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

PRINTED: 08/02/2018 **FORM APPROVED** OMR NO 0938-03

A. BUILDIN		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495359	B. WING		07/26/2018	
	PROVIDER OR SUPPLIER	NGE COUNTY HEALTH AND RE	HAB 1	BTREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE DRANGE, VA 22960	0772072010	-34_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC	אם
E 000	Initial Comments		E 000			
F 000	survey was conduct 07/26/18. The facil compliance with 42 Requirement for Loi INITIAL COMMENT An unannounced M survey was conduct Corrections are requCFR Part 483 Feder	ng-Term Care Facilities. S edicare/Medicaid standard ed 7/24/18 through 7/26/18. uired for compliance with 42 eal Long Term Care	F 000			
F 550 SS=D	was 145 at the time sample consisted of reviews (Residents 42, 27, 37, 39, 6, 116, 89, 62, 106, 123, 81, 112, 438, 86, 136, ar record reviews (Resident Rights/Exe CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a riself-determination, a access to persons aroutside the facility, in this section. §483.10(a)(1) A facili with respect and digresident in a manner promotes maintenancher quality of life, rec	flow. 64 bed certified bed facility of the survey. The survey 37 current Resident record \$5, 38, 119, 87, 74, 33, 69, 6, 28, 17, 95, 129, 47, 44, 88, 4, 1, 63, 60, 121, 83, 437, and 75) and three closed dents #137, 139, and 138). rcise of Rights \$(2)(b)(1)(2)	F 550	1. The facility has established corrective action plan for reside #33, #28, #74, for not serving food a manner to promote dignity dining areas to include: serving at same table/time, and for disposing of spilled food in a dignit manner. Alli 2000	ents d in in the not ied	

Executive

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

PRINTED: 08/02/2018

FORM APPROVED **VDH** STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ____ VA0180 B WING 07/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DOGWOOD VILLAGE OF ORANGE COUNTY HEALT 120 DOGWOOD LANE ORANGE, VA 22960 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 000 **Initial Comments** F 000 An unannounced biennial State Licensure Inspection was conducted 7/24/18 through 7/26/18. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 164 bed certified bed facility was 145 at the time of the survey. The survey sample consisted of 37 current Resident record reviews (Residents #5, 38, 119, 87, 74, 33, 69, 42) 27, 37, 39, 6, 116, 28, 17, 95, 129, 47, 44, 88, 89, 62, 106, 123, 81, 4, 1, 63, 60, 121, 83, 437, 112, 438, 86, 136, and 75) and three closed record reviews (Residents #137, 139, and 138). F 001 | Non Compliance F 001 1.The facility has established a corrective action for failing to obtain The facility was out of compliance with the license verification prior to the following state licensure requirements: employees' employment. This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and procedures. 2. The employees of the facility have Based on staff interview, employee record review the potential to be affected. and facility document review, it was determined that the facility staff failed to obtain a license 3. Human Resources will be educated verification prior to employment for one of 25 on 8/9/18 to ensure that the employee record reviews. employees requiring licensure, have The facility staff failed to obtain OSM (other staff proof of licensure upon hire. member) #3's license verification prior to the employee's employment. 4. To ensure compliance, audits will be conducted by human resources The findings include: (or Designee) every week x 4 weeks, OSM #3 (a speech language pathologist) was then monthly x 3 to ensure the hired for employment on 11/9/16. Review of OSM employees of the facility who require #3's employee record failed to reveal a license licensure have

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

verification for the time period around 11/9/16.

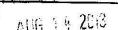
The record contained a license verification dated

TITLE

forwarded to QAPI for review.

(X6) DATE

9/4/18



employment. This information will be

proof prior

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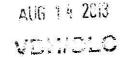
VDH STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ VA0180 B. WING 07/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DOGWOOD VILLAGE OF ORANGE COUNTY HEALT 120 DOGWOOD LANE ORANGE, VA 22960 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 001 Continued From Page 1 F 001 3/2/17 and a license verification dated 12/27/17. On 7/25/18 at 11:49 a.m., an interview was conducted with OSM #1 (the director of employee; relations). OSM #1 reviewed OSM #3's record and confirmed the above findings. OSM #1 was asked the facility process for obtaining license verifications. OSM #1 stated she completes licensed verifications when she is in the process of pre-employment testing along with background | checks and drug tests. When asked why, OSM #1 stated, "To make sure they are licensed and if there is anything against their license." On 7/25/18 at 6:06 p.m., ASM (administrative staff) member) #1 (the executive director) was made aware of the above findings. The facility policy titled, "Abuse Prevention" documented, "1. Screening...C.i. State licensure and certification agencies, and applicable registries, will be contacted, prior to hire, to validate current licensure or certification requirements and to determine if the potential employee is in good standing with the registry..." No further information was presented prior to exit. 12VAC5-371-340. Dietary and Food Service Program cross reference to F814 12 VAC5-371-200 B.1. Director of Nursing: Resident Services cross references to F658. 12 VAC5-371-220.B Nursing Services cross references to F695. 12VAC5-371-150. Resident Rights cross references to F550.

STATE FORM

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If continuation sheet 2 of 3



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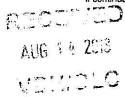
VDH (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING _ B. WING 07/26/2018 **VA0180** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 DOGWOOD LANE DOGWOOD VILLAGE OF ORANGE COUNTY HEALT ORANGE, VA 22960 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG **DEFICIENCY**) F 001 Continued From Page 2 F 001 12VAC5-371-250. Resident Assessment and Care Planning cross references to F656. 12VAC5-371-220. Nursing Services cross references to F693. 12VAC5-371-180. Infection Control cross references to F880. 12VAC5-371-300. Pharmaceutical services cross references to F761.

STATE FORM

02119

KV1511

If continuation sheet 3 of 3



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

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	ATE SURVEY OMPLETED
		495359	B. WING	B. WING		7/26/2018
- 10002 AV A3005 W	PROVIDER OR SUPPLIER OOD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CO 120 DOGWOOD LANE ORANGE, VA 22960		120/20 16
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	[PANT] [] [[[[[[[[[[[[[[[[[SHOULD BE	(X5) COMPLETION DATE
	§483.10(a)(2) The fraccess to quality caseverity of condition must establish and practices regarding provision of services residents regardless §483.10(b) Exercise The resident has the rights as a resident or resident of the Urresident can exercise interference, coercing from the facility. §483.10(b)(1) The fracesident can exercise interference, coercing from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility. Serve food in a manual dignity for three of 40 sample, Resident #33 in a manner to passed to a manual field of the facility staff fracesident fracesident #33 in a manner to passed on a manual fracesident #33 in a manner to pas	cility must protect and of the resident. facility must provide equal are regardless of diagnosis, and or payment source. A facility maintain identical policies and transfer, discharge, and the sounder the State plan for all so of payment source. For Rights, are right to exercise his or her of the facility and as a citizen inted States. Facility must ensure that the se his or her rights without on, discrimination, or reprisal esident has the right to be coercion, discrimination, and sility in exercising his or her ported by the facility in the er rights as required under this er rights	F 5	2. The residents of the factorial have meals in dining areas potential to be affected. 3. Facility Nursing staff we ducated on 8/9/18 on serin a manner to promote dining areas. This included at the same table/time disposing of spilled food in a manner. 4. To ensure compliance a be conducted by Administration (or designee) every week x then monthly x 3 on serving manner to promote dignity areas, including, serving at table/ time and for disposited food in a dignified This information will be forw QAPI for review. 12VAC5-371-150 cross refere F550.	have the rill be reving food dignity in d: serving and for a dignified didnits will ative staff 4 weeks, food in a in dining the same posing of manner.	9/4/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 08/02/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES			2000000				M APPROVEL D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 00 0000		CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495359	B. WING _			n:	7/26/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		, I LOI LO TO
DOGWO	OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	НАВ		DOGWOOD LANE ANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	: : :	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 550	Continued From pa	Windows and the second	F 55	60			
		oom without his meal for ninutes, while his tablemate meal.		e e			
и		failed to dispose of spilled food er for Resident #28.					
	dining experience for #74 was seated at a in the South Ground	failed to provide a dignified or Resident #74. Resident a table with another resident, d (SG) social dining area, but tray until 15 minutes after her and ate his meal.	9	8			
	The findings include	e:					
	8/26/15 and readmidiagnoses that incluacute kidney injury, cognitive impairmer recent MDS (minima quarterly assessment refere Resident #33 was compairment scoring	s admitted to the facility on ted on 3/15/18 with uded but were not limited to type two diabetes, and mild not. Resident #33"s most um data set) assessment was ment with an ARD note date) of 5/15/18. Toded as having cognitive 05 out of possible 15 on the w for mental status) exam.		Ti di	,		
	dining room was co Resident #33 was s resident. At 12:10 p his entree (grilled cl p.m., the tablemate	a.m., observation of the main nducted. At 11:40 a.m., litting at a table with another .m., the tablemate was served neese and soup). At 12:20 had finished his meal and dessert. At this time. Resident		v			

#33 still had not received his entree. At 12:30 p.m., Resident #33 received his entree.

On 7/26/18 at 10:52 a.m., an interview was

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON THE PROPERTY OF THE PROPERT	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
	- <u> </u>	495359	B. WING	- 	07/26/2018		
AN THE PROPERTY.	PROVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, Z 120 DOGWOOD LANE ORANGE, VA 22960			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE		
F 550	conducted with OSI When asked about dining room, OSM a comes into the dining order that is picked brought to the stear meals were served residents sitting at the same time, OSM #6 were sitting at the stime, their orders should be same time, of the stime of the same time of the same ti	ge 3 M (other staff member) #6. the dining process in the main #6 stated when each resident ag room, fills out a ticket/meal up by the dietary staff and m table. OSM #6 stated by order. When asked if two he same table around the e served their meal at the stated that if the residents ame table around the same table around the same table around the same hould have been taken at that the steam table. OSM #6	F 5	50			

On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

asked to which residents this writer was referring. OSM #6 stated the resident sitting with Resident #33 usually comes into the dining room at 11:30 a.m., and his order was probably taken first. When OSM #6 was informed that both residents were sitting at the table at 11:40 a.m., OSM #6 stated she understood what this writer was saying but she had no control over the ticket system. When asked how she would feel if she were at a restaurant and received her meal 20 minutes after everyone else, OSM # 6 stated she wouldn't be happy if she had ordered at the same time as

The facility policy titled, "The dining experience: Staff Responsibilities," documents in part, the following: "Individuals at the same table will be served and assisted at the same time."

No further information was presented prior to exit. 2. The facility staff failed to dispose of spilled food

everyone else.

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CO	(X3) DATE SURVEY COMPLETED			
	68	495359	B. WING			07	//26/2018
NAME OF PROVIDER OF		ANGE COUNTY HEALTH AND REI	НАВ	120 D	ET ADDRESS, CITY, STATE, ZIP CODE OGWOOD LANE NGE, VA 22960	1 0:	720/2010
PREFIX (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 550 Continued	d From pa	ige 4	F 5	550			23. 24.
÷	7/2/1	er for Resident #28.					in in
12/19/14 v not limited	with diagn d to: legal	admitted to the facility on noses that included but were blindness, Alzheimer's I pressure and depression.		* (See all all all all all all all all all a			9
The most	recent M	DS (minimum data set), a	Į.	85			77
quarterly a	assessme	ent, with an ARD (assessment	g 82				
		7/25/18 coded the resident as					
		of 15 on the BIMS (brief status indicating the resident		29			
was sever	ely impair	red cognitively. The resident		26			
was coded	d as requi	iring assistance for all					
activities o	of daily livi	ng.					
An observ	ation was	made on 7/24/18 at 12:36					
p.m. of Re	esident #2	8 and CNA (certified nursing					
		#7 scooped broccoli in a					37
Fall to a control of the control of		esident. The resident began ces of broccoli fell onto the		20	5		
		protector. CNA #7 scooped the					
		ning protector and put it back		2			
into the res	sident's ci	up while the resident					
continued	to eat out	t of the cup.					
Review of	the residu	ent's care plan initiated on					8
		ed on 5/13/18 documented,					100
"Problem/l	Need. (Na	ame of resident) HAS		2			-01 -02
		TUS LIMITATION		10 15			**
		ST WITH ADL'S (activities of		25			
		ated to) WEAKNESS, GAIT DOR VISION, COGNITIVE					
		paches. ASSIST WITH TRAY		si			
		G AS NEEDED. FOOD TO BE		760			
PLACED II	N CUPS F	FOR EASIER HANDLING					
FOR INDE	PENDEN	IT MEAL INTAKE."					<i>II</i>
An intervie	w was co	enducted on 7/25/18 at 2:33					î e

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/02/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
- N	495359	B. WING	45-200	07/26/2018
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	HAR	STREET ADDRESS, CITY, STATE, ZIP 120 DOGWOOD LANE ORANGE, VA 22960	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE COMPLETION IE APPROPRIATE DATE
resident spills food stated, "I would thin wipe it off." When the shared, CNA #7 stated about that, that's a leasked if that promot #7 stated, "No that was cop.m. with RN (regist manager. When ask resident dropped for stated, "If they can't change their shirt." Wobservation with Re "That's terrible." On 7/25/18 at 6:10 pmember) #1, the exterior of nursing a director of nursing we findings. Review of the facility documented, "Policy care for residents in environment that may resident's dignity and his or her individuali out the following act resident to maintain self-esteem and self practices demeaning. No further informatic 3. The facility staff for the state of the facility staff for the state of the facility staff for th	When asked what staff do if a conto their clothing, CNA #7 k you would get a tissue and the above observation was sted, "I guess I wasn't thinking ittle embarrassing." When sted the resident's dignity, CNA wasn't good." Inducted on 7/25/18 at 3:46 ered nurse) #3, the unit sted what staff should do if a cod on their clothing, RN #3 wipe it off they should offer to When informed of the above sident #28, RN #3 stated, I.M. ASM (administrative staff ecutive director, ASM #2, the and ASM #4, the assistant were made aware of the It's policy titled, "Dignity" It's policy titled, "Dignity" Ithe facility will promote a manner and in an anintains or enhances each direspect in full recognition of ty. Procedure: Staff will carry ivities that assist there and enhance his/her f-worth. 12. Refraining from	F 550		

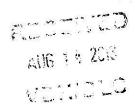
FORM CMS-2567(02-99) Previous Versions Obsolete

#74 was seated at a table with another resident,

Event ID: 093G11

Facility ID: VA0180

If continuation sheet Page 6 of 129



DEDARTMENT OF HEALTH AND HUMAN CERVICES

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		AND HUMAN SERVICES				FOR	RM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10000 00		CONSTRUCTION	(X3) C	OATE SURVEY OMPLETED
		495359	B. WING	·		(7/26/2018
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP		772072010
DOGWO	OD VILLAGE OF OR	ANGE COUNTY HEALTH AND RE	НАВ		DOGWOOD LANE ANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 550	Continued From pa	nge 6	F:	550	-	V6	
		d (SG) social dining area, but		000			
	was not served her tablemate received	tray until 15 minutes after her					
	Resident #74 was a	admitted to the facility on					
ā	9/5/14, with diagnor limited to: dementia	ses that included but were not a, depression, chronic pain e, arthritis, and muscle					
	assessment, a qua	DS (minimum data set) rterly assessment, with an					
		reference date) of 6/15/18, 4 as having both short and					
	long term memory i	mpairment, as well as		×			2
		ent of daily decision making. coded as requiring extensive					
		erson physical assistance for					
		ers, walking, dressing, toileting ne. She was coded as					
		sistance of one person					
	physical assistance	for locomotion and eating.					
		p.m. an observation of the social room dining area was					
		time, Resident #74 was sitting other resident, in the sunroom g area.	8				
.3		p.m., Resident #74's ed his tray and he began					
-	On 7/24/18 at 12:30	p.m., Resident #74's tray					

meal.

was placed in front of her and a CNA (certified nursing assistant) uncovered Resident #74's food containers. It was observed at this time that Resident #74's tablemate had completed his

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

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495359 B. WING			07/26/2018	
- CONTROL OF THE CONT		NGE COUNTY HEALTH AND RE	HAB 1	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE DRANGE, VA 22960	0172012	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COM	(X5) MPLETION DATE
F 550	On 7/25/18 at 2:44 conducted with CN/the process for serv	p.m., an interview was A #4. When asked to describe ring tables at mealtime, CNA e each person at each table at	F 550			
	observation of Residue 15 minutes after her that was unusual an needed assistance. "she should have be as the other person acknowledged she paserved 15 minutes as	dent #74 receiving her meal rablemate, CNA #4 stated at "maybe the resident". At that time, CNA #4 stated, een served at the same time at the table." CNA #4 personally would not like to be after everyone else at a table.			00 M M	
i i	date of 6/23/18, doc needed with eating." ASM (administrative executive director, A nursing, and ASM #4	staff member) #1, the SM #2, the director of the assistant director of aware of the above concerns				
	Experience", docum Individuals at the sai assisted at the same No further information Safe/Clean/Comforts CFR(s): 483.10(i)(1) §483.10(i) Safe Envi The resident has a ri	me table will be served and time." on was provided prior to exit. able/Homelike Environment (7)	F 584	corrective action plan for resid #74 for not having a dir	ent ing like	

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

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495359	B. WING_	<u> </u>	0:	07/26/2018	
DOGWO		ANGE COUNTY HEALTH AND RE		STREET ADDRESS, CITY, STATE, ZIP 120 DOGWOOD LANE ORANGE, VA 22960	CODE		
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	The facility must pr §483.10(i)(1) A safe homelike environmuse his or her persopossible. (i) This includes enceive care and sephysical layout of thindependence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) House services necessary and comfortable into §483.10(i)(3) Clean in good condition; §483.10(i)(4) Private resident room, as sp §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfolevels. Facilities initi 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMEN by:	ceiving treatment and ving safely. ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the refacility maximizes resident does not pose a safety risk. exercise reasonable care for e resident's property from loss exeeping and maintenance to maintain a sanitary, orderly,	F 58	2. The residents of the eat in dining areas have to be affected. 3. Facility Nursing staff educated on 8/9/18 or dining experience in a environment related to trays. 4. To ensure compliance, be conducted by Administ (or designee) every week then monthly x 3, to ensure having a dining experience like environment related on trays. Information forwarded to QAPI for revi	will be renaming a home like serving on audits will tration staff x 4 weeks, re residents in a home to serving will be	9/4/18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTER	FORM APPROVE OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584 Continued From page 9

document review, it was determined that the facility staff failed to provide a homelike dining experience for five of seven dining areas and one of 40 residents in the survey sample, Resident #74.

- 1. The facility staff failed to provide a homelike dining experience for residents in the west ground dining area during lunch on 7/24/18 and breakfast on 7/25/18. The residents were served meal plates on serving trays.
- 2. Resident #74, who was seated in the south ground social dining area, was served her meal on a tray, cafeteria/institutional style and her meal was not removed from the tray for a restaurant/home-like dining experience.
- 3. The facility staff failed to provide a homelike dining experience during lunch for residents in the facility's South Main Dining Room.
- 4. The facility staff failed to provide a homelike dining experience in the East Main dining room.
- 5. The facility staff failed to serve residents in a homelike manner in the West main dining room.

The findings include:

1. The facility staff failed to provide a homelike dining experience for residents in the west ground dining area during lunch on 7/24/18 and breakfast on 7/25/18. The residents were served meal plates on serving trays.

On 7/24/18 at 12:05 p.m. and 7/25/18 at 8:00 a.m., observations of staff serving residents

F 584

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

Event ID: O93G11

Facility ID: VA0180

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

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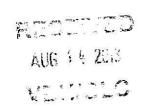
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		round dining area were		04			
	conducted. The sta	aff served residents their meal		10			
		ays and did not remove the					
	trays while the resid	lents ate their meals. The					
	meals were served	on trays to residents who fed	102	\$1			
	themselves and res	idents who required		50			
	assistance with feet	ding. The residents were not					
	cognitively intact.	¥		100			
19	On 7/25/18 at 1:41	p.m., an interview was					
	conducted with CNA	(certified nursing assistant)	1	552			
	#1. CNA #1 was as	ked why the residents were	Œ				
	served meal plates	on trays and why the trays	18				
		CNA #1 stated she really did					
		answer and that was how she					
		always provided meal service.					ľ
21	closslipped When	be that method provided more					15
2	on trave was homeli	asked if serving meal plates ke, CNA #1 stated, "No."		3			
	on days was nomen	ke, CNA#1 Stated, No.					
1	On 7/25/18 at 2:00 g	o.m., CNA#1 came to this		10			a a
	surveyor and stated	she had an answer for the					a a
	above question. CN	IA #1 stated the supervisors					3
		d providing meal plates on	20				
8		residents to get what they	20				
22		like utensils and condiments,					
16	When asked how so	ve the tray if residents asked.		80			
		sidents, CNA #1 stated she		Ē			*
		of the colors made it easier		10			
		and the tray was kind of like a					
	placemat.	en senninger komere 🕬 provinceser filtbiographismen i 6000					
92	A 70545			El.			v:
26	On //25/18 at 3:02 p	.m., an interview was		į			8
	conducted with RN (registered nurse) #1. RN #1		1			
	was askeu why resid	lents were served meal #1 stated, "I would say it		26 26			
83 92	probably helps them	with boundaries that way					
ĭ	(for) example a dem	ented resident, it sets a					10 E





Facility ID: VA0180

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This includes but is not in attractive, functional, like dining environment of that is roomy, cor, contrasting colors," as presented prior to exit is seated in the South g area, was served her institutional style and her	f .				
FE - Zei - Sieseseven enn Teach eile	A95359 COUNTY HEALTH AND RESTRICT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) Stuff begins and ends ins." When asked if assessed to determine if ays was beneficial for really can't answer that. It is sessment available at an asked if serving meal plates on trays me eating in a dining ing meal plates on trays ne eating in a dining ind be." ASM (administrative ecutive director) and sursing) were made ags. The Dining Experience: cumented, "2. Staff at will help to make at individual k forward to and that will This includes but is not a attractive, functional, ke dining environment that is roomy, cor, contrasting colors," Is presented prior to exit as seated in the South garea, was served her	COUNTY HEALTH AND REHAB TOF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) F 584 Stuff begins and ends ins." When asked if assessed to determine if asys was beneficial for ally can't answer that. I assessment available at a asked if serving meal elike, RN #1 stated, "I where I was watching ring meal plates on trays ne eating in a dining lid be." ASM (administrative ecutive director) and bursing) were made at individual k forward to and that will This includes but is not a attractive, functional, ke dining environment hat is roomy, cor, contrasting colors," Is presented prior to exit. Is seated in the South garea, was served her institutional style and her om the tray for a	A95359 A95359 B. WING STREET ADDRESS. CITY, STATE, ZIP 120 DOGWOOD LANE ORANGE, VA 22960 IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) TAG STATE TADDRESS. CITY, STATE, ZIP 120 DOGWOOD LANE ORANGE, VA 22960 IT OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) F 584 Stuff begins and ends ins." When asked if assessed to determine if anys was beneficial for ally can't answer that. I ssessment available at a sked if serving meal elike, RN #1 stated, "I where I was watching ing meal plates on trays ne eating in a dining lid be." ASM (administrative ecutive director) and jurising) were made gs. The Dining Experience: cumented, "2. Staff at will help to make at individual ke dining environment in attractive, functional, ke dining environment in attractive, functional, ke dining environment in the tray for a seated in the South garea, was served her institutional style and her out the tray for a	PROVIDERS LEPROLLA DENTIFICATION NUMBER: 495359 B. WING COUNTY HEALTH AND REHAB COUNTY STREET ADDRESS. CITY. STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960 PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 584 In asked if serving meal Bilke, RN #1 stated, "I Where I was watching ing meal plates on trays ne eating in a dining Ind be." ASM (administrative ecutive director) and cursing) were made logs. The Dining Experience: cumented, "2. Staff at will help to make at individual K forward to and that will This includes but is not nattractive, functional, ke dining environment) that is roomy, cor, contrasting colors, "" Is presented prior to exit. Is seated in the South garea, was served her notiful time to the state of the serving tray in the tray for a	

Resident #74 was admitted to the facility on

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limited to: dementia high blood pressure weakness.	ses that included but were not a, depression, chronic pain e, arthritis, and muscle	F 5≀	34		,	
assessment, a qua ARD (assessment coded Resident #74 long term memory is moderate impairmed Resident #74 was of assistance of one p bed mobility, transferand personal hygien requiring limited ass	DS (minimum data set) rterly assessment, with an reference date) of 6/15/18, 4 as having both short and mpairment, as well as ent of daily decision making, coded as requiring extensive erson physical assistance for ers, walking, dressing, toileting he. She was coded as sistance of one person for locomotion and eating.	1	M. 1.1			
South Ground (SG) performed. At that	p.m. an observation of the social room dining area was time, Resident #74 was sitting other resident, in the sunroom g area.		ø		***************************************	
distribute the food to trays were set down removed but the pla	p.m., the staff began to rays to each table. Once the i, the cover to the entrée was ite, cups silverware, and ed on each resident's tray.		31		9	
was placed in front of Resident #74's food on the cafeteria-like An interview was concurred nursing assistant) #	p.m., Resident #74's tray of her and a CNA uncovered containers and left the meal serving tray. nducted with CNA (certified 3 on 7/25/18 at 2:41 p.m. e food remained on the		50			

cafeteria-like trays when placed in front of the

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residents, CNA #3 stated that as long as she has worked there, staff have always served the meal on the tray. When asked why, CNA #3 stated, "I do not specifically know why" but "that is how they [the staff] have done it as long as I have worked here". When asked if this is a home-like way to serve a meal, CNA #3 stated it was not.

An interview was conducted with CNA #4 on 7/25/18 at 2:44 p.m. When asked why the meals were left on the cafeteria-like serving trays, CNA #4 stated it was "The facility's policy and it sets boundaries for each resident's meal area." When asked if serving residents on cafeteria-like trays provided a home-like environment, CNA #4 stated "No."

An interview was conducted with RN (registered nurse) #1 on 7/25/18 at 2:58 p.m. RN #1 was asked why the resident's meals remained on cafeteria-like trays after being served to the residents. RN #1 stated that it "Helps set boundaries for where their [the residents] stuff begins and ends." When asked if residents are assessed to determine if leaving the meals on the cafeteria-like trays helps to maintain eating independence, RN #1 stated she was "Unsure". When asked if she felt leaving the meal on the cafeteria-like tray provided a home-like eating experience, RN #1 stated, "It could be considered homelike." When asked if there was a policy regarding leaving resident's meals on the cafeteria-like trays, RN #1 stated she would have to check.

A review of Resident #74's comprehensive care plan, dated 9/5/14 with a most recent revision date of 6/23/18, documented in part "Assist as needed with eating."

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

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15 100000	executive director, A nursing, and ASM #	e staff member) #1, the ASM #2, the director of #4, the assistant director of e aware of the above concerns p.m.		28 48 50 50			я •
200	Experience: Staff Repart that "2.b. Staff will help to make dir individual patients/reThis includes but it	lity's policy "The Dining Responsibilities" documented in should provide service that ning a special "event" that residents will look forward to is not limited to: Providing an al, home-like or restaurant-like."	i i	100 H			
St Trans-	No further information	on was provided prior to exit.		3			447
	The facility staff f dining experience do facility's South Main	failed to provide a homelike furing lunch for residents in the n Dining Room.		65 85			
	conducted in the So lunch was being sen six residents were p tables in the social a	35, an observation was buth Main social area when rved. Observations revealed bresent and seated at three area. The resident's lunch all six residents on cafeteria		¥0 20			
i i i i (interview was condu nursing assistant) # home like environme CNA # 3 stated, "No centerpiece, the tabl	roximately 1:51 p.m., an ucted with CNA (certified 3. When asked to describe a ent for residents during meals a television, table clothes, le set with plate and utensils."					e

the residents on 07/24/18, CNA # 3 stated, "Yes." When asked if serving a meal on a tray portrays a



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F 584	"No. This is their his them feel comfortal the trays." On 07/25/18 at appinterview was conditured as home likeduring meals, RN # which dining room to lids and open contastiting with the residusit with others they leasked if serving a rehomelike, RN # 3 st. On 07/25/18 at appination of the finding was end for the finding. No further information. The facility staff of dining experience in the contral of the East Main dininglunch meal on trays.	ent for dining, CNA # 3 stated, ome and we want to make one. I was never told to remove roximately 1:58 p.m., an acted with RN (registered nager. When asked to e environment for residents 3 stated, "Give a choice of o eat at, the staff take off the iners, eating what they prefer, lents, having them (residents) know. if they want." When esident's meal on a tray was tated, "Probably not." roximately 6:00 p.m., ASM member) # 1, the executive 2, director of nursing, and director of nursing were made s. on was provided prior to exit. failed to provide a homelike the East Main dining room. I p.m., six residents present in groom were served their cafeteria/institutional style. s were not removed from the	F 5	584			

On 7/25/18 at 2:13 p.m., CNA #11 (Certified Nursing Assistant) was asked why the residents were served their meals on the trays. CNA #11 stated, "I have been here over a year and that is



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the way I was taught to do that. We always leave the food on the trays. I don't know why. In other facilities I have worked we normally take everything off the tray." When asked if this was homelike, CNA #11 stated, "No. I was taught ever since I got here to serve it on the tray. Even when I was going through orientation, they never said to take the plates off the tray. It is not a homelike dining experience. At other facilities, we were instructed to remove the trays, but not here. It's just more proper. I'm not sure why they didn't instruct us to do that here. I have wondered but we have not had any complaints from the patients."

On 7/25/18 at approximately 6:00 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to serve residents in a homelike manner in the West main dining room.

A dining observation was conducted on 7/24/18 at 12:20 p.m. in the West main dining room. There were four residents seated at each of the two tables. All of the residents were served their lunch on trays.

An interview was conducted on 7/25/18 at 2:15 p.m. with RN (registered nurse) #7. When asked why the residents ate their meals on trays in the dining room, RN #7 stated, "I don't know." When asked if she ate her meals on a tray on the table at home, RN #7 stated, "No. It's my home." When asked what the facility was to the residents, RN #7 stated, "It's their home."

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F 584 Continued From page 17

An interview was conducted on 7/25/18 at 2:24 p.m. with CNA (certified nursing assistant) #17. When asked why the residents were served their meals on trays, CNA #17 stated, "Because it comes up like that. However, we should probably ask if they would like it off the tray." When asked if eating off a tray was homelike, CNA #17 stated, "No."

An interview was conducted on 7/25/18 at 2:30 p.m. with CNA #18. When asked why the residents were served their meals on trays, CNA #18 stated, "I'm not sure." When asked if it was homelike, CNA #18 stated, "No."

On 7/25/18 at 6:10 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the director of nursing and ASM #4, the assistant director of nursing were made aware of the findings.

Review of the facility's policy titled, "The Dining Experience: Staff Responsibilities" documented, "Policy: The dining experience will enhance each individual's quality of life through person centered dining: providing nourishing, palatable, and attractive meals that meet the individual's daily nutritional needs and food and beverage preferences. Procedure: 2. Staff should provide service that will help to make dining a special "event" that individual patients/residents will look forward to and that will create lasting memories. This includes but is not limited to: b. Providing an attractive, functional, home-like or restaurant-like dining environment (depending on the facility) that is roomy, comfortable with nice décor, contrasting colors and appropriate furniture."

No further information was provided prior to exit.

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remain in the facility discharge the reside (A) The transfer or or resident's welfare at cannot be met in the (B) The transfer or obecause the resider sufficiently so the reservices provided by (C) The safety of indendangered due to status of the resider (D) The health of indotherwise be endang (E) The resident has appropriate notice, the under Medicare or Monpayment applies submit the necessar payment or after the Medicare or Medicair resident refuses to president who become admission to a facility resident only allowate or (F) The facility may not resident while the application of this charge notice from 431.220(a)(3) of this	r and discharge- ty requirements- permit each resident to r, and not transfer or ent from the facility unless- discharge is necessary for the nd the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the ty the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would gered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. If the resident does not ty paperwork for third party third party, including id, denies the claim and the pay for his or her stay. For a tes eligible for Medicaid after ty, the facility may charge a tole charges under Medicaid;	F 6	corrective action plan for #17, #123, #60, #119, #47 for not providing evider required information physician contact is resident representative information, special instrongoing care, advance direcomprehensive care plan transfers to hospital. 2. The residents of the freceive transfer to the hospital. 2. The residents of the freceive transfer to the hospital to be affected. 3. Facility licensed Nurses educated on 8/9/18 to eather required information physician contact in resident representative information, special instrongoing care, advance direcomprehensive care plan provided upon transfers to 4. To ensure compliance, be conducted by Director (or Designee) every week then monthly x 3 to ensure quired information	or residents 7, and #137 nce of the (including information, e contact ructions for rectives and goals) upon facility who ospital have d. will be re- ensure that in (including information, e contact inctions for ectives and in goals) is is hospital. audits will of Nursing ix 4 weeks, ive that the (including information, contact contact including information, contact including information, contact

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

PRINTED: 08/02/2018 FORM APPROVED

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NAME OF	PROVIDER OR SUPPLIER	493339	D. WING	15 (00074)		07	7/26/2018
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	facility. The facility that failure to transfe §483.15(c)(2) Document the facility transfer that failure to transfer §483.15(c)(2) Document the facility resident under any configuration in paragraphs (c)(1) section, the facility more discharge is documedical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility attemneeds, and the servifacility to meet the net (ii) The documentation (2)(i) of this section recessary under parthis section. (iii) Information provimust include a minim (A) Contact information responsible for the case of	dent or other individuals in the must document the danger er or discharge would pose. mentation. Insfers or discharges a of the circumstances specified (i)(A) through (F) of this must ensure that the transfer mented in the resident's appropriate information is a receiving health care. Ithe resident's medical record transfer per paragraph (c)(1) Iragraph (c)(1)(i)(A) of this resident need(s) that cannot upts to meet the resident ce available at the receiving eed(s). In required by paragraph (c) must be made by-physician when transfer or ary under paragraph (c) (1) ion; and a transfer or discharge is agraph (c)(1)(i)(C) or (D) of ded to the receiving provider num of the following: on of the practitioner are of the resident. Intative information including	F	322	ongoing care, advance directive comprehensive care plan goa provided upon transfers to hosp Information will be forwarde QAPI for review.	ıls) is ital.	9/4/18
		tions or precautions for		:		1000/mm	

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 08/02/2018

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					RM APPROVEI NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
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	ongoing care, as ap (E) Comprehensive (F) All other necess copy of the resident consistent with §48: any other document a safe and effective This REQUIREMEN by: Based on staff inter and facility document that the facility staff required documentar receiving facility for survey sample; Res #47 and #137. 1. The facility staff all required information, contact information, contact information, ongoing care, advarcomprehensive care the hospital staff what transferred to the hospital staff what and 06/29/18. 2. The facility staff fall required information, contact information, contact information, contact information, contact information, ongoing care, advancents and contact information.	propriate. care plan goals; sary information, including a d's discharge summary, 3.21(c)(2) as applicable, and tation, as applicable, to ensure transition of care. IT is not met as evidenced rview, clinical record review nt review, it was determined failed to evidence that all ation was provided to the six of 40 residents in the idents #17, #123, #60, #119, failed to provide evidence that cion (including physician resident representative special instructions for nce directives and e plan goals) was provided to en Resident #17 was espital on 04/25/18, 06/14/18 failed to provide evidence that ion (including physician resident #17 was espital on 04/25/18, 06/14/18					
	the hospital staff who transferred to the ho	en Resident #123 was espital on 06/06/18.	×				8

3. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
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F 622	ongoing care, advancementation comprehensive care the hospital staff what transferred to the hospital staff what required documentate receiving facility for hospitalization on 4/5. The facility staff required documentate receiving facility for on 4/5/18. 6. The facility staff fall required information, contact information, contact information, ongoing care, advancementative care comprehensive care.	a special instructions for nee directives and e plan goals) was provided to nen Resident # 60 was ospital on 05/29/18. Ifailed to evidence that all ation was provided to the Resident #119's 1/25/18. Ifailed to evidence that all ation was provided to the Resident #47's hospitalization was provided to the Resident #47's hospitalization ailed to provide evidence that tion (including physician resident representative special instructions for nee directives and e plan goals) was provided to the Resident #137 was ospital on 4/18/18.	F 62	22			

rne Findings include:

1. Resident # 17 was admitted to the facility on 01/19/17 and a readmission of 07/01/18 with diagnoses that included but were not limited to anemia (1), gastroesophageal reflux disease, (2), depressive disorder (3) and hypertension (4). Resident # 17's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/04/18, coded Resident # 17 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Facility ID: VA0180

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

PRINTED: 08/02/2018 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	(X3) DATE SURVEY COMPLETED	
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e.	The nurse's note da	ated "4/25/2018 at 4:48 PM					

The nurse's note dated "4/25/2018 at 4:48 PM (p.m.)" documented, "4/25/18 at 4:00 PM (p.m.) Resident sent to (Name of Hospital) ER (emergency room) via (by) ambulance. DX (diagnosis): SOB (shortness of breath)/Weight gain, Resident has 17 LB (pound) weight increase in last five days. C/O (complaint of) leg and back pain. Left dialysis early this AM (a.m.) due to pain. Resident is own RP (responsible party)."

The nurse's note for Resident # 17 dated "6/14/2018 at 9:46 PM (p.m.)" documented, "Resident C/O (complaint of) feeling like she is going to die. SOB (shortness of breath) with shallow respirations noted. Diminished lung sounds upon auscultation noted. Low-grade temp (temperature) noted: 99.1 O2 (oxygen) saturation was as low as 70 %-84% RA (room air). O2 applied at 3L (three liters) via (by) nasal cannula. O2 saturation brought up to 95%. Resident skipped dialysis earlier this week. Resident states she would like to go to the hospital if nursing and MD (medical doctor) felt it was appropriate. On call MD notified, N.O. (new order) send out to ER (emergency room) for further evaluation. RP (responsible party) self aware will continue to monitor until paramedics pick-up."

The nurse's note dated "6/29/2018 at 7:35 AM (a.m.)" documented, "Nurse received call from (Name of Dialysis Center); they reported that the resident was sent to (Name of Hospital) via ambulance for SOB (shortness of breath) and low grade fever. Resident is her own RP."

Review of the clinical record and EHR (electronic

	CENTERS FOR MEDICARE & MEDICAID SERVICES						RINTED: 08/02/2018 FORM APPROVED <u>MB NO</u> . 0938-0391
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F 622	evidence, physiciar representative cont instructions for ong and comprehensive provided to the hos was transferred to to 06/14/18 and 06/29. On 07/26/18 at app interview was condinurse) # 3, unit mandescribe the procestransferring a reside stated, "We notify the	Resident # 17 failed to contact information, resident act information, special oing care, advance directives act care plan goals were pital staff when Resident #17 the hospital on 04/25/18,	F 6	22			

transfer summary which includes why the resident is being sent, activities of daily living. resident status, copy of the physician's order sheet, current labs (laboratory tests), copy of the DNR (do not resuscitate) if applicable." When asked if a copy of the resident's comprehensive care plan or comprehensive care plan goals are sent with the resident, RN # 3 stated, "No."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM (other staff member) #7. admissions coordinator. When asked about transfer paper work for residents sent to the hospital, OSM # 7 stated, "I set up the 'Orange Folders' and put them at the nurse's station." OSM #7 was asked to describe what the 'Orange Folder' included and the purpose of the folder. OSM #7 stated, "It includes the bed hold policy and the 'Nursing Home Capabilities List. The folder is sent with the resident when they are transferred to the hospital." OSM # 7 further stated the nurse provides additional information to be sent with the resident and provided a copy

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 08/02/201 FORM APPROVEI OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, Z 120 DOGWOOD LANE ORANGE, VA 22960	07/26/2018 IP CODE
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Task Force" that do Information: 1. Face Orders - diet, meds allergies, code statu Changes in conditio Improvement Tool - hospitalizations, why physician is called), Doctor's orders, last Current labs. At an should include: 1. C. Condition Form, 3. F Status, 5. Flu/Pneur Review of Resident EHR (electronic hea	t-Acute Facility Readmission cumented, "Transfer e sheet, 2. Bed Hold Policy, 3. [medications], diagnosis, is, flu shot order date, 4. in form, 5. Quality has diagnosis, most recent y coming (used when 6. RN's call report, 7. is progress note, 8. RN note, 9. ininimum the information apabilities List, 2. Change in Face sheet, 4. ADLs/Code	F 6	22	

contact information, resident representative contact information, and special instructions for ongoing care, advance directives and comprehensive care plan goals to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18.

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:

(1) Low iron. This information was obtained from the website:

https://www.nlm.nih.gov/medlineplus/anemia.html

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X3) DATE SURVEY COMPLETED
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F 622 Continued From page 25

- (2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.
- (3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger. or frustration interfere with everyday life for weeks or more. This information was obtained from the

https://medlineplus.gov/ency/article/003213.htm.

- (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html.
- 2. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #123 was transferred to the hospital on 06/06/18.

Resident # 123 was admitted to the facility on 02/13/17 and a readmission of 06/12/18 with diagnoses that included but were not limited to schizoaffective disorder (1), gastroesophageal reflux disease, (2), depressive disorder (3) and anxiety (4).

Resident # 123's most recent MDS (minimum data set), a quarterly assessment with an ARD

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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** *** ***		· · · · · · · · · · · · · · · · · · ·	98 98		

F 622 Continued From page 26

(assessment reference date) of 07/06/18, coded Resident # 123 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

The nurse's note for Resident # 123 dated "6/6/2018 at 3:03 PM (p.m.)" documented, "Resident not feeling well this shift. Resident very tired. Resident continue on 3L (three liters) oxygen via (by) NC (nasal cannula) with humidification. Resident refused to eat breakfast and lunch this shift. Resident in no respiratory distress. Resident hurting all over. Resident medicated with Tylenol 650 mgs (milligrams) per MD (medical doctor) prn (as needed) order. (Name of Nurse Practitioner) notified that the resident was not acting like himself and that he needed to be assessed by him. Signee able to arouse resident by touch. Resident able to verbalize how he feels. After (Name of Nurse Practitioner) assessed resident he stated to send him out 911 for Acute Fluid Overload and possible kidney injury. 911 was called by signee at 2:20 a.m. Resident was assisted by staff to get cleaned up and ready for transport to (Name of Hospital). (Name of Responsible Party) notified of resident being sent out to ER (emergency room) for evaluation and treatment. Resident left facility at 3:05 p.m., by ambulance."

Review of the clinical record and EHR (electronic health record) for Resident # 123 failed to evidence physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital staff when Resident #123 was transferred to the hospital on 06/06/18.

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F 622 Continued From page 27

On 07/26/18 at approximately 8:02 a.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 was asked to describe the process staff follows when transferring a resident to the hospital. RN # 3 stated, "We notify the family by phone, send a copy of the resident's face sheet, medication list.

transfer summary which includes why the resident is being sent, activities of daily living, resident status, copy of the physician's order sheet, current labs (laboratory tests), copy of the DNR (do not resuscitate) if applicable." When

asked if a copy of the resident's comprehensive care plan or comprehensive care plan goals are sent with the resident, RN # 3 stated, "No."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM (other staff member) #7, admissions coordinator. When asked about transfer paper work for residents sent to the hospital, OSM # 7 stated, "I set up the 'Orange Folders' and put them at the nurse's station." OSM #7 was asked to describe what the 'Orange Folder' included and the purpose of the folder. OSM # 7 stated, "It includes the bed hold policy and the 'Nursing Home Capabilities List. The folder is sent with the resident when they are transferred to the hospital." OSM # 7 further stated the nurse provides additional information to be sent with the resident and provided a copy of the facility's "Post-Acute Facility Readmission Task Force" that documented, "Transfer Information: 1. Face sheet, 2. Bed Hold Policy, 3. Orders - diet, meds [medications], diagnosis, allergies, code status, flu shot order date, 4. Changes in condition form, 5. Quality Improvement Tool - has diagnosis, most recent

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-03		
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hospitalizations, why coming (used when physician is called), 6. RN's call report, 7. Doctor's orders, last progress note, 8. RN note, 9. Current labs. At a minimum the information should include: 1. Capabilities List, 2. Change in Condition Form, 3. Face sheet, 4. ADLs/Code Status, 5. Flu/Pneumonia Vaccine."

Review of Resident # 123's clinical record and HER (electronic health record) failed to evidence documentation that the facility provided physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18.

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:

- (1) A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/000930.htm.
- (2) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.



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	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	APPROVE 0938-039	
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blue, unhappy, mi Most of us feel thi short periods. Cli disorder in which f or frustration interf or more. This info website:	age 29 ay be described as feeling sad, serable, or down in the dumps. It was at one time or another for another for a mood eelings of sadness, loss, angelings with everyday life for week the same of the same o	r s				
(4) Fear. This info	rmation was obtained from the	F)				

3. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident # 60 was transferred to the hospital on 05/29/18.

https://www.nlm.nih.gov/medlineplus/anxiety.html

Resident # 60 was admitted to the facility on 10/04/16 and a readmission of 06/01/18 with diagnoses that included but were not limited to schizophrenia (1), Parkinson's disease, (2), dementia (3) and hypertension (4).

Resident # 60's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/15/18, coded Resident # 60 as scoring a 9 (nine) on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 (nine) - being moderately impaired of cognition for making daily decisions. Resident # 60 was coded as requiring extensive assistance

website:

#summary.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/02/2018 FORM APPROVED

CENTERS FOR MEDIC	ARE & MEDICAID SERVICES				0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495359	B. WING		07/:	26/2018	
NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS, CITY, STATE, Z			
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F 622 Continued From	m page 30	F 62	22			

The nurse's note for Resident # 60 dated "6/6/2018 at 3:03 PM (p.m.)" documented, "Resident requested to use the toilet, staff assisted resident to transfer to toilet without issue. After only minutes on the toilet resident became stiff, leaning back against the wall, then dropped her head and began drooling and mouth turned blue, resident began to shake for approximately 20 seconds, this happened twice, eyes rolled back and resident was unresponsive. Signee performed sternal rub and resident grunted but did not return at baseline. Lung sounds diminished and heart rate is weak. Resident was assisted to wheelchair then to the bed. Resident was evaluated by (Name of Physician) and order received to send resident to ER (emergency room). Unit manager present and aware. Message left with RP (responsible party), (Name of Responsible Party) to call back

of one staff member for activities of daily living.

Review of the clinical record and EHR (electronic health record) for Resident # 60 failed to evidence physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals were provided to the hospital staff when Resident # 60 was transferred to the hospital on 06/06/18.

to facility and RP, (Name of Responsible Party) aware of resident going to ER for evaluation and

On 07/26/18 at approximately 8:02 a.m., an interview was conducted with RN (registered nurse) #3, unit manager. RN #3 was asked to describe the process staff follows when transferring a resident to the hospital. RN #3

treatment."

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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stated, "We notify the family by phone, send a copy of the resident's face sheet, medication list, transfer summary which includes why the resident is being sent, activities of daily living. resident status, copy of the physician's order sheet, current labs (laboratory tests), copy of the DNR (do not resuscitate) if applicable." When asked if a copy of the resident's comprehensive care plan or comprehensive care plan goals are sent with the resident, RN # 3 stated, "No."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM (other staff member) # 7, admissions coordinator. When asked about transfer paper work for residents sent to the hospital, OSM # 7 stated, "I set up the 'Orange Folders' and put them at the nurse's station." OSM #7 was asked to describe what the 'Orange Folder' included and the purpose of the folder. OSM # 7 stated, "It includes the bed hold policy and the 'Nursing Home Capabilities List. The folder is sent with the resident when they are transferred to the hospital." OSM # 7 further stated the nurse provides additional information to be sent with the resident and provided a copy of the facility's "Post-Acute Facility Readmission Task Force" that documented, "Transfer Information: 1. Face sheet, 2. Bed Hold Policy, 3. Orders - diet, meds [medications], diagnosis, allergies, code status, flu shot order date, 4. Changes in condition form, 5. Quality Improvement Tool - has diagnosis, most recent hospitalizations, why coming (used when physician is called), 6. RN's call report, 7. Doctor's orders, last progress note, 8. RN note, 9. Current labs. At a minimum the information should include: 1. Capabilities List, 2. Change in Condition Form, 3. Face sheet, 4. ADLs/Code Status, 5. Flu/Pneumonia Vaccine."

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

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Review of Resident # 123's clinical record and EHR (electronic health record) failed to evidence documentation that the facility provided physician contact information, resident representative contact information, and special instructions for ongoing care, advance directives and comprehensive care plan goals to the hospital staff when Resident #17 was transferred to the hospital on 04/25/18.

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. Scoliosis (a sideways curve of your backbone, or spine.) This information was obtained from the website:

https://www.nlm.nih.gov/medlineplus/scoliosis.ht ml.

- (2) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.
- (3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website:

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F 622	Continued From pa	age 33 .gov/ency/article/000739.htm.	F 62	22	
	(4) High blood pres	sure. This information was			

4. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #119's hospitalization on 4/25/18.

https://www.nlm.nih.gov/medlineplus/highbloodpr

obtained from the website:

essure.html.

Resident #119 was admitted to the facility on 4/8/17 with the diagnoses of but not limited to end stage renal disease, dialysis, high blood pressure, depression, anxiety, schizoaffective disorder, convulsions, asthma, chronic obstructive pulmonary disease, osteoarthritis, obstructive sleep apnea, fluid overload, pancreatitis, and cholelithiasis. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/11/18. The resident was cognitively intact in ability to make daily life decisions.

A review of the clinical record revealed an MD (medical doctor) note dated 4/25/18 documented, '...declined dialysis today, "I've been throwing up all night. I just don't feel good at all...Physical Exam: General: Chronically ill appearing adult woman in no acute distress...Respiratory: lungs clear to auscultation bilaterally, breathing comfortably...Cardiovascular: regular rate...Gastrointestinal: soft, nontender, nondistended, normoactive bowel sounds...Musculoskeletal: no edema...Assessment...1. N/V (nausea and vomiting) supportive care, likely viral. monitor closely for dehydration, reassuring exam today...."

Facility ID: VA0180

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

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

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	A review of the nurs following:	ses' notes revealed the			
	body edema, received unable to take her, room), due to fluid since 4/21/18, refusalso request to be sroom]Dr (doctor)	.m.: "Resident has facial / yed call from dialysis, stated to send to ER (emergency over load, has not had dialysis sed to come 4/24/18, resident sent to ER [emergency aware to send to ER for eval P) aware, 911 called."			3
	reveal any evidence documentation (cor practitioner, resider advanced directive instructions or prec	ntact information of the nt representative information, information, special autions, comprehensive care ertinent information) was			
	#5 (Licensed Practi transfers, the facilit transfer form, curre recent physician's r that is all that is ser blank copy of the or documents it conta	a.m., in an interview with LPN cal Nurse), she stated that for y sends an orange folder, the nt orders, recent labs, and note if there is one. She stated at. LPN #5 then provided a range folder and the ined, and from a file drawer by of the "Patient Transfer			
	contained two pre-f	nge folder" revealed it iled documents in the pocket; lursing Home Capabilities List"			

admission/readmissions.

form, which identified the care, and services the

nursing home is able to provide for any

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	areas to be comple demographic informadvanced directives needs, wound care nursing assessment resident representation requirement on the comprehensive this form that should 4/25/18 hospitalizationical record.	tient Transfer Form" revealed ted by the facility for resident nation, physician information, s, diagnoses, basic care needs, appliances needs, it, immunization status, tive information. There was the form for the provision of care plan goals. A copy of d have been completed for the ion was not located in the		f x		×
	facility was provided needed from this re	oximately 12:00 p.m., the d with a list of documents sident's record. A copy of the equested on this list.				
		p.m., when providing the				

Nursing - ASM #2 - Administrative Staff Member) was asked about the transfer form, which was not included in the documents provided. ASM #2 stated they didn't have it and that the staff had not been consistently using the transfer form.

On 7/26/18 at 1:50 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to evidence that all required documentation was provided to the receiving facility for Resident #47's hospitalization on 4/5/18.

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

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

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F 622 Continued From page 36

F 622

Resident #47 was admitted on 1/1/15 and readmitted on 4/8/18 with the diagnoses of but not limited to diabetes, high blood pressure, dementia, osteoporosis, Barrett's esophagus, atrial fibrillation, deep vein thrombosis, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/31/18. The resident was severely impaired in ability to make daily life decisions.

A review of the clinical record revealed the following notes:

- 4/5/18 at 5:31 PM: "....Unable to obtain blood glucose reading after 5 attempts, a different glucometer, different strips, and different fingers used, glucometer read E-0. Supervisor notified. Resident had CBC {1} drawn this evening and awaiting results. MD (medical doctor) notified."
- 4/5/18 at 11:54 PM: "Nurse was unable to obtain a blood glucose reading on this resident this evening. CBC results received at 8:30 with critical lab value of hemoglobin 5.4. Nurse immediately notified supervisor and called MD with lab results. MD gave order to send to ED (Emergency Department) for evaluation and treatment for a blood transfusion. Nurse spoke with RP (responsible party). RP asked to call nurse right back after discussing with family. RP returned call and gave the ok to send this resident out to ED for evaluation and treatment. Nurse informed resident of the lab results and the need to go to the ED. Nurse informed resident that she had spoke with her sons about going to the hospital and that they were supportive. Resident acknowledged this and was positive and



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F 622 Continued From page 37

understanding of needing to go out to the hospital. Resident was awake and alert at this time, breathing normally and responsive to questions...."

- 4/6/18 at 3:24 PM (social worker note): "resident discharged to hospital yesterday - she is not a bedhold (Sic.) - notification of bedhold (Sic.) policy sent with her in the orange folder and mailed to her RP - belongings remain intact in her room in anticipation of her return."

Further review of the clinical record failed to reveal any evidence that the required documentation (contact information of the practitioner, resident representative information, advanced directive information, special instructions or precautions, comprehensive care plan goals, other pertinent information) was provided to the receiving hospital.

On 7/26/18 at 8:25 a.m., in an interview with LPN #5 (Licensed Practical Nurse), she stated that for transfers, the facility sends an orange folder, the transfer form, current orders, recent labs, and recent physician's note if there is one. LPN #5 stated that is all that is sent. LPN #5 then provided a blank copy of the orange folder and the documents it contained, and from a file drawer obtained a blank copy of the "Patient Transfer Form."

A review of the "orange folder" revealed it contained two pre-filed documents in the pocket; a bed hold and a "Nursing Home Capabilities List" form, which identified the care, and services the nursing home is able to provide for any admission/readmissions.

F 622

18 D

DEPARTMENT OF HEALTH				PRINTED: 08/02/201 FORM APPROVE OMB NO. 0938-039
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areas to be comple demographic inform advanced directives needs, wound care nursing assessmen resident representa no requirement on the comprehensive this form that should 4/5/18 hospitalizatio clinical record. On 7/26/18 at approfacility was provided needed from this re	ge 38 tient Transfer Form" revealed ted by the facility for resident mation, physician information, s, diagnoses, basic care needs, appliances needs, t, immunization status, tive information. There was the form for the provision of care plan goals. A copy of d have been completed for the on was not located in the eximately 12:00 p.m., the d with a list of documents sident's record. A copy of the equested on this list.	F 6	22	

On 7/26/18 at 1:29 p.m., when providing the requested documents, the DON (Director of Nursing - ASM #2 - Administrative Staff Member) was asked about the transfer form, which was not included in the documents provided. She stated they didn't have it and that the staff had not been consistently using the transfer form.

On 7/26/18 at 1:50 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

{1} CBC with differential - A CBC (complete blood count) tests measure the number and types of cells in your blood. This helps doctor's check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood

Facility ID: VA0180

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

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F 622 Continued From page 39

cancers, and immune system disorders.
Information obtained from
https://medlineplus.gov/bloodcounttests.html

6. The facility staff failed to provide evidence that all required information (including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #137 was transferred to the hospital on 4/18/18.

Resident #137 was admitted to the facility on 4/2/18. Resident #137's diagnoses included but were not limited to chest pain, difficulty swallowing and high blood pressure. Resident #137's admission MDS (minimum data set) with an ARD (assessment reference date) of 4/11/18, coded the resident as being cognitively intact.

Review of Resident #137's clinical record revealed a nurse's note dated 4/18/18, signed by LPN (licensed practical nurse) #1, that documented, "Resident c/o (complained of) pain in chest around heart 'firm pain' Stated pain started yesterday and has gotten worse tonight. VS (Vital signs) 97.1 (temperature) 86 apical (pulse) 20 (respirations) 140/88 (blood pressure). Talked with son and she wants to go to hospital. (Name of nurse practitioner) RP (responsible party) aware."

Another nurse's note dated 4/18/18 documented, "Pt (Patient) was sent to (name of hospital) by squad for c/o chest pain. RP (name) will meet them at hospital."

F 622

PRINTED: 08/02/2018

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT	OMB NO. 0938-039
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F 622 Continued From page 40

Further review of Resident #137's clinical record failed to reveal evidence of the information provided to hospital staff.

On 7/25/18 at 3:02 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked to describe the information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated a face sheet including demographics and insurance information. physician orders, a set of vital signs and any recent labs [laboratory tests] is provided. RN #1 stated physician contact information and responsible party (resident representative) contact information is documented on the face sheet. RN #1 stated advance directives are sent if they are in the resident's chart but the resident's code status (whether or not to provide cardiopulmonary resuscitation) is documented on the face sheet and physician orders. RN #1 stated special precautions or instructions for care are supposed to be documented on physician orders. When asked if residents' comprehensive care plan goals are provided to hospital staff, RN #1 stated, "No. Normally we don't send that." When asked how the facility staff evidences the information provided to hospital staff, RN #1 stated there was no evidence.

On 7/25/18 at 6:06 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the director of nursing) were made aware of the above findings.

On 7/26/18 at 10:35 a.m., an interview was conducted with LPN #1. LPN #1 was asked to describe to items provided to hospital staff when residents are transferred to the hospital. LPN #1 stated she provides a face sheet, physician

F 622

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

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Facility ID: VA0180

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

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND RI		•	HAR 1	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE DRANGE, VA 22960	1 07720/2010
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F 622	any recent lab word do not resuscitate form is usually set the residents' com LPN #1 stated, "HON 7/26/18 at 1:28 director of nursing transfer form for with transferred to the On 7/26/18 at 1:57 facility staff was not transfer form. When the contraction of the	ns given in the last eight hours, rk, history and physical and the form. LPN #1 stated a transfer nt. When asked if she provides prehensive care plan goals, onestly, I do not." 5 p.m., ASM #4 (the assistant) stated she could not locate a when Resident #137 was hospital. 7 p.m., ASM #2 stated the pt consistently using the en asked for a policy regarding ASM #2 stated the facility did	F 622		
	Notice Requireme CFR(s): 483.15(c) §483.15(c)(3) Notice Before a facility transition of the resident, the facility (i) Notify the resident representative(s) of the reasons for the language and man facility must send a representative of the Long-Term Care Composer Care Care Care Care Care Care Care Ca	ce before transfer. Insfers or discharges a y must- ent and the resident's of the transfer or discharge and e move in writing and in a iner they understand. The a copy of the notice to a he Office of the State embudsman. sons for the transfer or sident's medical record in aragraph (c)(2) of this section;	F 623	corrective action for residents #123, #60, #19 and #4 related notification of discharge whe	#17, d to n a the rred al to and d on or of tions iding

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

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	2-22	495359	B. WING		0.5	07/26/2018	
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	12	REET ADDRESS, CITY, STATE, ZIP CODE 0 DOGWOOD LANE RANGE, VA 22960		720/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)) BE	(X5) COMPLETION DATE
F 623	Continued From pa	ge 42	F6	23 _.	are transferred to the hospital.	8	
	(c)(8) of this section discharge required made by the facility resident is transferred. (ii) Notice must be repetited before transfer or die (A) The safety of incide endangered und this section; (B) The health of incide endangered, under this section; (C) The resident's hallow a more immediate transfer or die (D) An immediate transfer or discharge by the resident of the control	ed in paragraphs (c)(4)(ii) and the notice of transfer or under this section must be at least 30 days before the ed or discharged.		The state of the s	4. To ensure compliance, audits be conducted by Director of S Services (or Designee) every wee weeks, then monthly x 3, to as discharge/ transfer notification provided to the resident/ RPs.	ocial k x 4 ssure	9/4/18
	§483.15(c)(5) Contenotice specified in pmust include the foll (i) The reason for tr (ii) The effective dat (iii) The location to v	ansfer or discharge; e of transfer or discharge; which the resident is					
## ()	including the name, and telephone numb receives such reque to obtain an appeal of	arged; ne resident's appeal rights, address (mailing and email), per of the entity which sts; and information on how form and assistance in and submitting the appeal		-(



PRINTED: 08/02/2018

		I WIND HOMININ SEKVICES				FORI	M APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		ONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495359	B. WING _			07	7/26/2018
NAME OF	PROVIDER OR SUPPLIER	1		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1	/ZU/ZU IU
DOGWO	OD VILLAGE OF OR	ANGE COUNTY HEALTH AND REI	НАВ		DOGWOOD LANE NGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	24	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From pa	NACE NACE 10-0-0-0	F 62:	3			il disch
		ress (mailing and email) and		65 65 26			
	Long-Term Care Or	of the Office of the State mbudsman;					
	(vi) For nursing facil	ility residents with intellectual					
		disabilities or related diling and email address and					
82		of the agency responsible for		10			
	the protection and a	advocacy of individuals with					
		abilities established under Part ental Disabilities Assistance					
		ct of 2000 (Pub. L. 106-402,					
	codified at 42 U.S.C	C. 15001 et seq.); and					
		cility residents with a mental disabilities, the mailing and					
		telephone number of the					
	agency responsible	for the protection and					
		uals with a mental disorder he Protection and Advocacy					
	for Mentally III Indivi						
	§483.15(c)(6) Chan	iges to the notice.					
	If the information in	the notice changes prior to					
		er or discharge, the facility cipients of the notice as soon					
		the updated information					
	becomes available.						
	§483.15(c)(8) Notice	e in advance of facility closure					
	In the case of facility	y closure, the individual who is					25
		the facility must provide prior to the impending closure		11			20
		Agency, the Office of the					
	State Long-Term Ca	are Ombudsman, residents of					
		resident representatives, as the transfer and adequate					
		sidents, as required at §					

This REQUIREMENT is not met as evidenced

483.70(I).

by:

PRINTED: 08/02/2018

		AND HUMAN SERVICES					FORM APPROVED
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		792		ON	MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495359	B. WING		·		07/26/2018
NAME OF	PROVIDER OR SUPPLIER	3000 NO.	· I	STREET	ADDRESS, CITY, STATE, ZIP (CODE	
DOGWO	OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND R	ЕНАВ		GWOOD LANE GE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	!	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD I	BE COMPLETION
F 000				1			
F 623	Continued From pa	1100	F 6	23			
		rview, facility document	6) (3)	3			
		record review, it was	10				
		cility staff failed to provide					
		to the resident representative transfer to the hospital for five					
iš	25	ne survey sample; Residents	i.	*			
	#17, #123, #60, #119 and #47.						
ē.	1. The facility staff failed to provide written						
	notification to the resident and responsible party						
	(RP) and of a facility initiated transfer to the						
	hospital on 04/25/1. Resident # 17.	8, 06/14/18 and 06/29/18 for					
	notification to the re (RP) and of a facilit	failed to provide written esident and responsible party y initiated transfer to the 8 for Resident # 123.					
	3 The facility staff	failed to provide written		85			
		esident and responsible party					
		y initiated transfer to the					
j D		8 for Resident # 60.					
	4. The facility staff	failed to provide Resident					
		resentative with written		×			
	notification for the r 2/13/18, 3/20/18, 4/	esident's hospitalizations on /25/18, and 5/8/18.					
	5. The facility staff	failed to provide Resident					
		esentative with written					
99 St	notification for the r 4/5/18.	esident's hospitalization on		12			
	The findings include	e :					

1. Resident # 17 was admitted to the facility on 01/19/17, with a readmission on 07/01/18, with diagnoses that included but were not limited to

		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	ED: 08/02/201 RM APPROVE IO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	THE PROPERTY OF STREET	TIPLE CONSTRUCTION	(X3) D	DATE SURVEY COMPLETED
		495359	B. WING			07/26/2018
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, 120 DOGWOOD LANE ORANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 623	depressive disorder	ge 45 esophageal reflux disease, (2), r (3) and hypertension (4). st recent MDS (minimum data	F 62	23		
Theorem and the state of the st	(assessment refere	sessment with an ARD nce date) of 05/04/18, coded coring a 15 on the brief				W.

The nurse's note dated "4/25/2018 at 4:48 PM" (p.m.)" documented, "4/25/18 at 4:00 PM Resident sent to (Name of Hospital) ER (emergency room) via (by) ambulance. DX (diagnosis): SOB (shortness of breath)/Weight gain, Resident has 17 LB (pound) weight increase in last five days. C/O (complaint of) leg and back pain. Left dialysis early this AM (a.m.) due to pain. Resident is own RP (responsible party)."

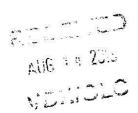
interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 17 was coded as requiring extensive assistance of one staff member for

activities of daily living.

The nurse's note for Resident # 17 dated "6/14/2018 at 9:46 PM (p.m.)" documented, "Resident C/O (complaint of) feeling like she is going to die. SOB (shortness of breath) with shallow respirations noted. Diminished lung sounds upon auscultation noted. Low-grade temp (temperature) noted: 99.1 O2 (oxygen) saturation was as low as 70 %-84% RA (room air). O2 applied at 3L (three liters) via (by) nasal cannula. O2 saturation brought up to 95%. Resident skipped dialysis earlier this week. Resident states she would like to go to the hospital if nursing and MD (medical doctor) felt it was appropriate. On call MD notified, N.O. (new order) send out to ER (emergency room) for

Facility ID: VA0180

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200 000	TIPLE CONSTRUCTION NG	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
<u> </u>		495359	B. WING		07/26/2018		
	PROVIDER OR SUPPLIER	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 623	further evaluation. aware will continue pick-up." The nurse's note da (a.m.)" documented (Name of Dialysis Cresident was sent to ambulance for SOB grade fever. Reside On 07/26/18 at 12:2	RP (responsible party) self to monitor until paramedics atted "6/29/2018 at 7:35 AM d, "Nurse received call from Center); they reported that the o (Name of Hospital) via B (shortness of breath) and low	F 6	23			

conducted with USM # 8 regarding the written notification to the resident and responsible party for Resident # 17's facility initiated transfers to the hospital. OSM # 8 stated the written notification is part of the bed hold form. Review of the bed hold form failed to evidence an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests; information on how to request an appeal hearing. Information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman. When asked if the written notification contained an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests. Information on how to request an appeal hearing; information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman OSM # 8 stated, "No."

PRINTED: 08/02/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED <u>D. 0938-039</u> 1	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	56 030000-00000000	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED	
200	75	495359	B. WING		40 <u>17000</u>	0.7	7/26/2018	
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	STREET ADDRESS, CITY, STATE, ZIP CODE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	(administrative staff director and ASM # 4, assistant director physician were made No further information. References: (1) Low iron. This in the website: https://www.nlm.nih (2) Stomach content the esophagus and was obtained from the https://www.nlm.nih (3) Depression may blue, unhappy, mise Most of us feel this short periods. Clinical disorder in which fee or frustration interfeor more. This inform website: https://medlineplus.edu.	roximately 1:55 p.m., ASM f member) # 1, the executive 2, director of nursing, ASM # of nursing, and ASM # 5, de aware of the findings. on was provided prior to exit. Information was obtained from agov/medlineplus/anemia.html Its to leak back, or reflux, into irritate it. This information the website: agov/medlineplus/gerd.html. It be described as feeling sad, erable, or down in the dumps. It way at one time or another for cal depression is a mood elings of sadness, loss, anger, re with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm.	F 6	23				

essure.html.

https://www.nlm.nih.gov/medlineplus/highbloodpr

2. The facility staff failed to provide written notification to the resident and responsible party (RP) for a facility initiated transfer to the hospital

on 06/06/18 for Resident # 123.

DEPAR	FORM APPROVED				
3.70	24W10 100 10 10 10 10 10 10 10 10 10 10 10	& MEDICAID SERVICES			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495359	B. WING		07/26/2018
	PROVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	OULD BE COMPLETION
F 623	o2/13/17, and reading diagnoses that inclusions that including the second that	ge 48 s admitted to the facility on mitted ofn06/12/18 with uded but were not limited to order (1), gastroesophageal depressive disorder (3) and ost recent MDS (minimum ly assessment with an ARD nce date) of 07/06/18, coded scoring a 15 on the brief status (BIMS) of a score of 0 nitively intact for making daily	F6	223	

The nurse's note for Resident # 123 dated "6/6/2018 at 3:03 PM (p.m.)" documented, "Resident not feeling well this shift. Resident very tired. Resident continue on 3L (three liters) oxygen via (by) NC (nasal cannula) with humidification. Resident refused to eat breakfast and lunch this shift. Resident in no respiratory distress. Resident hurting all over. Resident medicated with Tylenol 650 mgs (milligrams) per MD (medical doctor) prn (as needed) order. (Name of Nurse Practitioner) notified that the resident was not acting like himself and that he needed to be assessed by him. Signee able to arouse resident by touch. Resident able to verbalize how he feels. After (Name of Nurse Practitioner) assessed resident he stated to send him out 911 for Acute Fluid Overload and possible kidney injury. 911 was called by signee at 2:20 a.m. Resident was assisted by staff to get cleaned up and ready for transport to (Name of Hospital). (Name of Responsible Party) notified of resident being sent out to ER (emergency

decisions. Resident # 123 was coded as requiring extensive assistance of one staff

member for activities of daily living.

facility at 3:05 p.m., by ambulance."

ΞD 91

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						
	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY IPLETED		
49.0030		495359	B. WING _		07/	26/2018	
1	ROVIDER OR SUPPLIER DD VILLAGE OF ORA	NGE COUNTY HEALTH AND R	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
(3)	Continued From pa	ge 49 n and treatment. Resident lef	F 62	3			

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM # 8 regarding the written notification to the resident and responsible party for a facility initiated transfer for Resident # 123. OSM # 8 stated the written notification is part of the bed hold form. Review of the bed hold form failed to evidence an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests; information on how to request an appeal hearing. Information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State Long-Term Care ombudsman. When asked if the written notification contained the above information, OSM # 8 stated, "No."

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A mental condition that causes both a loss of contact with reality [psychosis] and mood problems [depression or mania]. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 000930.htm.

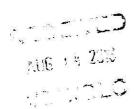
(2) Stomach contents to leak back, or reflux, into

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

Event ID: 093G11

Facility ID: VA0180

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495359	B. WING		07/26/2018
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORA	NGE COUNTY HEALTH AND R	FHAR 120	EET ADDRESS, CITY, STATE, ZIP (DOGWOOD LANE ANGE, VA 22960	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
was obtained from https://www.nlm.nih (3) Depression may blue, unhappy, mise Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This infort website: https://medlineplus. (4) Fear. This infort website: https://www.nlm.nih #summary. 3. The facility staff notification to the re (RP) and of a facility hospital on 05/29/16 Resident # 60 was 10/04/16 and a read diagnoses that incluschizophrenia (1), Fementia (3) and hy Resident # 60's moset), a quarterly ass (assessment refere Resident # 60 as so interview for mental - 15, 9 (nine) - being cognition for making 60 was coded as resident # 60 was coded w	irritate it. This information the website: a.gov/medlineplus/gerd.html. be described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood relings of sadness, loss, angerer with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. mation was obtained from the a.gov/medlineplus/anxiety.html failed to provide written resident and responsible party y initiated transfer to the soft of Resident # 60. admitted to the facility on dmission of 06/01/18 with uded but were not limited to Parkinson's disease, (2),			

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY IPLETED	
	VASS 10: 40	495359	B. WING		07/	26/2018
	OVIDER OR SUPPLIE	RANGE COUNTY HEALTH AND I	REHAB .	STREET ADDRESS, CITY, STATE, ZIP (120 DOGWOOD LANE DRANGE, VA 22960	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE

The nurse's note for Resident # 60 dated "6/6/2018 at 3:03 PM (p.m.)" documented. "Resident requested to use the toilet, staff assisted resident to transfer to toilet without issue. After only minutes on the toilet resident became stiff, leaning back against the wall, then dropped her head and began drooling and mouth turned blue, resident began to shake for approximately 20 seconds, this happened twice, eyes rolled back and resident was unresponsive. Signee performed sternal rub and resident grunted but did not return at baseline. Lung sounds diminished and heart rate is weak. Resident was assisted to wheelchair then to the bed. Resident was evaluated by (Name of Physician) and order received to send resident to ER (emergency room). Unit manager present and aware. Message left with RP (responsible party), (Name of Responsible Party) to call back to facility and RP, (Name of Responsible Party) aware of resident going to ER for evaluation and treatment."

On 07/26/18 at 12:20 p.m., an interview was conducted with OSM # 8 regarding the written notification to the resident and responsible party for a facility initiated transfer for Resident # 60. OSM # 8 stated the written notification is part of the bed hold form. Review of the bed hold form failed to evidence an explanation of the right to appeal to the State; the name, address (mail and email), and telephone number of the State entity which receives appeal hearing requests. Information on how to request an appeal hearing; information on obtaining assistance in completing and submitting the appeal hearing request; and the name, address, and phone number of the representative of the Office of the State

-000AN - 0000 AND-ANT211-00	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.8 2		(X3) DATE SU COMPLE	
	_	495359	B. WING		07/26/	2018
Association of the state of the	ROVIDER OR SUPPLIER DD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP COD 120 DOGWOOD LANE ORANGE, VA 22960	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE CO	(X5) DMPLETION DATE
	written notification of information, OSM # On 07/26/18 at app (administrative staff director and ASM # 4, assistant director	nbudsman. When asked if the contained the above	F 6	23		

References:

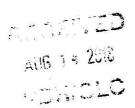
(1) A mental disorder that makes it hard to tell the difference between what is real and not real. This information was obtained from the website: https://medlineplus.gov/ency/article/000928.htm. Scoliosis (a sideways curve of your backbone, or spine.) This information was obtained from the

No further information was provided prior to exit.

https://www.nlm.nih.gov/medlineplus/scoliosis.ht ml.

- (2) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdi sease.html.
- (3) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.
- (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html.

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	ACCORDED AND ACCOUNT ACCOUNT OF SECURE SE	MIND HOMAIN SERVICES				FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495359	B. WING			07/26/2018
NAME OF F	PROVIDER OR SUPPLIER		-	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	0172072010
DOGWO	OD VIII I AGE OF OR	ANGE COUNTY HEALTH AND RE	.UAD	120	DOGWOOD LANE	
DOGWO	DD VICEAGE OF ORA	MIGE COUNTY HEALTH AND RE	ПАВ	ORA	ANGE, VA 22960	W. 100
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 623	Continued From pa	ge 53	F6	323		20 - 100 M
	an ba to terroristico, en esperiores - encare	failed to provide Resident		,20		
		resentative with written		19		
	notification for the r	esident's hospitalizations on				
	2/13/18, 3/20/18, 4/	/25/18, and 5/8/18.				
	Resident #110 was	admitted to the facility on				
		noses of but not limited to end		75		
	stage renal disease	e, dialysis, high blood pressure,				
		, schizoaffective disorder,				
	MUSERAL SECTION AND ADDRESS OF THE SECTION OF THE S	a, chronic obstructive , osteoarthritis, obstructive				
		overload, pancreatitis, and				
		most recent MDS (Minimum		189		
		arterly assessment with an				
	STATES AND A COMPANY OF THE PROPERTY OF THE PR	Reference Date) of 7/11/18. ognitively intact in ability to				
	make daily life deci					
	26					
	- Martin and State of the Control of	cal record revealed an MD				
		te dated 4/25/18 documented, today, "I've been throwing up				
		t feel good at allPhysical				
		nronically ill appearing adult				
		distressRespiratory: lungs				
		n bilaterally, breathing				
4	comfortablyCardi	ovascular: regular nal: soft, nontender,				
	nondistended, norn					
10	soundsMusculosl	keletal: no		5		
5		ent1. N/V (nausea and				
		e care, likely viral. monitor	i			
	closely for denydra	tion, reassuring exam today'	PL PL			
	A review of the nurs	ses' notes revealed the				
3		elating to all of the identified				
	hospitalizations:					

- 2/13/18 at 9:02 a.m.: "Dialysis called facility at approx (approximately) 730a.m. this morning

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES						
	PLAN OF CORRECTION IDENTIFICATION NUMBER		15 (5)	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495359	B. WING		07/26/20	18	
DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAE			EHAB	STREET ADDRESS, CITY, STATE, ZI 120 DOGWOOD LANE ORANGE, VA 22960	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	그 아니는 그 아니는	ION SHOULD BE COMP HE APPROPRIATE DA	X5) PLETION ATE	
F 623		page 54 sent to hospitalresident BP	F 6	623 _,			

- 2/13/18 at 12:17 p.m.: "Called (name of hospital) for update on resident...Reported that resident has been admitted...New Order: Discharge resident to (hospital), RP (responsible party - name of resident's RP) aware.

was vomiting non-stop, dialysis contacted dialysis DR (doctor) and they requested her to go to the

- 2/14/18 at 8:55 a.m.: "Resident out to the hospital yesterday - she is a bedhold (sic.) belongings remain intact in her room."

There was no evidence that the responsible party was provided with written notification of the hospitalization on 2/13/18.

There were no nurse's notes documenting the hospitalization on 3/20/18. However, "Administration" records for medication administration documented medications that were not administered due to "Resident not available. Resident out to ER [emergency room]. Never came back from dialysis today."

 A 3/21/18 (social worker note) at 9:33 a.m. documented: "resident discharged to the hospital yesterday - she is a bedhold (sic.) - belongings remain intact in her room in anticipation of her return."

There was no evidence that the responsible party was provided with written notification of the hospitalization on 3/20/18.

hospital...."

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			.1.	FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	15298			OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495359	B. WING _			07/26/2018
NAME OF	PROVIDER OR SUPPLIER	6 X		STREET ADDRESS, CIT	TY, STATE, ZIP CODE	
DOGWO	OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND REI	НАВ	120 DOGWOOD LANI ORANGE, VA 2296		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 623	Continued From pa	ige 55	F 62	23		
	- A nurses note dat documented: "Res received call from do her, to send to ER (over load, has not herefused to come 4/2 be sent to ERDr ([emergency room] faware, 911 called." - A nurses noted dadocumented: "Spot department) at (narradmitted." - A 4/26/18 (social documented: "(Res (hospital) on 4/25/12 Personal items to re BH notification and return." There was no evide was provided with whospitalization on 4/25/12 personal items to re BH notification and return."	ted 4/25/18 at 8:49 a.m. sident has facial / body edema, dialysis, stated unable to take (emergency room), due to fluid had dialysis since 4/21/18, 24/18, resident also request to (doctor) aware to send to ER for eval [evaluation], r/p (RP) ated 4/25/18 at 4:53 p.m. ke with ED (emergency me of hospital) she was worker note) at 8:26 a.m. sident #119) was discharged to 8. Desires BH (bed hold). emain in room. Worker sent authorization. Will assist with ence that the responsible party written notification of the //25/18.				
	documented: "Resi detailed message for name of RP) about	ated 5/8/18 at 9:51 a.m. ident had new ordersleft or RP (responsible party - that and also that resident				

(Shortness of Breath), sent there from dialysis...."

- A nurse's note date 5/8/18 at 9:53 a.m. documented: "Nurse from (dialysis center) called...states that during res (resident) dialysis tx (treatment) res c/o (complained of) SOB and chest pain. Res (resident) was transported from dialysis to (hospital) per res request. RP, UM

		HAND HUMAN SERVICES			PRINTED: 08/02/2018
CEN	TERS FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495359	B. WING _		07/26/2018
NAME	OF PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP (
DOG	WOOD VILLAGE OF OR	ANGE COUNTY HEALTH AND RE	НАВ	120 DOGWOOD LANE ORANGE, VA 22960	
(X4) PREI TAG	X (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F €	23 Continued From p	age 56	F 62	3	1
	NAMES OF THE OWNER, WITHOUT THE PARTY OF THE	N (director of nursing), MD			
	documented: "res yesterday - she is bedhold (sic) polic folder to the hospii policy and authoriz of responsible part	worker note) at 2:31 p.m. ident discharged to hospital a bedhold (sic.) - notice of y sent with her in the orange tal - copy of bedhold (sic.) ration form mailed to rp (name ty). belongings remain intact in pation of her return."			×
		ence that the responsible party written notification of the		£	
	(Other Staff Memb stated that they "d	m. in an interview with OSM #8 ler, the social worker), she o not have a written notification uirement of the regulation."	*0		
	and director of nur respectively - Adm made aware of the	p.m. The executive director sing (ASM #1 and #2 inistrative Staff Members) were findings. No further ovided by the end of the	×.	ig.	
	5. The facility staf	failed to provide Resident			

4/5/18.

#47's resident representative with written notification for the resident's hospitalization on

Resident #47 was admitted on 1/1/15 and readmitted on 4/8/18 with the diagnoses of but not limited to diabetes, high blood pressure,



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		& MEDICAID SERVICES					M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495359	B. WING	**************************************		١ ,	7/26/2018
NAME OF	PROVIDER OR SUPPLIER	And State Of the S	3	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	112012010
DOGWO	OD VILLAGE OF ORA	NIGE COUNTY HEALTH AND RE	НАВ		DOGWOOD LANE ANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 623	atrial fibrillation, deed dysphagia. The mode dysphagia	osis, Barrett's esophagus, ep vein thrombosis, and ost recent MDS (Minimum earterly assessment with an Reference Date) of 5/31/18. everely impaired in ability to	F 6	123			
	go out to the nospita	ai. Resident was awake and					49

responsive to questions...."

alert at this time, breathing normally and

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

PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495359	B. WING		07/26/2018	
00 00 00 00 00 00 00 00 00 00 00 00 00	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	HAR	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 623	Continued From pa	ge 58	F 623	3		
	"resident discharge not a bedhold (Sic.) policy sent with her	n. (social worker note): d to hospital yesterday - she is - notification of bedhold (Sic.) in the orange folder and selongings remain intact in her				
8	There was no evide	nce that the responsible party ritten notification of the				
	#8 (Other Staff Men stated that they "do	.m. in an interview with OSM her, the social worker), she not have a written notification rement of the regulation."				
20 20 20 20 20 20 20 20 20 20 20 20 20 2	and director of nursi respectively - Admir made aware of the f	istrative Staff Members) were				
1 1 1 1 1 1 1 1 1 1 3	count) tests measur cells in your blood. I your overall health. diagnose diseases a	ntial - A CBC (complete blood e the number and types of his helps doctor's check on The tests can also help to and conditions such as clotting problems, blood			#	
SS=E	cancers, and immur Information obtained https://medlineplus.g Develop/implement CFR(s): 483.21(b)(1 §483.21(b) Comprel	ne system disorders. If from gov/bloodcounttests.html Comprehensive Care Plan)	F 656	1.The facility has established corrective action for not follow the comprehensive care plan plan of care for Resident #89 relato tube feeding: Resident #37,	ving and ited	

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

Event ID: 093G11

Facility ID: VA0180

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495359	B. WING _	·····	07/26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0112012018
DOOMO	00 \	A STATE OF THE STA	AND CO. AND	120 DOGWOOD LANE	
DOGWO	OUD VILLAGE OF OR	ANGE COUNTY HEALTH AND RE	HAB	ORANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	OULD BE COMPLÉTION
F 656	care plan for each resident rights set for §483.10(c)(3), that objectives and time medical, nursing, an needs that are identical assessment. The codescribe the following (i) The services that or maintain the resident physical, mental, arrequired under §483.24, §48 provided due to the under §483.10, includer §483.10,	rehensive person-centered resident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial tified in the comprehensive emprehensive care plan must are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse	F 65	and #116 related to: administration of oxygen and resident #112 to a communication consystem. 2. The residents of facility what tube feeding, administration oxygen and communication computer systems have the post to be affected. 3. Facility Nursing staff will educated on 8/9/18 to comprehensive care plan and care related to tube for administration of oxygen	related mputer no have on of nication otential be re- follow plan of eeding,
	rehabilitative service provide as a result of recommendations. If findings of the PASA rationale in the residual in the residual in the residual in the resident's represent (A) The resident's godesired outcomes. (B) The resident's purpose of the resident's purpose of the resident in t	services or specialized es the nursing facility will of PASARR if a facility disagrees with the ARR, it must indicate its dent's medical record. ith the resident and the ative(s)- oals for admission and reference and potential for cilities must document t's desire to return to the essed and any referrals to es and/or other appropriate loose. in the comprehensive care		residents who require communication computer system 4. To ensure compliance and be conducted by RAI direct Designee) every week x 4 then monthly x 3, to ensure strollowing comprehensive care and plan of care regarding feeding, administration of	e a em. lits will tor (or weeks, taff are e plans tube oxygen mputer rded to
	plan, as appropriate	, in accordance with the thin paragraph (c) of this		F656.	

section.

DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES					ED: 08/02/201	
		& MEDICAID SERVICES					RM APPROVE	
1000	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IDI F (CONSTRUCTION	2 100	NO. 0938-039	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	W 45 5444		SONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ŀ								
		495359	B. WING_				07/26/2018	
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		01120/2010	
DOGWO	DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND RE				DOGWOOD LANE			
	OB TIELAGE OF ORA	MOE COUNT I REALIN AND RE	ПАВ	OR	ANGE, VA 22960			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
E 656	Continued From no	00		. 1				
1030	Continued From page		F 65	6				
H	by:	IT is not met as evidenced						
	1770 Table 1	ion, staff interview, facility						
		nd clinical record review, it						
		t facility staff failed to develop		-20				
	and implement the	comprehensive care plan for						
		in the survey sample,						
	Resident #89, 37, 39	9, 116, and #112.						
	1 The facility staff t	failed to check for residual						
		sident #89's tube feeding per		63				
		care plan and plan of care.						

- 2. The facility staff failed to follow Resident # 37's comprehensive care plan for the administration of oxygen.
- 3. The facility staff failed to implement Resident #39's comprehensive care plan for the administration of oxygen.
- 4. The facility staff failed to follow Resident #116's comprehensive care plan regarding the administration of oxygen at the physician ordered rate.
- 5. The facility staff failed to follow the comprehensive care plan to implement the communication computer system for Resident #112.

The findings include:

1. The facility staff failed to check residual prior to initiating Resident #89's tube feeding per the comprehensive care plan and plan of care.

Resident #89 was admitted the facility on 5/30/18 with diagnoses that included but were not limited

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	**************************************	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495359	B. WING		07/26/2018
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960	, 51125.5
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	JLD BE COMPLETION
two diabetes, dysph and hemiplegia (par Resident #89's mos set) was a 30 day so ARD (assessment re Resident #89 was cointact in the ability to 14 out of 15 on the Mental Status exam as requiring extensive bed mobility, transfer hygiene; and total de locomotion, eating, a was coded in Section as having a feeding Review of Resident.	eakness, cognitive cit, high blood pressure, type ragia (difficulty swallowing) (1) ralysis) (2) on the left side. St recent MDS (minimum data cheduled assessment with an eference date) of 6/27/18. Toded as being cognitively of make daily decisions scoring BIMS (Brief Interview for). Resident #89 was coded we assistance from staff with ears, toileting, personal ependence on staff with and bathing. Resident #89 on K "Nutritional Approaches"	F 6	56	

"Fibersource via g (gastronomy) tube (peg [percutaneous endoscopic gastrostomy (3)]/feeding tube for enteral nutrition) at 130 cc/hr (hour) x 10 hours for Nutrition -Start at 4 PM/stop at 2 AM.

Flush peg tube with 150 ml (milliliters) H20 (water) before and after feeding

Check placement of Peg before administering of medications/feedings/flushes

Check residual every shift hold if more than 60 cc (cubic centimeters) and notify MD (medical doctor)."

Review of the July 2018 MAR (medication

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		& MEDICAID SERVICES				FORI	MAPPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII 3	CIDLE C	CONSTRUCTION	10000000	D. 0938-0391
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		TE SURVEY
		495359	B. WING			0.7	//26/2018
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 01	120/2010
DOGWO	OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ		DOGWOOD LANE ANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	100	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPOLICIENCY)	DBE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 62	F 6	56		511	65 126 13 <u>6</u>
	administration recording residuals	rd) revealed that staff were at 6 AM, 2 PM and 10 PM. tinclude prior to his feeding		K			
	documented the foll requires a PEG tube intake r/t (related to cerebral artery) infa (left sided paralysis) dysphagiaApproacinitiating (Name of Fplacement of PEG FON 7/24/18 at 4 p.m observation was continuous personal placement of PEG FON 7/24/18 at 4 p.m observation was continuous personal pers	ches: check residual before Resident #89's) feeding, check PER MD ORDERS." , medication administration inducted with RN (registered		T .			a.
35 56	medications to Resi	tated she was going to give dent #89. RN #6 told this dy sanitized her hands. RN owing medications:					
R. S	brain to prevent seiz related to neurologic Oxycodone 5 mg 1 i used to treat moder	(milligrams); works in the cures and manage pain cal disorders. (4) tablet; narcotic analgesic ate to severe pain. (5) tabs; also known as vitamin					Ti.
	placed the contents then crushed the on crushed medication then crushed the thi	Sabapentin capsule and in a separate cup. RN #6 e oxycodone and placed the into a medication cup. RN#6 ame and placed the crushed arate medication cup. RN #6					

then added water per order to each medication cup, took a peg tube syringe out of a plastic bag, and attached it to Resident #89's tube feed. RN

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	TE SURVEY
		495359	B. WING			707	//26/2018
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	нав	120	REET ADDRESS, CITY, STATE, ZIP CODE DOGWOOD LANE ANGE, VA 22960		720/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<u> </u>	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO' CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	medications separate checking the placer tube prior to adminish tube prior tube prior to adminish tube prior tube	peg tube, slowly adding the stely. RN #6 was not observed ment of Resident #89's peg stering medications.	F6	56			
	(milliliter) of water p and into his peg tub Resident #89 up to his tube feed. On 7/24/18 at 4:21 writer were back at stated she forgot to feeding and that she	er order through the syringe e. RN #6 then hooked his tube feed and turned on c.m., after RN #6 and this the medication cart, RN #6 check residual of the tube e usually does. RN #6 stated be checked prior to initiating		i i			
	conducted with RN; for Resident #89. V staff follows prior to #2 stated that prior the she would check the then check the placem important, RN #2 staplace and to ensure receiving too much the purpose of the care.	a.m., an interview was #2, another nurse who cares when asked about the process initiating a tube feeding, RN to setting up the tube feed; e placement of the tube and fual. When asked why ment and residual were atted to ensure the tube was in the resident was not feeding. When asked the plan, RN #2 stated that the plan was to serve as a guide		# # # # # # # # # # # # # # # # # # #			

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CENTERS FOR MEDICARE		ЛАРРКОVED). 0938-0391				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	495359	B. WING		07	/26/2018	
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAE			STREET ADDRESS, CITY, STATE, ZIP CO. 120 DOGWOOD LANE ORANGE, VA 22960	DE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
RN #2 stated it was be accurate. When	nge 64 he best care for the resident. s important for the care plan to n asked if the care plan was not of the pen tube and residue		56			

medications, RN #2 stated that if they were not checked then the care plan was not followed. RN #2 confirmed the above interventions for the care of Resident #89's tube feed. RN #2 clarified that residuals should be checked per shift per order and prior to initiating his feeding per plan of care.

was not checked prior to initiating feeding and

On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

The facility policy titled, "Checking gastric residual volume" documents in part, the following: "The purpose of this procedure is to assess tolerance of enteral feeding and minimize the potential for aspiration...review of the resident's care plan and provide for any special needs of the resident."

The facility policy titled, "MDS and Care Planning Process" did not address the above concerns.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs. and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	AG GOOD TO THE TOTAL OF THE	LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	National Institutes of https://medlineplus. (2) This information National Institutes of https://medlineplus. (3) This information National Institutes of https://www.ncbi.nlm. 14992/. (4) This information National Institutes of https://www.ncbi.nlm. T0010419/?report=(5) This information National Institutes of https://www.ncbi.nlm. T0011537/. (6) This information National Institutes of https://pubs.niaaa.nd-142.htm. 2. The facility staff 37's comprehensive administration of ox Resident # 37 was a 02/12/18 and a read diagnoses that included.	gov/swallowingdisorders.html. was obtained from The of Health. gov/paralysis.html. was obtained from The of Health. n.nih.gov/pmc/articles/PMC31 was obtained from The of Health. n.nih.gov/pubmedhealth/PMH details. was obtained from The of Health. n.nih.gov/pubmedhealth/PMH details. was obtained from The of Health. n.nih.gov/pubmedhealth/PMH was obtained from The of Health. in.nih.gov/publications/arh27-2/13 failed to follow Resident # e care plan for the				

(3), and hypertension (4).

Resident # 37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 37 as scoring a 99 on the brief

interview for mental status (BIMS) coding

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	BIMS. Under "C060 Assessment for Me Conducted?" was co of Section C0600 recoded as a 2 (two)-cognition for making 37 was coded as reof two staff member On 07/26/18 at approbservation of Residlying in bed receiving concentrator throug Observation of the othe oxygen was bein and a half and two in the content of the oxygen was bein and a half and two in the content of the oxygen was bein and a half and two in the content of the oxygen was bein and a half and two in the content of the oxygen was bein and a half and two in the content of the content of the content of the oxygen was being and a half and two in the content of the conte	ntal Status (C0700-C1000) be oded as "Yes." Further review evealed Resident # 37 was being moderately impaired of g daily decisions. Resident # quiring extensive assistance is for activities of daily living. roximately 7:35 a.m., and dent # 37 revealed she was g oxygen from an oxygen h a nasal cannula. Oxygen flow meter revealeding administered between one liters per minute.				
	observation of Residulying in bed receiving concentrator throug Observation of the concentration of the concentrat	oxygen flow meter revealed ng administered between one				
	July 2018 document 2L/MIN (two liters per cannula as needed	ers for Resident # 37 dated ted, "O2 (oxygen) @ (at) er minute) via (by) nasal for COPD [chronic obstructive (5). Start Date: 06/01/18."				ı
	record) dated July 2 documented, "O2 (c	ic treatment administration 018 for Resident # 37 oxygen) @ (at) 2L/MIN (two a (by) nasal cannula as				

needed for COPD [chronic obstructive pulmonary disease] (5). Start Date: 06/01/18." Further review of the eTAR evidenced Resident # 37

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	o7/26/18.	two liters per minute on					
	dated 02/21/2018 do (Resident # 37) has related to her diagno	care plan for Resident # 37 ocumented, "Problem/Need. impaired gas exchange osis of COPD, and history of		H E H			и
0	resp (respiration) fai Under "Approaches"	ospital stay with acute chronic ilure with hypoxia present." " it documented, "Administer dical doctor) orders."		g.			ar .
Z.	interview was condu	oximately 10:00 a.m., an acted with RN (registered sked to describe the purpose		81		;	
	of the care plan RN resident is getting th	# 4 stated, "So that the e correct care for their s documented on the care		E.			
	plan it should followe important to follow the	ed." When asked why is it ne care plan RN # 4 stated, "If ed the resident is not getting					
\$ \$2	the correct care and asked what the O2 fi	could result in injury." When low rate should be for 4 stated, "It should be two."					
	RN # 4 looked at the administration record	e eTAR (electronic treatment d) for Resident # 37 in the		13			
6	ordered at two liters.	Ith record) and stated, "It is " RN # 4 was asked to read Resident # 37's oxygen				12	
W 1	concentrator. RN # 4 stated, "It's between	4 read the flow meter and one and a half and two." RN to adjust the oxygen flow rate					
2	to two liters per minu	ite. When asked how often		E E			

the oxygen flow rate should be checked, RN # 4 stated, "Every shift." RN # 4 was asked to review Resident # 37's care plan. When asked if the

care plan was being followed for Resident # 37's O2 administration, RN # 4 stated, "No."

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		roximately 1:55 p.m., ASM f member) # 1, the	0.3					

No further information was provided prior to exit.

administrator and ASM # 2, director of nursing. ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

References:

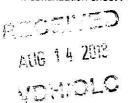
- (1) Low iron. This information was obtained from the website:
- https://www.nlm.nih.gov/medlineplus/anemia.html
- (2) Fear. This information was obtained from the website:

https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(3) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website:

https://medlineplus.gov/ency/article/003213.htm.

- (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpr essure.html.
- (5) Disease that makes it difficult to breath that can lead to shortness of breath) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.



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F 656	3. The facility staff #39's comprehensive administration of oxine Resident #39 was a 1/15/18 with diagnolimited to: heart failtobstructive pulmona disease that makes blood pressure, der depression. The most recent MI assessment, a quarassessment references ident as scoring interview for mental has severe cognitive making. The resident extensive assistance members for bed making. The resident extensive assistance members for bed making. The resident extensive assistance members for bed making, eating and O - Special Treatmer Programs, the resident extensive assistance members for bed making, eating and O - Special Treatmer Programs, the resident extensive assistance of the composition. A review of the composition of the comp	failed to implement Resident we care plan for the tygen. admitted to the facility on uses that included but were not ure, diabetes, chronic lary disease (a chronic lung it hard to breath) (1), high		656			

Approaches section of this problem/need the following was documented in part, "Administer O2

(oxygen) per MD (medical doctor)."

A review of Resident #39's clinical record documented the MD (medical doctor) order stating "O2 at 3 L/min (liters/minute) via nasal cannula (a plastic tube with two prong that are

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inserted just inside the nose) or simple mask to maintain Sats (oxygen saturation) above 90%. Check O2 Sats and flow meter every shift." Observation on 7/24/18 at 2:31 p.m. and 4:33 p.m. noted Resident # 39 reclining in his bed with oxygen on via nasal cannula connected to an oxygen concentrator with the flow meter set between 2.5-3 L/min. Observation on 7/25/18 at 8:08 a.m. noted Resident #39 sitting up with breakfast tray and oxygen on via nasal cannula connected to an oxygen concentrator with the flow meter set between 2.5-3 L/min. An interview was conducted with CNA (certified nursing assistant) #5 on 7/26/18 at 9:39 a.m. CNA #5 was asked the purpose of the care plan and CNA #5 stated, "To see status of resident" and that is should be "Individualized for specific patient." When asked if it was important to follow the care plans, CNA #5 stated, "Ves." On 7/26/18 at 8:12 a.m., RN (registered nurse) #4, was asked to assess Resident #39's current flow rate. She confirmed it was at 3 L/min. as ordered by the physician. RN #4 was advised that there were several observations of the flow meter reading between 2.5 and 3 L/min during the survey period. When asked how one should read the flow meter to ensure the correct flow of oxygen is being received, RN #4 stated, "The center of the ball should be on the 3 for [Resident #39's name]."	

nurse) #1 on 7/26/18 9:46 a.m. When asked the purpose of the care plan, RN #1 stated, "Tells the

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1 000	PRINTED CONTROL OF THE PROPERTY OF THE PROPERT	V 1941 184	F 000			
		t" and should be "personalized sident needs." When asked if				
	the care plan shoul	d be followed, RN #1 stated,				
	"Yes."					e.
	ASM (administrative	e staff member) #1, the				
	executive director,	ASM #2, the director of				
	•	ne assistant director of				
		5, (the medical doctor), where				
	1:50 p.m.	above concerns on 7/26/18 at				
d	Practice", Seventh & Wilkins, pg. 276 r care (patient care p directs the efforts o work with patients t	ncott Manual of Nursing Edition: by Lippincott Williams read: "The plan of nursing plan) is the written guide that if the nursing team as nurses o meet their health goalsIs individual characteristics and t."				Į.
14	No further informati	on was provided prior to exit.				
	National Institutes of https://medlineplus. 4. The facility staff #116's comprehens	was obtained from the of Health at gov/ency/article/000091.htm failed to follow Resident live care plan regarding the sygen at the physician ordered	,			
	10/2/14 and readmi diagnoses of but no	admitted to the facility on tted on 6/27/17 with the tlimited to congestive heart	:			

disease, senile degeneration of the brain, diabetes, depression, anxiety, adult failure to thrive, convulsions, and osteoporosis. The most

recent MDS (Minimum Data Set) was a

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significant change a (Assessment References ident was severe ability to make daily required extensive to activities of daily living the physician's order da 2 Liters via NC (nassisters of breath (saturation) Q (evenshift." A review of the care 10/2/14 and most re "(Resident #116) had (related to) dx (diagon heart failure), CAD (Angina, HTN (high bedema, chronic vencha (history) of hypok included an interven O2 (oxygen) per as a of breath) per MD (not observations made at 8:17 a.m. and 7/2) the oxygen concentric approximately 1.5 liteliters (as evidenced)	essessment with an ARD ence Date) of 7/5/18. The ely cognitively impaired in life decisions. The resident o total care for all areas of			

On 7/25/18 at 3:28 p.m. LPN #5 (Licensed Practical Nurse) was asked to observe the flow meter. LPN #5 stated the line (for the 2-liter mark) should be through the center of the ball. LPN #5 stated it was not and that the oxygen was

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not set at the right rate. When asked if the care plan documented to administer oxygen per orders, and the oxygen was not set at the ordered rate, then was the care plan being followed, LPN #5 stated, "That is a trick question. I will have to ask my manager about that."

On 7/25/18 at 3:44 p.m. LPN #6, the unit manager was asked if the care plan documented to administer oxygen as ordered and the oxygen was not set at the ordered rate, then was the care plan being followed, LPN #6 stated "No, the care plan is not being followed."

On 7/25/18 at approximately 6:00 p.m., the executive director and director of nursing (ASM #1 and #2 respectively - Administrative Staff Members) were made aware of the findings. No further information was provided by the end of the survey.

5. The facility staff failed to follow the comprehensive care plan to implement the communication computer system for Resident #112.

Resident #112 was admitted to the facility on 9/1/15 and readmitted on 9/6/16 with diagnoses that included but were not limited to: anoxic brain damage (1), hemiplegia (2), feeding tube and inability to speak.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 7/25/18 coded the resident as rarely to never being understood or to understand. The resident was coded as requiring staff assistance for all activities of daily living.

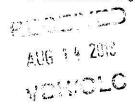
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FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: VA0180

If continuation sheet Page 74 of 129



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	a.m. of Resident #1 bed with eyes open dresser next to the turned on and the o pulled closed. There communication obs An observation was of Resident #112. R administering medic the feeding tube. RI resident at the time Review of the comp on 9/8/15 and revise "Problem/Need. (Na COGNITIVE LOSS BRAIN INJURY ANI COMMUNICATE/AF VERBAL DOES API (with) BUT NO OTH Approaches. TALK PROVIDING CARE YOU ARE DOING A ENCOURAGE YES W/ENCOURAGEMI SYSTEMSPOUSE COMPUTER SYSTI AID IN COMMUNIC USE OF SYSTEM A An interview was co p.m. with RN #7. Wi care plan, RN #7 sta take care of them."	s made on 7/24/18 at 11:10 112. The resident was lying in n. There was a light on over the bed. The television was curtain was three quarters re was no computer to aid in served. s made on 7/25/18 at 9:15 a.m. RN (registered nurse) #7 was ication to the resident through RN #7 was not talking to the e of the observation. prehensive care plan initiated sed on 6/23/18 documented, ame of resident) HAS S R/T (related to) ANOXIC ID INABILITY TO APHASIA. HE IS NON - PPEAR TO FOLLOW W/EYES HER MOVEMENT. TO HIM AS YOU ARE E AND LET HIM KNOW WHAT AS YOU COMPLETE TASKS. S/NO QUESTIONS IENT OF EYE-BLINK	i.	556			

dietary. The whole building."

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An interview was conducted on 7/25/18 at 3:58 p.m. with RN #3. When asked why residents have care plans, RN #3 stated, "So we know what their plan of care is." When asked if staff were expected to follow the care plan, RN #3 stated yes. When asked why staff hadn't been educated with the computer for Resident #112, RN #3 didn't have an answer.

An interview was conducted on 7/26/18 at 8:16 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked how she communicated with the resident, CNA #8 stated, "Sometimes he'll blink. We go in every two hours to turn him and say hello."

An interview was conducted on 7/26/18 at 9:15 a.m. with LPN (licensed practical nurse) #4, the resident's nurse. When asked how she communicated with Resident #112, LPN #4 stated, "When he first came in the wife said he could blink his answers but we never saw that." When asked if staff used the computer to aid in communication, LPN #4 stated, "His wife uses it when she's here but we've been never trained on it." When asked if she had watched the wife use the computer with the resident, LPN #4 stated she had not. When asked if there would be value in learning how to use the computer with the resident, LPN #4 stated, "Yes, he could tell us how he's feeling." LPN #4 stated, "We keep it locked in the medication room when she's not here." When asked why residents had care plans. LPN #4 stated, "So we know how they like to be cared for. How they transfer, their morning routine." When asked who used the care plan. LPN #4 stated, "The nurses, CNAs (certified nursing assistants)." When asked if staff were expected to follow the care plan, LPN #4 stated,

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 76	F 6	56			-
	"Yes, ma'am."						
	a.m. with ASM (adn the assistant director how staff communic ASM #4 stated, "Sh it (the computer). H When asked why re #4 stated, "We have how to care for the staff had not been e computer as docum #4 did not think the computer.	onducted on 7/26/18 at 9:30 ministrative staff member) #4, or of nursing. When asked cated with Resident #112, we (the wife) wants him to use it is not so willing to use it." esidents had care plans, ASM is a care plan to let us know resident." When asked why educated on the use of the pented on the care plan, ASM resident liked to use the					
	On 7/26/18 at 12:45 director and ASM #2 made aware of the f	p.m. ASM #1, the executive 2, the director of nursing were findings.					
	No further information	on was provided prior to ext.					
	1. Anoxic brain dam	age (lack of oxygen) - Anoxia					

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC38 14506/

2. Hemiplegia - Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	WAS DESCRIPTION STORY	PLE CONSTRUCTION		TE SURVEY
		495359	B. WING		07	//26/2018
	PROVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND RE	HAR	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960	1 0	720/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 656	Continued From pa	tained from:	F 656			
SS=D	§483.21(b)(2) A corbe- (i) Developed within the comprehensive (ii) Prepared by an includes but is not li (A) The attending p (B) A registered nur resident. (C) A nurse aide wit resident. (D) A member of foc (E) To the extent prother exident and the An explanation mus medical record if the and their resident renot practicable for the resident's care plant. (F) Other appropriated disciplines as determor as requested by the (iii) Reviewed and reteam after each assomprehensive and assessments. This REQUIREMEN by: Based on staff interreview, it was determation the provise the control of th	nd Revision 2)(i)-(iii) thensive Care Plans inprehensive care plan must a 7 days after completion of assessment. interdisciplinary team, that mited to— hysician. se with responsibility for the the responsibility for the acticable, the participation of a resident's representative(s). It be included in a resident's e participation of the resident are development of the e staff or professionals in mined by the resident's needs the resident. Vised by the interdisciplinary essment, including both the	F 657	1. The facility has establish corrective action for resident # 7/25/18 to ensure comprehensive care plan updated to identifying the bel of removing nasal cannula. 2. The residents of the facility wear nasal cannulas have potential to be affected. 3. Facility Nursing staff will be educated on 8/9/18 on updating comprehensive care plans residents who remove their cannula. 4. To ensure compliance audit be conducted by Director of Nor Designee every week x 4 x then monthly x 3 to ensure updating of comprehensive plans of residents who remove nasal cannula.	37 on the was navior who the of re- ng the of nasal cs will ursing weeks the care	9/4/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING O7/26/20 STREET ADDRESS. CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	CENTERS	S FUR MEDICARE	& MEDICAID SERVICES		88	OMB N	O. 0938-039	
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	AND PLAN OF CORRECTION IDENTIFICATION NITIMBER							
DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			495359	B. WING_		0	7/26/2018	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AN			REHAB	120 DOGWOOD LANE			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	

F 657 Continued From page 78

F 657

The facility staff failed to revise Resident # 37's comprehensive care plan to address her behavior of removing the nasal cannula (1).

The findings include:

Resident # 37 was admitted to the facility on 02/12/18 and a readmission of 05/08/18 with diagnoses that included but were not limited to pain, anemia (2), anxiety, (3), depressive disorder (4), and hypertension (5).

Resident # 37's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 05/18/18, coded Resident # 37 as scoring a 99 on the brief interview for mental status (BIMS) coding Resident # 37 as being unable to complete the BIMS. Under "C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted?" was coded as "Yes." Further review of Section C0600 revealed Resident # 37 was coded as a 2 (two) - being moderately impaired of cognition for making daily decisions. Resident # 37 was coded as requiring extensive assistance of two staff members for activities of daily living.

On 07/24/18 at approximately 2:16 p.m., an observation of Resident # 37 revealed she was lying in her bed the oxygen concentrator running and the oxygen tubing and nasal cannula lying on the bed uncovered.

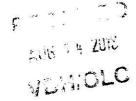
On 07/25/18 at approximately 4:45 p.m., an observation of Resident # 37 revealed she was lying in her bed the oxygen concentrator running and the oxygen tubing and nasal cannula draped over the top of the oxygen concentrator. The

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		E & MEDICAID SERVICES				M APPROVED D. 0938-0391
STATEMENT	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DA	D. 0930-039 I ATE SURVEY OMPLETED
		495359	B. WING _	<u> </u>	07	7/26/2018
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DOGWO	OU VILLAGE OF UKA	ANGE COUNTY HEALTH AND RE	HAB	ORANGE, VA 22960		
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F 657	Continued From pa	aae 79	F 65	57		18
30000 a same	177	hanging on the backside of	I [™] OO	:		1 2
	observation of Resisiting in her wheeld present in the room Resident # 37. The and nasal cannula vuncovered.	proximately 6:10 p.m., an ident # 37 revealed she was chair in her room. A nurse was a administering medications to e oxygen concentrator running was lying on the bed				
	July 2018 document 2L/MIN (two liters per cannula as needed	lers for Resident # 37 dated nted, "O2 (oxygen) @ (at) per minute) via (by) nasal for COPD [chronic obstructive] (6). Start Date: 06/01/18."				
	dated 02/21/2018 do (Resident # 37) has related to her diagno smoking. Recent ho resp (respiration) fai Under "Approaches"	e care plan for Resident # 37 documented, "Problem/Need. impaired gas exchange osis of COPD, and history of ospital stay with acute chronic oilure with hypoxia present." " it documented, "Administer edical doctor) orders."				
		roximately 10:00 a.m., an				80

nurse) # 4. RN #4 was asked to describe the process for storing a nasal cannula when it is not being used. RN #4 stated, "It should be placed in a plastic bag for infection control purposes." RN # 4 further stated, "The resident takes off her cannula when she wants." When asked if that was documented on the care plan, RN stated, "I don't know." Further review of Resident # 37's comprehensive care plan dated 02/21/2018 with RN #4 failed to evidence Resident #37's behavior of removing her nasal cannula.

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		& MEDICAID SERVICES					RM APPROVEI O. 0938-039
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S CONTRACTOR DONAGE	PROVIDER OR SUPPLIER	NGE COUNTY HEALTH AND RE	НАВ	120	EET ADDRESS. CITY, STATE, ZIP CODI DOGWOOD LANE ANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	100 miles	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 80	F 6	57 ⁸			5 38
	interview was condumember) # 12, MDS describe the process comprehensive care "Initially the compredeveloped during the period no later than working document; updated and revised IDT (interdisciplinar Resident # 37's beh	roximately 10:28 a.m., an ucted with OSM (other staff S coordinator. When asked to as of developing a e plan OSM # 12 stated, hensive care plan is see comprehensive assessment day 21 from admission. It is a the care plan is always being d from information from the y team). When asked about eavior of removing her oxygen t should it be part of the care		25			

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

plan." When asked why it is important to update or revise a resident's care plan OSM # 12 stated, "It individualizes it for the resident, provides the staff with the needed information to evaluate the resident and show any trends of behavior." OSM # 12 further stated, "Based on what you told me the care plan for Resident # 37 should be

No further information was provided prior to exit.

References:

revised."

(1) a device for delivering oxygen by way of two small tubes that are inserted into the nares. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/n asal+cannula.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495359	B. WING	B. WING		07/26/2018	
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND RE			HAB	STREET ADDRESS, CITY, STATE, ZIP CO 120 DOGWOOD LANE ORANGE, VA 22960			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	Continued From p	age 81	F 6	57			
	the website:	nformation was obtained from h.gov/medlineplus/anemia.html	i i	. *			
Enclosed to	website:	rmation was obtained from the h.gov/medlineplus/anxiety.html				II	
	blue, unhappy, mis Most of us feel this short periods. Clin disorder in which for frustration interf	y be described as feeling sad, erable, or down in the dumps. way at one time or another for ical depression is a mood eelings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the					
	(5) High blood pres	.gov/ency/article/003213.htm. ssure. This information was website: n.gov/medlineplus/highbloodpr					
	can lead to shortned was obtained from https://www.nlm.nil Services Provided CFR(s): 483.21(b)(3) Community The services provided as outlined by the comust- (i) Meet professions	n.gov/medlineplus/copd.html. Meet Professional Standards	F 65	1.The facility has estable corrective action for reside clarification order was worked 7/25/18 regarding use of powith pain medication and for #116 who was seen practioner on 8/8/18 that so negative response related checking 02 sats.	ent #69. A critten on arameters or resident by nurse howed no		

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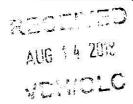
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2000 70-4000 70-500	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18	495359	B. WING		07/26/2018
	PROVIDER OR SUPPLIER	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP COI 120 DOGWOOD LANE ORANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
	document review, a was determined that follow professional of 40 residents in the 69 and 116. 1. The facility staff orders for pain med 2. The facility staff orders for pain med 2. The facility staff orders for pain med 2. The facility staff orders for pain med 3. The facility staff orders for pain med 4. Resident #69 was need for the use of orders for the use of orders for beadministered as The findings include 1. Resident #69 was 2/14/17 with diagnost limited to: diabetes, muscle weakness and the most recent MD assessment, a quart assessment reference resident as scoring a interview for mental shas severe cognitive making. The resident extensive assistance members for bed most toileting, eating and policiting, eating and policiting, eating and policiting orders for bed most toileting, eating and policiting the local policiting the local policities of the po	ion, staff interview, facility and clinical record review it at the facility staff failed to standards of practice for two se survey sample, Residents # failed to clarify the physician's ication for Resident #69. failed to follow professional e to document the respiratory dent #116 that indicated the exygen, which was ordered to needed. s admitted to the facility on ses that included but were not chronic pain, low back pain, and fatigue. S (minimum data set) erly assessment, with an ce date of 6/18/18, coded the impairment for daily decision to twas coded as requiring for at least one or more staff obility, transfers, dressing, personal hygiene. In Section resident was coded as using resident was coded as using	F 65	2. The residents of the factoreceive the administration of and have parameters for medication have the potent affected. 3. Facility Nursing staff will educated on 8/9/18 to physician orders regarding who have one or momedications ordered parameters in place and who receive the administric oxygen. 4. To ensure compliance at be conducted by Director of (or Designee) every week x then monthly x 3 to ensure Nursing staff to follow porders for residents who recommore pain medications, to parameters are placed administration of Information will be forward QAPI for review. 12VAC5-371-200 cross references.	f oxygen or pain ial to be I be re- follow residents re pain have residents ation of udits will Nursing 4 weeks, that the ohysician eive one o ensure d and oxygen. rded to

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		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	e .	495359	B. WING		07/26/2018
501	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ		
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F 658	tabs by mouth every. The physician order "Norco 5-325 (a hydrogon acetaminophen con relieve moderate-to medications called (1)) mg tablet: one that sheeded [for] Dx (order documented where the last sheeded as documented where the last sheeded as documented to be used based on the last sheeded as administered on 7/7 level of 8; on 7/8/18 of 8; on 7/11/18 at 2 on 7/16/18 at 8:23 at 7/18/18 at 8:56 a.m. 7/20/18 at 8:45 a.m. The July 2018 MAR physician order. The documented as administered as a ministered as	5 mg (milligram) tablet: take 2 y 6 hours as needed for pain." dated 12/5/17, documented: drocodone and abination product used to severe pain. It is in a class of opiate (narcotic) analgesics ab by mouth three times daily diagnosis): pain." Neither which pain medication should be resident's pain level. (medication administration of the above physician orders. As documented as 18 at 8:40 a.m. for a pain level of 3; m. for a pain level of 4; m. for a pain level of 5; m. for a pain level of 8; and on for a pain level of 8. documented the above a Acetaminophen was binistered on 7/11/18 at 12:02	F 658		

a most recent revision date of 5/23/18.

alteration in comfort related to pain." The "Approaches" documented in part, "Give meds [medications] per order; see EMAR [electronic

medication administration record]".

documented in part, "Problem/Need: Is at risk for

An interview was conducted with RN (registered nurse) #2 on 7/26/18 at 9:46 a.m. When asked how staff determined which pain medication is given to a resident when the resident has multiple

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	ask them the pain let they are having." Wabove order for Nor RN #2 stated, "We clarify which level or medication." ASM (administrative executive director, Anursing, ASM #4, th nursing, and ASM # made aware of the anade aw	ications, RN #1 stated, "We evel or to number the pain /hen asked to review the co 5-325 and Acetaminophen, need to ask the doctor to f pain requires which pain estaff member) #1, the ASM #2, the director of e assistant director of 5, (the medical doctor), where above concerns on 7/26/18 at cott Manual of Nursing ition: by Lippincott Williams &: "Nursing Alert: Unusual ar drugs should always be ealth care provider and dministration." On pg. 15, the need in part, "Inappropriate you cannot automatically hink is unsafe, you cannot I order, either. b Call the discuss your concerns with ateorders. c. Notify all d nursing personnel d.		558				

2. The facility staff failed to follow professional standards of practice to document the respiratory

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		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495359	B. WING		07/26/2018	
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DOGWO	OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	120 DOGWOOD LANE ORANGE, VA 22960		
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F 658	Continued From pa	ge 85	F 6	58	35	
		ident #116 that indicated the oxygen, which was ordered to needed.			e	
	10/2/14 and readmidiagnoses of but no failure, high blood p disease, senile degration diabetes, depression thrive, convulsions, recent MDS (Minimal significant change at (Assessment References identity as coded impaired in ability to The resident was cotal care for all areas	admitted to the facility on ted on 6/27/17 with the of limited to congestive heart pressure, peripheral vascular eneration of the brain, in, anxiety, adult failure to and osteoporosis. The most um Data Set) was a assessment with an ARD ence Date) of 7/5/18. The as severely cognitively make daily life decisions of activities of daily living.				
	at 8:17 a.m., and 7/2	25/18 at 3:25 p.m., revealed ng oxygen at that time.				
	A physician's order of "Oxygen @ (at) 2 Lit	dated 7/9/18, documented, ters via NC (nasal cannula)				

Review of the clinical record failed to reveal a nurse's note for 7/25/18 documenting a respiratory assessment that indicated the need

for the use of as-needed oxygen on 7/25/18.

as needed for shortness of breath and check 02 (oxygen) sats (saturation) Q (every) shift and flow

On 7/25/18 at 3:28 p.m., LPN #5 (Licensed Practical Nurse) stated an assessment should be documented.

On 7/25/18 at 3:44 p.m., in an interview with LPN

meter Q shift."

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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	oxygen is consider nurses should be or Resident #116 "decent level drops) frequence keep oxygen sats a stated that a respir documented, if the LPN #6 stated the any signs or symptothat indicated the number of the level director at the signs of the level director at the level director dit	age 86 dical Nurse) she stated that ed a medication and that shecking it. LPN #6 stated that stats" (desaturation - oxygen intly and the facility tries to at 90% or above. LPN #6 atory assessment should be resident is using the oxygen. documentation should include oms the resident was having eed to use the oxygen. oximately 6:00 p.m., the and director of nursing (ASM vely - Administrative Staff ade aware of the findings. No was provided by the end of the mentals of Nursing, Fifth Villiams & Wilkins, 2007, page gen is a drug, its use requires cies and standing orders often administer oxygen in as if the physician is not alle to write an order. Although safe when used properly, must be observed. As with all exists for causing harm with a52, Procedure 36-5, "3. roceed with 5 rights of trationRationale: Oxygen is ering using the 5 rights avoids . Document procedure and nale: Maintains legal record with healthcare team	F 6	58				
F 676	Activities Daily Living	g (ADLs)/Mntn Abilities	F 67	6 1.The	facility h	as establishe	d a	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY	
		495359	B. WING		07/26/2018		
	PROVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND RE	нав	STREET ADDRESS, CITY, STATE, ZIP CO. 120 DOGWOOD LANE ORANGE, VA 22960			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COMPLÉTIO	N	
SS=D	assessment of a recresident's needs an provide the necessal ensure that a reside daily living do not did of the individual's class that such diminution includes the facility §483.24(a)(1) A restreatment and service or her ability to carry living, including those of this section	1)(b)(1)-(5)(i)-(iii) on the comprehensive esident and consistent with the end choices, the facility must ary care and services to ent's abilities in activities of iminish unless circumstances linical condition demonstrate in was unavoidable. This ensuring that: sident is given the appropriate ices to maintain or improve his yout the activities of daily se specified in paragraph (b)	F6	U grant and	(a) the nunication t with assisting nt on staff to include provided o transfer have the who use to assist d require		
	accordance with paractivities of daily living \$483.24(b)(1) Hygie grooming, and oral of \$483.24(b)(2) Mobilition including walking, \$483.24(b)(3) Eliming \$483.24(b)(4) Dining snacks, \$483.24(b)(5) Common (i) Speech, (ii) Language,	ragraph (a) for the following ing: ene -bathing, dressing, care, ity-transfer and ambulation,		3. Facility Nursing staff edu 8/9/18 on how to use common computers to assist communication as well as residents for activities of daincluding transfers to get out. 4. To ensure compliance, as be conducted by Director of (or Designee) every week x then monthly x 3, to ensure allowing residents who communication compute communication have assistal residents who require assistal activities of daily living	sunication with assisting ally living, t of bed. udits will f Nursing 4 weeks, staff are no use ers for ince, and tance for		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
4		495359	B. WING			0	7/26/2018
#250.000 (#250.000 (#250.000) (#2	NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND RE			120	REET ADDRESS, CITY, STATE, ZIP CODE DOGWOOD LANE RANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	by: Based on observal document review as was determined that provide activities of promote maximum	NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to daily living assistance to level of functioning for one of	F 6	76	transfers are provided assistance staff to transfer out of Information will be forwarded QAPI for review.	bed.	9/4/18
	1. a. The facility sta #112, who was code activities of daily livi	survey sample, Resident #112. ff failed to ensure Resident ed as dependant on staff for ing including transfers, was e daily by staff to transfer out		#1 19			10 cm
	b. The facility staff failed to learn how to implement the communication computer to assist Resident #112 with communicating, as per the plan of care for Resident #112.			w			3
	The findings include	3 :		8			**************************************
	9/1/15 and readmitted that included but we	admitted to the facility on ed on 9/6/16 with diagnoses ere not limited to: anoxic brain egia (2), feeding tube and		Ş.			e company of the comp
	quarterly assessme reference date) of 7 rarely to never being understand. The res						
	a.m. of Resident #1	made on 7/24/18 at 11:10 12. The resident was lying in					

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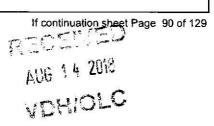
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>0. 0938-0391</u>
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY
		495359	B. WING			07	7/26/2018
NAME OF F	PROVIDER OR SUPPLIER		T	STF	REET ADDRESS, CITY, STATE, ZIP CODE	U 200	/==
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 676	Continued From pa	nge 89	F 6	76			3
1	NAME OF TAXABLE PARTY.	bed. The television was	50 com	i Eng			8
1	The curtain was thre	ntry western music channel. ree quarters pulled closed. puter to aid in communication	10 Miles		*		8
	An observation was of Resident #112. T with eyes closed. TI dresser. The televis	s made on 7/24/18 at 2:49 p.m. The resident was lying in bed the light was on over the sion was on the same channel. the quarters pulled closed.		20 40			2
n	of Resident #112. T with eyes closed. TI	s made on 7/25/18 at 8:04 a.m. The resident was lying in bed he lights were off. The ne same channel. The curtain		左			:
	a.m. of Resident #1	s made on 7/25/18 at 10:20 12. The resident had been s side. The room remained the	:	N.			ž.
×	p.m. of Resident #1 be in the same posi the curtains were cla	An observation was made on 7/25/18 at 12:15 p.m. of Resident #112. The resident appeared to be in the same position. The lights remained off, the curtains were closed and the television was on the same channel.		500			n e 8
	of Resident #112. The back with his eyes of	s made on 7/25/18 at 2:05 p.m. The resident was lying on his closed. The lights remained re closed and the television hannel.		100 100			10
	9/7/15 and revised of	ent's care plan initiated on on 6/23/18 documented, ame of resident) HAS					

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

FUNCTIONAL STATUS LIMITATIONS

Event ID: 093G11

Facility ID: VA0180



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DEI WILL	INCIAL OF LICUCIA	AND HOMAN SERVICES				FOR	KM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	\$43 majohan Augasha 1 man ang man				O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		OATE SURVEY OMPLETED
		495359	B. WING				7/26/2018
NAME OF F	PROVIDER OR SUPPLIER	For contractional desired at		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DOCWO		NOE COUNTY HEALTH AND BE	UAB	12	0 DOGWOOD LANE		
DUGWU	OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	пав	O	RANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	daily living) R/T AND TOTAL ASSIST FO ADLS/MOBILITY/H TOTAL CARE FOR TRANSFERS" Review of the July 2 documented, "MAY GERICHAIR AS TO At interview was cop.m. with RN (regis nurse. When asked RN #7 stated, "It lift morale boost." When	ST WITH ADL'S (activities of OXIC BRAIN DAMAGE. HE IS PRINTED AND	Po	576			
	try to get him up a cout here (indicating When asked why the bed everyday like the stated, "No reason."	cipated in, RN #7 stated, "We couple times a week. He sits the dining/social area)." he resident didn't get out of he other residents, RN #7 He does sit out here."					
	p.m. with CNA #12. important for reside stated, "Yes." Wher "They need to be up asked which of her bed, CNA #12 ment asked why the resid CNA #12 stated, "I'r up, I'll find out. We sthose residents."	onducted on 7/25/18 at 2:30 When asked if it was ents to get out of bed, CNA #12 hasked why, CNA #12 stated, or and moving around." When residents did not get out of tioned Resident #112. When dent did not get out of bed, man not sure I think he should be should we still try to stimulate					
	An interview was co	onducted on 7/25/18 at 2:33					

p.m. with CNA (certified nursing assistant) #7. When asked why the resident stays in a dark room with the curtain closed, CNA #7 stated,

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		AND HUMAN SERVICES & MEDICAID SERVICES			(FORM APPROVED DMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495359	B. WING_			07/26/2018
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u>-</u>
DOGWO	OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ		DOGWOOD LANE ANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 676	Continued From pa	ge 91	F 6	76		
	"That's how it's bee know why."	n since I've been here. I don't				at .
	p.m. with RN #3, the when residents got "Everyone should be When asked why, F Getting them social them out of bed." We #112 was left in a declosed, RN #3 state get up a couple time the dark all day."	enducted on 7/25/18 at 3:58 e unit manager. When asked out of bed, RN #3 stated, e offered to get out of bed." RN #3 stated, "Quality of life. ized with other people, getting /hen asked why Resident ark room with the curtains ed, "He gets up. They should es a week. He shouldn't be in				
	a.m. with CNA (cert resident's aide, Wh- got out of bed, CNA get up Monday, We shower days. He re have many visitors,	enducted on 7/26/18 at 8:16 ified nursing assistant) #8, the en asked when the resident a #8 stated, "He's supposed to ednesday and Friday, his ally likes music. He doesn't his wife comes in on the and hangs out for the day."		46		
e	a.m. with LPN (licer resident's nurse. W resident got out of t they were getting hi sitting in his geri cha	onducted on 7/26/18 at 9:15 used practical nurse) #4, the hen asked how often the bed, LPN #4 stated, "I know m up on shower days, he was air." When asked if there was of bed, LPN #4 stated, "Yes. It				e) 10

know.

relieves pressure on the areas they've been laying on for a while. Social interaction." When asked if there was any reason for the resident not to bet out of bed everyday, LPN #4 stated, "I know the wife thinks it can be over-stimulating for him." When asked what the resident looked like when he was over-stimulated, LPN #4 did not

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CENTERS FOR MED	ICARE & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495359	B. WING		07/26/2018
NAME OF PROVIDER OR SU	PPLIER OF ORANGE COUNTY HEALTH AND I	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE DRANGE, VA 22960	
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 676 Continued Fr	om page 92	F 676		10

An interview was conducted

1 0,0

An interview was conducted on 7/26/18 at 9:30 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked why the resident only got out of bed on his shower days, ASM #4 stated, "The wife doesn't want him over-stimulated." When asked what that looked like, ASM #4 stated she didn't know. When asked if it was important for residents to get out of bed, ASM #4 stated, it was. ASM #4 stated, "I would like to see him do something everyday." A request for the resident's activities of daily living documented by the CNAs was made at that time.

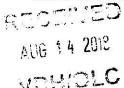
A review of the resident's activities of daily living forms documented that the resident got out of bed for his shower six times in July 2018. There was no other evidence that the resident had been out of bed or engaged in activities during that time.

On 7/26/18 at 12:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

- 1. Anoxic brain damage (lack of oxygen) Anoxia is the third most frequent cause of coma, after trauma and vascular lesions. The most common causes of post-anoxic coma in adults are: cardiopulmonary arrest, stroke, respiratory arrest and carbon monoxide poisoning. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC38 14506/
- 2. Hemiplegia Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages

Facility ID: VA0180

If continuation sheet Page 93 of 129



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		E & MEDICAID SERVICES				(V. 10749001F	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.100.107.000.000.000.000		CONSTRUCTION	(X3) DA	TE SURVEY
		495359	B. WING			07	7/26/2018
algorithe discount while securities. Then	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	НАВ	120	EET ADDRESS, CITY, STATE, ZIP CO DOGWOOD LANE ANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 676	can be complete or both sides of your k	brain and muscles. Paralysis partial. It can occur on one or body. It can also occur in just be widespread. This tained from:	F 6	76			5
	1 To	off failed to learn how to use computer as per the plan of 1112.					
	a.m. of Resident #1 bed with eyes open dresser next to the turned on to a cour The curtain was thr	s made on 7/24/18 at 11:10 112. The resident was lying in the there was a light on over the bed. The television was atry western music channel. The quarters pulled closed buter to aid in communication					
	of Resident #112. F administering medi the feeding tube. R	s made on 7/25/18 at 9:15 a.m. RN (registered nurse) #7 was cation to the resident through N #7 was not talking to the of the observation.	×				
	revised on 6/23/18 (Name of resident) (related to) ANOXIO	plan initiated on 9/8/15 and documented, "Problem/Need. HAS COGNITIVE LOSS R/T C BRAIN INJURY AND MMUNICATE/APHASIA. HE IS					at a second

NON - VERBAL DOES APPEAR TO FOLLOW W/EYES (with) BUT NO OTHER MOVEMENT. Approaches. TALK TO HIM AS YOU ARE

PROVIDING CARE AND LET HIM KNOW WHAT YOU ARE DOING AS YOU COMPLETE TASKS.

ENCOURAGE YES/NO QUESTIONS W/ENCOURAGEMENT OF EYE-BLINK

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		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495359	B. WING_		07/26/2018
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 676	An interview was cop.m. with RN #3, the why staff hadn't bee computer for Reside an answer. An interview was cop.m. with CNA (cert resident's aide. Whe communicated with "Sometimes he'll blit to turn him and say resident communicated with "I don't know the communicated with "I don't know the communicated with "When he first came blink his answers but asked if staff used to communication, LPI	E TO IMPLEMENT EM WHEN AVAILABLE TO CATION. STAFF TO TRAIN IN AND ENCOURAGE USE." Inducted on 7/25/18 at 3:58 In unit manager. When asked In educated on the use of the Interest of th	F 6	76	

how he's feeling."

it." When asked if she had watched the wife use the computer with the resident, LPN #4 stated she had not. When asked if there would be value in learning how to use the computer with the resident, LPN #4 stated, "Yes, he could tell us

An interview was conducted on 7/26/18 at 9:30 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	27.9	495359	B. WING		07	07/26/2018	
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960		20/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE	
F 679	#4 stated, "She (the computer). He is not asked if there would how to use the commercial resident, ASM #4 st "We're really not su Review of the clinical documentation evid willing to use the communication communi	cated with the resident, ASM wife) wants him to use it (the of so willing to use it." When it be value in having staff learn puter to communicate with the cated it would. ASM #4 stated, re how aware he is." all record failed to reveal any encing Resident #112 was not mmunication computer. The mentation evidencing the staff if on the use of the inputer. by p.m. ASM #1, the executive computer. The director of nursing were findings. con was provided prior to ext. est/Needs Each Resident	F6	ACC 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000 10000			
	the comprehensive and the preferences program to support activities, both facilit individual activities a designed to meet the physical, mental, and each resident, encorand interaction in the This REQUIREMEN by: Based on observational and the comprehensive the co	acility must provide, based on assessment and care plan of each resident, an ongoing residents in their choice of y-sponsored group and and independent activities, e interests of and support the d psychosocial well-being of uraging both independence		corrective action for resident for not documenting that the offered and engaged an oprogram of activities to resident's needs. 2. The residents of the facilit the potential to be affected. 3. Activities Staff will be re-ed on 8/9/18 related to document the offering and engaging resident on an ongoing program of activities resident's needs.	facility ngoing meet have licated enting idents		

	ATEMENT OF DEFICIENCIES AD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDINI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495359	B. WING		07/26/2018
	PROVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND RE	HAB	STREET ADDRESS, CITY, STATE, ZIP COD 120 DOGWOOD LANE ORANGE, VA 22960)E
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F 679	The facility staff fa offered and engag ongoing program of	at the facility staff failed to e activity program for one of 40 rvey sample, Resident #112. illed to provide evidence staff ed Resident #112 in an of activities to meet the r the months of April, May,	F 679	4. To ensure compliance au be conducted by Activities (or Designee), every week x 4 then monthly x 3, to ensure documenting the offerin engaging in ongoing progractivities to meet resident's new terms of the conductivities to meet resident new terms of the conductivities to meet resident new terms of the conductivities new	Director weeks, staff are g and ams of
)	9/1/15 and readmit that included but w	e: admitted to the facility on ted on 9/6/16 with diagnoses ere not limited to: anoxic brain legia (2), feeding tube and			17 25
	quarterly assessment reference date) of a rarely to never being understand. The results of the r	DS (minimum data set), a ent, with an ARD (assessment 7/25/18 coded the resident as g understood or to sident was coded as requiring all activities of daily living.			9 8
	a.m. of Resident #1 bed with eyes open dresser next to the turned on to a cour The curtain was thr	s made on 7/24/18 at 11:10 12. The resident was lying in There was a light on over the bed. The television was stry western music channel. ee quarters pulled closed. Duter to aid for communication			
1	of Resident #112. T with eyes closed. T dresser. The televis	he resident was lying in bed he light was on over the sion was on the same channel.			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495359	B. WING				7/26/2018
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 0	720,2010
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DOGWO	DD VIELAGE OF ORA	ANGE COUNTY HEALTH AND RE	HAB	ORA	ANGE, VA 22960		
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F 679	Continued From pa	ge 97	F 6	79			*
	of Resident #112. T with eyes closed. T television was on the was closed. An observation was a.m. of Resident #1 turned a little on his same. An observation was p.m. of Resident #1 be in the same posithe curtains were closed on the same chann. An observation was of Resident #112. T back with his eyes of the curtains were closed the curtains.	made on 7/25/18 at 2:05 p.m. he resident was lying on his closed. The lights remained re closed and the television		п			
	initiated on 9/7/15 d (Name of resident) AND SUPPORT (ille LONG TERM CARE READ TO HIM AND BROUGHT IN BOO TELEVISION AND I T.V. Approaches. W ON TAPE, CD PLAY WATCHES WESTE	ent's comprehensive care plan ocumented, "Problem/Need. NEED FOR SOCIALIZATION egible) INJ (injury) NEED FOR E, PER WIFE SOMEONE TO DENJOYS MUSIC. WIFE DKS ONTAPE (sic), RADIO ON STAFF TURN ON VIFE BROUGHT IN BOOKS YER IN ROOM, SIC, AND ERN ON TELEVISION THAT ELEVISION AND RADIO."					N N N N N N N N N N N N N N N N N N N

At interview was conducted on 7/25/18 at 1:59 p.m. with RN (registered nurse) #7, the resident's

PRINTED: 08/02/2018
FORM APPROVED
OMB NO 0038 0301

CENTERS	FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CE NOTICE DE COME	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495359	B. WING	and the second of the second of	07/2	6/2018	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
DOGWOOL	VILLAGE OF OR	ANGE COUNTY HEALTH AND R	REHAB	120 DOGWOOD LANE ORANGE, VA 22960			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
175 - 500	22						

F 679 Continued From page 98

nurse. When asked why residents had activities, RN #7 stated, "It keeps them busy. Lifts their spirits. They need a morale boost." When asked if activities were important even for resident who could not speak, RN #7 stated, "Yes." When asked what activities Resident #112 participated in, RN #7 stated, "We try to get him up a couple times a week. He sits out here (indicating the dining/social area)." When asked why the resident didn't get out of bed everyday like the other residents, RN #7 stated, "No reason. He does sit out here."

An interview was conducted on 7/25/18 at 2:33 p.m. with CNA (certified nursing assistant) #7. When asked why Resident #112 stays in a dark room with the curtain closed, CNA #7 stated, "That's how it's been since I've been here. I don't know why."

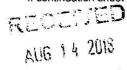
An interview was conducted on 7/25/18 at 4:47 p.m. with OSM (other staff member) #11, the director of activities. When asked what activities Resident #112 engaged in, OSM #11 stated, "He does get out of bed and goes to some of the music shows." When asked what other activities the resident was provided, OSM #11 stated, "We have a volunteer who comes to see him every week. He stays an hour and reads to him. He hasn't been here the past month." A request for the resident's activity record was made at this time. OSM #11 returned with the resident's activity records. In April 2018 the resident attended two out of ten music activities. In May 2018 the resident attended one of 14 music activities. In June 2018 the resident attended three of 14 music activities. In July 2018 the resident had attended one of ten music activities. F 679

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

Event ID: O93G11

Facility ID: VA0180

If continuation sheet Page 99 of 129



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PRINTED: 08/02/2018 FORM APPROVED OMB NO. 0038-0301

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				3 NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495359	B. WING			07/26/2018	
	POVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND R	ЕНАВ	STREET ADDRESS, CITY 120 DOGWOOD LANE ORANGE, VA 22960		L	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION TE DATE	
	Continued From pa	ge 99	F6	79	100		

An interview was conducted on 7/26/18 at 8:16 a.m. with CNA (certified nursing assistant) #8, the resident's aide. When asked when the resident got out of bed, CNA #8 stated, "He's supposed to get up Monday, Wednesday and Friday, his shower days. He really likes music. He doesn't have many visitors; his wife comes in on the weekends usually and hangs out for the day."

An interview was conducted on 7/26/18 at 9:30 a.m. with ASM (administrative staff member) #4, the assistant director of nursing. When asked what activities the resident was engaged in, ASM #4 stated, "I know he has the music on the TV. I have seen him in the social area." When informed of how many activities the resident was engaged in in the last four months, ASM #4 stated, "I would like to see him do something everyday." A request for the resident's activities of daily living documented by the CNAs was made at that time.

A review of the resident's activities of daily living forms documented that the resident got out of bed for his shower six times in July 2018. There was no other evidence that the resident had been out of bed or engaged in activities during that time.

On 7/26/18 at 12:45 p.m. ASM #1, the executive director and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled,
"Activities/Leadership" documented, "Activity
Types. Cognitive Stimulation should be
implemented daily through various trivia games
and word games. Activities that concentrate on
cognitive stimulation are card games and board

PRINTED: 08/02/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495359 B. WING 07/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB ORANGE, VA 22960 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 679 Continued From page 100 F 679 games." Review of the facility's policy titled, "Independent Programming or In-Room Visits" documented. "Procedure: Resident's individual participating in leisure activities will be assessed and continuously promoted." No further information was provided prior to exit. 1. Anoxic brain damage (lack of oxygen) - Anoxia is the third most frequent cause of coma, after trauma and vascular lesions. The most common causes of post-anoxic coma in adults are: cardiopulmonary arrest, stroke, respiratory arrest and carbon monoxide poisoning. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC38 14506/ 2. Hemiplegia - Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or

F 693 Tube Feeding Mgmt/Restore Eating Skills SS=D CFR(s): 483.25(g)(4)(5)

§483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must

both sides of your body. It can also occur in just

one area, or it can be widespread. This

information was obtained from: https://medlineplus.gov/paralysis.html

F 693

1. The facility has established a corrective action for resident #89 for failure to check for residual prior to initiating tube feeding according to physician orders and comprehensive care plan.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495359	B. WING			7/26/2040	
	PROVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND RE	HAB	STREET ADDRESS, CITY, STATE, ZI 120 DOGWOOD LANE ORANGE, VA 22960	P CODE	7/26/2018	
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	eat enough alone or enteral methods und condition demonstrated clinically indicated a resident; and §483.25(g)(5) A resimeans receives the services to restore, and to prevent complication but not limited diarrhea, vomiting, cabnormalities, and range abnormalities, and r		F	2. The residents of the receive tube feeding potential to be affected. 3. Facility Licensed Numeducated on 8/9/18 residual prior to infeeding per physician of comprehensive care plate. 4. To ensure compliant be conducted by Direct (or Designee) every weathen monthly x 3, checking residual prior tube feeding per physician of the comprehensive information will be feeding per physician will be	ses will be re- on checking itiating tube rders and the n. ce, audits will for of Nursing ek x 4 weeks, to include: to initiating sician orders care plan. All orwarded to	9/4/18	
	to initiating Resident	t #89's tube feeding per the nd comprehensive care plan.					
22	The findings include	:					
	with diagnoses that i to stroke, muscle we communication defic two diabetes, dyspha and hemiplegia (para	cit, high blood pressure, type agia (difficulty swallowing) (1) alysis) (2) on the left side.					
	to stroke, muscle we communication deficition deficition diabetes, dyspha and hemiplegia (para Resident #89's most	eakness, cognitive bit, high blood pressure, type agia (difficulty swallowing) (1)					

18

		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	0: 08/02/20 ⁴ 1 APPROVE 2: 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 04-000-00-00-00-00-00-00-00-00-00-00-00-	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 693	Resident #89 was of intact in the ability to 14 out of 15 on the Mental Status exam as requiring extension bed mobility, transfer hygiene; and total docomotion, eating, was coded in Section as having a feeding Review of Resident (physician order sur orders: "Fibersource via g (generating percutaneous endo	reference date) of 6/27/18. The coded as being cognitively of make daily decisions scoring BIMS (Brief Interview for a). Resident #89 was coded we assistance from staff with ers, toileting, personal ependence on staff with and bathing. Resident #89 on K "Nutritional Approaches" tube. #89's July 2018 POS mmary) revealed the following	F6	93				

at 2 AM. Flush peg tube with 150 ml (milliliters) H20 (water) before and after feeding

Check placement of Peg before administering of medications/feedings/flushes

(hour) x 10 hours for Nutrition -Start at 4 PM/stop

Check residual every shift hold if more than 60 cc (cubic centimeters) and notify MD (medical doctor)."

Review of the July 2018 MAR (medication administration record) revealed that staff were checking residuals at 6 AM, 2 PM and 10 PM. These times did not include prior to his feeding (4PM).

Review of Resident #89's care plan dated 6/8/18

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doc req inta cer (lef dys initi plac On obs nur med writ #6 Gal brai rela Oxy use Thia B1. RN plac cup plac cup plac cup plac second cup	uires a PEG tub ike r/t (related to ebral artery) infa t sided paralysis phagiaApproa ating (Name of it cement of PEG 7/24/18 at 4 p.m. rervation was co se) #6. RN #6 s dications to Res er she had alrea prepared the foll papentin 100 mg in to prevent sei ated to neurologi rcodone 5 mg 1 d to treat moder amine 100 mg 2 (6) #6 opened the 0 ced the contents . RN #6 then cru ced the crushed . RN #6 then cru crushed medical . RN #6 then ac dication cup, too stic bag, and atta d. RN #6 then fli ing the medication observed check	llowing: "(Name of resident) e for adequate nutritional b) (R [right]) MCA (middle arct (stroke) w/left hemiparesis		93				

After RN #6 administered medications to

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NAME OF PROV	VIDER OR SUPPLIER			STRE	ET ADDRESS. CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	3	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 693 Co	ntinued From pa	nge 104	F 69	13			
	W	proceed to hang his	1 03	J			(c)
		feed). RN #6 primed the					
		bing, capped the tip of the					
		on the pole. RN #6 then took a tic bag and placed it directly					96
1.55		ped. RN #6 uncapped	0				
		e feed and placed the syringe					
dire	ectly into his peg	tube. RN #6 poured 150 mls					
		per order through the syringe					
		be. RN #6 then hooked his tube feed and turned on					
	tube feed.	his tube reed and turned on					ii
		p.m., after RN #6 and this					
		the medication cart, RN #6					
		check residual of the tube e usually does. RN #6 stated					
		be checked prior to initiating					,
	tube feeding.	g and an					
On	7/26/18 at 9:53	a.m., an interview was					į.
		#2, another nurse who cares					
		When asked about the process					
		initiating a tube feeding, RN to setting up the tube feed;					
		e placement of the tube and					
		dual. When asked why					
		ment and residual were					
		tated to ensure the tube was in					
		the resident was not		2			
		feeding. RN #2 clarified that checked per shift per order					
		g his feeding per plan of care.					

On 7/26/18 at 11:19 a.m., further interview was conducted with RN #6. When asked the process prior to initiating a tube feed, RN #6 stated that she would first check placement of the tube feed and then check the residual. When asked how

		AND HUMAN SERVICES & MEDICAID SERVICES	2 8		FORM	D: 08/02/201 M APPROVE D. 0938-039	
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	PROVIDER OR SUPPLIER OOD VILLAGE OF ORA	ANGE COUNTY HEALTH AND F	REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960	2		
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F 693	po	ge 105	F 69	3		<u></u>	

would use her stethoscope, place it on the resident's abdomen, and listen as she injected air. When asked if she checked placement prior to administering medications on 7/24/18 to Resident #89, RN #6 stated that she did check placement before this writer observed her give medications. RN #6 stated that she should have checked placement with this writer present and that she was having a bad day. RN #6 could not determine why she did not tell this writer beforehand that she had already checked Resident #89's placement. When asked why it was important for residual to be checked, RN #6 stated to ensure the resident was not receiving too much of the feeding. When RN #6 was then informed, she had stated she did not check Resident #89's residual prior to initiating his feeding on 7/24/18. RN #6 stated she did check residual at the same time she checked placement before this writer observed her administer medications. When asked why she would admit to not checking residual after medication pass on 7/24/18, RN #6 stated, "I meant to say I should have checked it front of you."

On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

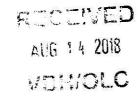
The facility policy titled, "Checking gastric residual volume" documents in part, the following: "The purpose of this procedure is to assess tolerance of enteral feeding and minimize the potential for aspiration...review of the resident's care plan and provide for any special needs of the resident."

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

Event ID: O93G11

Facility ID: VA0180

If continuation sheet Page 106 of 129



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3)	(X3) DATE SURVEY COMPLETED	
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5	Based on observa	tion, staff interview, facility and clinical record review it		physician orders relate administration.	30		

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OTATEMEN	T OF BEELOUS HOUSE	THE DELIVIORS	T		OIMR MC	<i>).</i> 0 <u>938-03</u> 91	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	190 000	JLTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
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	was determined that provide respiratory of 40 residents in the sign of the sidents in the sident	at the facility staff failed to care and services for three of survey sample, 3, and 37. failed to administer Resident # ing to the physician's orders. failed to administer oxygen to e physician ordered rate. failed to administer Resident # ing to the physician's orders. e: s admitted to the facility on ses that included but were not ure, diabetes, chronic ary disease (a chronic lung it hard to breath) (1), high mentia, anxiety and OS (minimum data set) terly assessment, with an one date of 5/22/18, coded the a "5" on the BIMS (brief status) score, indicating he example impairment for daily decision at was coded as requiring the of at least one or more staff obility, transfers, dressing, personal hygiene. In Section		4. To ensure compliant be conducted by Direct or Designee every week then monthly x 3 to enfollowing physician order oxygen administratinformation will be for QAPI for review. 12VAC5-371-220B cross F695.	for of Nursing sek x 4 weeks sure staff are ers related to sion. This forwarded to	9/4/18	
5	back period.						

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		AND HUMAN SERVICES			FORM APPROVED
	and the contract of the contra	& MEDICAID SERVICES	1	2 2	OMB NO. 0938-0391
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE 1 07/20/2018
DOGWO	OD VILLAGE OF ORA	NGE COUNTY HEALTH AND R	ЕНАВ	120 DOGWOOD LANE ORANGE, VA 22960	
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F 695	Continued From pa	ge 108	F 69	1	
		nt #39's clinical record	1 00	,,,	
	documented the MD) (medical doctor) order			
	stating "O2 at 3 L/m	in (liters/minute) via nasal			
	cannula (a plastic tu	ube with two prong that are the nose) or simple mask to			
	maintain Sats (oxyo	en saturation) above 90%.			
		flow meter every shift."			
	p.m. noted Residen oxygen on via nasal	4/18 at 2:31 p.m. and 4:33 t # 39 reclining in his bed with cannula connected to an r with the flow meter set n.			
	Resident #39 sitting oxygen on via nasal	5/18 at 8:08 a.m. noted up with breakfast tray and cannula connected to an r with the flow meter set n.			
	Resident #39 reclin	5/18 at 4:30 p.m. noted ing in his bed with oxygen on onnected to an oxygen 3 L/min.			
	01/26/18, with a most documented in part, gas exchange R/T [r Approaches section	prehensive care plan dated st recent revision on 6/12/18, "Problem/Need: Impaired related to] COPD". In the of this problem/need it is "Administer O2 (oxygen) per),"			
	#4, was asked to as:	a.m., RN (registered nurse) sess Resident #39's current rmed it was at 3 L/min. as			

ordered by the physician. RN #4 was informed that there were several observations of the flow meter reading between 2.5 and 3 L/min during

PRINTED: 08/02/2018

		AND HUMAN SERVICES				FOR	M APPROVE
10		& MEDICAID SERVICES	1	JO 2001		OMB NO	D. 0938-039
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F 695	Continued From pa	ae 109	E 6	895			i.
	the survey period. read the flow meter oxygen is being red	When asked how one should to ensure the correct flow of eived, she stated, "The center on the 3 for [Resident #39's	r c	193			
	instructions docume flowmeter, locate the the flowmeter. Nex	atrator manufacturer's ented, "To properly read the e prescribed flowrate line on t, turn the knob until the ball w, center the ball on the L/min	i	e e			
	executive director, A nursing, ASM #4, th nursing, and ASM #	e staff member) #1, the ASM #2, the director of se assistant director of 5, (the medical doctor), where above concerns on 7/26/18 at		w si			
	No further information	on was provided prior to exit.					
	National Institutes o	was obtained from the f Health at gov/ency/article/000091.htm		8			
		failed to administer oxygen to e physician ordered rate.					
	10/2/14 and readmit diagnoses of but no	admitted to the facility on ted on 6/27/17 with the t limited to congestive heart ressure, peripheral vascular					

disease, senile degeneration of the brain, diabetes, depression, anxiety, adult failure to thrive, convulsions, and osteoporosis. The most

recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 7/5/18. The

DEPAR	AND HUMAN SERVICES					NTED: 08/02/201	
		& MEDICAID SERVICES					ORM APPROVE 3 NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	LE CONSTRUCTION		3) DATE SURVEY COMPLETED	
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F 695	Continued From pa	ge 110	F 69	95			
		as severely cognitively	10 1001.0	96 70 0	r		
		make daily life decisions.		86	ı		
	total care for all are	oded as requiring extensive to as of activities of daily living.					
	physician's order da 2 Liters via NC (nas shortness of breath (saturation) Q (ever shift."	cal record revealed a ated 7/9/18 for "Oxygen @ (at) sal cannula) as needed for and check 02 (oxygen) sats y) shift and flow meter Q		19			
		plan revealed one dated					
	"(Resident #116) ha	ecently revised on 7/4/18 for as decreased cardiac output r/t					
		noses) of CHF (congestive					
		(coronary artery disease),					
		plood pressure), generalized					
		ous insuff (insufficiency), and kalemia." This care plan					
		ntion, undated, for "Administer					
		needed for SOB (shortness					
	of breath) per MD (r	medical doctor) orders"					
	Observations made	of Resident #116 on 7/25/18					
	at 8:17 a.m., and 7/2	25/18 at 3:25 p.m., revealed					
		rator flow meter set at			ā		
		ters and not the ordered 2 by the ball in the flow meter					
		between the 1 liter and 2 liter					
		o.m., LPN #5 (Licensed s asked to observe Resident		37			

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

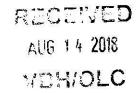
right rate.

#116's oxygen concentrator flow meter. LPN #5 stated that the line (for the 2-liter mark) should be through the center of the ball. LPN #5 stated it was not and that the oxygen was not set at the

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Facility ID: VA0180

If continuation sheet Page 111 of 129



PRINTED: 08/02/2018

		AND HUMAN SERVICES & MEDICAID SERVICES				FOF	RM APPROVEI 10. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000		CONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
		495359	B. WING		<u> </u>	0	7/26/2018
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	HAB	120	REET ADDRESS, CITY, STATE, ZIP CODE DOGWOOD LANE RANGE, VA 22960	<u>'</u>	1172012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 111	F 6	95			8
	orders and assess a such as cyanosis, high signs, lung sounds, (laboratory) results. On 7/25/18 at approximate app	umented, "Verify physician any special needs of resident hypoxia, oxygen toxicity, vital oxygen sats, and lab" oximately 6:00 PM, the and director of nursing (ASM rely - Administrative Staff de aware of the findings. No was provided by the end of the ff failed to administer Resident reding to the physician's orders. admitted to the facility on dmission of 05/08/18 with ided but were not limited to exiety, (2), depressive disorder	ı	v			E

On 07/26/18 at approximately 7:35 a.m., an

Resident # 37 as being unable to complete the

Assessment for Mental Status (C0700-C1000) be Conducted?" was coded as "Yes." Further review of Section C0600 revealed Resident # 37 was coded as a 2 (two) - being moderately impaired of . cognition for making daily decisions. Resident # 37 was coded as requiring extensive assistance of two staff members for activities of daily living.

BIMS. Under "C0600 Should the Staff

DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 08/02/2018
		& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-039
STATEMEN'	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495359	B. WING		07/26/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE
DOGWO	OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	НАВ	120 DOGWOOD LANE ORANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ION SHOULD BE COMPLETION HE APPROPRIATE DATE
F 695	observation of Resilying in bed receiving concentrator throug Observation of the othe oxygen was being one and a half and the oxygen was being observation of Resilying in bed receiving concentrator throug Observation of the oxygen was being one and a half and the oxygen was being one a	dent # 37 revealed she was ag oxygen from an oxygen th a nasal cannula. oxygen flow meter revealed ag administered at between two liters per minute. roximately 9:29 a.m., an dent # 37 revealed she was ag oxygen from an oxygen	F 69)5	

The comprehensive care plan for Resident # 37 dated 02/21/2018 documented, "Problem/Need.

review of the eTAR evidenced Resident # 37 received oxygen at two liters per minute on

resp (respiration) failure with hypoxia present." Under "Approaches" it documented, "Administer

07/26/18.

PRINTED: 08/02/2018 FORM APPROVED

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES							
	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED				
		495359	B. WING		07/26/2018			
	D VILLAGE OF OF	R RANGE COUNTY HEALTH AND F	REHAB 1	STREET ADDRESS, CITY, STATE, ZIP CODE 20 DOGWOOD LANE DRANGE, VA 22960				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC			

 695 Continued From page 113 oxygen per MD (medical doctor) orders."

> On 07/26/18 at approximately 10:00 a.m., an interview was conducted with RN (registered nurse) # 4. When asked to describe how the O2 (oxygen) flow meter is read, RN # 4 stated, "The line should be in the middle of the ball and it should be read at eye level." When asked what the O2 flow rate should be for Resident # 37, RN # 4 stated, "It should be two." RN # 4 looked at the eTAR (electronic treatment administration record) for Resident # 37 in the EHR (electronic health record) and stated, "It is ordered at two liters." RN # 4 was asked to read the O2 flow rate on Resident # 37's oxygen concentrator. RN # 4 read the flow meter and stated, "It's between one and a half and two." RN # 4 then proceeded to adjust the oxygen flow rate to two liters per minute. When asked how often the oxygen flow rate should be checked, RN # 4 stated, "Every shift." When asked why is it important to ensure the O2 flow rate is set correctly, RN # 4 stated, "There won't be enough oxygen to the brain and other organs."

> The "Operator's Manual" for (Name of Oxygen Concentrator" documented, "Flowrate. NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min line prescribed."

On 07/26/18 at approximately 1:55 p.m., ASM (administrative staff member) # 1, the executive director and ASM # 2, director of nursing, ASM # 4, assistant director of nursing, and ASM # 5, physician were made aware of the findings.

No further information was provided prior to exit.

F 695

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CENTE		& MEDICAID SERVICES					MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495359	B. WING			07	//26/2018
NAME OF	PROVIDER OR SUPPLIER	<i>a a</i>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	10/	120/2016
DOGWO	OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ		0 DOGWOOD LANE RANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 114	F 6	95		100.00	
	the website: https://www.nlm.nih	formation was obtained from .gov/medlineplus/anemia.html mation was obtained from the					
	website:	.gov/medlineplus/anxiety.html					
	blue, unhappy, mise Most of us feel this v short periods. Clinic disorder in which fee or frustration interfer or more. This information website:	be described as feeling sad, brable, or down in the dumps. Way at one time or another for cal depression is a mood elings of sadness, loss, anger, re with everyday life for weeks nation was obtained from the gov/ency/article/003213.htm.					
÷	obtained from the we	ure. This information was ebsite: gov/medlineplus/highbloodpr					
	can lead to shortnes was obtained from the	kes it difficult to breath that s of breath) This information ne website: gov/medlineplus/copd.html.					
	3b. The facility staff nasal cannula in a sa	failed to store Resident # 37's anitary manner.					

On 07/24/18 at approximately 2:16 p.m., an observation of Resident # 37 revealed she was lying in her bed, the oxygen concentrator was

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING						(X3) DATE SURVEY COMPLETED	
		495359	B. WING				<u>134—4%</u>	07/26/2018	
	i	NGE COUNTY HEALTH AND RE	НАВ	120	EET ADDRESS DOGWOOD ANGE, VA	LANE	ATE, ZIP CODE		12012016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH C	ORRECTIVE EFERENCE	IN OF CORRECT E ACTION SHOU D TO THE APPRO CIENCY)	JLD BE	(X5) COMPLETION DATE
F 695	running and the oxywere lying on the beaution of Resilying in her bed, the running and the oxywere draped over the concentrator. The inthe backside of the uncovered. On 07/25/18 at approbaction of Resilesitting in her wheeld present in the room Resident # 37. The	gen tubing and nasal cannula	F€	895					
	interview was condunurse) # 4. When as for storing a nasal cused, RN # 4 stated plastic bag for infectinformed of the above 37's nasal cannular not have a reply. On 07/26/18 at appreciation (administrative staff director and ASM # 24, assistant director	oximately 10:00 a.m., an octed with RN (registered sked to describe the process annula when it is not being, "It should be placed in a ion control purposes." When we observations of Resident # oot being covered, RN # 4 did oximately 1:55 p.m., ASM member) # 1, the executive 2, director of nursing, ASM # of nursing, and ASM # 5, a aware of the findings.		(2 mm) (2 mm) (3 mm) (4					
	No further informatio Label/Store Drugs a	n was provided prior to exit.	F 76	61 1	. The fa	cility ha	ıs establish	ed a	1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	man na pangan lamas. Pala pangananan	(X3) DATE SURVEY	
- San Grand Control	DENTIFICATION NUMBER:	A. BUILDIN	NG	COMPLETED	
	495359	B. WING _		07/26/2018	
NAME OF PROVIDER OR SUPPLIER DOGWOOD VILLAGE OF ORAN		EHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960	3,,20,20,0	
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage of \$483.45(h)(1) In according to the fact biologicals in locked of temperature controls personnel to have accept when the Comprehensive Extended for the Comprehensive E	of Drugs and Biologicals is used in the facility must be ewith currently accepted is, and include the ry and cautionary expiration date when of Drugs and Biologicals ordance with State and illity must store all drugs and compartments under proper, and permit only authorized cess to the keys. Cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the imal and a missing dose can is not met as evidenced on, staff interview and facility was determined that the ensure medications were for two of the four facility ected, East Ground Unit redication carts).	*	corrective action for ha medications in carts that were dated upon opening as required. 2. The residents of the facility receive medications have potential to be affected. 3. Facility licensed Nurse will be educated on 8/9/18 to ensure medications are dated upon operas required. 4. To ensure compliance, audits be conducted by Director of Nur (or Designee) every week x 4 we then monthly x 3 to ensure medications are dated upon operas required. Information will forwarded to QAPI for review. 12VAC5-371-300 cross reference for F761.	who the re- that ning will sing eks, sure ning be	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495359	B. WING	-		07	7/26/2018
	PROVIDER OR SUPPLIER	ANGE COUNTY HEALTH AND REI	НАВ	120	REET ADDRESS, CITY, STATE, ZIP CODE DOGWOOD LANE ANGE, VA 22960	1 2.	TEGIES IS
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ .	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 761	opened to determine be discarded, on the medication cart; and ophthalmologic eye opened to determine be discarded, on the The findings include On 7/26/18 at appromedication cart on the inspected. The folio Calcitonin {1} nasal label on it that documopening," had been open date document On 7/26/18 at 12:55 LPN #7 (Licensed Pathat it should have beened. On 7/26/18 at appromedication cart on the inspected. The folio Latanoprost {2} ophthad a pharmacy laborder was filled on 6 discard 28 days after opened but there was 1:12 pm #5 (Licensed Practice should have been discard approximately	ne when the medication should be East Ground Unit of failed to ensure Latanoprost of drops were dated when he when the medication should be East Main medication cart. The example of the East Ground unit was owing concern was identified: a spray which had a pharmacy amented the order was filled on ented to "discard 35 days after a opened but there was no need. The p.m., in an interview with Practical Nurse) she stated been dated when it was owing concern was identified: athalmologic eye drops, which bel on it, that documented the 16/29/18 and documented to the 16/29/18 and stated that it lated when opened.	F 7	61			
	for Medication Stora	ity policy "General Guidelines age" documented, ological's are stored safely,					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					ED: 08/02/201
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					RM APPROVE IO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) D	OATE SURVEY OMPLETED
		495359	B. WING			,	7/26/2018
NAME OF	PROVIDER OR SUPPLIER		· 1	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
DOGWO	OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	НАВ		20 DOGWOOD LANE DRANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 761	Continued From pa	ge 118	F 76	61			
	securely and prope recommendations of The policy provided medication when it On 7/26/18 at 1:50 and director of nurs respectively - Admir made aware of the	rly following manufacturer's or those of the supplier" I did not document to date a					
	past menopause an take estrogen productive disease that causes more easily. Calcito is also found in salm bone breakdown and (thickness). Information obtained https://medlineplus.ytml {2} Latanoprost oph glaucoma (a conditi pressure in the eye vision) and ocular hy causes increased production of the production of the causes increased production of the causes increased production of the cause	men who are at least 5 years and cannot or do not want to ucts. Osteoporosis is a sobones to weaken and break whin is a human hormone that mon. It works by preventing and increasing bone density of from gov/druginfo/meds/a601031.h thalmic is used to treat on in which increased can lead to gradual loss of ypertension (a condition which					

F 814 Dispose Garbage and Refuse Properly SS=F CFR(s): 483.60(i)(4)

of the eye.

prostaglandin analogs. It lowers pressure in the eye by increasing the flow of natural eye fluids out

F 814

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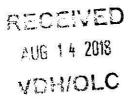
F 814 Continued From page 119 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain the dumpsters in good repair. Multiple cracks were observed in two of three dumpsters. The findings include: On 7/25/18 at 7:40 a.m., observation of the facility dumpsters was conducted. The following was observed: -One crack (approximately two inches long by less than one half inch wide) resembling a back slash symbol was observed near the bottom of the far left dumpster (while facing the dumpster). White debris was visible. -Multiple cracks (large enough to place a hand through) were observed on the plastic lids of the far left dumpster (while facing the dumpsters). Table Continued From page 119 §483.60(i)(4)- Dispose of garbage and refuse property. F 814 1. The facility accomplished corrective action for the two dumpsters cited on the most recent annual inspection 7/26/18. The facility received two dumpsters that were free from cracks and were in good repair on 7/30/18. 2. The other dumpster located on the property has the potential to be affected by the same deficient practice. The facility non 7/27/18 to ensure that it was in good repair as required. 3. The Dining Services will be inserviced by Executive Director on 8/9/18 regarding the importance of maintaining dumpsters that are free from cracks and are in good repair as required. 4. To ensure compliance the Director of Dining Services or designee will round weekly for 4 weeks and then monthly for 3 months to ensure that the dumpster (while facing the dumpsters).	AND PLAN OF CORRECTION INTERPRETATION NUMBER 1			(X2) MUL A. BUILD	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
DOGWOOD VILLAGE OF ORANGE COUNTY HEALTH AND REHAB (X4) D	! }		495359	B. WING	<u> </u>	07/26/2018
CAU D SUMMARY STATEMENT OF DEFICIENCES PREFIX (EACH DEFICIENCY MUST be preceded by the properly CACH DEFICIENCY PREFIX TAG CONSTRETE PLAN OF CORRECTION COMPETITION PREFIX TAG CONSTRETE PLAN OF CORRECTION COMPETITION CONSTRETE PLAN OF CORRECTION CONSTRETE PROPORTIATE CONSTR			NGE COUNTY HEALTH AND RE	НАВ	120 DOGWOOD LANE	
\$483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to maintain the dumpsters in good repair. Multiple cracks were observed in two of three dumpsters. The findings include: On 7/25/18 at 7:40 a.m., observation of the facility dumpsters was conducted. The following was observed: -One crack (approximately two inches long by less than one half inch wide) resembling a back slash symbol was observed near the bottom of the far left dumpster (while facing the dumpsters). White debris was visible. -One crack (large enough to place a hand through) were observed on the plastic lids of the far left dumpster (while facing the dumpsters).	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE COMPLETION
-Multiple cracks (large enough to place a hand through) were observed on the plastic lids of the far right dumpster (while facing the dumpsters). On 7/25/18 at 9:00 a.m., an interview was conducted with OSM (other staff member) #2 (the director of maintenance). OSM #2 stated the		§483.60(i)(4)- Disporproperly. This REQUIREMENT by: Based on observation document review, it facility staff failed to good repair. Multiple cracks were dumpsters. The findings include On 7/25/18 at 7:40 and dumpsters was concobserved: -One crack (approximates than one half included the far left dumpster White debris was visted to the far left dumpster White debris was visted approximated bottom of the dumpster while facing the dumpster while facing the dumpster (when the dumpster	ose of garbage and refuse NT is not met as evidenced ion, staff interview and facility was determined that the maintain the dumpsters in e observed in two of three a.m., observation of the facility ducted. The following was mately two inches long by ich wide) resembling a back beserved near the bottom of (while facing the dumpsters). sible. mately two vertical inches half inch wide) was ately 18 inches from the ster on the far left dumpster inpsters). White debris was ge enough to place a hand wed on the plastic lids of the while facing the dumpsters). ge enough to place a hand wed on the plastic lids of the while facing the dumpsters). m., an interview was I (other staff member) #2 (the	F 8	1. The facility according corrective action for the dumpsters cited on the most annual inspection 7/26/1 facility received two dumpst were free from cracks and good repair on 7/30/18. 2. The other dumpster located property has the potential affected by the same of practice. The facility inspect other dumpster of the fact 7/27/18 to ensure that it was repair as required. 3. The Dining Services will serviced by Executive Direct 8/9/18 regarding the import maintaining dumpsters that from cracks and are in good required. 4. To ensure compliance the of Dining Services or design round weekly for 4 weeks a monthly for 3 months to ensure the dumpsters are free from and are in good repair as revariances will be corrected audits will be revived Administrator or designee for the dumpsters or designee for the duministrator or designee for the dumpsters or designee for the duministrator or designee for the dumpsters are free from and are in good repair as revariances will be corrected audits will be revived administrator or designee for the dumpsters are free from and are in good repair as revived administrator or designee for the dumpsters are free from and are in good repair as revived administrator or designee for the dumpsters are free from and are in good repair as revived administrator or designee for the dumpsters are free from and are in good repair as revived administrator or designee for the dumpsters are free from and are in good repair as revived administrator or designee for the facility accounts and the most and the facility accounts are free from a facility accounts and the facility accounts are free from a facility accounts and a facility accounts accounts accounts and accounts	trecent The ters that were in d on the I to be deficient ted the cility on a in good I be interested to a free free repair as Director nee will not then that in cracks required. Ed. The by the or trends

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

Event ID: 093G11

Facility ID: VA0180

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	994000	495359	B. WING			5 <u>5205</u>	07	7/26/2018
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	120	REET ADDRESS, CIT DOGWOOD LANE LANGE, VA 2296			720,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	(EACH CORR	S PLAN OF CORRECTION SHOUL ECTIVE ACTION SHOUL ENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 814	asked about the faction dumpsters are main #2 stated someone department makes in the dumpsters.	ned by the county. When ility process for ensuring the stained in good repair, OSM from the maintenance sure the drain in the ground is not stopped up and makes	F 8	14	additional recommendate 12VAC5-371-34	oversight ions. 40 cross reference	and to	9/4/18
	sure the dumpsters asked if the facility sare intact, OSM #2 sthere should be any OSM #2 stated, "No No." When asked w"Because of infection critters get in there at #2 was made aware	are closed every day. When staff ensures the dumpsters stated, "Yes." When asked if cracks in the dumpsters, that go all the way through.						
! !	On 7/25/18 at 6:06 p staff member) #1 (th made aware of the a	.m., ASM (administrative e executive director) was bove concern.						
97	multiple policies was assistant director of p.m., ASM #4 returne	ity had no policy regarding		1				
	exit.Information obtain	n was presented prior to ined from ov/druginfo/meds/a697003.h						
SS=D	Infection Prevention of CFR(s): 483.80(a)(1) §483.80 Infection Color The facility must esta	(2)(4)(e)(f)	F 88	ř	corrective action actio	has establishe on for residents or ouching items/c	#5,	
	idoliny midot cota	enon ano mantalitali			200 m 1000 2000 200 2000 2000 2000 2000	picking up food		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	6	495359	B. WING	<u></u>	<u> </u>	07/26/2018
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	INGE COUNTY HEALTH AND REI	НАВ	STREET ADDRESS, CITY, STA 120 DOGWOOD LANE ORANGE, VA 22960	ATE, ZIP CODE	07725/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCEI	IN OF CORRECTION E ACTION SHOULD D TO THE APPROPE CIENCY)	BE COMPLETION
The state of the s	designed to provide comfortable enviror development and tradiseases and infect §483.80(a) Infection program. The facility must estand control program a minimum, the followard for the facility must estand communicable staff, volunteers, vis providing services us arrangement based conducted according accepted national staff staff (ii) A system of surversible communicable to (i) A system of surversible communication infections before the persons in the facility (iii) When and to who communicable disease reported; (iiii) Standard and tradito be followed to prefer (iv) When and how is resident; including be (A) The type and dur	and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. a prevention and control tablish an infection prevention a (IPCP) that must include, at a pwing elements: tem for preventing, identifying, ing, and controlling infections diseases for all residents, itors, and other individuals inder a contractual upon the facility assessment g to §483.70(e) and following andards; In standards, policies, and rogram, which must include, if illance designed to identify able diseases or y can spread to other y; im possible incidents of use or infections should be insmission-based precautions went spread of infections; olation should be used for a	F8	their bare hands we sanitizing hands. (b) Replacing line soiled in proper mate (c) Disposing of a manner. (d) Proper placemeduring a tube feeding. 2. The other reside have the potential to t	en when dirty inner. brief in a sani ent of equipm ng. ents of the fact to be affected. staff will be n (a) not touch idents not pick heir bare had or soiled linens disposing of a be er and (d) pro- ipment during viewek x 4 were lated to: items or ot picking up for hands with g hands. n when dirty	tary nent cility re- hing king inds inds in a brief oper g a will sing eks, ther bod out

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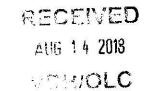
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495359	B. WING		07/26/2018	
	PROVIDER OR SUPPLIER POD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	НАВ	STREET ADDRESS, CITY, STATE, ZIP CODE 120 DOGWOOD LANE ORANGE, VA 22960	1 01120/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	DBE COMPLETION	
	least restrictive posicircumstances. (v) The circumstance must prohibit emploidisease or infected contact with resider contact will transmit (vi)The hand hygien by staff involved in city (vi)The hand hygien by staff (vi)The hand hand hands. §483.80(a)(4) A systidentified under the corrective actions to sinfection. §483.80(e) Linens. Personnel must hand transport linens so a infection. §483.80(f) Annual residention. §483.80(f) Annual residention.	hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct at sor their food, if direct at the disease; and are procedures to be followed direct resident contact. Item for recording incidents facility's IPCP and the aken by the facility. Indie, store, process, and as to prevent the spread of seview. In uct an annual review of its eight program, as necessary. It is not met as evidenced on, staff interview and facility was determined facility staff ection control practices for in the survey sample,	F 88	(c) Disposing of a brief in a san manner. (d) Proper placement of equipmoduring a tube feeding. This information will be forwarded QAPI for review. 12VAC5-371-180 cross reference to F880.	ment ed to	

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Event ID: 093G11

Facility ID: VA0180

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1900				10. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	AULTIPLE CONSTRUCTION ILDING		(X3) ((X3) DATE SURVEY COMPLETED	
		495359	B. WING		· · · · · · · · · · · · · · · · · · ·		07/26/2018	
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RE	НАВ	STREET ADDR 120 DOGWOO ORANGE, V			51720,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF C CH CORRECTIVE ACTI S-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	failed to dispose of resident #5. 5. The facility staff of practices while flush. The findings include Resident #28 was a 12/19/14 with diagon not limited to: legal disease, high blood. The most recent MI quarterly assessme reference date) of 7 having an eight out interview for mental was severely impair was coded as required activities of daily living An observation was of Resident #28 and assistant) #7. CNA with her meal when went over to anothe get out of her chair. resident to sit back of CNA #7 then took her and put it back. CNA Resident #28 and piner bare hands, but the resident. CNA #	ck on the resident's bed and briefs in a sanitary manner for failed to follow infection control ning Resident #89's peg tube. Edmitted to the facility on oses that included but were blindness, Alzheimer's pressure and depression. DS (minimum data set), a nt, with an ARD (assessment 1/25/18 coded the resident as of 15 on the BIMS (brief status indicating the resident ried cognitively. The resident ring assistance for all	F 8	80				

Review of the resident's care plan initiated on 12/31/14 and revised on 5/13/18 documented,

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		AND HUMAN SERVICES			FORM APPROVED
STATEMENT	T OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The same was a second or second	IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495359	B. WING _		07/26/2018
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z	
DOGWO	OD VILLAGE OF ORA	NGE COUNTY HEALTH AND RI	EHAB	ORANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE COMPLETION THE APPROPRIATE DATE
F 880	FUNCTIONAL STAREQUIRING ASSIST daily living) R/T (reliable and all plus in particular in the particula	ame of resident) HAS TUS LIMITATION TOT WITH ADL'S (activities of ated to) WEAKNESS, GAIT DOR VISION, COGNITIVE oaches. ASSIST WITH TRAY G AS NEEDED. FOOD TO BE FOR EASIER HANDLING IT MEAL INTAKE." Inducted on 7/25/18 at 2:30 When asked if it was a resident's food in your bare ated, "No. It's not sanitary." Inducted on 7/25/18 at 2:33 When asked if staff should food with their bare hands, wer." When asked why, CNA Total tis sanitary reasons. There's a ware of the above Total staff, and the staff show to		0	

Review of the facility's policy titled, "Hand Hygiene Using Alcohol Hand Rubs for Residents

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
		495359	B. WING	<u></u>		07/26/2018	
	PROVIDER OR SUPPLIER OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	HAB	STREET ADDRESS, CITY, STA 120 DOGWOOD LANE ORANGE, VA 22960	TE, ZIP CODE	0112012016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE	
	and Employees" do policy of this facility techniques to help profections. This policy protection of all perspatients. Procedure Rub in the following contact with patient. No further information. No further information. 2. The facility staff factories putting it backfailed to dispose of laresident #5. Resident #5 was ad 10/27/10 with diagnor not limited to: bone in high blood pressure. The most recent MD quarterly assessment reference date) of 7/having scored a 13 content interview for mental was cognitively intact the resident was cofor all activities of date.	to guide proper hygiene prevent transmission of cy is designed for the sons including staff and staff may use Alcohol Hand situations: Before director	F 8	80			
3	of Resident #5 and L #4 and LPN #8. LPN blanket up off the flo	made on 7/24/18 at 4:30 p.m. PN (licensed practical nurse) #8 picked the resident's or and placed it back over picked a pillow up off the					

floor and placed it under the resident's head.

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		AND HUMAN SERVICES 8 MEDICAID SERVICES			10	FORM APPROVED MB NO. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495359	B. WING			07/26/2018
NAME OF	PROVIDER OR SUPPLIER	2007		STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
DOGWO	7 2 2	ANGE COUNTY HEALTH AND REI	HAB	120 DOGWOOD LANE ORANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD THE APPROPE	BE COMPLETION
F 880	Continued From pa	ige 126	F 88	80		
	made of Resident # and CNA (certified resident was requested removed from under thrown her sheet and pulled the three bries and placed them on pillow and sheet up under the resident's resident. CNA #7 the floor and disposed of the company of the company of the over-bed the trash and throw was acceptable to perform floor, RN #3 stated, #3 stated it was an incompany of the company	a.m. an observation was #5, RN (registered nurse) #7 nursing assistant) #12. The sting that the briefs be erneath her. The resident had not pillow on the floor. CNA #7 refs from under the resident in the floor. RN #5 picked the refs from under the pillow of the floor, placed the pillow is head and the sheet over the nen picked the briefs up off the of them in the trash. Inducted on 7/25/18 at 3:36 re unit manager. When asked are to be discarded, RN #3 restaught to place them on the stable and then put them in them away." When asked if it place the briefs directly on the "No." When asked why, RN infection control issue. P.m. ASM (administrative staff recutive director, ASM #2, the and ASM #4, the assistant were made aware of the				

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No further information was provided prior to exit.

3. The facility staff failed to follow infection control practices while flushing Resident #89's peg tube.

Resident #89 was admitted the facility on 5/30/18 with diagnoses that included but were not limited

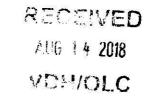
communication deficit, high blood pressure, type

to stroke, muscle weakness, cognitive

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O <u>V</u>	<u>1B NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	((X3) DATE SURVEY COMPLETED
		495359	B. WING		.) (1	07/26/2018
NAME OF F	PROVIDER OR SUPPLIER		8	STREET ADDRESS, CITY, STATE	, ZIP CODE	V)
DOČMO		ANGE COUNTY HEALTH AND RE	LIAD	120 DOGWOOD LANE		
DOGWO	OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	INAD	ORANGE, VA 22960		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD E O THE APPROPRI	BE COMPLETION
F 880	Continued From pa	age 127	F	380		
	31	hagia (difficulty swallowing) (1)				
		aralysis) (2) on the left side.				
		st recent MDS (minimum data	11			
		scheduled assessment with an				
		reference date) of 6/27/18.				
1		coded as being cognitively				
		to make daily decisions scoring				
		BIMS (Brief Interview for				
		n). Resident #89 was coded ive assistance from staff with	8			
		er, toileting, personal hygiene;				
		nce on staff with locomotion,				
		. Resident #89 was coded in	58			
		nal Approaches" as having a				
	feeding tube.					
	Review of Resident	t #89's POS (physician order				
		the following orders:				
		(gastronomy) tube (peg				
2		oscopic gastrostomy				
		r enteral nutrition) at 130 cc/hr				
		or Nutrition -Start at 4 PM/stop	26			
	at 2 AM."					
	Flush peg tube with (water) before and	n 150 ml (milliliters) H20 after feeding."				
	On 7/24/18 at 4 p.n	n., medication administration				
		enducted with RN (registered				
		N #6 administered medications				
1		ne proceed to hang his				
		l feed). RN #6 primed the				×
		bing, capped the tip of the				
•		on the pole. RN #6 then took a	2			
		itic bag and placed it directly bed. The tip of the syringe that				
		serted into the peg tube was		*		
	30	Lag .aaa				

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directly touching the bed surface. RN #6 uncapped Resident #89's tube feed and placed

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CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1	495359	B. WING			07/26/2018
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	
DOGWO	OD VILLAGE OF ORA	ANGE COUNTY HEALTH AND RE	НАВ		DOGWOOD LANE	
				OR	ANGE, VA 22960	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 880	Continued From pa	nge 128	F.8	380		91 91 91
	50 12 NOODS 10 10 10 II DR	into his peg tube. RN #6	J - 2	,00		N.
		illiliters) of water per order	**			
		and into his peg tube. RN #6		20		
		ent #89 up to his tube feed		:		
	and turned on his tube feed.					
	On 7/26/18 at 11:19					
	conducted with RN					
	had placed the syri					
	should not have do					
	an infection control issue and nurses should avoid picking up any extra germs when flushing a					
	peg tube.	y extra germs when flushing a				
	On 7/26/18 at 1:50 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.					
	The facility policy tit	lled, "Gastric Feeding Tubes"				;
		above concerns. No further				
18	information was pre	esented prior to exit.		50		
		was obtained from The				
	National Institutes of					
		gov/swallowingdisorders.html.				
7	National Institutes of	was obtained from The				(F
	https://medlineplus.					
		was obtained from The				
	National Institutes of			8		
	https://www.ncbi.nlr 14992/.	m.nih.gov/pmc/articles/PMC31				8 8
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