITIFYING INFORMATION) | S REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | IN RE COMPLETION I | |
| F 252 Continued From page | ge 6 | | F 252 | | | |
| to the extent possible | 9. | | . 202 | F252 | | |
| This Requirement is Based on observation determined the facility residents with a safe, homelike environment common areas. Findings: Facility staff failed to passe, clean, comfortate environment in 15 of common areas. The famade on the initial tou 3/22/16 and continued ending at 4:30 PM on The following observate. 1. Resident rooms were and debris build up on thick behind the doors, were observed to be well from the walls in rooms was scraped and chipp bedrooms and needed were observed to be scequipment damage. The floors were broken and was observed in rooms 210, 207, 208, 205, 114 and 103. 2. In the hallways, vinyl to observed to be warping the walls. The hallway till broken sporadically throises. | or, and staff interview y staff failed to provide residents with clean, comfortable at in their rooms and provide residents with their 30 rooms and including observations and particular beginning at 12:45 through the entire staff of the vinyl baseboar arping and pulling are and bathrooms. Paged on the walls of repair. The room do uffed and scarred free vinyl tiles covering missing in areas. The vinyl tiles covering missing in areas. The 216, 214, 212, 20, 109, 103, 105, 102 baseboards were and coming away frees were chipped and some proving the coming and pulling areas. The room do uffed and scarred free vinyl tiles covering missing in areas. The common the coming areas are and coming away frees were chipped and coming and coming away frees were chipped and coming and coming away frees were chipped and coming | th a in the as were and the swere and the as were as were as the survey dirt cularly ds way aint the his leg, 2, 101, and the as were as the his leg, 2, 101, and the as were as the his leg, 2, 101, and the as were as the his leg, 2, 101, and the as were as the as were as the as were as the as were as | : | Rooms where build up is per the floors and behind door cleaned, loose vinyl baseb secured where present inchallways, painting will be per where needed in rooms and bathrooms, room doors wit sanded or repaired, vinyl tit replaced/repaired in rooms 212, 209, 210, 207, 208, 20, 109, 103, 105, 102, 101, and hallway tiles will be replaced/repaired, handrail handrail outside the Director Nursing Office secured, living carpet cleaned or replaced, in living room repaired/replacedges of doors repaired, stabathrooms cleaned, basebos secured, painting in bathroom needed, carpeting in the Bustoffice, MDS Office, and Admit office will be secured/replaced. All areas of the facility will be reviewed to ascertain where additional repairs or replacem necessary. | rs will be pard will be pluding performed and libe les will be seed, 214, 5, 114, dd 103. Is repaired, or of the proom furniture acced, and seed, and seed where siness mistrator and seed. | |

| DEPARTMENT OF HEALTH A | AND HUMAN SERVICES & MEDICAID SERVICES | | | Printed: 04/05/ FORM APPRO OMB NO. 0938- | V |
|---|---|--|---|--|--|
| TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | <u> </u> |
| | 495166 | B. WING | ANNOTES A | C 03/24/2016 | |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER 508 | ADDRESS, CITY, I RISON STRE NVILLE, VA 2 | ET | | |
| PREFIX (EACH DEFICIENCY MUST I TAG OR LSC (DEN | EMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATO TIFYING INFORMATION) | DRY PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPRI DEFICIENCY) | JED RE COMPLET | |
| F 252 Continued From pag | e 7 | F 252 | | | |
| slab crack was raisin widthwise projectile in Paint was scuffed and 3. The handrails in the They were observed a splintered areas in the hallways. One section the DON's (director of firmly secured to the veasily with one hand. 4. The living room car stained and unsightly, room was observed to wood in the legs of bot wooden table, being us polishing station, had be | g and cracking tiles in a full the middle of the two hall. It has been a full the middle of the two hall. It has been a full the middle of the two halls. It has been a full the middle of the middle | I | All areas cited during the surve be reviewed monthly for three months by the Administrator to assure they are maintained/reand inspect entire facility for cleanliness and repairs. The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting Completion Date 5/2/16 | e to epaired e e ity | |
| director) was interviewed the facility. He said he leand was trying to catch conditions that needed "It's a very old facility. It attention." On 3/24/16 at 2:45 PM, with the MD (maintenantic said the | attention in this facility, requires a lot of during a tour of the facility ce director) the surveyor handrails were very worn as the MD said he kept as he could—but they nent (wheelchairs. | | | | The state of the s |

The MD said he would like to get new handrails for the facility made of a material that didn't

| DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | ICES | | | FOR | d: 04/05/201 RM APPROVEI IO. 0938-039 |
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| splinter the way woo anyone getting a spl with an infection cau was contained on the The surveyor also poseveral doors that woon the edges by equiphad a potential for hand or arm against. The surveyor also poseveral clinging loos from the DON's (direshook easily with one come off the wall if a applied to it. 5. Two staff bathroom and trash behind the was noted behind the was noted behind the baseboards which we away from the walls. The paint was scuffed were wearing on the con unit II was full of woverflowing. No one wissue during this observed in the administrator' to need new carpet. Tor two—but the ripples throughout all three of tripped over one of the entering the Business | od does. The MD not inter like that could dised by whatever orge surface. Dinted out the edges ere worn or had been ipment. These rougharm if any resident suffers them. Dinted out a loose set in the wall acrost them. Dinted out a loose set in the wall acrost them. Dinted out a loose set in the wall acrost them. Dinted out a loose set in the did and and could early with date of the wall acrost them. The warped and falling the edges. The staff bat water from a toilet was aware of attendigners and rolls were all oblined in the official was not in a single and rolls were preventices. This surveyor errolled up areas were in the official warpers. | end up ganism of en gauged h edges craped a ection of is the half e. It sily t were ark debris debris debris ng a tiles hroom ing the ot served ces was gle area ralent all ractually when | F 252 | | | |

On 3/24/16 at 4:00 PM the DON (director of

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| F 252: Continued From pa nursing) and admin these findings. | age 9 istrator were informed of | f | F 252 | | |
| observations on 3/2 | | eyor's | | F272 | |
| a comprehensive, as reproducible assess functional capacity. A facility must make assessment of a resident assessment by the State. The as least the following: identification and der Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior presychosocial well-bei Physical functioning a | nduct initially and periodic ccurate, standardized ment of each resident's a comprehensive ident's needs, using the instrument (RAI) specifi sessment must include a mographic information; | cally | F 272 | The MDS Coordinator an will be in-serviced by a Reimbursement Nurse complete accurate CAAs MDS for residents 1, 2, 5 be updated and accurate. All residents have the post affected. All future CAAs the location and date of documentation. Audits of CAAs will be documented that week b designee weekly x 4 then ensure the date and lesupporting documentation. | the Regional on how to on an MDS. i, 6, 7, 8 will tential to be will include supporting the for MDS y DON or monthly to ocation of |
| Disease diagnosis and Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sum the additional assessmareas triggered by the Data Set (MDS); and | d health conditions; status; | ire | | documented. The results of the audit reviewed at the mor committee meeting. Completion date 5/2/16 | ts will be nthly QA |

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| MANE OF BOOLOGED OF GLOWING | | | 03/24/2016 |
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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

Printed: 04/05/2016

F 272 Continued From page 10

F 272

This Requirement is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Care Area Assessment Summary (CAA'S) for 6 of 16 Residents in the sample survey, Resident #1, Resident #2, Resident #6, Resident #5, Resident #7 and Resident #8.

The Findings Included:

1. For Resident #1 the facility staff failed to ensure a complete and accurate Section V. Care Area Assessment Summary (CAA's) on an Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/9/16. Resident #1 was a 66 year old male who was admitted on 2/2/16. Admitting diagnoses included, but were not limited to: spinal stenosis in the lumbar region, degeneration disc disease, diabetes mellitus, hypertension, and high cholesterol.

The most current MDS located in the clinical record was a 30 Day MDS assessment with an ARD of 3/1/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #1 required set up assistance (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's).

On March 22, 2016 at 3:10 p.m. the surveyor reviewed Resident #1's clinical record. Review of the clinical record produced an Admission MDS assessment with an ARD of 2/9/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 15. The facility staff also

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| | coded that Resident | t #1 required extensi | ve | - - | | | |
| | assistance (3/3) with | h ADL's. In Section ' | V. CAA'S | | | | |
| | in the column titled, | "Location and Date | of CAA | | | | |
| | documentation" the | facility staff coded | . "CAA | | | | |
| | WS (work sheet) da | ited 2/15/16CAA t | WS dated | | | | |
| | 2/10/16," (sic) Cont | inued review of the I | MDS | | | | |
| | produced CAA work | sheet. The CAA wo | rksheet | | | | |
| | documented what "ti | riggered" from the M | IDS. The | | | | |
| | CAA'S did not docur | ment the location or | date of | | | | |
| | supporting documen making decision. | itation for the CAA's | care plan | | | | |
| | On March 22, 2016 | of 2:50 n m. than arm. | | | | | |
| | notified the Director | at 3.50 p.m. the surv of Nursina (DON) th | eyor of | | | | Ì |
| | Resident #1's Admis | in (MOD) girland in is | at antwith | | | | - |
| | the ARD of 2/09/16 d | did not have complet | e and | | | | 1 |
| | accurate CAA'S. The | e survevor reviewed | o ana | | | | 1 |
| | Resident #1's clinical | record with the DO | N. The | | | | • |
| | surveyor pointed out | that the CAA'S were | e not | | | | I |
| | complete and accura | ate. The surveyor po | inted out | | | | Ī |
| | that the facility staff of | locumented, "CAA V | VS (work | | | | ļ |
| | sheet) dated 2/15/16 | CAA WS dated 2/ | 10/16." | | | | |
| | (slc) The surveyor no | otified the DON that | the | | | | ļ |
| | specific location and | date of the supporting | <u>ng</u> | | | | |
| | documentation had to V. CAA'S. | | | | | | |
| | On March 23, 2016 a | it 3:50 p.m. the surve | ey team | | | | |
| | met with the Administ | trator (Adm), DON, A | Assistant | | | | l |
| | Director of Nursing (A | ADON) and Corporal | te | | | | |
| | Compliance Nurse (C | CN). The surveyor | notified | | | | |
| | the Administrative Tea | am (AI) that Reside | nt #1's | | | | Į |
| | Admission MDS asse 2/09/16 CAA'S were r | ssment with the ARI | O of | | | | |
| | No additional information | tion was provided | ior to | | | | |
| | exiting the facility as to | nuir was provided pr | IUI IU ff failed | | | | |
| | to ensure a complete | and accurate CAA'S | n tallet Sfor | | | | 1 |
| | Resident #1. | min dominic OW C | i (UI | | | | [|
| | 2. For Resident #2 tl | he facility staff failed | to | | | | 1 |
| | ensure complete and | accurate Section V | Care | | | | |
| | Area Assessment Sun | mmary (CAA'S) on a | n | | | | |
| . • | Annual Minimum Date | Set (MDS) assessr | nent | | | | 1 |

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| CENTERS FOR | MEDICARE & MEDICAL | D SERVICES |

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| 9/15/15. Resident #2 was a originally admitted 2/28/14. Admitting not limited to the focerebrovascular acosteoarthritis, mori | nt Reference Date (Al in 85 year old female on on 1/1/11 and readming diagnoses included, ollowing: fall, diabetes exident, hypertension, old obesity, urinary tra- repathy, anxiety, depres | who was tted on but were mellitus, | F 272 | | | | |

The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 2/3/16. The facility staff coded that Resident #1 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #2 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). On March 23, 2016 at 2:30 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced an Annual MDS assessment with an ARD of 9/15/15. The facility staff coded that Resident #2 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #2 required extensive assistance (3/3) to total nursing care (4/2) with ADL's. In Section V. CAA'S in the column titled, "Location and Date of CAA documentation" the facility staff coded ... "CAA WS (work sheet) dated 9/21/15 CAA WS dated 9/18/15 ... CAA WS dated 9/16/15." (sic) Continued review of the MDS produced CAA worksheet. The CAA worksheet documented what "triggered" from the MDS. The CAA'S did not document the location or date of supporting documentation for the

On March 24, 2016 at 9 a.m. the surveyor notified the MDS Nurse that Resident #2's Annual MDS with the ARD of 9/15/15 CAA'S were not accurate/complete. The surveyor reviewed the MDS with the MDS Nurse. The surveyor

CAA's care plan making decision.

asthma and bipolar.

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| F 272 Continued From previewed Section \ | page 13 V. CAA'S and the CA | • A'S | F 272 | | |

supporting documentation for the care plan decision making was not documented on the CAA'S or CAA'S worksheet. The surveyor notified the MDS Nurse that specific location and dates of supporting documentation regarding the care plan making decision had to be documented.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate

worksheet with the MDS Nurse. The surveyor pointed out that specific location and date of

met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #2's Annual MDS assessment with the ARD of 9/15/15 CAA'S were not completed.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate CAA'S for Resident #2.

3. For Resident #6 the facility staff failed to ensure complete and accurate Section V. Care Area Assessment Summary (CAA'S) on an Admission and 5 Day Medicare Minimum Data Set (MDS) assessment with an Assessment Reference Date of 2/20/16.
Resident #6 was a 92 year old female who was

admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2)

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| | to extensive assista | ance (3/2) with Activit | ies of | | | | |
| | Daily Living (ADL's) |). | | | | | |
| | On March 22, 2016 | at 4:05 p.m. the sun | /eyor | | | | |
| | reviewed Resident | #6's clinical record. | Review of | | | | |
| | the clinical record p | roduced an Admissic | on and 5 | | | | |
| | Day Medicare MDS | assessment with an | ARD of | | | | |
| | 2/20/16. The facility | staff coded that Res | ident #6 | | | | |
| | nad a Cognitive Sur | mmary Score of 9. T | he facility | | | | |
| | stair also coded that | t Resident #6 require | ed limited | | | | |
| | of Daily Living (ADI | ssistance (3/2) with A | Ctivities | | | | |
| | Assessment Summ | is). In Section V. Ca ary (CAA's) column t | re Area | | | | |
| | "I ocation and Date | of CAA documentation | nied, Sprika | | | | |
| | facility staff docume | nted, "CAA WS (wor | лг me k shoot) | | | | |
| | dated 2/22/16" for ea | ach CAA triggered. (s | r sneer) | | | | |
| | Continued review of | the MDS produced (| 3.ΔΔ | | | | |
| | worksheet. The CA | A worksheet docume | inted | | | | |
| | what "triggered" fron | n the MDS. The CA | A'S did | | | | |
| | not document the loa | cation or date of sup | portina | | | | |
| | documentation for the decision. | ne CA is care plan mi | aking | | | | ************************************** |
| | | at 4:55 p.m. the surv | evor | | | | |
| | notified the Director | of Nursing (DON) the | at | | | | |
| | Resident #6 's Admis | ssion and 5 Day Med | icare | | | | ļ |
| | MDS assessment wi | ith the ARD of 2/20/1 | 6 did not | | | | [|
| | have complete and a | accurate CAA'S. The | • | | | | - |
| | surveyor reviewed R | esident #6's clinical | | | | | Į. |
| | record/MDS with the | DON. The surveyor | pointed | | | | |
| | out that the CAA'S w | ere not complete and | d t | | | | |
| | accurate. The surve | yor pointed out that t | he | | | | |
| | facility staff documen | nted, "CAA WS (work | sheet) | | | | |
| | dated 2/22/16." (sic) | The surveyor notifle | d the | | | | ļ |
| | DON that the specific | c location and date of | f the | | | | |
| | supporting document | tation had to be docu | mented | | | | I |
| | in Section V. CAA's for | or the decision makin | ng | | | * | |

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant

Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified

process.

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| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE CENTER | | 508 RISC | ESS, CITY, STATE, ZIP CODE ON STREET LE, VA 24541 | |

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)

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F 272 Continued From page 15

the Administrative Team (AT) that Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 CAA'S were not completed.

SUMMARY STATEMENT OF DEFICIENCIES

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate CAA'S for Resident #6.

4. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #5. The resident's clinical record was reviewed on 3/23/16 at 9:00 AM.

Resident # 5 was admitted to the facility on 10/6/15. The diagnoses included Bipolar disorder, diabetes, coronary artery disease and cerebral vascular accident with hemi-plegia.

The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.)

The MDS contained CAA's signed and dated 10/19/15. The location and date section (Section V) of the CAA documentation was observed to be incomplete for location and dates of the summarized material.

This information was shared with the DON and administrator on 3/23/16 at 3:30 PM. No additional info was provided.

5. Facility staff failed to complete an accurate CAA (Care Area Assessment) summary for Resident #7. Resident #7's clinical record was reviewed on 3/23/16 at 11:30 AM.

Resident #7 was admitted to the facility on 2/2/16.

F 272

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| | The diagnoses inclu | uded hypertension, o | ongestive | | | | |
| | pulmonary disease, Hepatitis C. | end-stage renal disc | ease and | | | | |
| | The resident's annu assessment dated 2 slightly impaired cog #7 required staff ass of daily living.) | gnitive impairment. F | ldent with Resident | | | | |
| | The MDS contained 2/11/16. The location documentation (Sec incomplete for dates information upon wh | n and date of the CA tion V) was observed and location of the | A d to be | | | | |
| | This information was administrator 0n 3/23 | s shared with the DC 3/16 at 3:30 PM. | N and | | | | |
| | 7. Facility staff faile CAA (Care Area Ass Resident # 8. The re reviewed on 3/23/16 | essment) summary i sident's clinical reco | for | | | | |
| | Resident # 8 was add 10/1/10. The diagnost depression, hyperten | ses included psycho: | sis, | | | | Tarabayan and ta |

summarized material.

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

daily living.)

The resident's annual MDS (minimum data set) assessment dated 10/6/15 coded the resident with unimpaired cognitive ability. Resident #8 required staff assistance for all ADL (activities of

The MDS contained CAA's signed and dated 10/13/15. The location and date section (Section V) of the CAA documentation was observed to be

incomplete for location and dates of the

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERVEN | /ICES /ICES | | | Printed: 04/05/201 FORM APPROVE |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE | PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING | | LE CONSTRUCTION | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED |
| | 495166 | | B, WING | | C 03/24/2016 |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | 508 RIS | RESS, CITY, S' SON STREE LLE, VA 24 | TATE, ZIP CODE ET 541 | |
| TAG OR LSC IDE | NTIFYING INFORMATION) | 8 REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OUT O DE COMPLETION |
| F 272 Continued From pa | ge 17 | | F 272 | | |
| This information wa administrator on 3/2 additional info was p | s shared with the DC 3/16 at 3:30 PM. No provided. | ON and | _ | F278 | |
| F278 483.20(g) - (j) ASSE SS=D ACCURACY/COOR | SSMENT DINATION/CERTIFI | ED | F 278 | Resident #6's MDS 2/20/16 was amende | ed to reflect |
| The assessment must accurately reflect the resident's status. | | | | coding of a UTI and Psyc use. All residents have be affected. | chotropic drug e potential to |
| A registered nurse m each assessment wit participation of health | th the appropriate | linate | | Resident #5's Significant dated 10/13/15 was reflect use of antipsyc | amended to |
| A registered nurse massessment is complete. | ust sign and certify ti eted. | hat the | | the look back period. have the potential to be | All residents |
| Each individual who o assessment must sign that portion of the ass | n and certify the acc | of the uracy of | | The MDS Coordinator an will be educated by t | d MDS nurse the Regional |
| Under Medicare and It willfully and knowingly false statement in a resubject to a civil mone | certifies a material a sident assessment i y penalty of not mor | and s e than | | Reimbursement Nurse coding of UTIs and psychuse including but not antipsychotics. | otropic drug |
| \$1,000 for each asses willfully and knowingly to certify a material an resident assessment is penalty of not more that assessment. | sment; or an individi causes another indi d false statement in s sublect to a civil me | ual who vidual a | | An audit of completed I done weekly x 4 weeks designee then monthly proper coding of psychotropics. | by DON or |
| Clinical disagreement of material and false state | ement. | | | The results of the aud reviewed at the mocommittee meeting. | its will be onthly QA |
| This Requirement is not Based on staff interview It was determined that the ensure a complete and Set (MDS) assessment | v and clinical record he facility staff failed accurate Minimum I | review I to Data | | Completion date 5/2/16 | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERVICES & MEDICAID SERVICES | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | A TO THE PORT OF T | (X2) MULTIPLE CONSTRUCTION A. BUILDING | 0 |

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| AND | PLAN | OF C | ORRE | CTION |

X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

B. WING STREET ADDRESS, CITY, STATE, ZIP CODE

03/24/2016

C

STRATFORD HEALTHCARE CENTER

508 RISON STREET DANVILLE, VA 24541

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**

(X5) COMPLETION DATE

Continued From page 18

the sample survey, Resident #6 and Resident #5. The Findings Included:

1. For Resident #6 the facility staff failed to code/capture a Urinary Tract Infection and Psychotropic Drug use on an Admission and 5 Day Medicare Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 2/20/16.

Resident #6 was a 92 year old female who was admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection. encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #8 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's).

On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced a hospital History and Physical dated 2/11/16. The History and Physical documented that Resident #6 was seen in the emergency room after Resident #6 had a change in mental status. The History and Physical also documented that Resident #6 had urinary frequency and painful urination. The History and Physical documented that Resident #6's urinalysis showed a small amount of blood, small leukoctye esterase with WBC's (white blood cells) between 5-10. The History and Physical documented "Metabolic encephalopathy secondary to urinary tract infection complicated by advanced dementia." (sic) Lastly the History and Physical documented that the physician

F 278

| DEPARTMENT | OF HEALTH AND | HUMAN SERVICES |
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| CENTERS FOR | MEDICARE & ME | DICAID SERVICES |

Printed: 04/05/2016

| CENTERS FOR MEDICARE | & MEDICAID SERV | ICES | | | OMB N | IO. 0938-039 |
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| | 495166 | | B. WING | | 03 | C /24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| STRATFORD HEALTHCARE | CENTER | 1 | ION STREE LE, VA 249 | | | |
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| F 278 Continued From particles or dered ceftriaxone 24 hours. Further review of the admission orders for physician signed admission orders for physician signed admission and provided from the February 2016 Marker (Marks). The documented that receive the Resperidene 0.25mg physician. Additional review of the an Admission and 5 massessment with a for the control of the c | e clinical record procer Resident #6. Reviews incluing record procer (a psycolor) and the clinical record policy and the facility staff all the clinicy and the clinical record and the clinical r | duced ew of the ded, but chotropic ee a day)." roduced ation MAR's he oduced e facility itive iso coded of Daily noses 10 Days) staff #6 did s within eyor at care 6 was dent #6's or | F 278 | | | |

documented that Resident #6 was admitted into the hospital with a UTI. The surveyor also pointed out that Resident #6 was admitted into the facility with orders for Risperidone and that the MAR's

documented that Resident #6 received the

| DEPARTMENT | OF HEALTH AND HUMAN SERVICES |
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| ·· · · · · · · · · · · · · · · · · · · | | 495166 | _ | B. WING | | 03/ | C / 24/2016 |
| | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | |
| STRAT | FORD HEALTHCARE | CENTER | 508 RIS | ON STREE | T | | |
| | | | DANVIL | .LE, VA 24 | 541 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST OR LSC IDE | ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION) | s ÆGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 278 | 3 Continued From pa | | | F 278 | | | |
| | Risperidone. The | surveyor then review | ed the | | | | |
| | Admission and 5 Da | y Medicare MDS wit | h the | | | | |
| | DON. The surveyor | pointed out that the | UTI and | | | | |
| | captured/coded on t | ig use (Risperidone) | was not | | | | |
| | | at 3:50 p.m. the surv | ev team | | | | |
| | met with the Adminis | strator (Adm), DON, | Assistant | | | | |
| | Director of Nursing (| (ADON) and Corpora | ite | | | | |
| | Compliance Nurse (| CCN). The surveyor | notified | | | | |
| | the Administrative Te | eam (AT) that Reside | nt #6's | | | | |
| | | y Medicare MDS ass | | | | | |
| | Surveyor notified the | I/16 was inaccurate. AT that the MDS did | ine not | | | | |
| | capture/code Reside | ent #6's UTI or psych | nut otropic | | | | |
| | drug use. | and o o strait payon | опорю | | | | |
| | No additional informa | ation was provided p | rior to | | | | |
| | exiting the facility as | to why the facility sta | aff failed | | | | |
| | | and accurate MDS | | | | | |
| | assessment for Resi | | | | | | |
| | 2. Facility start falled | to ensure a comple | te and | | | | |
| | for Resident #5. The | num data set) asses | sment otio | | | | |
| | medication (Fluopera | rcoident a antipayon izine) was not record | led se | | | | |
| | part of her drug regin | nen. The clinical reco | ord was | | | | |
| | reviewed 3/23/16 at 9 | 9:00 AM. | | | | | |
| | Resident # 5 was add | mitted to the facility o | on . | | | | |
| | 10/6/15. The diagnos | es included Bipolar | disorder, | | | | |

use of antipsychotics

diabetes, coronary artery disease and cerebral

The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.) The resident was not coded during the MDS look-back period for the

The CCP (comprehensive care plan) reviewed

vascular accident with hemi-plegia.

| | EPARTMENT OF HEALTH ENTERS FOR MEDICARE | AND HUMAN SERV | /ICES | | | Printed: 04/05/2016 FORM APPROVED |
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| S | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| <u> </u> | | 495166 | | B. WING | | C 03/24/2016 |
| | ME OF PROVIDER OR SUPPLIER FRATFORD HEALTHCARE | CENTER | 508 RIS | DRESS, CITY, STA SON STREET LLE, VA 2454 | • | |
| ΡÌ | KENK (EACH DENGENCY MUST | ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION) | S REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ORE COMPLETION |
| | F 278 Continued From particles and revised 1/19/16 potential for adverse due to psychotropic depression and psycinterventions include 1. Assess the reside 2. Meds per order 3. Monitor the actions inappropriateness 4. Monitor the reside on on-going basis. Resident #5's physicided dated 2/27/16, including (milligram)take for Bipolar." The order and observed daily or beginning on 10/6/15 On 9/23/16 at 9:00 AM staffer) was asked whappear on Resident #6 MDS—even though shifted medication through period. MDS I said the This information was administrator on 3/23/1 additional info was provided. | included the resider of drug related complimed use: Diagnosis, shotic bipolar disorded: nt's mood state and is of the resident for nt's mental status fundan's orders, signed and "Trifluoperazine he is tab by mouth ever was implemented to the medication recommend and continued until put the antipsychotics is significant changing the had been provided to the entire look-by must have overlook hared with the DON 16 at 3:30 PM. No vided. | cations Major Major The behavior nctioning and lcL 2 ry day by staff bords bresent. ata set did not e l with back ked lt. | F 278 | F279 Resident #2's Compreher Plan has been updated communication deficit. Resident #3's Compreher Plan has been updated to in deficit. | to include nsive Care nclude ADL |
| SS | A facility must use the r to develop, review and comprehensive plan of The facility must develop plan for each resident the objectives and timetable medical, nursing, and medical. | RE PLANS esults of the assess revise the resident's care. p a comprehensive and includes measure as to meet a resident | care able | F 279 | Resident #6's Comprehent Plan has been updated to Nutritional Status. The MDS Coordinator and Nowill be educated by the including communication de ADL deficits. The Registered | O include IDS nurse DON on ficits and |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | & MEDICAID SERV | ICES | | | Printed: 04/05/201 FORM APPROVED OMB NO. 0938-039 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | R/CLIA /IBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | 495166 | | B. WING | | C 03/24/2016 |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | 508 RIS | DRESS, CITY, STATESON STREET LLE, VA 2454 | | |
| TAG OR LSC IDEN | ITIFYING INFORMATION) | s EGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | I D RE COMPLETION |
| F 279 Continued From page needs that are identical assessment. The care plan must of to be furnished to attraction to be furnished to attract page 1.0 psychosocial well-being \$483.25; and any serbe required under \$480.10, including the under \$483.10(b)(4). | fied in the comprehence in the relation or maintain the relation of maintain the relation of t | s that are esident's r erwise ovided der | F 279 | and Dietary Manager wi by the DON on includi Status in the Compre Plans. All current Care Plans accuracy to include co deficit if applicable, nutritional status to ic residents at risk. | ng Nutritional hensive Care reviewed for mmunication ADLs and lentify other |
| This Requirement is a Based on observation record review, it was a staff failed to develop Plan (CCP) for 3 of 16 survey, Resident #2, F #6. The Findings Included 1. For Resident #2 the develop a Comprehensinclude a care plan for triggered and identified Data Set (MDS) with an Date (ARD) of 9/15/15. Resident #2 was an 85 originally admitted on 1 2/28/14. Admitting diagnot limited to the following cerebrovascular accide osteoarthritis, morbid of infection, cardiomyopati asthma and bipolar. The most current MDS record was a Quarterly in ARD of 2/3/16. The fact Resident #1 had a Cogri | , staff interview and letermined that the factormined that the satesident #3 and Rester failed sive Care Plan (CCF Communication as on an Annual Minimal Assessment Refervances included, but ing: fall, diabetes ment, hypertension, pesity, urinary tractiny, anxiety, depressionated in the clinical MDS assessment willity staff coded that | clinical acility are mple ident to) to num ence were ellitus, ion, ith an | | A care plan audit will be x 4 weeks of care plans diby DON or designee then all new admits going ensure accuracy to communication deficit, and nutritional status. The audit results will be the monthly QA Committee Completion Date 5/2/16 | ue that week monthly on forward to include ADL deficit |

| DEPARTME | ENT OF HEALTH | AND HUMAN | SERVICES |
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| CENTERS | FOR MEDICARE | & MEDICAID | SERVICES |

Printed: 04/05/2016 **FORM APPROVED**

| OFMITHOLOU MEDICARE | & IVIEDICAID SERV | ICES | | | OMB NO. 0938-039 |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE (X1) PROVIDER/SUPP | | | | | (X3) DATE SURVEY COMPLETED |
| | 495166 | | B. WING | | C 03/24/2016 |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | 508 RIS | RESS, CITY, S ON STREI LE, VA 24 | | |
| PREFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION) | REGULATORY: | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP | OULD BE COMPLETION |

F 279 Continued From page 23

F 279

DEFICIENCY)

14. In Section B. Hearing, Speech, and Vision the facility staff coded that Resident #2 was "1. Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." (sic) The facility staff also coded that Resident #2 was "1. Usually understands-misses some part/intent of message but comprehends most conversation." (sic) The facility staff also coded that Resident #2 required extensive (3/3) to total nursing care (4/2) with Activities of Daily Living (ADL's). On March 23, 2016 at 2:30 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced an Annual MDS assessment with an ARD of 9/15/15. The facility staff coded that Resident #2 had a Cognitive Summary Score of 15. The facility staff coded in Section B. Hearing, Speech, and Vision the facility staff coded that Resident #2 was "1. Usually understood-difficulty communicating some words or finishing thoughts but is able if prompted or given time." The facility staff also coded that Resident #2 was "1. Usually understands-misses some part/intent of message but comprehends most conversation." (sic)The facility staff also coded that Resident #2 required extensive assistance (3/3) to total nursing care (4/2) with ADL's. In Section V. Care Area Assessment Summary (CAA'S) Resident #2 "triggered" for Communication. The facility staff documented that a care plan would be developed to address Resident #2's Communication deficit. Continued review of the clinical record produced the CCP. Review of the CCP failed to include a care plan for Resident #2's Communication deficit. On March 23, 2015 at 3 p.m. and on March 24, 2015 at 9:30 a.m. the surveyor interviewed

Resident #2. The surveyor noted that Resident

#2's speech was garbled due to being

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | /ICES /ICES | | | Printed: 04/05/20 FORM APPROVE OMB NO. 0938-039 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | ER/CLIA | (X2) MULTIPL A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | 495166 | | B. WING | V | 03/24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | | | TATE, ZIP CODE | |
| STRATFORD HEALTHCARE | : CENTER | | ON STREE LE, VA 24 | | |
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| herself several time understood the surv On March 24, 2016 the MDS Nurse that Communication on the of 9/15/15. The surv that the facility staff would be developed Communication defined MDS Nurse that reviproduce a care plan Communication defined the CCP and care plan that address Communication defined On March 23, 2016 and with the Administ Director of Nursing (Americal Communication (Americal Communication) | urveyor also had to rest to ensure that Resiveyor. at 9 a.m. the surveyor to Resident #2's "trigged the Annual MDS with veyor notified the MD documented that a cit to address Resident icit. The surveyor notiew of the CCP failed that addressed Resident #2's icit. The MDS Nurse and was unable to lock that addressed Resident #2's icit. The MDS Nurse icit. The MDS Nu | yor notified gered" for h the ARD DS Nurse care plan not #2's cotified the d to sident #2's cate a vey team Assistant ate r notified cility staff to include the crior to aff failed ale who gnoses | F 279 | | |

and paralysis agitans.

disease, restless leg syndrome, dementia, urinary tract infection, hypertension, vitamin D deficiency

The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/16/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #3

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| | 495166 | B. WING | | 03/ | C 24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | ADDRESS, CITY, ST | ATE, ZIP CODE | ····· | |
| STRATFORD HEALTHCARE | 1 | RISON STREE | | | |
| | DAN | VILLE, VA 24 | 541 | | |
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| F 279 Continued From pa | | F 279 | | | |
| required limited (2/2 | 2) to extensive assistance | | | | |
| (3/2) with Activities | of Daily Living (ADL's), In | | | | |
| Section V. Care Are | a Assessment Summary | | | | |
| (CAA's) Resident # | 3 "triggered" for ADL's. The | | | | |
| he developed to ad- | ented that a care plan would | | | | |
| deficit. | dress Resident #3's ADL | | | | |
| | at 9 a.m. the surveyor | | | | |
| reviewed Resident | #3's clinical record. Review of | f | | | |
| the clinical record p | roduced the Comprehensive | | | | |
| Care Plan (CCP). F | Review of the CCP failed to | | | | |
| include a care plan t | that addressed Resident #3's | | | | |
| ADL deficit. | | | | | |
| Continued review of | the clinical record produced | | | | |
| a Social Worker (SV | V) note stating that Resident | | | | |
| On March 22, 2016 | e conference on 3/22/16. | | | | |
| notified The Director | at 10:15 a.m. the surveyor of Nursing (DON) that | | | | |
| Resident #3 "trigger | ed" for ADL's on the Annual | | | | |
| MDS with the ARD o | of 3/16/16. The surveyor | | | | |
| notified the DON tha | it the facility staff documented | | | | |
| that a care plan would | ld be developed to address | | | | |
| Resident #3's ADL d | eficit. The surveyor notified | | | | |
| the DON that a care | plan that addressed | | | | |
| Resident #3's ADL de | eficit could not be located in | | | | |
| the CCP. The surve | yor reviewed the Annual | | | | |
| IVIUS WITH the ARD of | f 3/16/16 and the CCP with | | | | |

3/16/16.

the DON. The DON was unable to locate a care plan that addressed Resident #3's ADL deficit. On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff

failed to develop a CCP, to include ADL status/deficit, as "triggered/identified" on the Annual MDS assessment with the ARD of

No additional information was provided prior to exiting the facility as to why the facility staff failed

| | DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | Printed: 04/05/20 FORM APPROVE OMB NO, 0938-039 | | | | |
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| - | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | ER/CLIA | (X2) MULTIPLE A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495166 | | B. WING | | 03/24/2016 |
| | NAME OF PROVIDER OR SUPPLIER | | STREET ADDF | RESS. CITY, STA | ATE, ZIP CODE | |
| | STRATFORD HEALTHCAR | E CENTER | ſ | ON STREET LE, VA 245 | ·- | |
| | PREFIX (EACH DEFICIENCY MUS | TATEMENT OF DEFICIENCIE ST BE PRECEDED BY FULL I DENTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | OULD BE COMPLETION |
| | F 279 Continued From p | | | F 279 | <u></u> | |
| | to develop a CCP f | for Resident #3. | | | | |
| | 3. For Resident # | #6 the facility staff faile | ed to | | | |
| | develop a Comprei | hensive Care Plan as | \$ | | | |
| | "triggerea/identified | d" on an Admission ar | nd 5 Day | | | |
| | Niedicare ivinimum | n Data Set (MDS) ass | essment | | | |
| | Willi all MSSessiner The facility staff fai | nt Reference Date of | 2/20/16. | | | |
| | andressed Resider | iled to develop a care nt #6's Nutritional Stat | pian inai | | | |
| | Resident #6 was a | in #0 s Numbonai Stat 92 year old female w | (US. | | | |
| | admitted into the fa | acility on 2/13/16. Adn | IIU Was | | | |
| | diagnoses included | d, but were not limited | thung to | | | |
| | hypertension, urinar | rv tract infection. | . to. | | | |
| | encephalopathy, alf | tered mental status, a | acitation. | | | |
| | confusion, dementia | ia, diabetes mellitus a | and | | | |
| | coronary artery dise | ease. | | | | |
| | The most current M | IDS located in the clin | nical | | | |
| | record was a Quarte | terly MDS assessmen | nt with an | | | |
| | Assessment Refere | ence Date (ARD) of 3/ | 3/12/16. | | | |
| | The facility staff cod | ded that Resident #6 I | had a | | | |
| | Cognitive Summary | Score of 11. The fac | cility staff | | | |
| | also coded that Kes | sident #6 required limi | ited (2/2) | | | |
| | To extensive assista | ance (3/2) with Activitie | es of | | | |
| | Daily Living (ADL's). Swallowing/Nutrition |). IN Section K. nal Status Resident th | ma faailih | | | |
| | | | | | | |

therapeutic diet.

staff coded that Resident #6 was receiving a

On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced an Admission and 5 Day Medicare MDS assessment with an ARD of 2/20/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 9. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities

of Daily Living (ADL's). In Section K.

Swallowing/Nutritional Status the facility staff coded that Resident #6 was receiving a therapeutic diet. In Section V. Care Area Assessment Summary (CAA's) Resident #6 "triggered/identified" for Nutritional Status. The

| DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OM | | | | | | | | |
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| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMB | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED | | |
| <u> </u> | | 495186 | · | B. WING | | C 03/24/2016 | | |
| | OF PROVIDER OR SUPPLIER | | STREET ADI | DRESS, CITY, STA | TE, ZIP CODE | | | |
| SIR | ATFORD HEALTHCARE | CENTER | | SON STREET LLE, VA 2454 | | | | |
| (X4) PREI TAI | FIX (EACH DEFICIENCY MUST OR LSC IDEN | VTIFYING INFORMATION) | S REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | IIDRE COMPLETION | | |
| F | 279 Continued From page | ge 27 | | F 270 | | | | |
| facility staff documented that a care plan would be developed to address Resident #6's Nutritional Status. Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP falled to include a care plan that addressed Resident #6's Nutritional Status. On March 22, 2016 at 4:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 "triggered" for Nutritional Status. The surveyor notified the DON that review of the CCP falled to include a care plan that addressed Resident #6's Nutritional Status. The surveyor reviewed the MDS and CCP with the DON. The DON was unable to locate a care plan that addressed Resident #6's Nutritional Status. On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP, to include Nutritional Status, as "triggered/identified" on Resident #6's Admission and 5 Day Medicare MDS assessment with the ARD of 2/20/16 No additional information was provided prior to exiting the facility as to why the facility staff failed | | | Nutritional roduced deview of t us. eyor at icare 6 veyor failed to ent #6's if the was ed y team assistant e | F 279 | F309 The facility has a signed couthe Dialysis provider and a policy. | | | |
| | | | | All residents are at risk who receiving dialysis. The Administrator will revie contracted resident services contracts and policies are president. | ew all s to assure | | | |
| 5 | to develop a CCP, to in for Resident #6. | clude Nutritional Sta | atus, | | current. | | | |
| SS=C | 483.25 PROVIDE CARI HIGHEST WELL BEING Each resident must reci provide the necessary of or maintain the highest in mental, and psychosocia | G eive and the facility pare and services to practicable physical | attain | F 309 | The Administrator will review Dialysis contract and policy refor three months. Results will reviewed at the monthly Quarance Committee meeting. | monthly ill be ality | | |
| | accordance with the con and plan of care. | mprehensive assess | ment | | Completion Date: 5/2/16 | | | |

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| STRATFORD HEALTHCARE CENTER 5 | | | RESS, CITY, S CON STREE LE, VA 24 | - - | | |
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

F 309

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(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined the facility staff falled to maintain a contractual agreement with a dialysis service for 1 of 16 residents (Resident #7) to ensure the resident received and the facility provided the necessary care and services in accordance with the comprehensive assessment and plan of care. Resident #7's clinical record was reviewed on 3/23/16 at 11:30 AM.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

OR LSC IDENTIFYING INFORMATION)

Resident #7 was admitted to the facility on 2/2/16. The diagnoses included hypertension, congestive pulmonary disease, end-stage renal disease and Hepatitis C.

The resident's annual MDS(minimum data set assessment dated 2/9/16 coded the resident with slightly impaired cognitive impairment. Resident #7 required staff assistance for all ADL activities of daily living). The resident was coded with receiving dialysis services.

Resident #7 had a physician's order, signed and dated 2/4/16, for dialysis Monday, Wednesday and Friday.

The resident's CCP (comprehensive care plan) reviewed and revised on 2/9/16 gave the problems:

1. Resident receives dialysis treatments three times weekly. ESRD (end stage renal disease)

The CCP interventions included:

- 1. Monitor shunt/cath site for bleeding or signs of infection.
- 2. No labs B/P on shunt arm.

Printed: 04/05/2016

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| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERVI | ICES ICES | | | FORM | 04/05/201 APPROVE |
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| NAME OF PROVIDER OR SUPPLIER | 495166 B. WING F PROVIDER OR SUPPLIER STREET ADDRESS CITY STATES AND A | | | | | |
| STRATFORD HEALTHCARE | | 508 RIS DANVII | ON STRE | ET | | |
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| orgers. | bruit per routine or sp | ecific | F 309 | F312 | | |
| Assess/monitor for signs of bleeding Assist with transfer needs when going to dialysis. Maintain communication with dialysis staff a physician per routine. Dialysis per orders. Tuesday, Thursday, Saturday. The resident was observed on 3/23/16 at 11:30 | | | | Residents 5 and 7 have recare. | ceived nail | |
| | | | | All residents were reviewe need of nail care. | d for the | |
| AM. He was lying quid was observed to have with dark debris embe CNA I agreed it was ti | etly in his bed. The re long ragged fingerna edded under all ten na me to trim his nails. | esident ails ails. | | 100% licensed nurses and no will be in-serviced by designee on nail care policed document refusals. | DON or | |
| On 3/23/16 at 2:00 PN DON for the dialysis of policy and procedure for contract/agreement be provider. The DON procedure for policy and procedure for the policy and policy | ommunication sheets or dialysis and the electron the facility and ovided the dialysis out did not have a curr | s, d the | | Random resident care audit performed by DON or des ensure residents have rece care weekly for four weeks. | ignee to ived nail | |
| policy and procedure for managing dialysis services. She also said she did not have a contract/agreement with the dialysis company—but the administrator was trying to obtain one from the dialysis facility. | | 0 | | The results of the audits reviewed at the month committee meeting. Completion Date 5/2/16 | | |
| This information was st administrator on 3/24/1 administrator did tell the agreement/contract was company and there was procedure. | 6 at 4:30 PM. The s survey team that no s in place with the dis |) alveie | | | | The second secon |
| F 612 483.25(a)(3) ADL CARE SS=D DEPENDENT RESIDEN | PROVIDED FOR | ı | F 312 | | | |
| A resident who is unable daily living receives the remaintain good nutrition, | 1606ssan/saninaa te | ~ | | | | |

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| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | STREET ADDRESS, CITY, STATE, ZIP CODE 508 RISON STREET DANVILLE, VA 24541 | | т | | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATOR TAG OR LSC IDENTIFYING INFORMATION) | | S REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETION |
| F 312 Continued From pa | ge 30 | | F 312 | | |

and oral hygiene.

This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide adequate ADL (activities of daily living) assistance (nail care) to 2 of 16 residents (Resident #7 and #5.)

Findings:

1. Facility staff failed to assist Resident #7 with nall care as needed. Resident #7's clinical record was reviewed on 3/23/16 at 11:30 AM.

Resident #7 was admitted to the facility on 2/2/16. The diagnoses included hypertension, congestive pulmonary disease, end-stage renal disease and Hepatitis C.

The resident's annual MDS(minimum data set assessment dated 2/9/16 coded the resident with slightly impaired cognitive impairment. Resident #7 required staff assistance for all ADL activities of daily living.)The resident was coded with receiving dialysis services.

The resident's CCP (comprehensive care plan) reviewed and revised on 2/9/16 gave the problems:

1. Needs assistance with all ADLs r/t decreased mobility/function and weakness.

The CCP interventions included:

1. Provide assistance with ADLs/oral needs per routine and as needed.

The resident was observed on 3/23/16 at 11:30

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Printed: 04/05/2016

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| STRATFORD HEALTHCARE CENTER | | | RESS, CITY, STA ON STREET LE, VA 245 | Γ | <u> </u> | |
| PRÉFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCI TBE PRECEDED BY FULL INTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X6) COMPLETION DATE |
| was observed to hat with dark debris em CNA I agreed it was This information was administrator on 3/2 2. Facility staff failed needed nail care. The was reviewed on 3/2 Resident # 5 was as 10/6/15. The diagnor diabetes, coronary a vascular accident with the resident with unimpart of the resident with the resident with the resident with the resident with the resi | uietly in his bed. The live long ragged finge bedded under all ter at time to trim his nail. It is shared with the DC 23/16 at 3:30 PM. If the resident's clinical 23/16 at 9:00 AM. If the resident's clini | ernails in nails. In nails. In nails. In nails. In nails. In nails. In 1/18/16 in nails. In 1/18/16 in nails. In 1/18/16 in nails. In 1/18/16 in nails. In n | F 312 | | | |

This information was provided to the DON and administrator on 3/23/16 at 3:30 PM.

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| This information was administrator on 3/23 additional info was p | shared with the DON 3/16 at 3:30 PM. No rovided. | N and | | F328 | |
| F 326 483.25(k) TREATME SS=D NEEDS | NT/CARE FOR SPE | CIAL | F 328 | Resident #3 was sch podiatry services. | neduled for |
| The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide podiatry services for 1 of 16 Residents in the sample survey, Resident #3. The Findings Included: Resident #3 was an 85 year old female who was admitted on 11/12/11. Admitting diagnoses included, but were not limited to: ischemic heart disease, restless leg syndrome, dementia, urinary tract infection, hypertension, vitamin D deficiency and paralysis agitans. The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/16/18. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #3 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). | | | | Resident #3 refused podion 3/28/16 and this was in her record. Podiatrist will attempt resident #3 each time he was a common to the resident performed by DON or community services received and refusals document to the results of the audion reviewed at the most committee meeting. Completion date 5/2/16 | to treat risits. dits will be lesignee to es offered, mented. |

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| | & MEDICAID SERV (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM 495166 CENTER | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495166 STREET ADDE 508 RISE DANVIL ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495166 STREET ADDRESS, CITY, S 508 RISON STREET DANVILLE, VA 24 ATEMENT OF DEFICIENCIES ID PREFIX | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495166 STREET ADDRESS, CITY, STATE, ZIP CODE 508 RISON STREET DANVILLE, VA 24541 ATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHON STIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPRINCED. | | |

F 328 Continued From page 33

Continued review of the clinical record produced a "Podiatry Note" dated 7/20/15. The Podiatry Note documented that Resident #3 had complained of discomfort from long thick toenails. The notes also documented that pedal pulses were not palpable. The notes also documented that the toenails were thick, discolored and flaking.

On March 23, 2016 at 10:50 a.m. the surveyor requested to see Resident #3's toenails. A Restorative Aide approached the surveyor and informed the surveyor that Resident #3 was up in her wheelchair and at the side of her bed. The surveyor and Restorative Aide walked down to Resident #3's room. The surveyor observed a Licensed Practical Nurse (LPN #1) sitting beside Resident #3 administering her medications. The surveyor asked Resident #3 if she could look at her toenails and Resident #3 stated, "Yes." The surveyor pulled back a white towel exposing Resident #3's feet. The surveyor observed that the toenails were extremely long, thick and discolored. The surveyor informed the Restorative Aide and LPN (#1) that Resident #3 's toenails were too long, thick and discolored. On March 23, 2016 at 11 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3's toenails were long, thick and discolored. The DON stated that the podiatrist usually visited quarterly. The surveyor notified the DON that Resident #3 had not been seen by the podiatrist 8 months.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #6's toenalls were long, thick and discolored. The surveyor notified the AT that Resident #3 should have been seen by the podiatrist. The DON

F 328

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| care at times. The s review of the nursin refusal of podiatry s the DON if she, the notes documenting podiatry services to surveyor. No additional inform exiting the facility as to provide podiatry s | t #3 refused treatments urveyor notified the I g notes did not document on the surveyor DON, was able to loo Resident #3's refusal provide a copy to the to why the facility state or why the facility state or refused to the to why the facility state or resident #8 revices to Resident #8 | DON that ment a or notified cate I of rior to aff failed 3. | F 328 | | | The state of the s |
| F 329 483.25(I) DRUG REG SS=E UNNECESSARY DR Each resident's drug unnecessary drugs. drug when used in ex duplicate therapy); or without adequate mod indications for its use adverse consequence should be reduced or combinations of the re Based on a comprehe resident, the facility m who have not used an given these drugs unle therapy is necessary to as diagnosed and doc record; and residents of drugs receive gradual behavioral intervention contraindicated, in an ed drugs. | regimen must be fre An unnecessary drug cessive dose (includ for excessive durationitoring; or without act or in the presence of the discontinued; or any easons above. ensive assessment of ust ensure that residitipsychotic drugs are assess antipsychotic drug treat a specific con umented in the clinic who use antipsychotidose reductions, and s, unless clinically | e from g is any ling on; or dequate of dose f a ents not g dition al c | F 329 | F329 | | |
| | | | | Residents #2, 3, 5 an | d 6 now have | |
| | | | | behavior monitoring s | heets in place | |

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| F 329 Continued From page | ge 35 | | F 329 | | |
| F 329 Continued From parties Requirement is Based on observation record review, it was staff failed to ensure sample survey were medications, Resident #6, Resident #5, Resident #6, Resident #2 the facility staff failed drug use in the Resident guse in the Resident psychotropic medicated The Findings Includent. For Resident #2 the monitor for psychotromal Sprinkles in use to includent interventions, side effections, side effections and soriginally admitted on 2/28/14. Admitting dia not limited to the following cerebrovascular accided infection, cardiomyope asthmal and bipolar. The most current MDS record was a Quarterly ARD of 2/3/16. The fare Resident #1 had a Cognity of 2/3/16. The fare Resident #1 had a Cognity Infection of 2/3/16. The fare Resident #1 had a Cognity Infection of 2/3/16. The fare Resident #1 had a Cognity Infection of 2/3/16. The fare Resident #2 staff all required extensive (3/3) with Activities of Daily I. On March 23, 2016 at 2 reviewed Resident #2's the clinical record productions. Signed physicial were not limited to: "Set tablet for > Zoloft F/C tablet for > Zoloft F/C tablet." | a not met as evidence, staff interview and determined that the that 6 of 16 Reside free from unnecess nt #2, Resident #3, ident #8 and Resided to monitor psycholients, who received ions. d: he facility staff falled pic drug (Depakote ide: specific behaviorets and effectivenes syear old female with 1/1/11 and readmitt agnoses included, being: fall, diabetes not ent, hypertension, obesity, urinary tracity, anxiety, depressionative Summary Science of the cility staff coded that initive Summary Science coded that Reside to total nursing callving (ADL's). 2:30 p.m. the survey clinical record. Reside of the cility and the cility in the cility staff coded that in the cility | d clinical a facility ints in the ary Resident ent #9. tropic d to or, ess. ho was ed on ut were nellitus, ti sion, cal with an it ore of lent #2 re (4/2) vor view of an but | F 329 | management policy to utilizing and documenting b | with the fors and # 9 has sident #8 has been # 1 be in-behavior include behaviors behaviors behaviors behavior onitoring the the target his was lift. medical DON or sethen ## will be |
| every morning for depre Sodium 125 mg cap (ca for> Depakote Sprinkle by mouth twice daily for | psule) Sprink (sprin take 2 capsules (25 | Oma\ | | committee meeting. Completion Date 5/2/16 | |

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| CENTERS FOR MEDICARE | & MEDICAID SERVICES |

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) DATE SURVEY COMPLETED

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495166

B. WING ____

03/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

508 RISON STREET DANVILLE, VA 24541

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY
OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 329: Continued From page 36

STRATFORD HEALTHCARE CENTER

The order for the Depakote was changed on 12/11/15. The order for the Zoloft originated on 12/11/15.

Further review of the clinical record produced an original physician order for Depakote Sodium 125mg by mouth TID (three times a day) on 10/15/15.

Continued review of the clinical record falled to produce behavior monitoring for October and November 2015. Additionally the behavior monitoring sheet for December 2015 documented that Zoloft (an antidepressant) and Depakote Sodium (a psychotropic) were being administered for depression and withdrawal. The behavioral monitoring sheet did not identify that Resident #2 was receiving the Depakote for a diagnosis of being Bipolar.

On March 23, 2016 at 3:15 p.m. the surveyor notified the Director of Nursing (DON) that Resident #2 was on Depakote Sprinkles for a diagnosis of being Bipolar and Zoloft for a diagnosis of depression. The surveyor notified the DON that review of the clinical record failed to produce behavior monitoring sheets for October and November 2015. The surveyor notified the DON that the facility had to monitor for specific behaviors related to the psychotropic (Depakote) medication use, medication effectiveness, interventions and side effects. The surveyor also notified the DON that Resident #2's December 2015 behavior monitoring sheet stated that the Zoloft and Depakote were being administered for depression and withdrawal, when in fact Resident #2 was receiving the Depakote for a diagnosis of being Bipolar. The surveyor notified the DON that the behavioral monitoring for Zoloft (an antidepressant) and the Depakote (a psychotropic) could not be documented on the same behavioral monitoring sheet. The surveyor reviewed Resident #2's clinical record with the

F 329

| DEPARTMENT OF | HEALTH AND | HUMAN SERVICES |
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| CENTERS FOR M | EDICARE & ME | DICAID SERVICES |

Printed: 04/05/2016 FORM APPROVED

| CENTERS FOR MEDICARE | & MEDICAID SERV | ICES | OMB NO. 0938-03 | |
|---|-----------------|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU 495166 | | AMPIU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED C 03/24/2016 |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 508 RISON STREET DANVILLE, VA 24541 | | 707.42010 |

(X4) ID SUMMARY STATEM

PRÉFIX

TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY
OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X6) COMPLETION DATE

F 329 Continued From page 37

DON. Behavioral monitoring sheets for October and November 2015 could not be located. The surveyor reviewed the December 2015 behavioral monitoring sheet with the DON and pointed out that the behavioral monitoring sheet was inaccurate.

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that that Resident #2 was on Depakote Sprinkles for a diagnosis of being Bipolar. The surveyor notified the AT that behavior monitoring was not done in October and November 2015. The surveyor also informed the AT that Resident #2's behavior monitoring sheet for December 2015 stated that Resident #2 was receiving the Zoloft and Depakote Sprinkles for withdrawal and depression, when in fact, Resident #2 was receiving the Depakote Sprinkles for a diagnosis of being Bipolar. The surveyor informed the AT that the facility staff had to monitor for specific behaviors related to the psychotropic medication use, medication effectiveness, interventions and side effects. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #2 was free from unnecessary medications. The facility staff failed to monitor for specific behaviors related to the Depakote Sprinkles (a psychotropic medication) use, medication effectiveness, interventions and side effects.

2. For Resident #3 the facility staff failed to monitor for psychotropic drug (Seroquel and Abilify) use to include: specific behavior, interventions, side effects and effectiveness. Resident #3 was an 85 year old female who was admitted on 11/12/11. Admitting diagnoses included, but were not limited to: ischemic heart

F 329

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | ICES ICES | | | Printed: 04/05/2016 FORM APPROVED OMB NO. 0938-0391 |
|---|--|--------------|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 195166 | | | | (X3) DATE SURVEY COMPLETED C 03/24/2016 | |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | | ESS, CITY, STATON STREET LE, VA 2454 | | |
| PREFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI | JLD BE COMPLETION |

F 329 Continued From page 38

disease, restless leg syndrome, dementia, urinary tract infection, hypertension, vitamin D deficiency and paralysis agitans.

The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 3/16/16. The facility staff coded that Resident #3 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #3 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On March 24, 2016 at 9 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced the April, May, June, July and August 2015 Medication Administration Records (MAR's). Review of the MAR's documented that Resident #3 received Seroquel 25mg by mouth every night at bedtime. Continued review of the clinical record falled to produce behavioral monitoring sheets for the Seroquel for April, May, June, July and August of 2015. The Seroquel was discontinued on 8/25/15.

Further review of the clinical record produced signed physician orders that included, but were not limited to: "Abilify 2 mg tablet take 1 tab (tablet) by mouth every morning for DPSD **Do Not Switch-Brand dispensed for Insurance**." (slc) The order for the Abilify originated on 6/23/15.

Continued review of the clinical record failed to produce behavioral monitoring sheets for the Abilify for June, July, August, September, October, November and December of 2015. On March 23, 2016 at 10:15 a.m. the surveyor notified The Director of Nursing (DON) that Resident #3 was on Seroquel 25 mg every night at bedtime during April, May, June, July and August of 2015. The surveyor also notified the DON that Resident #3 received Abilify since

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CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

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

Printed: 04/05/2016 FORM APPROVED MR NO 0938-0391

| CENTERS FOR MEDICARE | & MEDICAID SERV | ICES | | | OMB NO. 0938-039 |
|--|--|-------------------------------------|------------------------------|--|-------------------------------|
| 3TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | 495166 | | B. WING | | 03/24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | |
| STRATFORD HEALTHCARE | CENTER | 3 | ON STREET | | |
| | | 3 | LE, VA 245 | | |
| PREFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP | OULD BE COMPLETION |
| | | | | DEFICIENCY) | |
| F 329 Continued From pa | | | F 329 | | |
| 6/23/15. The survey | or notified the DON | that | | | |
| behavioral monitorir | ng sheets to monitor | for | | | |
| specific behaviors, i | nterventions, side et | fects and | | | |
| enectiveness could | not be located in the | clinical | | | |
| September October | /, June, July, August r, November and De | , | | | |
| of 2015 for the Sero | quel and the Abilify. | The | | | |
| surveyor reviewed the | he clinical record wit | h the | | | |
| DON, The DON wa | s unable to locate be | ehaviorai | | | |
| monitoring sheets for | or April, May, June, J | ulv. | | | |
| August, September, | October, November | rand | | | |
| December of 2015. | | | | | |
| On March 23, 2016 | at 3:50 p.m. the surv | ey team | | | |
| met with the Adminis | strator (Adm), DON, | Assistant | | | |
| Director of Nursing (| ADON) and Corpora | ate | | | |
| Compliance Nurse (the Administrative Te | CUIV). Ine surveyor | r notified | | | |
| failed to monitor Res | dent #2 for payabat | cility stan | | | |
| drug use (Seroquel a | and Ahilful during An | rupic rii Mau | | | |
| June, July, August, S | Spiember October | rn, iviay, | | | |
| November and Dece | | Surveyor | | | |
| informed the AT that | the facility staff had | to | | | |
| monitor for specific b | ehaviors related to t | the | | | |
| psychotropic medica | tion use (Seroquel a | ind | | | |
| Abilify), medication effectiveness, interventions and side effects. | | | | | j |
| | | | | | |
| No additional informa | ation was provided p | rior to | | | |
| exiting the facility as to ensure that Reside | to why the facility sta | att falled | | | |
| unnecessary medica | tions. The facility of | eff fatta d | | | 1 |
| to monitor Resident # | 11000. The lacilly su | dii idileo | | | |
| (Seroquel and Abilify) |) use for specific bel | naviors | | | |
| medication effectiven | ess, interventions a | nd side | | | |
| effects. | | | | | İ |
| 3. For Resident #6 i | the facility staff failed | d to | | | ļ |
| monitor for psychotro | pic drug | · · · · · · · · · · · · · · · · · · | | | |
| (Risperidone/Risperd | a) use to include: s | pecitic | | | ļ |
| behavior, intervention effectiveness. | is, side ellects and | | | | |
| Resident #6 was a 92 | Vear old famala wh | n was | | | ROOM |
| TOOLSOIL TO HOS A OZ | - Jour Old Idillaid Mil | o was | | | 1 |

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

Printed: 04/05/2016

| TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1 PROVIDER STREET PROVIDER OR SUPPLIER | OF HEALTH AND HUMAN SERVICES MEDICARE & MEDICAID SERVICES | FORM APPRO OMB NO. 0938- |)VE |
|--|---|--|-----|
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE CENTER STREET ADDRESS, CITY. STATE, ZIP CODE STRATFORD HEALTHCARE CENTER SOR RISON STREET DANVILLE, VA 24541 (X4) ID PREFIX (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 40 F 329 admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease. The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced signed physician orders adead 2/13/16. Signed physician orders included, but not limited to: "Risperdione (Risperdal) 0.25 mg 1 po (by mouth) BID (twice daily)." (sic) The order for the Risperdione/Risperdal was changed to: Risperdal 0.25 mg po Q am (every morning) and Risperdal 0.25 mg po QHS (every evening at bedtime). | (XI) THOUSENED TELLIOLIA | TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED | |
| STRATFORD HEALTHCARE CENTER 508 RISON STREET DANVILLE, VA 24541 | 495166 B. WiNG | | |
| DANVILLE, VA 24541 XA) D SUMMARY STATEMENT OF DEFICIENCES TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPUTED PROVIDER'S PLAN OF CARCHIOLOGY SHOULD BE CARCH | OR SUPPLIER STREET ADDRESS, CITY. | . STATE, ZIP CODE | |
| PREFIX TAG RECHOEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG CROSS-REFERENCED TO THE APPROPRIATE DATA OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 40 F 329 admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease. The most current MDS iocated in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced signed physician orders included, but not limited to: "Risperidone (Risperdal) 0.25 mg 1 po (by mouth) BID (twice daily)." (sic) The order for the Risperidone/Risperdal was changed on 3/11/16. The order was changed to: Risperdal 0.25mg po q am (every morning) and Risperdal 0.25mg po QHS (every evening at bedtime). | | | |
| admitted into the facility on 2/13/16. Admitting diagnoses included, but were not limited to: hypertension, urinary tract infection, encephalopathy, altered mental status, agitation, confusion, dementia, diabetes mellitus and coronary artery disease. The most current MDS located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/12/16. The facility staff coded that Resident #6 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On March 22, 2016 at 4:05 p.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced signed physician orders dated 2/13/16. Signed physician orders included, but not limited to: "Risperidone (Risperdal) 0.25 mg 1 po (by mouth) BID (twice daily)." (sic) The order for the Risperidone/Risperdal was changed to Risperdal 0.25 mg po q am (every morning) and Risperdal 0.25 mg po Q HS (every evening at bedtime). | FICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX | (EACH CORRECTIVE ACTION SHOULD BE COMPLE CROSS-REFERENCED TO THE APPROPRIATE | |
| Further review of the clinical record failed to produce the February and March 2016 behavioral monitoring sheets. On March 22, 2016 at 4:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #6 was on Risperidone (Risperdal) twice a day since admission into the facility. The surveyor notified the DON that behavioral monitoring for the psychotropic drug use, Risperidone (Risperdal), for February and March 2016 could not be located in the clinical record. The surveyor reviewed the clinical record with the DON. The DON was unable to locate behavioral monitoring sheets for psychotropic drug use for Resident #6. | ad into the facility on 2/13/16. Admitting ses included, but were not limited to: ension, urinary tract infection, allopathy, altered mental status, agitation, on, dementia, diabetes mellitus and ry artery disease. Set current MDS located in the clinical was a Quarterly MDS assessment with an ment Reference Date (ARD) of 3/12/16. Was a Guarterly MDS assessment with an ment Reference Date (ARD) of 3/12/16. Was taff coded that Resident #6 had a ve Summary Score of 11. The facility staff ded that Resident #6 required limited (2/2) sive assistance (3/2) with Activities of ving (ADL's). Ch 22, 2016 at 4:05 p.m. the surveyor d Resident #6's clinical record. Review of cal record produced signed physician orders 4, but not limited to: "Risperidone dai) 0.25 mg 1 po (by mouth) BID (twice (sic) The order for the done/Risperdal was changed on 3/11/16. er was changed to: Risperdal 0.125 mg (every morning) and Risperdal 0.25mg (every evening at bedtime). The February and March 2016 behavioral ng sheets. Ch 22, 2016 at 4:55 p.m. the surveyor the Director of Nursing (DON) that the February and March 2016 behavioral ng sheets. Ch 22, 2016 at 4:55 p.m. the surveyor the Director of Nursing (DON) that the was on Risperidone (Risperdal) day since admission into the facility. The rotified the DON that behavioral ng for the psychotropic drug use, one (Risperdal), for February and March uld not be located in the clinical record. Veyor reviewed the clinical record with the he DON was unable to locate behavioral ng sheets for psychotropic drug use for | * | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM 495166 | | | 1 | LE CONSTRUCTION | (X3) DATE S | LETED |
| | | | B. WING | | 03/2 | C 24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | TATE, ZIP CODE | | ······································ |
| STRATFORD HEALTHCARE | CENTER | 1 | ON STREE .LE, VA 24 | | | |
| PRÉFIX (EACH DEFICIENCY MUST | NTEMENT OF DEFICIENCE BE PRECEDED BY FULL I NTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| met with the Admini | at 3:50 p.m. the sunstrator (Adm), DON, (ADON) and Corpora (CCN). The surveyoream (AT) that the fassident #6 for psychone/Risperdal for Februeyor informed the to monitor for specifithe psychotropic mesperdal), medication entions and side effection was provided pation. The facility stent #6 was free from the for psychotropic edal) use for specific an effectiveness, interest to ensure that effective that effective that effective in the facility of the facility of the facility of the for psychotropic edal) use for specific an effectiveness, interest to ensure that effective that effective the facility of the facility | Assistant ate are rotified cility staff tropic ruary and AT that ic edication ects. orior to aff failed at taff failed drug erventions | F 329 | | | |

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

was provided for Resident #5 who was taking antipsychotics and anxiolytics. The clinical record

Resident # 5 was admitted to the facility on 10/6/15. The diagnoses included Bipolar disorder, anxiety, diabetes, coronary artery disease and cerebral vascular accident with hemi-plegia.

The resident's significant change MDS (minimum data set) assessment dated 10/13/15 coded the resident with unimpaired cognitive ability. Resident #5 required staff assistance for all ADL (activities of daily living.) The resident was not coded during the MDS look-back period for the use of antipsychotics —but was observed to be

was reviewed 3/23/16 at 9:00 AM.

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

Printed: 04/05/2016
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| OLIVILING FOR WEDICARE | - A MEDICAID SERVIC | <u> </u> | | | OMB N | <u>O. 0938-039</u> |
|---|--|---|---------------------|---|--------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER | | | LE CONSTRUCTION | (X3) DATE : COMPL | LETED |
| | 495166 | | B. WING | | 03/ | C 24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | ************************************** |
| STRATFORD HEALTHCAR | E CENTER | | ON STREE | | | |
| | | DANVII | LE, VA 249 | 541 | | |
| PREFIX (EACH DEFICIENCY MUST | TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION) | ; EGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 329 Continued From pa | age 42 | | F 329 | ************************************** | · | |
| The CCP (comprehand revised 1/19/16 potential for advers due to psychotropic depression and psy interventions includ 1. Assess the residu 2. Meds per order 3. Monitor the action inappropriateness | nensive care plan) revi 6 included the resident ie drug related complic c med use: Diagnosis, chotic bipolar disorder | t's cations Major r. The behavior | 1 525 | | | |
| dated 2/27/16, inclumg (milligram)tal for Bipolar." The ord and observed daily administration record continued until presented. The same physician | cian's orders, signed a ded "Trifluoperazine H ke 1 tab by mouth eve der was implemented t on the MAR (medication des) beginning on 10/6, ent. | loL 2 ery day by staff on /15 and | | | | |
| twice daily as neede This order was imple | ed for anxiety and agita emented on 10/6/15 a MAR by nursing staff of | ation. and | | | | |

The behavior monitoring sheets, a tool used by the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be complete for diagnoses, medications or behaviors.

"as needed basis." The MARS document 23 administrations of as needed Ativan between

The behavior sheet for March 2016 contained no diagnoses and the behaviors were listed as

10/6/15 and 2/24/16.

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

Printed: 04/05/2016
FORM APPROVED

| CENTERS FUR MEDICARE | & MEDICAID SERVICE | <u> </u> | | OMB N | <u>10. 0938-</u> 039 |
|---|--|------------------------|---|-----------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/GI IDENTIFICATION NUMBE | | TIPLE CONSTRUCTION NG | (X3) DATE | SURVEY LETED |
| | 495166 | B. WING | | 03/ | C /24/2016 |
| NAME OF PROVIDER OR SUPPLIER | S | TREET ADDRESS, CITY, | STATE, ZIP CODE | 1 | |
| STRATFORD HEALTHCARE | | 508 RISON STRE | | | |
| | | DANVILLE, VA 2 | 4541 | | |
| PRÉFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REG ENTIFYING INFORMATION) | GULATORY PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 329 Continued From pa | | F 329 | | | |
| delusions/paranoia. | . The medications being | j | | | |
| | ol of the delusion/parano | | | | |
| Were Cympalia, Trill | fluoperazine and Ativan. o treat major depression | • \$ | | | |
| edults and may also | o treat major depression o be used to reduce pair | n in In from | | | |
| certain illnesses. It is | is not used to treat | , i troin | | | |
| delusions/paranoia. | Ativan is an anxiolytic u | used to | | | |
| relleve anxiety. It ls i delusions/paranola.) | not used to treat | | | | |
| | for February 2016 did n | | | | |
| | for the use of Triflouper | | | | |
| | for assessmentbut no | | | | |
| | were provided to assess g—even if nursing staff o | | | | |
| have floured out wha | g-even it hursing statt o at drug was being provid | JOUIU Jahi | | | |
| for which diagnosis of | or to control what behav | viors. | | | |
| The January 2016 be | ehavior sheet was lacki | ing a | | | |
| diagnosis for bipolar | disorder, but contained | 1 | | | |
| | and anxiety as justificati | ion for | | | |
| the use of trifloupera | izine - even though ot recommended for the | ^ | | | |
| treatment of anxiety. | A recommended for the | ; | | | ! |
| On 3/23/16 the DON | I was asked to explain the | ihe | | | |
| facility's procedure to | o monitor a resident on | (A W 0) | | | |
| antipsychotics and ar | nxiolytics. She said it di | <i>i</i> dn't | | | i |

#5.

have to be in the behavior sheets—it could be documented anywhere in the clinical record. The DON did not return with additional baseline symptoms or documented behaviors on Resident

On 3/24/16 at 1:16 PM, LPN II was asked about Resident #5's medications and her behaviors. LPN II said the resident was taking the

antipsychotic Cymbalta and Lorazepam to control her behaviors. LPN II said the resident got confused, obsessed over things and was

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | /ICES /ICES | | | FOR | d: 04/05/201 RM APPROVEI IO. 0938-039 |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
| | 495166 | | B. WING | | 03, | C /24/2016 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, STA | NTE, ZIP CODE | | |
| STRATFORD HEALTHCARE | CENTER | | ON STREET LE, VA 245 | | | |
| PREFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCI BE PRECEDED BY FULL I NTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 329 Continued From pa | age 44 | | F 329 | Maria de la companya | | |
| | (None of these sym | ptoms | . 020 | | | |
| these things, holdin Residents #5 and # behaviors on here a things. I don't really delusionalit would | etimes it's hard to fog up behavior sheets 8. They have no targ and it's hard to follow know what they mea just make it so much a're supposed to be | s for get these an by a simpler | | | | |
| Resident # 5. She sa | stification for the | hrenic but She said | | | | |
| Since the diagnoses were incomplete on LP II or LP III could a diagnoses, behavior medications they we | the behavior sheets, accurately determine s, or effectiveness or | neither the | | | | |
| The DON and admin surveyor's findings o surveyor asked how expected to determin a resident she had pibegun with antipyretiantidepressants. If the are not in the records and available when then the documentatias to be used effective | n 3/24/16 at 4:00 PM a medication nurse on the baseline behalicked up after treatmos, anilities and self the baseline syntam and are not clear, and are not clear, and nurses are on the on hasn't been organized. | M. The could be viors of lent had inptoms accurate the floor, | | | | |

No additional info was provided.

5. Facility staff failed to ensure that effective

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

Printed: 04/05/2016 FORM APPROVED MR NO. 0938-0301

| VENIL | INO I OIL MILDIOMILE | A MILDICAID SERVI | UES | | | OMB NO | D. 0938-039 |
|---|---|--|------------------|--|---|-----------|----------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES (DENTIFICATION NUM | | | | | (X3) DATE SURVEY COMPLETED | | |
| | | 495166 | | B. WING | | 03/2 | C 24/ 2016 |
| | PROVIDER OR SUPPLIER FORD HEALTHCARE | E CENTER | 508 RIS | RESS, CITY, ST ON STREE LLE, VA 24 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE FBE PRECEDED BY FULL R INTIFYING INFORMATION) | s EGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 329 | Continued From pa behavior monitoring was provided for Re | age 45 g and medication ass asident #8 who was to | essment aking | F 329 | | | |

Resident # 8 was admitted to the facility on 10/1/10. The diagnoses included depression, hypertension, diabetes, and coronary artery disease. The resident had previously suffered a stroke (CV.)

Pedestrian for pseudo affect. The clinical record

was reviewed 3/23/16 at 9:00 AM.

The resident's annual MD'S (minimum data set) assessment dated 10/6/15 coded the resident with unimpaired cognitive ability. Resident #8 required staff assistance for all ADSL (activities of daily living.)

Resident #8's MD'S did not trigger care planning for psychotropic medication—since she was not using any antipyretics, antidepressants or anilities. The latest CC (comprehensive care plan) for Resident #8 could not be located for review.

On 2/28/16 the resident's physician ordered Pedestrian 20/10 mg QED for pseudo affect. The medication was administrated by nursing staff between 2/29/16 until the physician discontinued them on 3/23/16.

Pseudo affect is characterized by emotional liability, often either crying or laughing at times when it's inappropriate. Victims may laugh when in reality, they are angry and cry when told an amusing anecdote. This is generally caused by neurological damage from a stroke or other brain injury.

There was no documentation regarding the assessments of this medication after the

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| CENTERS FOR | MEDICARE | & MEDICAID | SERVICES |

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| <u> </u> | LITO FOR MEDICARE | - A MEDICAID SEKA | ICES | | | OMB N | <u>40. 0938-039</u> |
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| • | | 495166 | i | B. WING | | 03 | 3/24/2016 |
| | F PROVIDER OR SUPPLIER | | ŧ | | TATE, ZIP CODE | · | 4 |
| STRAI | FORD HEALTHCARE | E CENTER | | SON STREE LLE, VA 24 | | | |
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| F 32 | 9 Continued From pa | | | F 329 | | ······································ | <u></u> |
| | behavior monitoring observed. (No inappus Just angry, agitated pseudo affect.) On 1/5/16 and 2/12/Resident is anxious, at timeshoards for On 3/24/16 at 1:16 FResident #8's Pedes said she gave the Pedisorder. We watch angry and fusses an | paseline assessments g (pseudo affect) were propriete laughing, control of outbursts—not typical distributions and trash in room the propriete and verbally food and trash in room PM LP II was asked a strian administrations bedestrian for her biport for hoarding and she and goes off sometime because she didn't general properties as the properties of the | re crying etc cal of cluded, y abusive m* about is. LP II colar e gets e. She | | | | |
| | LP II said she didn't sheet for the Pedest | have a behavior mor trian, but she didn't k | nitoring (now why. | | | | |
| | She said Resident #8 diagnosis, but she wa and even hit one stat | ed on 3/24/16 at 9:00 #8 didn't have a psych was very aggressive w aff member with a stic an accident. "She's ju | h with staff ck and | | | | |
| | On 3/24/16 at 10:30 apsychiatric consults for said the resident had | AM the DON provide for Resident #8. The d depression associa | consult | | | | |

a stroke and a personality disorder. The DON pointed out the resident had been given the Pedestrian "because she is bipolar."

The surveyor pointed out to the DON the medication was provided for pseudo affect (written right on the psych consult), not bipolar disorder, as she thought. The surveyor asked about the resident's symptoms for administration

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| | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| STRAT | FORD HEALTHCARE | CENTER | | ON STREET LE, VA 2454 | | | |
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| F 32 | Continued From pa | ige 47 | - | F 329 | | | |
| | and what staff was behavior monitoring medication nurses. | to monitor—since the g tool in place for the | the | | | | |
| | aggressive with star property when she of knew the staff mem preacher/stickshe | esident was verbally ff, was a hoarder, an got upset. When ask ber who was struck said she had not he d in the clinical recor | d hid staff ed if she with a ard that, it | | | | |
| | resident's behaviors | for information that were being monitor Pedestrian. No more vided. | ed while | | | | |
| | administrator on 3/2 surveyor asked how expected to determine a resident she had purely begun with antipyret antidepressants. If the are not in the record and available when a | ne If the baseline syr s and are not clear, a med nurses are on th tion hasn't been orga | could be could be eviors of ent had enptoms accurate ne floor, | | | | |
| | No additional info w | as provided. | | | | | |
| | monitoring and medi | 3/24/16 at 9:00 AM. nitted to the facility of the discharged at the hospital dated by the hospital. | or mood cal n ging I | | | | |

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

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| STRATFOR | D HEALTHCARE | CENTER | ŧ . | ON STREET | | | |
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| | ontinued From pa | | | F 329 | | | |
| ob hyj rea | structive pulmona pothyroidism. The | pertension, diabetes ary disorder, and e resident had a colo She had no docume | stomy for | | | | |
| Re she | sident #9 did not | have an MD'S or Co hission. Her physician e acting CC. | C since n's orders | | | | |
| | | s, signed and dated e following medication | | | | | |
| ant Sch 2. [(Mo disc | lpsychotic used for nizophrenia Divalproax Sodiur nod stabilizer for t order.) | t bedtime. (This is a or the treatment of m 500 mg three time treatment of schizoc | s a day. arp | | | | |
| for 4. T (an use | treatment of acut opamax 200 mg tipsychotic for col d for migraine he | times a day. (antips te and chronic psych every night at bedtir ntrol of seizures and sadaches and adjunct plar and schizophrer | oses.) ne. also ct therapy | | | | |
| pop | ulations.) b://www.ncbi.nlm. | .nih.gov/pmc/articles | | | | | |
| were | | were reviewed and the past or present documents | | | | | |
| (SW beel chai | social worker in moved due to "inge took place or | ange" documented b ndicated the residen conflict with roomma n 3/15/16—the day of details were describ | t had ate." This f her | | | | |
| | | M the DON was ask | • | | | en e | |

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| CENTERS FOR | MEDICARE | & MEDICAID | SERVICES |

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| STRATFORD HEALTHCARI | E CENTER | 1 | SON STREE LLE, VA 24 | | | |
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| she and her rooma over who was to op were both giving it is and that, but no one made the room chat and the room chat the DON was asked not documented in behavior sheets—as monitored by the strength psychiatric diagnosis medications and medications and medications are disorder as her diagnosed to a | noved. She said it was the had a screaming re- perated the TV contro to each other and F e hit anybody. Staff p ange." The deal why this angry out the nursing notes or s it should be a behav- aff given the resident es and antipsychotic | match ol. "Theing this bromptly tburst was on the avior at's many cet listed coaffective ons they bia were | F 329 | | | |
| The diagnosis for bi | ipolar disorder and ar | ngry | | | | |

the resident's diagnoses and behavior monitoring for the medications she was providing. LPN I, who said she had cared for the resident since her admission said she didn't know anyting about

agitation noted on her first day in the facility were

On 3/24/16 at 2:00 PM LPN I was asked about

not documented for behavior monitoring.

that-she'd have to look at the chart.

When informed the surveyor in question had the records already in hand—the LPN left the desk and disappeared, refusing to answer further questions. She was later seen walking out of the DON's office--but again refused to discuss the resident's treatment assessment and kept walking down the hall.

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| i e | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | PLE CONSTRUCTION 3 | (X3) DATE SU | . 0938-0391 PRVEY |
| | 495166 | | | | C 03/24/2016 | |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | | | TATE, ZIP CODE | | |
| | | DANVI | ION STRE | | | } |
| TAG OR LSC IDEN | ITIFYING INFORMATION) | B EGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | I D AF | (X5) COMPLETION DATE |
| F 329: Continued From pay The DON and admin surveyor's findings of surveyor asked how expected to determin a resident she had pit begun with antipsych antidepressants. If the are not in the records and available when me then the documentation as to be used effective No additional inforwas F-371 483.35(i) FOOD PRO SS=E STORE/PREPARE/SE | distrator were informed in 3/24/16 at 4:00 PM as medication nurse of the baseline behavioked up after treatmed otics, anxiolytics and elf the baseline symmon and are not clear, and are not clear, and are not clear, and hasn't been organiely. | I. The could be viors of ent had ptoms ccurate | F 371 | | | |
| The facility must - (1) Procure food from considered satisfactor, authorities; and (2) Store, prepare, dist under sanitary condition. This Requirement is not based on observation a determined the facility sprepare, distribute and conditions. On 3/22/16 at 1:15 PM, the kitchen the following 1. Paper toweling shelve ple crusts and cake flou 2. Cups, napkins and trasame shelving with sugar | sources approved or y by Federal, State or y by Federal, State or insure and serve footins of met as evidenced and staff interview, it staff failed to store, serve food under said during the initial tour were observed: and with "Thick & Easy r. | by: was hitary of | | F371 The facility is in compliance wiregulations for dry goods stora food in the pantry refrigerator removed and disposed of. All food storage areas will be reviewed to assure storage procedures are followed both a storage and refrigerated storage staff will be in-serviced on propfood storage both dry and refrigerated. | age. The was dry ge. All | |

| DEPARTMENT OF HEALTH CENTERS FOR MEDICARE | AND HUMAN SERV | /ICES | | | FOR | d: 04/05/20 RM APPROVE |
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| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | 508 RIS | RESS, CITY, 8 ION STREI LE, VA 24 | | | |
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| F 371 Continued From particles 3. Boxes of Styrofoal with toasted oat cere 4. Eight boxes of plate shelving with cracker DM I (dietary manage tour if she was award stored separately from dry good section. DM non-food items on a confood racksbut they just of the prefrigerator was inspected in the prefrigerator was inspected in the prefrigerator was inspected by the prefrigerator was inspected in the prefrigerator of serving the properties of the procedure for storing repartry refrigerator. She was also policy and procedure facility. He said he did in the procedure facility is a policy and administratives of the procedure facility. He said he did in the prefrigerator. She was a policy and administratives of the prefrigerator. She was a policy and administratives of the prefrigerator. She was a policy and administratives of the prefrigerator. She was a policy and procedure facility. He said he did in the prefrigerator. She was a policy and administratives of the prefrigerator. She was a policy and procedure facility. He said he did in the prefrigerator. She was a policy and procedure facility. He said he did in the prefrigerator. She was a policy and procedure facility. He said he did in the prefrigerator. She was a policy and procedure facility. He said he did in the prefrigerator was a policy and procedure facility. He said he did in the prefrigerator was a policy and procedure facility. He said he did in the prefrigerator was a policy and procedure facility and procedure facility and procedure facility and procedure facility. He said he did in the prefrigerator was a policy and procedure facility an | im bowls housed on ball, stic cutlery housed or rs, condiments and er) was asked during the food items weren the non-food items of I said she tried to know the resident's panyorded. It contained: It contained: It contained: It contained or expiration date or labeled for Room 1 be opened. It contains of V-8 juice, and a paghetti, which had to resident, go contained a Tupper foods contents in it. In name on it—but the figurated items in a said she did not. In the policy and a strator was asked if for food storage in not. The DON (director of the policy and the policy and the policy and the policy and the said she did not. | g this e to be s in the eep the m the try n it of 04-b, ned not erware This e food d the he had the | F 441 | The Administrator or deaudit the pantry refriger for four weeks to assure dating on any items store. The results of the audits reviewed at the monthly Assurance Committee me Completion Date: 5/2/16 | ator weekly appropriate ed within. will be Quality eeting. | |
| # | | | | | | 1 |

| ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | | E CONSTRUCTION | OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED |
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| ME OF PROVIDER OR SUPPLIER FRATFORD HEALTHCARE | CENTER | 508 RIS | RESS, CITY, ST ON STREE LE, VA 24 | | |
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| F 441 Continued From pag | | | F 441 | | |
| Infection Control Pro safe, sanitary and co to help prevent the de | mfortable environm evelopment and | rovide a ent and | | F441 | |
| (a) Infection Control F The facility must esta Program under which (1) Investigates, control in the facility; (2) Decides what productions related to infections related to infection determines that a resiprevent the spread of isolate the resident. (2) The facility must produce the contact will direct contact will trans (3) The facility must rehands after each direct hand washing is indicated professional practice. (c) Linens Personnel must handle transport linens so as the infection. | Program Iblish an Infection Control and Infection Control and Control Program dent needs isolation infection, the facility rohibit employees we or infected skin less the disease. In the disease and the dis | olation, olation, of; and orrective of to y must of must of must of their or which | | LPN #2 has been educated infection control politication administration to but not limited to not medications with bare hands 100% licensed nurses educated on the infection policy and medication admit to include but not limited touching medications with hands. Med pass observations performed weekly x 4 week or designee then at random the infection control policy followed and no medicated being touched with bare hand. The audit results will be revited monthly QA Committee of Completion date 5/2/16 | cy and to include touching 5. will be n control instration d to not ith bare will be s by DON to ensure is being tions are ds. |

observation, staff interview, clinical record review and facility document review it was determined

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| F 44 | 1 Continued From pa | age 53 | | F 441 | | M | |
| | | failed to implement | an | , | | | |
| | infection control pol | icy and procedure fo | r 1 of 16 | | | | |
| | Residents in the sai | mple survey, Reside | nt #5. | | | | |
| | The Findings Includ | | | | | | |
| | Resident #5 was a t | 66 year old female w | no was | | | | |
| | 10/6/15 Admitting | on 2/21/15 and readn diagnoses included, | nitted on | | | | |
| | not limited to: dvsnh | olagnoses included, lagia, chronic kidney | dieesee | | | | |
| | hemiplegia, cerebro | vascular accident | uisease, | | | | |
| | atherosclerotic hear | | | | | | |
| | hypertension and big | polar. | | | | | |
| | The most current Mi | inimum Data Set (MI | DS) | | | | |
| | located in the clinica | il record was a Quar | terly MDS | | | | |
| | | Assessment Refere | | | | | |
| | | he facility staff code | | | | | |
| | The facility of the | Cognitive Summary Stalso coded that Res | core of | | | | |
| | rounired total nursing | g care (4/2) with Acti | ident#5 | | | | |
| | Dally Living (ADL's). | 8 care (412) Mitti ACti | vides of | | | | |
| | On March 23, 2016 | | evor | | | | İ |
| | made a medication p | pass and nour obser | vation | | | | |
| | with Licensed Practic | cal Nurse (LPN #2). | The | | | | 1 |
| | surveyor observed L | PN (#2) pour severa | 1 | | | | |
| | medications into a pl | lastic medication cur | . The | | | | |
| | surveyor documente | d that one of the me | dications | | | | |
| | was a Colace 100mg | g capsule. The survi | eyor | | | | ľ |
| | observed LPN (#2) a | pproach Resident# | 5's | | | | |
| | bedside and place th | e plastic medication | cup on | | | | 1 |
| | the over the bed table | e. Kesident #5 reac | ned into | | | | |
| | the medication cup a | ina optained several | | | | | |

medications and placed the medications in her mouth. Resident #5 then obtained a cup of water and swallowed the pills. Resident #5 reached back into the plastic medication cup, the surveyor observed the Colace capsule roll across the over the bed table. LPN (#2) reached down with an ungloved hand, pick up the Colace capsule and place the Colace capsule back into the plastic medication cup. Resident #5 continued to take the remainder of her medications, including the

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| | | 495166 | | B. WING | The state of the s | 03/2 | C 24/2016 |
| | NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTER | 508 RIS | RESS, CITY, ST. ON STREE LE, VA 248 | | ************************************** | |
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| | reviewed Resident: the clinical record p orders. Signed phy were not limited to: mouth) BID (twice d On March 23, 2016 informed LPN (#2) t observed LPN (#2) bedside table, with a the Colace capsule cup. The surveyor r Resident #5 had tak stated, "I should hav another one." On March 23, 2016 | at 8:25 a.m. the surveyon the Colace of the | Review of ician d, but (by sic) (by sic) (by sic) (by sic) (by sic) (by sic) (by sic) (c) (c) (c) (c) (c) (c) (c) (c) (c) (| F 441 | | | |

the DON that LPN (#2) touched Resident #5's Colace with a bare hand and place it back into Resident #5's plastic medication cup. The DON stated, "(name of staff member withheld) already told me."

On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that LPN (#2) touched Resident #5's Colace with her bare hand. The surveyor notified the AT that Resident #5

| CENTERS | ENT OF HEALTH FOR MEDICARE | AND HUMAN SERVEN MEDICAID SERVEN | /ICES /ICES | | | FORM APPROV OMB NO. 0938-03 |
|--|--|--|---|----------------------------|--|---|
| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | R/CLIA MBER: | (X2) MULTIF A. BUILDING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495166 | | B. WING | | C 03/24/2016 |
| (X4) ID PREFIX (EATTAG TAG TAG TAG TAG TAG TAG TAG TAG TA | ontinued From pa ok the medication ck into the plastic e surveyor notified neern regarding in additional informating the facility as mplement a policy dication administration for Resident a 3.75(I)(1) RES CORDS-COMPLE | TECENTER ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION) TO BE 55 after the Colace was medication cup by the AT that she han fection control, ation was provided p to why the facility st y and procedure for ration, regarding infer #5. ETE/ACCURATE/ACC | STREET ADD 508 RIS DANVII ES REGULATORY S placed PN (#2). d a prior to aff failed ection | 8. WING | TATE, ZIP CODE TT 541 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REFERENCED TO THE APPR DEFICIENCY) F514 Residents #2, #3, #5 and medical records systematically organized. Resident #9 has been disc | TION (X8) ULD BE COMPLETION OPRIATE CATE #8's thinned are now charged, the estematically |
| The information of the informati | plete; accurately essible; and syste clinical record mumation to identify lent's assessmentices provided; the dmission screening or staff interview, it was determined to maintain clinicants in accordances in accordances in accordances accurately disible; and system dents #2, 3, 5, 8, a indings included: or Resident #2 the complete and accomplete accomp | is and practices that documented; readily matically organized. Just contain sufficient the resident; a records; the plan of care a results of any and clinical record wand clinical recorded that the facility stal records on 5 of 10 e with accepted and practices that a ocumented; readily organized, and 9). | rd of the and State; d by: d taff are | | educated on the proper systematically thin a record. All current resident's thinned have been systematically organized to ensure records are systematically organized to ensure records are systematically organized the monthly QA Committee of the monthly QA Committee organized the monthly QA Comm | ed records ganized. pleted by e thinned ganized. viewed at |

| DEPAR CENTE | TMENT OF HEALTH. RS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | ICES | | ·, | FOR | d: 04/05/201 IM APPROVEI O. 0938-039 |
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| | | 495166 | | B. WING | ······································ | 03/ | C 24/2016 |
| | PROVIDER OR SUPPLIER | | STREET ADD | RESS. CITY, STA | NTE, ZIP CODE | | |
| STRATI | FORD HEALTHCARE | CENTER | | ION STREET LLE, VA 245 | | | |
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| F 514 | Continued From pa | | | F 514 | | | |
| | the thinned record w | lity staff failed to ens | ure that | | | | |
| | Resident #2 was an | vas systematically or 85 year old female | rganized. | | | | |
| | originally admitted o | on 1/1/11 and readmi | wno was | | | | |
| | 2/28/14. Admitting of | disanoses included | hut were | | | | |
| | not limited to the foll | lowing: fall. diabetes | mellitus. | | | | |
| | cerebrovascular acc | cident, hypertension, | | | | | |
| | osteoarthritis, morbi | | | | | | |
| | infection, cardiomyo | | ession, | | | | |
| | asthma and bipolar. | | | | | | ! |
| | The most current Mi record was a Quarte | | | | | | |
| | ARD of 2/3/16. The | tacility staff coded t | n willian hat | | | | |
| | Resident #1 had a C | Cognitive Summary S | Score of | | | | |
| | The facility staff | also coded that Res | sident #2 | | | | |
| | required extensive (3 | 3/3) to total nursing a | care (4/2) | | | | |
| | with Activities of Dail | y Living (ADL's). | | | | | |
| | On March 23, 2016 a reviewed Resident # | at 2:30 p.m. the surv | eyor | | | | |
| | the clinical record pro | | | | | | |
| | orders. Signed phys | sician orders include | iciali d hut | | | | |
| | were not limited to: " | Sertraline HCL ER 5 | i ma | | | | |
| | tablet for > Zoloft F/C | | | | | | |
| | every morning for de | | | | | | |
| | Sodium 125 mg cap | (capsule) Sprink (sp | rinkles) | | | | |
| | for> Depakote Sprink | kle take 2 capsules | (250mg) | | | | |
| | by mouth twice daily | for Bipolar Disorder | '." (SiC) | | | | |
| | The order for the Dep 12/11/15. The order f | pakote was changed for the Zoloft origina | on todos | | | | |
| | 12/11/15. | or the Zolott Origina | led on | | | | |
| | Further review of the | clinical record produ | uced an | | | | |
| | original physician ord | ler for Depakote Soc | dium | | | | |
| | 125mg by mouth TID 10/15/15. | (three times a day) | on | | | | |
| | Continued review of t | the clinical record or | oduced | | | | |
| | the thinned clinical re | cord. Review of the | clinical | | | | |
| | record failed to produ | ice behavior monitor | ring for | | | | 1 |
| | October and Novemb | er 2015. Additionall | y the | | | | |
| | behavior monitoring s documented that Zolo | sheet for December oft (an antidepressa | 2015 nt) and | | | | Tenunca anno ang ang ang ang ang ang ang ang ang ang |

| DEPARTME | NT OF HEALT | H AND HUMAN | SERVICES |
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Printed: 04/05/2016 FORM APPROVED DMB NO. 0938-0391

| | W MICOIONIO OFILA | IVILU | | | ען פועוט | 10. 0930-039 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | I | E CONSTRUCTION | (X3) DATE | |
| | 495166 | i | B. WING | | 03 | /24/2016 |
| NAME OF PROVIDER OR SUPPLIER | <u> </u> | STREET ADD | RESS, CITY, STA | NTE, ZIP CODE | | <u></u> |
| STRATFORD HEALTHCARE | : CENTER | 1 | ON STREET LE, VA 245 | | | |
| PREFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL I ENTIFYING INFORMATION) | REGULATORY: | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 514 Continued From pa | | *** ********************************* | F 514 ¹ | | | |
| Depakote Sodium (| (a psychotropic) were | a being | | | | |
| | pression and withdra | | | | | |
| | ng sheet did not iden ceiving the Depakote | | | | | |
| | Bipolar. The surveyor | | | | | |
| the clinical record fo | | , , 61, 61, 44 | | | | |
| attempting to find ne | ecessary documenta | | | | | |
| | kote Sprinkles. The | | | | | |
| | ematically organized | | | | | |
| Un March 23, 2010 | at 3:15 p.m. the sun | veyor | | | | |
| | of Nursing (DON) the Depakote Sprinkles | | | | | |
| | Bipolar and Zoloft for | | | | | |
| diagnosis of depress | sion. The surveyor r | notifled | | | | |
| the DON that review | v of the clinical record | d failed to | | | | |
| produce behavior m | onitoring sheets for | October | | | | |
| and November 2015 | The surveyor also ent #2's December 2 | notitied | | | | |
| | ent #2's December 2 sheet stated that the | | | | | |
| and Depakote were | | | | | | |

organized.
On March 23, 2016 at 3:50 p.m. the survey team met with the Administrator (Adm), DON, Assistant Director of Nursing (ADON) and Corporate

depression and withdrawal, when in fact Resident #2 was receiving the Depakote for a diagnosis of being Bipolar. The surveyor notified the DON that

psychotropic) could not be documented on the same behavioral monitoring sheet. The surveyor

the behavioral monitoring for Zoloft (an antidepressant) and the Depakote (a

reviewed the December 2015 behavioral monitoring sheet with the DON and pointed out that the behavioral monitoring sheet was inaccurate. The surveyor reviewed the thinned record with the DON. The surveyor and DON reviewed the thinned clinical record for a prolonged time, attempting to find necessary documentation regarding the Depakote Sprinkles. The thinned record was not systematically

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE (X4) EVANCE (X4) EVANCE (X5) MULTIPLE CONSTRUCTION (X3) DATE SURV COMPLETE (X4) EVANCE (X4 | /EY D |
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| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE CENTER STRATFORD HEALTHCARE CENTER B. WING | 2016 |
| STRATFORD HEALTHCARE CENTER 508 RISON STREET DANVILLE, VA 24541 | |
| DANVILLE, VA 24541 | |
| (YA) ID SUMMARY STATEMENT OF DEFICIENCIES IN THE STATEMENT OF DEFICIENCIES | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE C TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) OMPLETION DATE |
| F 514 Continued From page 58 Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that that Resident #2 was on Depakote Sprinkles for a diagnosis of being Bipolar and Zoloft for depression. The surveyor also informed the AT that Resident #2's behavior monitoring sheet for December 2015 stated that Resident #2 was receiving the Zoloft and Depakote Sprinkles for withdrawal and depression, when in fact, Resident #2 was receiving the Depakote Sprinkles for a diagnosis of being Bipolar. The surveyor notified the AT that the behavior sheet was not accurate/complete. The surveyor also notified the AT that behavior monitoring sheets could not be located for October and November 2015. No additional information was provided prior to exiting the facility as to why the facility staff falled to ensure a complete and accurate clinical record, December 2015 behavior monitoring sheets. Furthermore, no additional information was provided prior to exit as to why the thinned record was not systematically organized. 2. For Resident #3 the facility staff falled to ensure a complete and accurate clinical record. Resident #3 the facility is staff falled to ensure a complete and accurate clinical record. Resident #3 the facility staff falled to ensure a provided prior to exit as to why the thinned record was not systematically organized. 2. For Resident #3 the facility staff falled to ensure a complete and accurate clinical record, Resident #3 the facility staff falled to ensure a complete and accurate clinical record, Resident #3 the facility staff falled to ensure a complete and accurate clinical record. Resident #3 the facility staff coded that Resident #3 the facility staff also coded that Resident #3 the facility staff also coded that Resident #3 the facility staff also coded that Resident #3 the facility staff also coded that Resident #3 the facility as a.m. the surveyor reviewed Resident #3 scinical record. Review of | |

| D | EF | Ά | R | T | M | 43 | ŧΤ | OF | - | ΙE | AL | T | Н | ÍΑ | ND | Η | JM | AN | SER | VIC | ES |
|---|----|----|---|---|---|----|----|----|---|----|----|---|---|----|----|----|-----|----|-----|------|----|
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| NAME OF | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | , |
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| F 514 | Continued From pa | | | F 514 | | | |
| | the clinical record p | roduced the April, M | ay, June, | | | | |
| | | 15 Medication Admin | | | | | |
| | | Review of the MAR's | | | | | |
| | | esident #3 received : | Seroquel | | | | |
| | 25mg by mouth eve | | | | | | |
| | | f the clinical record fa | | | | | |
| | produce behavioral | monitoring sheets fo | r the | | | | |
| | | lay, June, July and A | | | | | i |
| | | l was discontinued o | n | | | | |
| | 8/25/15, | n aliminal reserved and | l | | | | |
| | Figned physician or | e clinical record prod fers that included, bu | iucea | | | | |
| | | y 2 mg tablet take 1 | | | | | ĺ |
| | | ery morning for DPS | | | | | |
| | | spensed for Insuran | | | | | |
| | | he Abilify originated | | | | | |
| | 6/23/15. | no ribing diignialed | 011 | | | | |
| | | the clinical record fa | iled to | | | | |
| | | monitoring sheets fo | | | | | 1 |
| | Abilify for June, July | | | | | | l |
| | October, November | and December of 20 | 15. | | | | |
| | Further review of the | | | | | | |
| | produce the MAR's f | or October and Nove | ember | | | | - |
| | 2015. | | | | | | |
| | On March 23, 2016 | at 10:15 a.m. the sur | veyor | | | | |
| | notified The Director | | | | | | |
| | Resident #3 was on | | | | | | |
| | at bedtime during Ap | rii, May, June, July a | and | | | | |
| | August of 2015. The | | | | | | j |
| | DON that Resident # 6/23/15. The surveyor | | | | | | Ī |
| | behavioral monitoring | n chapte to monitor i | nat for | | | | |
| | specific behaviors, in | | | | | | [|
| | effectiveness could r | | | | | | 1 |
| | record for April, May, | | viii iiveli | | | | - |
| | September, October | | ember | | | | 1 |
| | of 2015 for the Seroc | | | | | | |
| | surveyor reviewed th | | | | | | |
| | DON. The DON was | | | | | | |
| | | April, May, June, Ju | | | | | |

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| :TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | E CONSTRUCTION | (X3) DATE | SURVEY LETED |
| | 495166 | B. WING | | 03/ | C 24/2016 |
| NAME OF PROVIDER OR SUPPLIER | STRE | EET ADDRESS, CITY, ST | ATE, ZIP CODE | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ····· |
| STRATFORD HEALTHCAR | | 108 RISON STREE DANVILLE, VA 245 | | | |
| PREFIX (EACH DEFICIENCY MUS | TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL REGUL DENTIFYING INFORMATION) | ID ATORY PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULO BE | (X5) COMPLETION DATE |
| F 514* Continued From p | page 60 er, October, November or | F 514 | | | |
| | Additionally, the surveyor | | | | |
| | AR's for October and | | | | |
| | ould not be located in the | | | | |
| | e DON was unable to locat lovember 2015 MAR's. | e | | | |
| | 6 at 3:50 p.m. the survey te | am | | | |
| met with the Admir | nistrator (Adm), DON, Assis | stant | | | |
| Director of Nursing | (ADON) and Corporate | | | | |
| | (CCN). The surveyor notif | | | | |
| | Team (AT) that the facility sesident #3 for psychotropic | | | | |
| | esident #5 for psychotropic I and Abilfy) during April, M | | | | |
| | , September, October, | ω,, | | | |
| November and De | cember of 2015. The surve | yor | | | |
| informed the AT the | at the facility staff had to | | | | |
| monitor for specific | behaviors related to the cation use (Seroquel and | | | | |
| | cation use (Seroquei and Leffectiveness, intervention | e | | | |
| | The surveyor also notified t | | | | |
| AT that Resident # | 3's MAR's for October and | | | | |
| | ould not be located in the | | | | |
| clinical record. | | | | | |
| | mation was provided prior to s to why the facility staff fai | | | | |
| | e a complete and accurate, | | | | |
| | organized record for Resid | | | | |
| | d to maintain clinical record | İs | | | |
| | ordance with accepted | | | | |
| professional standa | ards and practices that are | | | | |
| | ly documented; readily | | | | j |
| | stematically organized. The reviewed 3/23/16 at 9:00 A | | | | |
| | dmitted to the facility on | | | | |
| | oses included Bipolar disor | | | | |
| | oronary artery disease and ccident with hemi-plegia. | | | | ļ |

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

Printed: 04/05/2016 FORM APPROVED OMB NO. 0938-0391

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| l | TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | 1 | E CONSTRUCTION | (X3) DATE COMPI | LETED |
| L | | 495166 | | B. WING | | 03/ | C 24/2016 |
| | NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, STA | ATE, ZIP CODE | | |
| | STRATFORD HEALTHCARE | CENTER | 1 | ON STREET LE, VA 245 | | | |
| | PREFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE FBE PRECEDED BY FULL I INTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| | data set) assessme resident with unimp Resident #5 require (activities of daily liv coded during the MI use of antipsychotic documented as recommended as recommended as revised 1/19/16 potential for adverse due to psychotropic depression and psycinterventions include 1. Assess the reside 2. Meds per order 3. Monitor the action inappropriateness 4. Monitor the reside on on-going basis. Resident #5's physic dated 2/27/16, including (milligram)tak for Bipolar." The ordered and observed daily of the serior of the | ficant change MDS (ant dated 10/13/15 count dated 10/13/15 count dated cognitive ability of staff assistance for ing.) The resident was observed by the care plan of the resident of the care plan of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the resident of the manual status of the resident of the MAR (medicateds) beginning on 10/16 | oded the y. r all ADL as not for the d to be ylewed at's ications , Major er. The behavior unctioning and HcL 2 ery day by staff ition | F 514 | | | |
| | The same physician Lorazepam 0.5 mg. Twice daily as needed This order was imple documented on the Name and the Name of the Nam | Take one tablet by m d for anxiety and agit mented on 10/6/15 MAR by nursing staff he MARS document needed Ativan betw | outh tation. and on an : 23 een | | | | |
| | The behavior monitor | ring sheets, a tool us | sed by | | | | 1 |

| DEPARTMENT | OF HEALTH A | ND HUMAN | SERVICES |
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Printed: 04/05/2016

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495166 B. WING NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) TAG (X4) ID OR LSC IDENTIFYING INFORMATION) F 514: Continued From page 62 The nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be (X2) MULTIPLE CONSTRUCTION A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE COMF (X3) DATE COMF A. BUILDING (X3) DATE COMF A. BUILDING (X3) DATE COMF A. BUILDING (X3) DATE COMF A. BUILDING (X3) DATE COMF A. BUILDING (X3) DATE COMF (X4) ID (X5) ID (X5) ID (X6) ID (X7) ID (X6) ID (X7) ID (X7) ID (X6) ID (X7) ID (X7) ID (X7) ID (X7) ID (X2) ID (X4) ID (X4) ID (X4) ID (X5) ID (X6) ID (X6) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X6) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X6) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X4) ID (X4) ID (X4) ID (X5) ID (X6) ID (X7) ID (X7) ID (X6) ID (X7) ID (X6) ID (X7) ID (X7) ID (X6) ID (X7) ID (X7) ID (X6) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID (X7) ID | O. 0938-039 |
|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 608 RISON STREET DANVILLE, VA 24541 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514: Continued From page 62 the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be | SURVEY PLETED |
| STRATFORD HEALTHCARE CENTER 508 RISON STREET DANVILLE, VA 24541 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) F 514: Continued From page 62 the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be | C /24/2016 |
| (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 514: Continued From page 62 the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be | |
| PRÉFIX TAG CRACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 514: Continued From page 62 the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be | |
| the nursing staff to provide them with baseline behaviors and enable them to assess the effects of the medication by monitoring the resident's symptoms/behaviors were not observed to be | (X5) COMPLETION DATE |
| complete for diagnoses, medications or behaviors. The behavior sheet for March 2016 contained no diagnoses and the behaviors were listed as delusions/paranoia. The medications being assessed for control of the delusion/paranoia were Cymbalta, Trifluoperazine and Ativan. (Cymbalta is used to treat major depression in adults and may also be used to reduce pain from certain illnesses. It is not used to treat delusions/paranoia. Ativan is an anxiolytic used to relieve anxiety. It is not used to treat delusions/paranoia.) The behavior sheet for February 2016 did not contain a diagnosis for the use of Triflouperazine. It did contain Ativan for assessment—but no baseline symptoms were provided to assess the effects of either drug—even if nursing staff could have figured out what drug was being provided for which diagnosis or to control what behaviors. The January 2016 behavior sheet was lacking a diagnosis for bipolar disorder, but contained | |

On 3/23/16 the DON was asked to explain the facility's procedure to monitor a resident on antipsychotics and anxiolytics. She said it didn't have to be in the behavior sheets-it could be documented anywhere in the clinical record. The DON did not return with additional baseline

delusional paranoia and anxiety as justification for

the use of triflouperazine - even though antipsychotics are not recommended for the

treatment of anxiety.

| DEPARTMENT OF HEA | LTH AND HUMAN SERVICES |
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Printed: 04/05/2016

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| | NT OF DEFICIENCIES N OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | (X3) DATE | SURVEY LETED |
| | | 495166 | | B. WING | | 03/ | C /24/2016 |
| | PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | TATE, ZIP CODE | | |
| STRAT | FORD HEALTHCARE | ECENTER | | ON STREE | | | |
| | | | DANVII | LE, VA 24 | 541 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I INTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 514 | Continued From pa | ge 63 | | F 514 | <u> </u> | | ······································ |
| | symptoms or docum #5. | nented behaviors on | Resident | | | | |
| | Resident #5's medic LPN II said the resident the resident the resident psychotic Cymbher behaviors. LPN confused, obsessed withdrawn at times, warrant the use of a LPN II stated, "Som these things, holding Residents #5 and #6 behaviors on here a things. I don't really delusionalit would | alta and Lorazepam Il said the resident g I over things and was (None of these sym | to control got s ptoms llow if for et these in by simpler | | | | |
| | Resident # 5. She sa did not have hallucin | | renic but She said | | | | |
| | Since the diagnoses were incomplete on the LP II or LP III could a | the behavior sheets, | neither | | | | and the second s |

diagnoses, behaviors, or effectiveness of the

The DON and administrator were informed of the surveyor's findings on 3/24/16 at 4:00 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had

medications they were administering.

begun with antipyretics, anilities and

| | DEPARTMENT OF HEALTH A | AND HUMAN SERV & MEDICAID SERV | ICES | | | FOR | d: 04/05/201 MAPPROVE O. 0938-039 |
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| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | | (X2) MULTIPLI A. BUILDING | CONSTRUCTION | (X3) DATE | |
| L | | 495166 | | B. WING | A CONTRACTOR OF THE PROPERTY O | 03/ | 24/2016 |
| ĺ | NAME OF PROVIDER OR SUPPLIER | | | RESS, CITY, STA | | | |
| | STRATFORD HEALTHCARE | | DANVIL | ON STREET LE, VA 245 | | | |
| | PREFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION) | es Regulatory | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE APPROPRIATE | (X6) COMPLETION DATE |
| | F 514 Continued From pa | | | F 514 | | | |
| | antidepressants. If the are not in the record | he if the baseline sy Is and are not clear, | mptoms | | | | |
| | and available when | med nurses are on t | he floor. | | | | |
| | then the documenta as to be used effecti | tion hasn't been orga ively. | anized so | | | | |
| | No additional Info wa | as provided. | | | | | |
| | 4. The facility fails | ed to maintain clinica | al records | | | | |
| | Resident #8 in accor professional standar | rdance with accepted ds and practices that | d Itare | | | | |
| | complete; accurately | / documented; readil | ly | | | | |
| | accessible; and syste clinical record was re | ematically organized eviewed 3/23/16 at 9 | I. The ::00 AM. | | | | |
| | Resident # 8 was add 10/1/10. The diagnos hypertension, diabete disease. The residen stroke (CV.) | ses included depresses, and coronary arte | sion, erv | | | | |
| | The resident's annua | l MD'S (minimum da | ata set) | | | | |
| | assessment dated 10 | 0/6/15 coded the res | ident | | | | |
| | with unimpaired cogn required staff assistar daily living.) | nce for all ADSL (ac | nt #8 tivities of | | | | |
| | Resident #8's MD'S d | lid not trigger care p | lanning | | | | |
| | using any antipyretics | s, antidepressants or | 7 | | | | |
| | anilities. The latest Co plan) for Resident #8 | C (comprehensive c | are | | | | |
| | review. | COURT HOLDE FOCATE(|) T O r | | | | |
| | On 2/28/16 the reside | ent's physician order | ed | | | | |
| | Pedestrian 20/10 mg medication was admir | ਪ⊏⊔ for pseudo affo nistrated by nursing | ect. I ne staff | | | | |

them on 3/23/16.

between 2/29/16 until the physician discontinued

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

Printed: 04/05/2016 FORM APPROVED OMB NO 0938-0391

| CENTERS FOR MEDICARI | <u>= & MEDICAID SERVI</u> | CES | | | OMB N | IO. 0938-039 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM | | 1' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | 495166 | | B. WING | | 03 | C / 24/2016 |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCAR | 1 | 508 RIS | RESS, CITY, ST ON STREE LE, VA 24 | | , | |
| PRÉFIX (EACH DEFICIENCY MUS | TATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL RI ENTIFYING INFORMATION) | S EGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| liability, often eithe when it's inappropi in reality, they are a amusing anecdote | page 65 haracterized by emotion or crying or laughing at riate. Victims may laughang and cry when tole. This is generally caus ge from a stroke or other | times h when d an sed by | F 514 | | | |
| assessments of thi initiation. No prior to behavior monitoring observed. (No inap | umentation regarding this medication after the paseline assessments g (pseudo affect) were apropriate laughing, cryd outbursts-not typical | for her | | | | |
| Resident is anxious | 2/16 nursing notes inclus, hostile and verbally a food and trash in room. | abusive | | | | To the second se |
| Resident #8's Pede | PM LP II was asked al estrian administrations. Pedestrian for her bipol | LP II | | | | |

LP II said she didn't have a behavior monitoring sheet for the Pedestrian, but she didn't know why.

disorder. We watch for hoarding and she gets angry and fusses and goes off sometime. She threw a fit one day because she didn't get a hot

LP III was interviewed on 3/24/16 at 9:00 AM. She said Resident #8 didn't have a psych diagnosis, but she was very aggressive with staff and even hit one staff member with a stick and claimed later it was an accident. "She's just mean."

On 3/24/16 at 10:30 AM the DON provided psychlatric consults for Resident #8. The consult

| DEPAR CENTE | RTMENT OF HEALTH , ERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | /ICES /ICES | | | FOR | od: 04/05/20 ⁻ RM APPROVE IO. 0938-039 |
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| 8TATEME | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | ER/CLIA | (X2) MULTIPL A. BUILDING | LE CONSTRUCTION | (X3) DATE | SURVEY PLETED |
| | | 495166 | í | B. WING | * | 03 | C /24/2016 |
| | PROVIDER OR SUPPLIER | Mil. Mars Nr. & Hallengton Sung. | ł | | TATE, ZIP CODE | Marian Ma | |
| | FORD HEALTHCARE | | DANVIL | SON STREE LLE, VA 24 | - • | | <u></u> |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE TBE PRECEDED BY FULL F ENTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 514 | 4 Continued From pa | | | F 514 | | | |
| | a stroke and a person pointed out the reside Pedestrian "because The surveyor pointer medication was proving written right on the public disorder, as she thou | ed out to the DON the vided for pseudo affe psych consult), not b pught. The surveyor a | DON the e ect bipolar asked | | | | |
| | about the resident's and what staff was to | symptoms for admir to monitor-since the tool in place for the | nistration ere was no the | | | | |
| | aggressive with staff property when she g | f, was a hoarder, and got upset. When aske ber who was struck v said she had not hea | d hid staff ed if she with a ard that, It | | | | |
| | The surveyor asked to resident's behaviors she was taking the P information was prov | were being monitore Pedestrian. No more | ed while | | | | |
| | This information was administrator on 3/23 surveyor asked how a expected to determin a resident she had pibegun with antipyretic antidepressants. If the are not in the records and available when me then the documentation as to be used effective. | 3/16 at 3:30 PM. The a medication nurse one the baseline behalicked up after treatmics, anilities and he If the baseline symmeters and are not clear, amed nurses are on the lon hasn't been organical medical process. | e could be aviors of nent had mptoms accurate he floor, | | | | |

No additional info was provided.

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

Printed: 04/05/2016

| CENTERS FOR MEDICARE | AND HUMAN SERV & MEDICAID SERV | ICES ICES | | | FORM APPROVE B NO. 0938-039 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | (X2) MULTIP A. BUILDING | LE CONSTRUCTION (X3) D | DATE SURVEY COMPLETED |
| | 495166 | | B. WING | | C 03/24/2016 |
| NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE | CENTED | | | TATE, ZIP CODE | |
| 3 TOAT FORD HEALTHCARE | CENIEK | | ON STREE LE, VA 24 | | |
| PRÉFIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F INTIFYING INFORMATION) | REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | |
| Resident #9 in acco professional standa complete; accuratel | age 67 led to maintain clinic ordance with accepte rds and practices that y documented; readitematically organized | d at are ily | F 514 | | |

Resident #9 was admitted to the facility on 3/15/16. Her diagnoses from the discharging hospital, signed and dated by the hospital physician on 3/6/16, included schizophrenia, bipolar disorder, hypertension, diabetes, chronic obstructive pulmonary disorder, and hypothyroidism. The resident had a colostomy for reasons unknown. She had no documented history of seizures.

clinical record was reviewed 3/24/16 at 9:00 AM.

Resident #9 did not have an MD'S or CC since she was a new admission. Her physician's orders were in place as the acting CC.

The physician orders, signed and dated on 3/15/16, included the following medications:

- 1. Clozaril 150 mg at bedtime. (This is an antipsychotic used for the treatment of Schizophrenia
- 2. Divalproax Sodium 500 mg three times a day. (Mood stabilizer for treatment of schizocarp disorder.)
- 3. Haldol 20 mg two times a day. (antipsychotic for treatment of acute and chronic psychoses.)
- 4. Topamax 200 mg every night at bedtime. (antipsychotic for control of seizures and also used for migraine headaches and adjunct therapy for psychoses in bipolar and schizophrenic populations.)

(http://www.ncbi.nlm.nih.gov/pmc/articles/PMC18 1115/)

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

Printed: 04/05/2016 FORM APPROVED OMB NO. 0938-0391

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| | | 495166 | | B. WING | | 03 | C / 24/2016 |
| | VIDER OR SUPPLIER | | STREET ADDR | ESS, CITY, ST/ | ATE, ZIP CODE | | |
| STRATFO | RD HEALTHCARE | : CENTER | | ON STREET LE, VA 245 | | | |
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| A (S be ch ac Oi the sh ov we | rere no behaviors, y the nursing staff. "notice of room chesW) social worker een moved due to hange took place of dmission. No other in 3/24/16 at 1:33 For e resident was more and her roomate wer who was to ope ere both giving it to | nange" documented I indicated the resider "conflict with roomm on 3/15/16the day or details were described. She said it was a had a screaming merated the TV control of each other and Fhit anybody. Staff pr | by the ht had hate." This of her bed. ked why because hatch | F 514 | | | |
| no be | it documented in the havior sheetsas | d why this angry outb ne nursing notes or o it should be a behav ff given the resident's | on the ior | | | | |

The resident's behavior monitoring sheet listed only "paranoia" as a behavior and Schizoaffective disorder as her diagnosis. The medications they were supposed to assess for the paranoia were listed as divalproax sodium, clozaril, Haldol and

psychiatric diagnoses and antipsychotic medications and mood stabalizers.

The diagnosis for bipolar disorder and angry agitation noted on her first day in the facility were not documented for behavior monitoring.

On 3/24/16 at 2:00 PM LPN I was asked about the resident's diagnoses and behavior monitoring for the medications she was providing. LPN I, who said she had cared for the resident since her

Topamax.

| DEPARTMENT CENTERS FO | OF HEALTH | AND HUMAN SERV & MEDICAID SERV | ICES | | | Printed: 04/05/20 FORM APPROVE OMB NO. 0938-039 |
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| | | (X1) PROVIDER/SUPPLIED IDENTIFICATION NUMBER 1 | | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 495166 | | B. WING | | 03/24/2016 |
| NAME OF PROVIDE STRATFORD I | | E CENTER | 508 RIS | RESS, CITY, STA ON STREET LE, VA 245 | | |
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| F 514 Cont | inued From pa | age 69 | | F 514 | | |

When informed the surveyor in question had the records already in hand--the LPN left the desk and disappeared, refusing to answer further questions. She was later seen walking out of the DON's office--but again refused to discuss the resident's treatment assessment and kept

admission said she didn't know anyting about

that-she'd have to look at the chart.

The DON and administrator were informed of the surveyor's findings on 3/24/16 at 4:00 PM. The surveyor asked how a medication nurse could be expected to determine the baseline behaviors of a resident she had picked up after treatment had begun with antipsychotics, anxiolytics and antidepressants. If the If the baseline symptoms are not in the records and are not clear, accurate and available when med nurses are on the floor, then the documentation hasn't been organized so as to be used effectively.

No additional info was provided.

walking down the hall.

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| ATEMENT OF DEFICIENCIES AD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | ER/CLIA IMBER: | (X2) MULTIP A. BUILDING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| ľ | F PROVIDER OR SUPPLIER | | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | |
| | FORD HEALTHCARE C | | DANVILI | ON STREET LE, VA 24541 | | |
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| F 00 | 0 initial Comments | | | F 000 | | |
| | survey and biennial was conducted 03/2 complaint was inves Corrections are requ CFR Part 483 Feder | rginia Rules and Reg Nursing Facilities. The report will follow. Ocertified bed facility vey. The survey sament Resident reviews of 12) and 4 closed resident reviews | pection 16. One urvey. with 42 gulations he Life was 52 nple | | | |
| F 001 | Non Compliance | , | | | F30 9 | |
| 7 001 | Non Compliance The facility was out of following state licensu | ure requirements: | ė | F 001 | The facility has a signed on the Dialysis provider and policy. | contract with a dialysis |
| | This RULE: is not me The facility was not in following Virginia Rule | compilance with the as and Regulations for | or the | | All residents are at risk wreceiving dialysis. | ho are |
| | Licensure of Nursing I I. 12 VAC 5-371-14 Based on staff intervie facility staff failed to in policies and procedure | io. Policies and proc w it was determined aplement and operat | the ionalize | | The Administrator will rev contracted resident service contracts and policies are current. | es to assure |
| | storage and 2. Contract the survey the team re procedures for the afor | ctual dialysis service quested policies and rementioned. | . During | | The Administrator will rev Dialysis contract and polic for three months. Results | y monthly will be |
| • | On 3/24/16 at 3:30 PM leam he did not have a | ine administrator to | ld the trect | | reviewed at the monthly C Assurance Committee mee | |
| } { | with the dialysis service veither was there a po or dialysis services. (f | e used by the facility. licy and procedure in | | i | Completion Date: 5/2/16 | rung. |
| | DIRECTOR'S OR PROTUDENTS | APLIER REPRESENTATI | VE'S SIGNA | TURE | ADMINISMA TIN | 4/13/16 |
| E FORM | | 0211 | 99 | | MIUL11 | If continuation sheet 1 of 6 |

| , State of Virginia | | | | | LAKM M | PRO |
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| | 495166 | | B. WING | | 03/24/2 | D18 |
| NAME OF PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, S | TATE, ZIP CODE | 1 | . |
| STRATFORD HEALTHCARE C | | 508 RISON DANVILLE | | | | |
| PREFIX (EACH DEFICIENCY TAG REGULATORY OR LE | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY BC IDENTIFYING INFORMA | FILL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JUDBE ~ | (X5) DMPLET DATE |
| F 001 : Continued From Pa | ge 1 | | F 001 | | | |
| additional info. | | | | F371 | | |
| not have a written p | d procedures be mai for the Licensure of I collicies and procedure y shall implement where approved by the ecommended change erning body for appround the annual policy review dates, participal action dates of the be maintained, operational policies de, but are not limited and discharge; and discharge; and physician services in discharge and nursing services; vices, including drug nursing facility; | food o. fre the intained Nursing res. itten viewed at es eval. view, bants, bants, and ed to: s; | | The facility is in compliance or regulations for dry goods sto food in the pantry refrigerator removed and disposed of. For storage policy completed. All food storage areas will be reviewed to assure storage procedures are followed both storage and refrigerated storage staff will be in-serviced on profood storage policy both dry a refrigerated. The Administrator or designee audit the pantry refrigerator will be for four weeks to assure approaching on any items stored with the results of the audits will be reviewed at the monthly Qualification Date: 5/2/16 | rage. The or was od dry ige. All iper ind will reekly opriate thin. | |
| Safety and emerge procedures; and | ncy preparedness | | | | | |

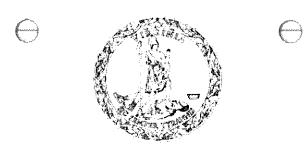
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| STATEMENT OF DEFICIENT AND PLAN OF CORRECTION | CIES | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA MBER: | A. BUILDIN | PLE CONSTRUCTION | | SURVEY |
| NAME OF BOOMBER OF | ***** | 495166 | *************************************** | B. WING | | 03/ | 24/2016 |
| NAME OF PROVIDER OR: STRATFORD HEALTI | ICARE C | | 508 RISC DANVILL | DDRESS, CITY, S ON STREET .E, VA 24541 | STATE, ZIP CODE | | |
| PREFIX (EACH D | PEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY BC IDENTIFYING INFORMA | FIRE | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION 8HO CROSS-REFERENCED TO THE APPI DEFICIENCY) |)) C RE | (X5) COMPLETE DATE |
| F 001 Continued | From Pa | ge 2 | | F 001 | | | |
| 15. Profess a. Confider b. Truthful c. Observa informed cd d. Preserva attention to impaired, an 16. Facility: No additions survey team 2. 12 VAC 5 Facility Prac 12 VAC 5 reference to Based on sta and facility d that the facilit and procedu The facility st background o references fo past 12 mont The Findings On March 24, reviewed the "Resident Abi in part "Policy: This f Abuse, Involu residents or M by anyone policy to under employees an of current emp The Facility wit new employees | sional and attality of communitace of apponsent and the need of the dy security. al information of rest. al information of exit. al information of a communitaces. al information of a comm | d clinical ethics, inclures ident information; cation with residents propriate standards at refusal of treatmer sident dignity, with sist of the aged, the coing; and ation was offered price. C. Resident Behavior (A,D.12,E.2,E.3): Coew, employee record review it was determited to implement poshibit abuse. to obtain criminal heck for licenses and Employees hired with the complement of the | of of ot; and oecial gnitively or to the & ross review lined licies d check ithin the titled, e read tment, its property is the oecords s. a. og a on | | F226 Employees that did not have background checks have had background checks completed potential new hires will have reference checks completed Occupational Therapist hired 12/21/15 has had their licent verified. All employee files will be reviassure that background check itcensure verification, and reference checks completed. All potential new hires will have reference checks completed. Administrator will conduct an monthly for three months of a hires to assure they have compreference checks, background and licensure verification. The results of the audits will be reviewed at the monthly Quality Assurance Committee Meeting Completion Date: 5/2/16 | d ed. All e l. The d on sure lewed to ks, ference The audit all new peted checks, | |

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495166 B. WING 03/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STRATFORD HEALTHCARE CENTER **508 RISON STREET** DANVILLE, VA 24541 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 001 Continued From Page 3 F 001 ii. Check with applicable nurse assistant registry, and any other nurse assistant registries that the Facility has reason to believe contain information on the individual, prior to using the individual as a nurse assistant; iii. Check with all applicable licensing and certification status to ensure that the employee hold the requisite license/and/or certification stats to perform their job functions; iv. Conduct criminal background check in accordance with Stat law and facility policy; ..." On March 24, 2016 at 2:10 p.m. the surveyor reviewed 20 employee records with the Human Resources Director HRD). The surveyor made the following observations: A Housekeeping employee hired on 12/1/15 did not have reference checks. 2. A Dietary employee hired on 11/11/15 did not have reference checks. 3. An Occupational Therapist hired on 4/1/15 did not have a Criminal Background Check (CBD) or reference checks. 4. An Activities employee hired on 2/9/16 did not have reference checks. 5. A Dietary employee hired on 6/5/15 did not have reference checks. 6. An Admission Coordinator employee hired on 6/15/15 did not have reference checks. 7. An Occupational Therapist hired on 12/21/15 did not have Licensure verification and reference checks. A Physical Therapist hired on 4/16/15 did not have reference checks. 9. A dietary employee hired on 7/29/15 did not have reference checks. 10. A Certified Nursing Assistant (C.N.A.) did not have reference checks. 11. An Other Admission employee hired on 6/23/15 did not have reference checks. The surveyor pointed out to the HRM that the employee records were missing License

State of Virginia **TATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495166 B. WING 03/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STRATFORD HEALTHCARE CENTER **508 RISON STREET** DANVILLE, VA 24541 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 001 Continued From Page 4 F 001 Verifications, CBC and References. The HRM acknowledged that she had not obtained the reference checks. The HRM stated that one of the employees was transferred from a sister facility and that was the reason she did not have the CBC. The surveyor notified the HRM that she, the HRD, should have the CBC on file. No additional information was provided as to why the HRD failed to implement the policy and procedure to prohibit abuse. On March 24, 2016 at 3:05 p.m. the surveyor notified the Administrator (Adm) that the HRD failed to obtain license verification CBC and reference checks on 11 of 20 employees hired within the past 12 months. 12 VAC 5-371-140. Resident Behavior & Facility Practices. 12 VAC 5-371-140 (A,D.12,E.2,E.3); Cross reference to F-226. 12 VAC 5-371-150. Quality of Life. 12 VAC 5-371-150 (A, B.1-3): Cross reference to F-244. 12 VAC 5-371-370, Quality of Life. 12 VAC 5-371-370 (A, B,C,D,E,G,H,I): Cross reference to F-252 & 253. 12 VAC 5-371-250. Resident assessment and care planning. 12 VAC 5-371-250 (A.1 THRU A.14) Cross Reference to F-272 12 VAC 5-371-250. Resident assessment and care planning. 12 VAC 5-371-250 (A,D.E) Cross Reference to F-278 12 VAC 5-371-250. Resident assessment and

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State of Virginia **FATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495166 B. WING 03/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE STRATFORD HEALTHCARE CENTER **508 RISON STREET DANVILLE, VA 24541** (X4) ID **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 001 Continued From Page 5 F 001 care planning. 12 VAC 5-371-250 (G) Cross Reference to F-279 12 VAC 5-371-220. Quality of Care. 12 VAC 5-371-220 (A THRU G) Cross reference to F-309. 12 VAC 5-371-220. Quality of Care. 12 VAC 5-371-220 (A THRU G) Cross reference to F-312. 12 VAC 5-371-370. Physical Environment. 12 VAC 5-371-370 Cross reference to F-252. 12 VAC 5-371-220. Quality of Care. 12 VAC 5-371-220 (A, B) Cross reference to F-328. 12 VAC 5-371-220. Quality of Care. 12 VAC 5-371-220 (B) Cross reference to F-329. 12 VAC 5-371-340. Dietary Services. 12 VAC 5-371-340 (A) Cross reference to F-371. 12 VAC 5-371-180. Infection Control. 12 VAC 5-371-180 (A,B,C) Cross reference to F-441. 12 VAC 5-371-370. Physical Environment. 12 VAC 5-371-370 Cross reference to F-252. 12 VAC 5-371-360. Clinical Records 12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514



COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Melvin D. Carter EXECUTIVE DIRECTOR

State Fire Marshal's Office Western Region 6744 Thirlane Road Roanoke, VA 24019 Phone: 540-561-7033

Kathaleen Creegan-Tedeschi, Director Office of Licensure/Certification Division of Long Term Care Virginia Department of Health 9960 Mayland Drive Perimeter Center Suite 401 Henrico, VA 23233

RE: Stratford Healthcare Center

508 Rison Street Danville, VA

File Number: W-0733-004

CMS Certification Number: 495166

Event ID Number: MF6E21

The attached report is forwarded to you with the following comments:

| I. | SURVEY X |
|------|---|
| [X | Recommend certification based on compliance with Life Safety Code.] Recommend certification based on acceptable POC. Recommend certification based on acceptable POC and a scope and severity of C or less with no |
| | revisit required. Recommend certification based on compliance with LSC by requested continuous waiver. |
| Įχ | Recommend certification based on compliance with LSC by requested Time Limited waiver. |
| [] | Recommend certification based on satisfactory results from application of the FSES. |
| [] | Do not recommend certification. |
| II. | POST SURVEY [] |
| [] | All deficiencies corrected: |
| [] | All deficiencies not corrected: |
| | [] Recommend certification based on acceptable POC [] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required. |
| | [] Recommend certification based on approved or requested continuous waiver. |
| | [] Recommend certification based on approved or requested Time Limited waiver. [] Do not recommend certification. |
| If y | ou have any questions or if we may be of further assistance, please contact me at 804-371-0220 |
| | Sincerely, |
| | Ronald C Reynods - JC Ronald C. Reynolds |
| | |
| | Interim State Fire Marshal |

Survey Date: <u>04/07/2016</u> SOD Sent: <u>4/11/16</u> POC Rec 'd: 4/25/16 POC to HQ: 4/25/16

Highest Scope/Severity: F

| CEN | ARTMENT OF HEALTH TERS FOR MEDICARE | & MEDICAID SERY | VICES | Trial sections | W-0733-004 | FOI | ed: 04/12/20 RM APPROV IO, 0938-03 | |
|---|---|---|--|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | (X3) DATE | (X3) DATE SURVEY COMPLETED | |
| | | 495166 | : | B. WING | | 04/ | /07/2016 | |
| | F PROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | 200-11-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1 | | |
| STRA | TFORD HEALTHCARE | CENTER | | ION STREE LE, VA 24 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST | TEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION) | SEGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTOR SHOULD REFERENCED TO THE APPR DEFICIENCY) | BE CROSS. | COMPLETION DATE | |
| K OC | 00 INITIAL COMMENT | ************************************** | | K 000 | terenen andere de en en anne anne anne anne anne anne | | | |
| | Surveyor: 21761 | | | ** | | | And the state of t | |
| | Construction Type: | V (111) | Maryleter press. | Agente | | | | |
| | Description of structs wood framed building The facility is divided | g on a concrete slab | floor. | ************************************** | | | | |
| | Sprinkler Status: The with a NFPA 13 systems. The system | oe i | Medital Per - Monday Sylva Lines - com | K021 | | of the special party of the sp | | |
| | water. | | | *************************************** | The solled linen room | | and the same of th | |
| | An unannounced recertification Life Safety Co survey was conducted 04/07/16 in accordance | | | Wilderston, sweet to | has been adjusted so t | hat It | mili Viria innu repensa | |
| | with 42 Code of Fede | 483: | ###################################### | closes completely. | | THE THE PARTY OF T | | |
| | Requirements for Lon | es. The | No. of Street, | The Maintenance Direc | | | | |
| | facility was surveyed t LSC 2000 Existing reg | the true | 201 | designee will test all do | ors in | | | |
| j | not in compliance with | the Requirements | or i | 1 | the facility to assure th | at they | | |
| | Participation Medicare | and Medicaid. | . , | TYLERA A MA IMPORTAN | close completely. | Villeant | | |
| | The findings that follow | v demonstrate | | Maria Laguide | The Maintenance Direc | | | |
| | non-compliance with T Regulations, | me 42 Gode of | | Average to 100 | designee will test all do | ors in | | |
| | 483.70(a) et seq (Life (| į | 1 | the facility to assure the | et they | | | |
| 1 | NFPA 101 LIFE SAFET | | RD | K 021 | close completely. This w weekly for six weeks. | /ill be | | |
| | Doors in an exit passageway, stairway enci | | losure, | Alah - Angalasaya | The results of the tests v | will be | | |
| | horizontal exit, smoke barrier or hazardous are | | | 1 | reviewed at the monthly | | 1 | |
| | enclosure are self-closing and kept in the closed | | | | Quality Assurance Comm | 1 | | |
| | position, unless held open by as release device complying with 7.2.1.8.2 that automatically close | | | | | nttee |] | |
| 8 | all such doors througho | s wat autometically lut the amoke | CIUBOS | 4 | meeting. | | ĺ | |
| C | all such doors throughout the smoke compartment or entire facility upon activation of: | | | AP-VANTE BASE | Completion Date: 4/8/16 | | 1 | |
| (| a) The required manual | il fire alarm system i | and | | · ····· make TIMI AU | • | | |
| (| b) Local smoke detecto | ors designed to dete | ct | | | INVESTIGATION | 1 | |
| 8 | moke passing through | the opening or a re- | quired | | | necessary pag. | | |
| RATORY | Adres A | SUPPLIER REPRESENTAT | · · | | | *************************************** | İ | |

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

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

Printed: 04/12/2016 FORM APPROVED OMB NO. 0938-0391

| | TEMENT OF DEFICIENCIES I PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 | | | (X3) DATE SURVEY COMPLETED | |
|-------------------|---|--|---|--|--|---|-------------------------------|--|
| | | 495166 | 3 | B. WING | | 0.4 | /07/2016 | |
| 4 | E OF PROVIDER OR SUPPLIER RATFORD HEALTHCARE | CENTER | 508 RIS | RESS, CITY, SON STRE | | | V//2V 18 | |
| (X4) PRE TA | FIX (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION) | S REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIES OF THE PROPRIES OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF THE PROVIDER OF T | AF CDOSE | (X6) COMPLETION DATE | |
| | O21 Continued From pa smoke detection sys (c) The automatic sp 18.2.2.2.6, 18.3.1.2, 7.2.1.8.2 Door assemblies in vapproved type with a rating. 8.2.3.2.3.1 Boiler rooms, heater equipment rooms door This Standard is not Surveyor: 21761 Based on observation observation and intermaintain smoke doors Survey findings includ On 04/07/16, at approximately observation to the Engineering Direct evidence through observation observation smoke doors. | stem and prinkler system, if ins 19.2.2.2.6, 19.3.1.2 rertical openings are appropriate fire protections, and mechanors are kept closed, met as evidenced by it was revealed the view that the facility it. e: e: ximately 12:25 PM, on and interview, the or is not completely it tor witnessed this revation and interview. | o of an oction dical y: rough failed to lt was a Solled closing. | K 021 | The unprotected penetric through the Laundry Rowall has been secured wall has been secured wappropriate protection. The Maintenance Direct designee will inspect sin penetrations where protection would be requite assure the protection appropriate. The Maintenance Directed designee will conduct we audits of similar penetratiassure the protection is appropriate. This will be converted weekly for six weeks. The results of the audits weekly reviewed at the month | orn with or or milar uired ls or or ekly clons done | | |
| K 021 | One hour fire rated con rated doors) or an approper extinguishing system in and/or 19.3.5.4 protects the approved automatic option is used, the areas other spaces by smoke doors. Doors are self-cl field-applied protective page inches from the botto permitted. 19.3.2.1 This Standard is not me | struction (with o hor oved automatic fire accordance with 8, hazardous areas, fire extinguishing s s are separated from resisting partitions a osing and non-rated plates that do not ex- im of the door are | ur fire- 4.1 When ystem n and | K 029 | Quality Assurance Commit meeting. Completion Date: 4/8/16 | | | |

| DEPARTMENT | OF HEALTH AND HUMAN | SERVICES |
|--------------------|---------------------|----------|
| <u>CENTERS FOR</u> | MEDICARE & MEDICAID | SERVICES |

Printed: 04/12/2016 FORM APPROVED MB NO. 0938-0391

| ĺ | ERO FOR MEDICARE & MEDICAID SERVICES | | | | | OMB N | O. 0938-039 |
|---|---|--|--|---------------------------------------|--|-------------|---|
| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ER/CLIA MBER: | | IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01 | (X3) DATE (| SURVEY |
| | | 495166 | | B. WING | | 04/ | 07/2016 |
| | NAME OF PROVIDER OR SUPPLIER STRATFORD HEALTHCARE CENTER | | 508 RIS | RESS, CITY, S ION STRE LE, VA 2 | | | ANNOUNCE COMMUNICATION COMMUNICATION COMMUNICATION COMMUNICATION COMMUNICATION COMMUNICATION COMMUNICATION COMM |
| (X4) ID PREFIX TAG | , (EACH DEFICIENCY MUST | ATEMENT OF DEFICIENCY BE PRECEDED BY FULL I NTIFYING INFORMATION) | 8 REGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE (REFERENCED TO THE APPROPR DEFICIENCY) | ROSS. | COMPLETION (XE) |
| K 051 N A Call of the sign of | Continued From particular Surveyor: 21761 Based on observation and interpretation and interpretation and interpretation and interpretation and interpretation of 04/07/16, at approved the end of the columbing line. The Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Directly of the Engineering Safety of the Engineering | on, it was revealed the review that the facility itions. Ide: oximately 12:32 PM ion and interview, the tration through the Lorridor by a 1 1/2 incomposed this ervation and interview. TY CODE STANDA installed with system is for the purpose in a 70, National Electrical Fire Alarm Code to any offire in any parestem wiring or other monitored for integration and interview of the parester wiring or other monitored for integration in the parester wiring or other monitored in the parester wiring or detection system is by manual alarm system than alarm some and visual alarm some and visual alarm automatically of functions. System of functions. System of functions. | , it was here is aundry hew. IRD ms and ic Code of the rrity. Inth of the rrity. Ith of the rrity. Ith of the rrity. Ith of the rrity. Ith of the rrity. | K 029 | The fire alarm panel power supply breaker is now indicated at the main fire alarm panel power supply breaker has had a lock installed. The Maintenance Director or designee will examine all alarm panels to assure they are indicated on the main fire alarm panel and that any other panel power supply breakers also have a lock installed. The Maintenance Director will audit all fire alarm panels weekly for six weeks to assure they are in compliance. The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting. Completion Date: 4/8/16 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES Printed: 04/12/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED 495166 B. WING NAME OF PROVIDER OR SUPPLIER 04/07/2016 STREET ADDRESS, CITY, STATE, ZIP CODE STRATFORD HEALTHCARE CENTER 508 RISON STREET DANVILLE, VA 24541 (X4) ID PRÉFIX **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PROVIDER'S PLAN OF CORRECTION (EACH PREFIX CORRECTIVE ACTION SHOULD BE CROSS-TAG OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DAT REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) K 051 Continued From page 3 K 051 18.3.4, 19.3.4, 9.6 K062 This Standard is not met as evidenced by: The sprinkler at the central Surveyor: 21761 Based on observation, it was revealed through nursing station has be cleaned observation and interview that the facility falled to and is dust free. The sprinkler maintain the fire alarm system. in the walk in cooler will be Survey findings include: replaced. 1. On 04/07/16, at approximately 11:50 AM, it The Maintenance Director or was revealed by observation and interview, the designee will examine all fire alarm panel power supply breaker location is sprinkler heads in the facility not indicated at the main fire alarm panel. to assure they are dust free 2. On 04/07/16, at approximately 11:55 AM, it was revealed by observation and interview, the and not corroded. fire alarm panel power supply breaker does not The Maintenance Director or have a breaker lock. designee will examine all The Engineering Director witnessed this sprinkler heads in the facility evidence through observation and interview. weekly for six weeks to assure K 062 NFPA 101 LIFE SAFETY CODE STANDARD they are dust free and not K 062 SS≒F corroded. Required automatic sprinkler systems are continuously maintained in reliable operating The results of the audits will condition and are inspected and tested be reviewed at the monthly periodically. 19.7.6, 4.6.12, NFPA 13, NFPA

Survey findings include:

25, 9.7.5

Surveyor: 21761

This Standard is not met as evidenced by:

Based on observation, it was revealed through observation and interview that the facility failed to

maintain the sprinkler system. This violation

1. On 04/07/16, at approximately 11:53 AM, it was revealed by observation and interview, there

affected 3 of 3 smoke compartments.

Quality Assurance Committee

Facility is requesting stime

limited waiver request for this

deficiency. The issue is availability of the sprinkler

head in the walk in cooler.

Completion Date: 7/9/16 7/16/16

meeting.

| <u> </u> | DEPAI | RTMENT OF HEALTH ERS FOR MEDICARE | AND HUMAN SER & MEDICAID SER | VICES VICES | | | FO | ed: 04/12/2016 RM APPROVED |
|---------------|--|---|--|---|--|--|--|--|
| | | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER (DENTIFICATION NUM | | R/CLIA (X2) MULTIPLE CONSTRUCTION ABER: A. BUILDING 01 - MAIN BUILDING 01 | | TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED | |
| enineri//owen | a parternamento de la composição de la c | | 495168 | 66 B. WINC | | | 04/07/2016 | |
| | | PROVIDER OR SUPPLIER | | STREET ADI | DRESS, CITY, | STATE, ZIP CODE | V-13 | OTTEN TO |
| 31 | KAII | FORD HEALTHCARE | | DANVI | SON STRE | | | *************************************** |
| PA | (4) ID LEFIX 'AG | OR LSC IDEA | NTIFYING INFORMATION) | SEGULATORY | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE (REFERENCED TO THE APPROPR DEFICIENCY) | 20000 | (X8) COMPLETION DATE |
| } | < 082 | Continued From pag are two corroded spi | ge 4 rinklers in the kitche | n pontru | K 062 | | | |
| | | 2. On 04/07/16, at a was revealed by obs | pproximately 12:04 ervation and intervie | PM, It | TV/mm->-tulleton | K147 The extension cords in the | | The state of the s |
| | | is a dust laden sprinkler in the Central Nurse Station area. | | | | Physical Therapy Room and Beauty shop (Director of | ! : | |
| | | On 04/07/16, at ap was revealed by obsets is a corroded sprinkle cooler. | W there | Variation and Administration | Nursing Office) have been removed. | The state of the s | | |
| | ļ. | Cooler. The Engineering Directividence through observed. | ctor witnessed this | star | C (MINISTER) | The Maintenance Director or designee will review all room in the facility to assure no | | |
| K 1 | | NFPA 101 LIFE SAFE | | ₹D K 147 | K 147 | extension cords are being | With the second | |
| 50 | E a | Electrical wiring and ecocordance with Nation NFPA 99) 18.9.1, 19.9 | nal Electrical Code. | | elemental interver a major . | used. If they are present they will be removed. | F | |
| | T | his Standard Is not m urveyor: 21761 | tandard is not met as evidenced by: | | | The Maintenance Director or designee will review all rooms | 5 | 1 |
| | ODSG | ased on observation, i servation and intervie operly use electrical e | W that the facility fe | ugh illed to | THE C. C. COMMANDER C. C. C. C. C. C. C. C. C. C. C | in the facility weekly for six weeks to assure no extension cords are being used. | | |
| | Su | Survey findings include: 1. On 04/07/16, at approximately 11:40 AM, it was revealed by observation and interview, an extension cord is being used as permanent wiring in Physical Therapy. | | | Officers - management of | The results of the audits will be reviewed at the monthly | ************************************** | |
| | ext | | | | | Quality Assurance Committee meeting. | TO AMERICA, or a major m | |
| | 2. was exte | On 04/07/16, at appro revealed by observa ension cord is being u ing in the Beauty Shop | iximately 12:20 PM, tion and interview, a sed as permanent | it an | ************************************** | Completion date: 4/8/16 | | |
| | The evid | Engineering Director ence through observe | witnessed this ation and interview. | | Marie Communication of the Com | | - Company of Control o | |