STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO (X3) DATE SU COMPLE	IRVEY
	495134	B. WING		C 03/31/2016	
NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NUF	SING & PEUADU D	RESS, CITY, S	TATE, ZIP CODE	03/3	12010
	DUFFIE	SS CARTI LD, VA 24	ER BOULEVARD 1244		
TAG OR LSC IDE	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	י פר	(X5) COMPLET DATE
F 000 INITIAL COMMENT	S	F 000	,		
Survey was conducted One complaint was survey. Corrections with 42 CFR Part 48 requirements. The Laurvey/report will follow. The census in this 12 112 at the time of the consisted of 24 curre	20 certified bed facility was survey. The survey sample of Resident reviews				
reviews (Residents #		i !		í :	
F 157 483.10(b)(11) NOTIF' SS=E (INJURY/DECLINE/R	Y OF CHANGES OOM, ETC)	F 157			
known, notify the residence or an interested family accident involving the injury and has the pote intervention; a significate physical, mental, or post deterioration in health, status in either life three clinical complications); significantly (i.e., a nee existing form of treatment consequences, or to contreatment); or a decision the resident from the fat §483.12(a).	lent's legal representative member when there is an resident which results in ential for requiring physician ant change in the resident's ychosocial status (i.e., a mental, or psychosocial atening conditions or a need to alter treatment d to discontinue an ent due to adverse mmence a new form of n to transfer or discharge cility as specified in	2.	medications are at risk for this issue	the ds of se ed by	
or interested family men change in room or room specified in §483,75(e)(mate assignment as	: : : : E /	APR 2.7 2016 VDH/OLC	;	
	1/1/1 4/26	17016	1 3/11-1	(X6) DAT	
safeguards provide sufficient protection	terisk (*) denotes a deficiency which the	institution ma	ay be excused from correcting providing it ng homes, the findings stated above are dhe above findings and plans of correction and an approved plan of correction is	s determine	1 that

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C2N611

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICAKE	E & MEDICAID SERVICES			OMB NO. 0938-03
STATEMENT OF C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495134	B. WING		C 03/31/2016
	VIDER OR SUPPLIER			', STATE, ZIP CODE	00.01.20.5
		RSING & REHABILII 157 DUF		RTER BOULEVARD	
TAG .	ACH DEFICIENCY MUST OR LSC IDE	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATOR ENTIFYING INFORMATION)	ID DRY PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO
res reg this The the leg This Bas revi phy take Res The The and a da	gulations as speci is section. The facility must rece e address and pho- gal representative This Requirement is used on staff intervi- view, the facility sta- ysician and respon- tie medication orders ident # 15). The findings include:	er Federal or State law or sified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. Is not met as evidenced by: view and clinical record raff failed to notify the nsible party of the refusal to ered for 1 of 23 residents (must uring ocument to the tothe ication ur plinary
The with resid assis trans	16/14 with diagnos cer, dysphagia, chease, hypertension ease, dementia, ar significant change a reference date dinet with a cognitive dent was assessed stance of 1-2 persisfers, dressing, to ene.	Imitted to the facility on ses of fractured pubis, skin hronic obstructive pulmonary n, gastro-esophageal reflux rthritis, and anxiety. The Minimum Data Set (MDS) of 11/23/15 assessed the ive score of "9" of "15". The od requiring extensive to total sons for bed mobility, illeting, bathing, and		4. The Director of Nursing or designed verify that notification of medication being refused repeatedly is docume in the resident's clinical record. This verification will be documented 5 doweek x 4 weeks and then weekly x 4 weeks. The Director of Nursing will report the results of this monitoring to the QAF committee monthly for the duration the monitoring for review and recommendation.	on ented is lays a 4 he

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and

ordered Bisac-Evac 10 mg suppository unwrap

C2N611

The allegation of compliance date for all aspects

of this plan of correction is April 29, 2016

If continuation sheet Page $\,2$ of 65

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AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	MRED:		LE CONSTRUCTION	(X3) DATE S	SURVEY
:					COMPLETED	
NAME OF PRODUCTION	495134	-	B. WING		03/31/2016	
NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NUR	SINC & DELIABILIS		RESS, CITY, ST			
THE SECTION WANTER TOOK	SING & REHABILI		ELD, VA 242	R BOULEVARD 244		
PREFIX (EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 157 Continued From pa	ge 2	1	F 157			
The medication adm March 2016 was rev documented on the flad refused the supposition of the flad refused through 3/16/documentation the positified of the refusal The nurses also circle through 3/29/16 indice given. There was not physician/ RP had be there was not documentation was elevated were notified of the modern through 3/29/16 indices were notified of the modern through 3/29/16 indices were notified of the modern three through 3/20/16 indices in the sum of the modern three indices in the modern three indices in the sum of the	iewed. The nurses he front of the MAR the cository every evenire 16. There was no hysician/ RP had below their initials from the ed their initials from the ed their initials from the en notified of the referentation on the back nedication was not go be reviewed and no widenced the physicial edication not administrating were informentally with the survey the director of nursing with the survey the director of nursing the director of nu	resident resident regiren 3/18/16 res red resident regiren red resident regiren regire				
provided the facility por Rights. The policy start document in the clinical refuses a medication a	ted the facility should al record when a res and the physician sh	d sident ould be			; 1	
notified of a refusal for hours. 2. For Resident #20, for the physician when the medication for a month	acility staff failed to a resident refused a	:			· · · · · · · · · · · · · · · · · · ·	

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with hemodialysis, hypertension, gastroesophageal reflux disease,

cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment

If continuation sheet Page 3 of 65

APR 27 2016

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		L." \	2) MULTIPI BUILDING	E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		495134		B. WING			C 03/31/2016	
	F PROVIDER OR SUPPLIER ECREST MANOR NUF	SING & REHABILIT	TREET ADDRESS 157 ROSS DUFFIELD,	CARTE	R BOULEVARD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGINTIFYING INFORMATION)	ULATORY PRI	ID EFIX AG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 15	During clinical recorsurveyor noted on the record (MAR) for Margor Lantus (insulin) for Margor Lantus (insulin) for 9 PM except 3/18, which were documented or nurse's progress not the physician being reconsistently been reformed for manager indicated the refusing insulin for yellood sugar went too the insulin and the heapproximately 12:30 discussing the Lantus and obtaining an order medication. She state that the resident had in 4 months. Staff we resident refusing the mentioning it to the physician of medication o	d review on 3/31/16, the medication administrated 2016 that the signal 100 units per 1 ml inject y at bedtime for DMII were circled every date was blank. No explanation the backs of the MAR res. There was no reconnotified that the insulin housed. It was a supervisor and direct that the resident had been at the resident had been are because he though low between the effects amodialysis. On 3/31/16 PM, the DON reported is insulin with the physicial are accustomed to the medication and had stop the physician. The provided in the policy for dication omission was for the reason on the back a physician was in the building the physician was in the building the physician was in the building the provided was in the building the physician was in the building the provided was in the building the physician was in the physi	e ation atures 10 fons or in rd of had eyor tor of unit n t his s of S, at had alin pped or k of sion. ng	157 ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;				
F 274 SS=D	483.20(b)(2)(ii) COMP AFTER SIGNIFICANT	REHENSIVE ASSESS CHANGE	F 2	74 [

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C2N611

If continuation sheet Page 4 of 65

APR 27 2016
VDH/OLC

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DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVI & MEDICAID SERVI	ICES CES				FORM	. 04/14/2 // APPRO\). 0938-03
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495134		B. WING_			C 03/31/2016	
	PROVIDER OR SUPPLIER CREST MANOR NUR	SING & REHABILI			ΓER	BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL R NTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 214	assessment of a restacility determines, of that there has been resident's physical of purpose of this section means a major declaresident's status that itself without further implementing standarinterventions, that has one area of the residential termines in the resident of the resident in the residen	ge 4 uct a comprehensive sident within 14 days or should have detern a significant change in mental condition. (I on, a significant charine or improvement in twill not normally resintervention by staff card disease-related clas an impact on more lent's health status, a nary review or revision	nined, in the For nge the olve or by inical than nd	F 274	1.	been performed to ensure that transition was captured in a sig change assessment.	f19 to spice on dd date e care has the nificant	
	Based on staff interv review it was determ complete a significan	a set (MDS) assessme was admitted to how mitted to the facility of sis include but is not bood pressure, renal	rd ailed to num s icant nent, for spice. n			The MDS Registered nurses have reeducated concerning the need complete a significant change assessment for a resident when admitted to hospice care. One of the MDS RNs will attend morning clinical meeting and be to hear the review of all recent of including new hospice orders. The information will be used to initial significant change assessment.	they are the present prders,	

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status.

dementia, psychotic disorder, and gastrostomy

Review of the residents clinical record revealed his most recent MDS (minimum data set) assessment completed on this resident was a significate change assessment with an ARD (assessment reference date) of 02/18/16. Section K coded the resident to have a feeding tube. Section B coded the resident to understand and to be understood. This significate change MDS

C2N611

If continuation sheet Page 5 of 65

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APR 27 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES Printed: 04/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING_ COMPLETED 495134 B. WING 03/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RIDGECREST MANOR NURSING & REHABILITY 157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 274 Continued From page 5 F 274 The Director of Nursing will maintain a was done for the reason of the newly inserted list of residents on hospice services. The feeding tube. MDS RN coordinator will review the list Resident #19 's clinical record had a physician 's and document that resident started order dated 2/29/16 for consult for Hospice. The hospice, the date of the start, the date order also contained the order to do not of the significant change assessment resuscitate. completion and submission weekly x4 A nurse 's note dated 3/1/16 at 16:01 read " weeks and then monthly x2 months. spoke with (name of hospice) today. Resident will be admitted to their services today. The MDS RN will report the findings of On 3/31/16 at 2:00pm., the MDS nurse was this monitoring to the QAPI committee asked why a significate change MDS was not monthly for the duration of the done after resident #19 had been admitted to monitoring for review and hospice. MDS nurse #1 said after reviewing the recommendations. record said "we didn't do one.' At 3:20 pm the administration staff was informed of the staff failure to do the significate changes The allegation of compliance date for all MDS when Resident #19 was placed on hospice. aspects of this plan of correction is April No further information was provided to the 29, 2016. surveyor related to the failure to do the MDS.

F 278

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F 278 483.20(g) - (j) ASSESSMENT

assessment is completed.

that portion of the assessment.

resident's status.

SS=D ACCURACY/COORDINATION/CERTIFIED

each assessment with the appropriate participation of health professionals.

The assessment must accurately reflect the

A registered nurse must conduct or coordinate

A registered nurse must sign and certify that the

Each individual who completes a portion of the assessment must sign and certify the accuracy of

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is

C2N611

If continuation sheet Page 6 of 65

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Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495134

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

> C **03/31/2016**

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING

RIDGECREST MANOR NURSING & REHABILI7

157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244

(X4) ID PREFIX TAG

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

ID PREFIX TAG

F 278

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

(X5) COMPLETION DATE

F 278 Continued From page 6

subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This Requirement is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate Minimum Data Set (MDS) assessment for 1 of 24 Residents in the sample survey, Resident #14.

The Findings Included:

For Resident #14, the facility staff failed to code section C (cognitive pattern) on the resident's quarterly MDS assessment with an ARD (assessment reference date) of 3/6/16.

Resident #14 was originally admitted to the facility on 4/18/14. His diagnosis included, but was not limited to: high blood pressure, anxiety, aphasia, schizophrenia, intellectual disabilities and dementia.

The current minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 3/6/16 for Resident #14 was an annual MDS assessment. The surveyor observed that Section C, had dash marks. In section C the dash marks were in the staff mental status assessment.

- - There has been a modification submitted for Resident #14 and #24 on 4-26-2016 to ensure the most recent assessments are complete and accurate.
 - 2. All residents in the facility are at risk for this issue.
 - The MDS RNs have been reeducated to review all assessments prior to submission.
- 4. The MDS Coordinator will verify that the sections C and L have been completed appropriately for all assessments prior to submission x 4 weeks. The MDS Coordinator will report the findings of the verifications to the QAPI committee monthly for the duration of the monitoring for review and recommendations.
- 5. The allegation of compliance date for all aspects of this plan of correction is April 29, 2016

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

C2N611

If continuation sheet Page 7 of 65

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APR 27 2016

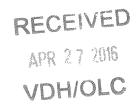
Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

						OMB N	<u>O. 0938-03</u>
AND PL	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER	/CLIA		TIPLE CONSTRUCTION	(X3) DATE	SURVEY
""	WO CONTECTION	IDENTIFICATION NUM	BER:	A. BUILDIN	VG	1' '	LETED
		495134		B. WING			С
111115					03/	03/31/2016	
	F PROVIDER OR SUPPLIER				STATE, ZIP CODE		
KIDGE	CREST MANOR NUR	SING & REHABILIT	157 R	DSS CART	TER BOULEVARD		
			DUFFI	ELD, VA 2	4244		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	. (X5)
PREFIX TAG	OR LSC IDEI	BE PRECEDED BY FULL RENTIFYING INFORMATION)	GULATORY	PREFIX	(EACH CORRECTIVE ACTION	ON SHOULD BE	COMPLÉTION
		The state of the s		TAG	CROSS-REFERENCED TO THE DEFICIENCY	IE APPROPRIATE	DATE
F 27	8 Continued From pa	ne 7		F 270	32. (3.21/3)	,	1
		s interviewed on 3/31/	16 and	F 278			
	asked if section C st	hould have been asse	ro and				£
	mental status by sta	ff assessment. She sa	aid the				
	social worker codes	those sections	ind title :	:			
							1
	Social worker #1 was	s asked why she had		i			
	 answered section C 	for mental status by s	taff				
	assessment with a d	ash. She responded.	" Didn '	:			:
	t know I should go ba	ack and mark the no. '	•				£
	0.00040.0						
	On 3/30/16, the surve	eyor informed the	1	1			
	auministration staff of	f the above findings.	They	;			
	were again informed	on 3/31/16 at 3:20 pm	1.	i			s •
	No further information	was provided prior to	. 46	4			:
	exit conference on 3/3	1 was provided prior ((31/16) the			:	
	2. The facility staff fail		rato	i		;	
	Minimum Data Set (M	IDS) for Resident #24	hv				
	: failing to identify in Se	ction L for Oral/ Denta	al	:			
	Status that the resider	nt had a broken tooth.		*			
	Resident #24 was adr	nitted to the facility on					
	9/7/10 with diagnoses	of anoxic brain dama	ge,				
	respiratory failure, anx	riety, anemia, and per	sistent	1		;	
	vegetative state.					# 4	
:	The annual MDS with	a reference date of 3/	1/16	,			
,	assessed the resident	with coma and requir	ing				
:	total assistance of 1-2 dressing, toileting, batl	persons for ped mobi	iity,				
ı	Resident #24 was obse	erved to have a broke	n				
	front tooth. Section "L	" for Dental Oral Sta	tue :	4		8	I
	was reviewed and part	"D" under Section	" "				
	was blank for "obviou	s or likely cavity or bro	oken	1		1	
	natural teeth ".		1	i			
	The MDS coordinator (RN#3) stated the toot	h '	. !			
í	had been broken for a	long time.					Ì
	The administrator, direc	ctor of nursing, and		ŧ		T.	
	assistant director of nui	rsing were informed o	f the			2	
: 1	findings during a meetir	ng with the survey tea	m on			<i>,</i> .	
	3/30/16 at 4:40 p.m.						
F 280	483.20(d)(3), 483.10(k)	(2) RIGHT TO		F 280			1

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

C2N611

If continuation sheet Page 8 of 65



AND PLAN OF CORRECTION A 95134 NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NURSING & REHABILI1 (X4) ID PREFIX TAG CANUMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION) F 280 CONTINUED FOR SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION) F 280 CONTINUED FOR SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION) F 280 CONTINUED FOR SUMMARY STATEMENT OF DEFICIENCIES OR LSC IDENTIFYING INFORMATION) F 280 CONTINUED FOR PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NURSING & REHABILI1 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION) F 280 Continued From page 8 SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	(X3) DATE SURVEY COMPLETED
RIDGECREST MANOR NURSING & REHABILI1 STREET ADDRESS, CITY, STATE, ZIP CODE 157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 280 Continued From page 8 SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	C 03/31/2016
DUFFIELD, VA 24244 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) TAG OR LSC IDENTIFYING INFORMATION) F 280 Continued From page 8 SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	
F 280 Continued From page 8 SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	
SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	D RE COMPLETION
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	:
incompetent or otherwise found to be 1. The care plan for Resident #24 was incapacitated under the laws of the State, to	
participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative, and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for Resident #24 to reflect the resident had increased secretions requiring frequent mouth care. Resident #24 was admitted to the facility on 9/7710 with diagnoses of anoxic brain damage, respiratory failure, anxiety, anemia, and persistent vegetative state. The annual MDS with a reference date of 3/1/16	esidents re care nurses ny reased II when a s and nee will sident heir plan is g will to the ew and

C2N611

assessed the resident with coma and requiring

DEPARTMENT OF HEALTH AND HUMAN SERVICES Printed: 04/14/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495134 B. WING 03/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RIDGECREST MANOR NURSING & REHABILIT 157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX (X5) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 280 Continued From page 9 F 280 total assistance of 1-2 persons for bed mobility, dressing, toileting, bathing, and hygiene. Resident #24 was observed on 3/31/16 at 10:40 a.m. returning from the shower requiring suctioning from her tracheostomy. The resident ' s mouth had a dry crust on her lips with teeth coated with secretions. The mother was present and stated the resident required frequent mouth care because of increased secretions. The respiratory therapist confirmed the resident had secretions in her mouth frequently and required mouth care often. The comprehensive care plan was reviewed. The care contained interventions to provide oral care daily and as needed. The care plan was not individualized to note the resident had excess secretions in her mouth and required more frequent mouth care. The administrator, director of nursing, and assistant director of nursing were informed of the findings during a meeting with the survey team on 3/30/16 at 4:40 p.m. F 281: 483.20(k)(3)(i) SERVICES PROVIDED MEET F 281 SS=E PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. 1. The physician has been notified of the medication errors for Residents #18, This Requirement is not met as evidenced by: #11, #20, #7, #5, #10, #16, and #15. No Based on staff interview, facility document review new orders were received at that time.

and clinical record review, the facility staff failed to follow professional standards of nursing practice for medication administration for 8 of 24 residents (Resident #18, Resident #11, Resident #20, Resident #7, Resident #5, Resident #10, Resident #16, and Resident #15). The findings included:

1. The facility staff failed to document the reasons medication was not administered to 2. All residents are at risk for this issue.

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C2N611

If continuation sheet Page 10 of 65

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	d: 04/14/2 MAPPROV O. 0938-0
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S	SURVEY _ETED
	495134	B. WING		03/:	C 31/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 00,0) 1/2010
RIDGECREST MANOR NUR	RSING & REHABILII 157 RO		ER BOULEVARD		
TAG (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ULD RE	(X5) COMPLETIC DATE
F 281 Continued From pa	ge 10	F 281			
Resident #18.					
The clinical record o	of Resident #18 was reviewed		3. Licensed nursing staff have been		
3/30/16 and 3/31/16	6. Resident #18 was admitted		reeducated concerning the me		
to the facility 5/22/13	3 and readmitted 12/6/15 with		administration/documentation	n policy.	
diagnoses that include	ded but not limited to acute		This includes when to notify th		
respiratory failure wit	th tracheostomy,		physician and responsible party		
morbid obesity enils	ia, type 2 diabetes mellitus,		issue.	, = . = .	
⊹ anovic hrain damage	epsy, depression, anxiety,		The nurses are now required to	^	
anoxic brain damage	e, encephalopathy, c obstructive pulmonary		document a review of the MAR		
disease, and bariatric	coursery				
Resident #18's annu	al minimum data set (MDS)		change of shift during the shift		
assessment with an	assessment reference date		report to identify any variance f		
(ARD) of 2/5/16 had	dash marks for short and		policy. The nurses must sign the		
long term memory an	nd severely impaired		the MAR book attesting that the		
cognitive skills for dec	cision making.		completed this review and that		
March 2016 physiciar	n orders included an order		medication administration has b	peen	
that read "Ergocalcife	erol 8000unit/1 ml (milliliter)		completed according to the poli		
drops For > Drisdol G	Sive 1 ml via tube every day		· -	·,·	
9AM 12/10/14." Upon	review of the March 2016	, 4	4. The Director of Nursing or design	lliw com	
medication administra	ation records (MARs), two		monitor that the sign in sheet is		
dates had been circled	d-March 28 and March 29.				
The surveyor reviewed	d the reverse side of each		signed daily. This monitoring will		
of the March MARs ar	nd found no documentation		documented 5 days a week for 4		
for the circled medicat	tions.		3 days a week for 4 weeks, and t		
The surveyor reviewed	d the March 28 and March		weekly for 4 weeks. The Director		
29 progress notes. In	he clinical record did not		Nursing or designee will review to	the	
reveal the reasons the	Ergocalciferol was not		MARs for each resident and docu	ument	
administered on 3/28/1	16 and 3/29/16.		their findings weekly for 12 week		
on 3/31/16 at 1·20 n m	ved the director of nursing		The Director of Nursing will repor		
was asked to review th	n. The director of nursing		results of the monitoring to the n		
reasons the medication	ne clinical record for the n was not administered		OAD committee for residue and	nonthly	
3/28/16 and 3/29/16. A	1 Was not administered		QAPI committee for review and		
stated she was unable	to locate why the		recommendations.		

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medications had not been administered. The

DON stated the nurse had been called but no

what would the standard of practice be. The

response from that nurse. The surveyor asked the DON when medications aren't administered,

REdicontinuation sheet Page 11 of 65

APR 27 2016

5. The allegation of compliance date for all

29, 2016

C2N611

aspects of this plan of correction is April

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE	
	495134	B. WING			C
NAME OF PROVIDER OR SUPPLIER	CTOPETADD	2500 01511 0		03/	/31/2016
RIDGECREST MANOR NUI			TATE, ZIP CODE		
		LD, VA 24	ER BOULEVARD 244		
PREFIX (EACH DEFICIENCY MUS	FATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 281 Continued From page 1	age 11	F 281	,		· ·
	e the medication and put the	1 201			1
reasons the medica	ations weren't administered on				
the reverse side of	the MAR or chart in the				
nurse's notes. The	surveyor requested the facility				
policy on standard	of nursing practice for				
medication adminis	tration.	!			
The surveyor review	ved the facility standard of				
nursing practice for	medication administration				
titled "6.0 General D	Oose Preparation and				;
Medication Adminis	tration" on 3/31/16. The	•			í
policy read in part "A	Applicability: The Policy 6.0	1			;
sets forth the proced	dures relating to general dose				<u> </u>
preparation and med	dication administration.	ş			1
Procedure: 6. After i	medication administration,	ì			1
Facility staff should t	take all measures required by				
Facility policy and Ap	oplicable Law, including, but	i :			
not limited to the following	owing: 6.1 Document	£			: !
necessary medicatio	n administration/treatment	í			
information [e.g., (that	at is) when medications are	2		,	
opened, when medic	cations are given, injection				
site of a medication,	if medications are refused,	:		;	
prn (whenever neces	ssary) medications,			1	
application sight] on a	appropriate forms."			;	
During the interview (with the DON, the surveyor				
stated "on the reverse	ate forms" were. The DON	!		i	1
chart."	e side of the MAR or in the	:		:	
	d the administrative staff of				` '
the above finding on 3	3/31/16 at 3:20 p.m.				
No further information	n was made available prior				
to the exit conference	on 3/31/16				ĺ
2. The facility staff fa	iled to document the			i .	
reasons medications	were not administered to			:	
Resident #11.	The first daminiotered to	ì			
	s reviewed 3/30/16 and			F]
3/31/16. Resident #11	was admitted to the facility			ř	
4/25/14 with diagnose	s that included but not			\$ •	
limited to rectocele/cys	stocele without uterine				
prolapse, diabetes me	llitus type 2. urine retention	ŧ		:	- 1
senile dementia, neph	ritis and nephropathy,			3	

If continuation sheet Page 12 of 65

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Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	S	(X3) DATE SURVEY COMPLETED
	495134	B. WING		C 03/31/2016
NAME OF PROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, S	TATE, ZIP CODE	
RIDGECREST MANOR NUF	The state of the s	57 ROSS CARTI UFFIELD, VA 24	ER BOULEVARD 244	
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULAT NTIFYING INFORMATION)	ID TORY PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
F 281 Continued From pa	ge 12	F 281		
heart failure, pain, a Resident #11's annu assessment with an (ARD) of 3/1/16 ass cognitive summary s	al minimum data set (MDS assessment reference date essed the resident with a score of 12 out of 15.	e .		
orders both schedul surveyor reviewed the	/sician orders included insued and sliding scale. The ne March 2016 medication	ılin :		
blanks for the admin 3/3/16 and 3/4/16 at	ds (MARs). There were istration of Lantus insulin o 9:00 p.m., blanks on 3/15/1 on 3/20/16 and 3/21/16 at	n : :		
9:00 a.m., blanks on on 3/26/16 at 9:00 a. 9:00 p.m.	3/23/16 at 9:00 a.m., blank m., and blanks on 3/30/16 a	at ,		: !
the blood sugar was a.m.	ulin entry had no evidence obtained on 3/23/16 at 6:00 ed the reverse side of the) :		; ; ;
March 2016 medicati There was no docum insulins were not adn	on administration records. entation as to the reason the reason the blood sugar 2016 progress notes were	ar i		: :
reviewed as well. The Resident #11 did not blood sugar as ordere The surveyor interview	ere was no evidence why receive insulin as ordered c ed. ved licensed practical nurse	e		
L.P.N. #2 the March 2 the scheduled and slid	p.m. The surveyor showed 016 MAR and specifically ding scale insulin surveyor asked L.P.N. #2	d :		; ;
what nurses do when administered. L.P.N.	medications are #2 stated when medications are initialed. L.P.N. #2	S		
The surveyor interview on 3/31/16 at 1:20 p.m	red the director of nursing . The surveyor asked the s aren't administered, what	; ; t		

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

C2N611

If continuation sheet Page 13 of 65

AFR 7 2016 VDH/OLC

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA IBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE S	
		495134		B. WING			C 31/2016
	PROVIDER OR SUPPLIER		STREET ADD	RESS. CITY S	TATE, ZIP CODE	03/3	31/2010
RIDGEC	REST MANOR NUF	RSING & REHABILIT	157 RC		R BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS.	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	EGULATORY.	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 13		F 204			·
!	would the standard	of practice be. The D	ON	F 281			1
	stated to circle the	medication and put the	ON .				4
	reasons the medica	itions weren't administ	orod on				
	the reverse side of	the MAR or chart in th	ered on .	i			
	nurse's notes. The	surveyor requested th	e fooilit				
	policy on standard of	of nursing practice for	e racility				
1	medication administ	ration	,				
		ed the facility standar	d of	4			
	nursing practice for	medication administra	u ui tion	3			!
	titled "6.0 General D	ose Preparation and	ition			:	
:	Medication Administ	ration" on 3/31/16. Th	ام				
	policy read in part "A	applicability: The Police	v 6 0				
; ;	sets forth the proced	lures relating to gener	al dose			:	
: 1	preparation and med	lication administration	ar dose ;			:	
· i	Procedure: 6. After n	nedication administrat	ion	3		j.	
, F	acility staff should t	ake all measures requ	ired by			t	
· F	-acility policy and Ap	plicable Law, including	a but	1		:	
ŗ	not limited to the follo	owing: 6.1 Document	g, but			1	
ŗr	necessary medication	n administration/treatn	nent :	1			
ii ii	nformation [e.g., (tha	it is) when medication	s are			1	
; O	pened, when medic	ations are given, iniec	tion				
S	ite of a medication, i	f medications are refu	sed.	:			
p	rn (whenever neces	sary) medications.		:			1
a	pplication sight] on a	appropriate forms."	!				1
; D	uring the interview v	vith the DON, the surv	eyor			i i	1
, a:	sked what "appropria	ate forms" were. The	DON	:		1	
St	lated "on the reverse	side of the MAR or in	the 📒				
Cr	nart."						
	ne surveyor informed	d the administrative st	aff of				1
: tn	e above finding on 3	3/31/16 at 3:20 p.m.	\$ -	•			
- IVI	o further information	was made available p	prior			·	
: 10	the exit conference	on 3/31/16.	j.				
36	For Resident #20,	facility staff failed to f	ollow				
. 818	andard nursing pract	tice for medication				8	
au	Iministration for insu	iin.					
D	seidont #20 was = -	dittant to the control of the contro					1
10	/20/10 and roads:	nitted to the facility on					
1 U.	th diagnoses include	ed to the facility on 6/1	2/13			:	
wit	th hemodialysis, hype	ng end stage renal dise ertension,	ease			\$ 4	

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE	
			Advantage and the second of th	СОМРІ	ETED C
	495134	B. WING		03/3	31/2016
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE		·····
RIDGECREST MANOR NU		OSS CARTE ELD, VA 24	ER BOULEVARD 244		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 281 Continued From p	page 14	F 281		,	ļ
gastroesophageal		1 201			
cardiopulmonary d	isease, and insulin dependent	:			1
diabetes mellitus.	The resident scored 15/15 on				1
the brief interview t	for mental status on the				*
minimum data set	assessment with assessment	d .			1
reference date 3/12	2/16.				:
During clinical reco	rd review on 3/31/16, the				
surveyor noted on t	he medication administration	:		3	
record (MAR) for M	arch 2016 that the signatures	ž .		į	
for Lantus (insulin)	100 units per 1 ml inject 10			ì	
units subcutaneous	ly at bedtime for DMII				
scheduled for 9 PM	were circled every date				
except 3/18, which	was blank. Humalog 100 units	i			
/ 1 ml (milliliter) inje	ct subcutaneously before				
meals and at bedting	ne per sliding scale for blood				
sugar 70-140 units =	= 0; 141-180=1 units;			1	
181-220=2units; 221	1-260=3units; 261-300=				
4units, 301-340= 5u	nits; 341-600= 6units for	j t			
diabetes contained t	planks on 3/5, 14, 18, and 23.			1	
indicating not admir	times which were circled,	;			
27 28 and 20 2 uni	istered. On 3/17, 18, 20, 26,	9		ţ.	
than the ordered dos	its were administered rather				ĺ
documented on the	se. No explanations were packs of the MAR or in				
nurse's progress not	es. There was no record of			4	
the physician being r	notified that the insulin had				1
consistently been ref	used, not administered, or	ż		:	1
administered in a dos	se other than ordered			3	
i i i i i i i i i i i i i i i i i i i	oc other than ordered	;		i	
On 3/31/16 at approx	imately 11:30, the surveyor				
interviewed the nursing	ng supervisor and director of	# E			1
nursing about the om	itted medications. The unit				
manager indicated th	at the resident had been	:			1
refusing insulin for ve	ars because he thought his	3			1
blood sugar went too	low between the effects of	ŧ		•	
the insulin and the he	modialysis. On 3/31/16, at				
approximately 12:30 F	PM, the DON reported				
discussing the Lantus	insulin with the physician	I		4	
and obtaining an orde	r to discontinue the			4	



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	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE	SURVEY LETED
		495134	B. WING			C /31/2016
	F PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, S	STATE, ZIP CODE		31/2010
RIDGE	ECREST MANOR NUR	RSING & REHABILI 157 RO		ER BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 28	Continued From pa	ige 15	F 281			
	medication. She stathat the resident had in 4 months. Staff v	ated that the record indicated d not received Lantus insulin were accustomed to the emedication and had stopped	1 2.0 1 s			
	director of nursing redocumentation of methe nurse to docume the MAR and notify the She said she consideration policy practice for the facility physician was in the days. 3b. For Resident #20	the nursing standard of y. She stated that the building for part of most , facility staff failed to follow				
	nursing standards of administration for ins	practice for medication				
:	10/20/10 and readmit with diagnoses includ with hemodialysis, hy gastroesophageal refl cardiopulmonary disediabetes mellitus. The the brief interview for	ux disease, ase, and insulin dependent resident scored 15/15 on mental status on the ressment with assessment				
	record (MAR) for Marc PO (by mouth) BID (by 3/24/16. Two times per doses. The MAR had documentation of adm	review on 3/31/16, the emedication administration sh 2016. Bactrim DS 1 tab mouth) X 5 days ordered r day for 5 days required 10 only 9 spaces indicated for inistration of Bactrim, with uses on 3/25, 26, 27, and				

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C2N611 If continuation sheet Page 16 of 65

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Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED
	495134	B. WING		C 03/31/2016
NAME OF PROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE	
RIDGECREST MANOR NUI	į.	ROSS CARTI FIELD, VA 24	ER BOULEVARD 244	
PREFIX (EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATOR ENTIFYING INFORMATION)	ID RY PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 281 Continued From pa	age 16	F 281		:
	was documented on 3/29/16.			3
The space for the s	second dose on 3/29 was X'd	4		E.
out. There was no	documentation to indicate that			i
a 10th dose of Bact	trim had been administered.			
	Lantus (insulin) 100 units per	1 :		
ml inject 10 units su	bcutaneously at bedtime for	•		:
DMII scheduled for	9 PM were circled every date			*
except 3/18, which	was blank. Humalog 100 units			
/ 1 ml (milliliter) inje	ct subcutaneously before			
meals and at bedting	ne per sliding scale for blood			
sugar 70-140 units	= 0; 141-180=1 units;			#
181-220=2units; 22	1-260=3units; 261-300=			!
4units; 301-340= 5u	nits; 341-600= 6units for	4		
diabetes contained l	blanks on 3/5, 14, 18, and 23.	\$		1
3/24, 26, and 27 had	d times which were circled,	1		
indicating not admin	istered. On 3/17, 18, 20, 26,	4 4		
27, 28, and 29, 2 un	its were administered rather	1		
than the ordered dos	se. No explanations were			1
documented on the	backs of the MAR or in	1		
nurse's progress not	es. There was no record of	1		:
trie physician being r	notified that the insulin had	: :		·
consistently been ret	fused, not administered, or			1
administered in a do	se other than ordered	1		
On 3/31/16 at approx	imataly 11,20 the	:		ŧ
interviewed the nursi	kimately 11:30, the surveyor ng supervisor and director of			
nursing about the or	nitted medications. Both			;
counted the doses of	Bactrim administered and			,
agreed that only 9 ha	id been administered. They			:
acknowledged that the	ne insulin had not been	3		ŧ
documented adminis				
accamented daminis	crea as ordered.	:		
During a summary m	eeting on 3/30/16, the	· ·		
director of nursina rea	ported that the policy for			;
documentation of me	dication omission was for	4		
the nurse to documer	nt the reason on the back of			:
the MAR and notify th	e physician of the omission.	•		· · · · · · · · · · · · · · · · · · ·
She said she conside	red the medication			;
administration policy t	the nursing standard of			;
practice for the facility	. She stated that the			:
				i i

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

C2N611

If continuation sheet Page $\,$ 17 of 65

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APR 27 2016

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
·		495134	B. WING		Į.	C 1/2016
	PROVIDER OR SUPPLIER	1		TATE, ZIP CODE	***************************************	**************************************
NIDGEC	TREST WANCK NU		LD, VA 24	ER BOULEVARD 244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	Continued From p	age 17	F 281		·	····
	physician was in the days.	e building for part of most	:			
		7, facility staff failed to follow ractice for medication asulin.	· · · · · · · · · · · · · · · · · · ·		; ; ;	
	11/16/15 with diagn disease with kidney dementia, and insul mellitus. The reside interview for mental	dmitted to the facility on oses including end stage renal failure, hypertension, lin dependent diabetes ent scored 10/15 on the brief status on the minimum data h assessment reference date				
	surveyor noted on the record (MAR) for Maspace for Lantus (in 20 units subcutaneous scheduled for 9 PM 100 units / 1 ml (mill before meals and at blood sugar 151-200 251-300= 5units; 30 and call MD contained blanks on 3/25. No documented on the bourse's progress not	packs of the MAR or in es. There was no record of enotified that the insulin had				
s r c	surveyor reported the nursing reported that of medication omission document the reason	teeting on 3/30/16, the econcern. The director of the policy for documentation on was for the nurse to on the back of the MAR an of the omission. She said				

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

C2N611

If continuation sheet Page 18 of 65



Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S	
	495134	B. WING		03/3	C 31/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, S	TATE, ZIP CODE	1 00/0	7172010
RIDGECREST MANOR NUR	SING & REHABILI7 157 RO		ER BOULEVARD		
PREFIX (EACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 281 Continued From pa	ge 18	F 281			
she considered the policy the nursing st	medication administration and ard of practice for the hat the physician was in the	1 201			
5. For Resident #5, f standard nursing pra administration for ins	acility staff failed to follow ctice for medication ulin.	; ; ;			
3/31/11 with diagnose diabetes mellitus, and disorder. The resider interview for mental set assessment dated	nitted to the facility on es including hypertension, xiety, depression, and bipolar nt scored 13/15 on the brief tatus on the minimum data d 2/5/16, and was assessed delirium, psychosis, or				
Lantus insulin 30 units documented as admir administration record	on 3/30/16, revealed that is twice per day was not nistered on the medication (MAR) at 9 AM on 3/26/16. It omission was found in the st.				
during a summary medirector of nursing repreduction of medithe nurse to document the MAR and notify the She said she consider administration policy the practice for the facility. physician was in the budays. 6. The facility staff failed	orted that the policy for ication omission was for the reason on the back of physician of the omission. The medication respectively. The property of the medication of the stated that the uilding for part of most				



Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
***		495134	B. WING	No agreement and the control of the	03/	C 03/31/2016	
	VIDER OR SUPPLIER ST MANOR NUF	RSING & REHABILIT 157 R		TATE, ZIP CODE ER BOULEVARD 244	***************************************		
(X4) ID PREFIX (EA TAG	CH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
re Re 10 lim de CC Th ass qua refe pat 14 res	esident #16 was a /08/14. Diagnose lited to, seizure dipression, anxiety. OPD (chronic obside most recent ME essment complementerly assessment erence date) of 03 terns) of this assect out of a possible ident was cognitive.	dmitted to the facility on sincluded, but were not sorder, chronic pain, heart failure, diabetes and cructive pulmonary disease). OS (minimum data set) ted on this resident was a not with an ARD (assessment 3/04/16. Section C (cognitive resident scored the resident 15 points indicating the rely intact. Section B coded stand and to be understood.	F 281				
3/9/ resi inte /or o	16. The care plar dent was an insul rventions included oral medication as	care plan was reviewed on a contained a focus area the in dependent diabetic. The d to administer insulin and sordered, obtain blood port to physician any BS parameters.					
phys orde follo subd and "If b 151- 201- 251- 301-	sician orders date er for administratio ws: "Novolog 100						

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

C2N611

If continuation sheet Page 20 of 65

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APR 27 2016

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495134		B. WING		03/	C / 31/2016
	PROVIDER OR SUPPLIER	E .			TATE, ZIP CODE	***************************************	
RIDGE	CREST MANOR NU	RSING & REHABILI		DSS CARTE ELD, VA 24:	R BOULEVARD 244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RE- ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	· ·			F 281			:
	March 2016, was a	ministration record (MA also reviewed. On 3/21/ ation for a blood sugar.					f
	following order Nov	of the MAR revealed the volog Mix 70-30 units/ml cutaneously twice daily ver (6am and 5pm).	l vial	· · · · · · · · · · · · · · · · · · ·			
	times no document	on the following dates a ation to support that the t 5pm, 3/6/16 at 6am, 3 6/16 at 5pm.	insulin				· · · · · · · · · · · · · · · · · · ·
:	look at the MAR an	p.m., LPN #1 was asked tell the surveyor if the red after looking she sa hey aren't mine."	insulin	:			
		3/31/16 the administratorere informed of the insu	,	; ; ; ;			
	was provided to the The survey team was standard of nursing administration titled Preparation and Mer 3/31/16. The policy The Policy 6.0 sets to general dose prepadministration. Proceedings of the Policy 6.0 sets to general dose prepadministration.	as provided the facility practice for medication "6.0 General Dose dication Administration" read in part " Applicabiforth the procedures relipionarion and medication bedure: 6. After medication	on lity: ating				
	administration, Facil measures required b	ity staff should take all by Facility policy and		ž		;	

C2N611

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

If continuation sheet Page 21 of 65

RECEIVED APR 27 2016

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		A. BUILDING	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495134		B. WING		03/	C / 31/2016
	PROVIDER OR SUPPLIER				FATE, ZIP CODE	<u> </u>	
RIDGE	CREST MANOR NU	RSING & REHABILIT		SS CARTE LD, VA 24	ER BOULEVARD 244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BT BE PRECEDED BY FULL RI BENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	following: 6.1 Doc administration/trea is) when medication medication, if med (whenever necess sight] on appropriation of practice in documental physician ordered in mouth every day for the most recent Miles assessment complete quarterly with an AF date) of 01/12/16, a usually understand Review of Resident revealed a physician Levaquin 750mg by A review of the resid (medication administicality staff had not medication Levaquin documented as admithrough 3/15/16. Ho	cluding, but not limited cument necessary medication [e.g. ons are opened, when ven, injection site of a ications are refused, prary) medications, applied to forms. failed follow nursing stanching and administer medication Levaquin 75 or Resident #10. admitted to the facility (d. but were not limited to the facility (d. seed on this resident was the facility of the facility (d. seed on this resident to facility (d. seed on this resident to facility (d. seed on the facility of the facility of the facility (d. seed on this resident to facility of the facili	incation, (that in cation andards the 50mg by 08/4/15. o as a ance or a stood. 6 for d the sof the stood the st	F 281			
	no documentation o MAR to indicate the administered or adm	n the front or the back	of the	;		:	

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

If continuation sheet Page 22 of 65



Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		495134	B. WING		03	C / 31/2016
	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
RIDGE	CREST MANOR NUF	.	DSS CARTI ELD, VA 24	ER BOULEVARD 244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 22	F 281			
		ne medication Levaquin.				1
	On 3/30/16 at 9:30 (LPN) #2 was asked medication Levaqui wasn ' t here at 9 pr	am licensed practical nurse d if she had given the n on the 16th. She stated " I m. "				
	nurse who worked of medication. She state said she didn't know said we sent 4 back box the math is off. 2 stat box slips thate 750mg one dose ear slips that also reque	ctor of nurses was asked if the on the 16th had given the ted "I'm not sure the nurse w." The pharmacy manifest and pulled 4 from the stat The pharmacy said they had requested the Levaquin ch. They also had 2 stat box sted the Levaquin 750 each or residents name on it."				
	standard of nursing padministration titled Preparation and Med 3/31/16. The policy of The Policy 6.0 sets for the Policy 6.0 sets for general dose prepadministration. Procadministration, Facility measures required by Applicable Law, inclustration/treatm is) when medications are given medications are given medication, if medica (whenever necessary sight] on appropriate The surveyor informethe above finding on 3	dication Administration " on read in part " Applicability: both the procedures relating aration and medication edure: 6. After medication by staff should take all by Facility policy and ding, but not limited to the ment necessary medication ent information [e.g., (that are opened, when note, injection site of a tions are refused, prn and the administrative staff of 3/31/16 at 3:20 p.m. It was made available prior				

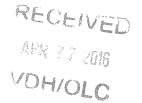
Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1	PLE CONSTRUCTION	(X3) DATE	SURVEY
AND I DAILO CONTECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP	LETED
	495134	B. WING		03/	C (31/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
RIDGECREST MANOR NUI			ER BOULEVARD		
		LD, VA 24			
(X4) ID SUMMARY ST	FATEMENT OF DEFICIENCIES				
PREFIX (EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 281 Continued From p	age 23	F 281	***************************************		:
	failed to follow professional	1 201			1
standards of nursin	g service by failing to notify				\$ 1
the physician/response	onsible party (RP) of	1			
medication not adm	ninistered for Resident #15.	ŧ			
	admitted to the facility on				i E
1/5/14 with diagnos	es of fracture pubis, skin				4
	anemia, hypertension,				,
	reflux disease, chronic				4
obstructive pulmona	ary disease, dementia,				1
anxiety, coronary ar	tery disease, and arthritis.	1			1
The significant char	nge Minimum Data Set (MDS)	4			
with a reference dat	e of 11/23/15 assessed the				: :
resident with a cogr	nitive score of "9" of "15".	1			1
The resident was as	ssessed requiring total				
assistance of 2 pers	sons for bed mobility,				1 2
	eating, toileting, bathing, and				Í
hygiene.		F			
The medication adm	ninistration record (MAR) for	1			
	riewed. The nurses had	:			:
documented on the	front of the MAR the resident	1			
had refused the sup	pository every evening from			:	
3/1/16 through 3/16/	16. There was no	i			
documentation the p	hysician/ RP had been			!	1
notified of the refusa					1
The nurses also circ	led their initials from 3/18/16			4	1
through 3/29/16 indic	cating the medication was not				
given. There was no				1	
physician/ RP had be	een notified of the refusal.			:	
There was no docum	entation on the back of the	:			
	medication was not given.			,	
The nursing notes we		•			ļ
documentation was e	evidenced the physician/ RP	;		1	ĺ
were notified of the m	nedication not administered.	1			
The administrator, director, director, director, director, director, director, and director, and director, and directors are also directors and directors are directors.	ector of nursing, and			1	
assistant director of r	ursing were informed of the	Ÿ.			
unuings during a mee	eting with the survey team on			i	
3/30/16 at 4:00 p.m.	The director of nursing			*	
provided the facility p	olicy on Resident Medication	1			1
Rights. The policy sta	ted the facility should				
aocument in the clinic	al record when a resident				i

C2N611

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

If continuation sheet Page 24 of 65



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(X4) ID

PREFIX

TAG

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

(X5)

COMPLÉTION

DATE

X3) DATE SURVEY COMPLETED C 03/31/2016

CENTERS FOR MEDICARE	& MEDICAID SERV	ICES ICES	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING
	495134		B. WING
NAME OF PROVIDER OR SUPPLIER			ESS, CITY, STATE, ZIP CODE
RIDGECREST MANOR NUR	SING & REHABILI		SS CARTER BOULEVARD .D. VA 24244

ID

PREFIX

TAG

F 281

F 309

F 281 Continued From page 24 refuses a medication and the physician should be notified of a refusal for periods greater than 24 hours. F 309 483.25 PROVIDE CARE/SERVICES FOR SS=E HIGHEST WELL BEING

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY

OR LSC IDENTIFYING INFORMATION)

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This Requirement is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to follow physician orders for 5 of 27 residents in the survey sample (Residents #20, 1, 6, 10, and 15)

1. For Resident #20, facility staff failed to follow physician orders for medication administration for insulin and antibiotics.

Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease. cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment reference date 3/12/16.

During clinical record review on 3/31/16, the surveyor reviewed the medication administration record (MAR) for March 2016. Bactrim DS 1 tab PO (by mouth) BID (by mouth) X 5 days ordered

1. The physician was notified concerning the medication errors for Residents #20, #1, #6, #10, and #15. There were no new orders at that time.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

- 2. All residents are at risk for this issue.
- 3. Licensed nursing staff have been reeducated concerning the medication administration/documentation policy. This includes how to transcribe medication orders and when to notify the physician and responsible party of an issue.

The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.

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

If continuation sheet Page 25 of 65 RECEIVED

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR A. BUILDING		(X3) DATE SURVEY COMPLETED
	495134	B. WING		C 03/31/2016
NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NUR	SING & REHABILIT 157 RC	RESS, CITY, STATE, ZIP CO SS CARTER BOUL LD, VA 24244		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	PREFIX (EACH	OVIDER'S PLAN OF CORREC I CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
doses. The MAR hadocumentation of a staff documenting 2 28. Only one dose. The space for the scout. There was no do a 10th dose of Bactron The signatures for Lamber 10 units supported by 1 ml (milliliter) injecting and at bedtime sugar 70-140 units = 181-220=2units; 221 4units; 301-340= 5undicating not adminicating not adminicating not adminicating not adminicating not adminicating not adminicating properties and indicating not adminicating and the nurse's progress not the physician being repositive documented in a documented the doses of agreed that only 9 had acknowledged that the documented administing a summary madirector of nursing repositive documentation of medicating not approximately as summary madirector of nursing repositions.	per day for 5 days required 10 ad only 9 spaces indicated for dministration of Bactrim, with doses on 3/25, 26, 27, and was documented on 3/29/16. Econd dose on 3/29 was X'd ocumentation to indicate that tim had been administered. In antus (insulin) 100 units per 1 becutaneously at bedtime for 10 PM were circled every date was blank. Humalog 100 units at subcutaneously before e per sliding scale for blood 10; 141-180=1 units; 1260=3 units; 261-300=1 units; 341-600=6 units for blanks on 3/5, 14, 18, and 23. It times which were circled, stered. On 3/17, 18, 20, 26, at were administered rather the lacks of the MAR or in 10 es. There was no record of the lacks of the MAR or in 10 es. There was no record of the lacks of the maximistered, or 10 es other than ordered. It is supervisor and director of litted medications. Both 11 Bactrim administered and 12 does not been administered. They we insulin had not been	moni signe docu 3 day week Nursi MARs their The D result QAPI recon	Director of Nursing or delitor that the sign in sheeled daily. This monitoring mented 5 days a week for 4 weeks, arely for 4 weeks. The Directing or designee will review for each resident and defindings weekly for 12 weblied of the monitoring to the committee for review are mendations. Allegation of compliance the of this plan of corrections of the splan of corrections of the splan of corrections.	et is being will be or 4 weeks, and then ctor of ew the document veeks. eport the he monthly and

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

If continuation sheet Page 26 of 65

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Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	ELE CONSTRUCTION	(X3) DATE COMPI	
	495134	B. WING		03/	31/2016
NAME OF PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		TATE, ZIP CODE	***************************************	**************************************
RIDGECREST MANOR NU		OSS CARTE LD, VA 24	ER BOULEVARD 244		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY. ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309 Continued From p		F 309			
She said she cons administration polic	y the physician of the omission. idered the medication by the nursing standard of lility. She stated that the	\$			
physician was in th days.	e building for part of most	t *			
physician ordered r	failed to administered the medication Nudexta 10x20 1 veek start after EKG ny) for Resident #1.				:
Diagnoses included	dmitted to the facility 07/7/15. I, but were not limited to sion, and atrial fibrillation.				
assessment comple quarterly with an AF date) of 02/29/16, a	DS (minimum data set) eted on this resident was a RD (assessment reference ssessed the resident to and to usually be understood.				
order dated 2/23/16 Nudexta 10-20mg 1 after EKG. 2nd wee cap BID (twice daily	that included the order cap every day x 1 week start ek give Nudexta 20-10mg I every 12 hours. EKG prior a, EKG 4 hours after 1st dose				
facility staff had adm the EKG was done o	ents current MAR tration record) indicated the inistered the 1st dose after on 2/24/16. However there f Nudexta given on 2/24/16 at			:	
The Nudexta was no 2/25/16.	t documented as given on	r.			
Licensed practical nu	urse (LPN) #2 stated she had			1	

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

C2N611 If continuation sheet Page 27 of 65

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APR 27 2016

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Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED		
	495134			B. WING		03/	C 31/2016
	PROVIDER OR SUPPLIER	CINC 9 DELIADILI			STATE, ZIP CODE		
KIDGEC	REST MANOR NUR	SING & REHABILI		ELD, VA 2	ER BOULEVARD 4244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 27		F 309			
	EKG and at 5:00pm 25th. On 03/30/16 at appr	on 2/24/16 at 1:00 pm but was not working coximately 2:55 p.m., eeting with the admin	g on the				
	DON (director of nur staff was notified that administered the me	rsing). The administr at the facility staff had edication incorrectly.	ative d	*** **********************************			
;	standard of nursing administration titled	" 6.0 General Dose	on	1			
	Preparation and Med 3/31/16. The policy	read in part " Applica	ability:				
7	The Policy 6.0 sets f to general dose prep	paration and medicati	ion				
!	administration. Proc administration, Facili			Mar 44 - 1700 001 1000			
1	measures required by Applicable Law, inclu-	y Facility policy and	j	1			
	following: 6.1 Document	ment necessary med	lication	1			
	administration/treatm is) when medications medications are give	are opened, when	, (that	i			
	medication, if medica (whenever necessary sight] on appropriate	ations are refused, pr y) medications, appli					
	No further information provided to the surve conference.						
i	The facility staff fai physician ordered me mouth every day for F	edication Levaquin 75		-			
1	Resident #10 was ad Diagnoses included, I dementia, hypertensid	but were not limited t				2	

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

C2N611 If continuation sheet Page 28 of 65

APR 2.7 2016

VDH/OLC

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		A. BUILDING		(X3) DATE COMP	LETED
	495134		B. WING		03/	C / 31/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	TATE, ZIP CODE		
RIDGECREST MANOR NUF	RSING & REHABILIT		DSS CARTE ELD, VA 24:	R BOULEVARD 244		
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309 Continued From pa	age 28	1	F 309			:
osteoporosis.		1	ŧ			
[1			
	DS (minimum data se eted on this resident v		i			
	RD (assessment refe		ŧ.			r j
	ssessed the resident		1			:
,	and to usually be und		3			;
		!				į.
, , , , , , , , , , , , , , , , , , , ,	#10 's clinical record					:
	n 's order dated 3/10	/16 for				
Levaquin 750mg by	mouth every day.		1			Ì
A review of the resid	dente current MAD	1				
	stration record) indica	ted the	1			1
	administered all 7 da		1			
	n. The medication wa					1
	ninistered starting on		3			
	wever, on the 16th th		10.0 p			;
	n the front or the bac					
	medication was not	1	•			
administered or adn	ninistered. There was	no				:
corresponding nurse	e's note related to th	e lack of	:			
documentation of th	e medication Levaqu	in.	:			
						î
	am licensed practical	nurse	Y care			1
	I if she had given the		1			
	n on the 16th. She sta	ated 1				
wasn 't here at 9 pn	n.		:			
At 2:00 pm the direct	tor of nurses was ask	red if the	1			
	n the 16th had given		i			
	ted "I'm not sure th		4 2 3			
	w. " The pharmacy m					
	and pulled 4 from the					
	The pharmacy said th		1			
	requested the Levaqu		į			!
750mg one dose ea	ch. They also had 2 s	tat box				
	sted the Levaquin 750					
one dose that had no	o residents name on i	it. "				:
			Í			1

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

If continuation sheet Page 29 of 65



Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED		
	495134	B. WING			C 03/31/2016	
NAME OF PROVIDER OR SUPPLIER	l l		TATE, ZIP CODE			
RIDGECREST MANOR NUI	1	SS CARTI LD, VA 24	ER BOULEVARD			
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	COMPLETION DATE	
F 309 Continued From p	age 29	F 309			1	
The surveyor inform	med the administrative staff of	1				
the above finding o	n 3/31/16 at 3:20 p.m.	1			*	
No further informat	ion was made available prior	1				
to the exit conferer	nce on 3/31/16.					
	failed to follow physician	1				
	on administration to Resident 🕝				:	
	ff failed to administer					
Lactulose as ordere					£	
	wed Resident #6's clinical	1			1	
	3/31/16. Resident #6 was	1			:	
	lity 12/26/14 and readmitted	;			* *	
	ses that included but not	1				
1	f first and fourth cervical					
	chronic respiratory failure,				-	
	d pneumonia, tracheostomy,	1				
malnutrition, gastro						
	nusitis, aphonia, dysphagia, perlipidemia, hypertension,	i			ı	
	norrhage, osteoarthritis,				;	
	I pressure ulcer, anemia,				1	
anxiety, and depres		!				
	erly minimum data set (MDS)	1				
	reference date (ARD) of				1	
	e resident with a cognitive					
	2 out of 15 in Section C				1	
Summary Score.		4 444 7			:	
	ed the February 2016 and	į			:	
	an orders. Telephone order	:				
written 2/24/16 1550	(3:50 p.m.) read in part	!				
	ms)/15 ml (milliliter), 30 ml					
PT (peg tube) q (eve	ery) 8 h (hour) x 5 doses then	·			í	
30 ml PT daily. ?NH		!			ì	
	medication administration				:	
	ed. The entry on the	1			:	
	s read "Lactulose 10G/15 ml					
	oses 6A, 2P, 10P 2/24."	#			` <u> </u>	
	4/16 at 10P for Lactulose 30	1				
	circled. The surveyor	· F				
	side of the February 2016	1				
MAR. There was no	documentation as to why					

(X2) MULTIPLE CONSTRUCTION

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495134	B. WING		03	C / 31/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
RIDGE	CREST MANOR NU	i i	DSS CARTE ELD, VA 24	ER BOULEVARD 244		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL REGULATORY	ID PREFIX	PROVIDER'S PLAN OF CORRE		(X5) COMPLETION
TAG		ENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE API DEFICIENCY)		DATE
F 309	Continued From p	page 30	F 309			
	•	s not administered. The				
		2/24/16 did not reveal a				
	reason for the med					
	The surveyor inter-	viewed the director of nursing				
	on 3/30/16 at 12:30	p.m. concerning the order for	÷ .			
	Lactulose. The dir	ector of nursing was unable to				
	identify the reason	Resident #6 did not receive				J
		se of Lactulose on 2/24/16.				1
		med the administrative staff of	1			
		n 3/30/16 at 4:40 p.m.				
		ion was provided prior to the	3 5			
	exit conference on	The state of the s				ŧ
		failed to follow the physician				:
		ration of medication for				§
	Resident #15.	1	**			í
		admitted to the facility on				ı
		es of fracture pubis, skin	1			
		anemia, hypertension,	i			
		reflux disease, chronic				
		ary disease, dementia,				
		tery disease, and arthritis. nge Minimum Data Set (MDS)				
		te of 11/23/15 assessed the				
1		nitive score of "9" of "15".	í			
		ssessed requiring total	;			:
,		sons for bed mobility,	:			
	•	eating, toileting, bathing, and				:
	hygiene.	caung, tonothing, bathing, and				`
		bserved on 3/30/16 at 8:15				
'		ing medications administered				
:		N#2). The medications were	3			
		current physician orders. The	ž 1			
		n a telephone order dated	ı			,
		the medication, Dronabinol	1			
		daily before lunch and				!
		inistered the Dronabinol at				·
		ely after breakfast. LPN#2			i	
		e medication and stated she			:	
	had given it too early					
	The administrator, d	irector of nursing, and				

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

If continuation sheet Page 31 of 65



Printed: 04/14/2016

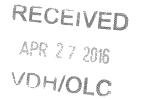
	RS FOR MEDICARE						1 APPROVE). 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495134			1	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
				B. WING _		03/31/2016	
	PROVIDER OR SUPPLIER CREST MANOR NUF	SING & REHABILI	157 RC		STATE, ZIP CODE FER BOULEVARD 4244	MANAGEMENT AND	Nemakan keduluk kerabuat myujuda baha
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
	findings during a me 3/30/16 at 4:00 p.m	f nursing were inform eeting with the survey	y team on	F 309			
	daily living receives		vities of	F 312	 Resident #24 had mouth care a it was identified as being needed 3/31/16. All residents with increased ora 	ed on	
:	Based on observation record review, and of complaint investigate provide mouth care residents (Resident The findings include The facility staff failed needed (prn) for Resident #24 was as 9/7/10 with diagnose respiratory failure, and vegetative state. The annual MDS with assessed the resident total assistance of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the complete record in the state of 1-dressing, toileting, but the state of 1-dressing, to 1-dressing, to 1-dressing, toileting, the state of 1-dressing, the state of 1-dressing, toileting, the state of 1-dressing, the	to to provide mouth consident #24. Idmitted to the facility are of anoxic brain dannatiety, anemia, and put har reference date of the with coma and requations, and hygiene. In the served on 3/31/16 at the side of the side of the served on 3/31/16 at the side of the s	are as on nage, persistent 3/1/16 uiring obility,		secretions are at risk for this iss 3. Current nursing staff have been reeducated concerning the proportion procedure and that the mouths residents must be assessed with visit into the room, at the least e hour. Resident #24, and any other residentified, now has a sheet that for as frequent as hourly docume of any mouth care performed. The sheets are kept in the ADL book is documentation and in the MAR blicensed staff documentation. The Administrator is no longer with the sheets.	per of these n each each ident allows entation These for CNA book for	
9	suctioning from her to mouth had a dry crus	racheotomy. The resi	th	d	facility. The current Administrate aware that documentation of the resolution and the family's respon	9	

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mouth care often.

and stated the resident required frequent mouth care because of increased secretions. The respiratory therapist confirmed the resident had secretions in her mouth frequently and required

If continuation sheet Page 32 of 65



should be documented.

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NURSING & REHABILTI (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG (EACH DEFICIENCY) F 312 Continued From page 32 The respiratory therapist (RT#1) was interviewed on 3/31/16 at 11:00 a.m. RT#1 stated the resident had "stiff lungs" making it difficult for the resident to cough and clear her secretions. RT#1 stated the resident to dry and crust because the resident was a "mouth breather". RT#1 stated Resident #24 frequently had secretions come from the tracheotomy requiring suctioning and also up into her mouth requiring frequent mouth care. RT#1 stated the resident the resident the resident to her important requiring responsibility to provide the mouth care as needed. RT#1 stated the resident to appearing. The comprehensive care plan was reviewed. The care plan contained an intervention to provide good oral care daily and prn (as needed). The unit manager (RN#3) was interviewed on STREET ADDRESS. CITY, STATE, ZIP CODE 157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244 FROSS CARTER BOULEVARD PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 312 4. The Director of Nursing or designee will monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 weeks, 3 days a week for 4 weeks, 3 days a week for 4 weeks, 18 documented 5 days a week for 4 weeks, 18 document their findings weekly for 12 weeks. The Director of Nursing or designee will review the MARs for each resident and document their findings weekly for 12 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee for review and recommendations for the duration of the monitoring process.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 03/31/2016	
157 ROSS CARTER BOULEVARD DUFFIELD, VA 24244 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES TAG CRACH CORRECTION OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		495134	B. WING			
F 312 Continued From page 32 The respiratory therapist (RT#1) was interviewed on 3/31/16 at 11:00 a.m. RT#1 stated the resident had "stiff lungs" making it difficult for the resident to cough and clear her secretions. RT#1 stated the resident to dry and crust because the resident was a "mouth breather". RT#1 stated Resident #24 frequently had secretions come from the tracheotomy requiring frequent mouth care. RT#1 stated this was a nursing responsibility to provide the mouth care as needed. RT#1 stated the resident 's lips would become dry and crusted appearing. The comprehensive care plan was reviewed. The care plan contained an intervention to provide good oral care daily and prn (as needed). The unit manager (RN#3) was interviewed on		SING & REHABILIT 157 RO	OSS CARTER	BOULEVARD		
The respiratory therapist (RT#1) was interviewed on 3/31/16 at 11:00 a.m. RT#1 stated the resident had " stiff lungs " making it difficult for the resident to cough and clear her secretions. RT#1 stated the resident had a lip balm applied to her lips per request of the mother and this tended to dry and crust because the resident was a " mouth breather". RT#1 stated Resident #24 frequently had secretions come from the tracheotomy requiring suctioning and also up into her mouth requiring frequent mouth care. RT#1 stated this was a nursing responsibility to provide the mouth care as needed. RT#1 stated the resident's lips would become dry and crusted appearing. The comprehensive care plan was reviewed. The care plan contained an intervention to provide good oral care daily and prn (as needed). The unit manager (RN#3) was interviewed on	PREFIX (EACH DEFICIENCY MUST	BE PRECEDED BY FULL REGULATORY	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
on 3/31/16 at 11:00 a.m. RT#1 stated the resident had " stiff lungs " making it difficult for the resident to cough and clear her secretions. RT#1 stated the resident had a lip balm applied to her lips per request of the mother and this tended to dry and crust because the resident was a " mouth breather " . RT#1 stated Resident #24 frequently had secretions come from the tracheotomy requiring suctioning and also up into her mouth requiring frequent mouth care. RT#1 stated this was a nursing responsibility to provide the mouth care as needed. RT#1 stated the resident ' s lips would become dry and crusted appearing. The comprehensive care plan was reviewed. The care plan contained an intervention to provide good oral care daily and prn (as needed). The unit manager (RN#3) was interviewed on	•		F 312		6	
provided mouth care and checked the resident whenever they went in the room. There was no documentation in the clinical record the resident had received mouth care more often than twice daily. A staff nurse (LPN#5) was asked how often in a 12 hours shift was mouth care provided and she stated she checked the resident 3-4 times a day. The resident was also ordered to have medication applied to her mouth twice daily. The director of nursing provided the grievance log for the facility. The grievance log included a complaint from the resident's mother dated 9/28/15 that oral care was not done. The staff were re-educated and oral care provided. Another grievance was dated 3/25/16 from the mother that mouth care was not done and the care was offered. Another grievance dated 3/29/16 also was regarding turning and mouth	The respiratory ther on 3/31/16 at 11:00 resident had " stiff I the resident to coug RT#1 stated the res to her lips per reque tended to dry and c was a " mouth brea #24 frequently had s tracheotomy requirin her mouth requiring stated this was a number the mouth care as no resident 's lips would appearing. The comprehensive care plan contained good oral care daily. The unit manager (R 3/30/16 at 1:20 p.m. provided mouth care whenever they went documentation in the had received mouth daily. A staff nurse (LPN#5 12 hours shift was m stated she checked to the resident was also medication applied to the facility. The gromplaint from the resident was also medicated and Another grievance was mother that mouth care was offered. And	apist (RT#1) was interviewed a.m. RT#1 stated the ungs " making it difficult for and clear her secretions. dent had a lip balm applied at of the mother and this tust because the resident ecretions come from the g suctioning and also up into frequent mouth care. RT#1 stated the discome dry and crusted and prn (as needed). RT#1 stated the discome dry and crusted and prn (as needed). N#3) was interviewed on RN#3 stated the nurses and checked the resident of the room. There was no clinical record the resident care more often than twice her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is growned to have her mouth twice daily. It is dated 3/25/16 from the rewas not done and the other grievance dated	4	monitor that the sign in sheet signed daily. This monitoring documented 5 days a week for 3 days a week for 4 weeks, an weekly for 4 weeks. The Director of Nursing or destreview the MARs for each restrained document their findings week weeks. The Director of Nursin report the findings of the monthly QAPI committee and recommendations for the of the monitoring process. The allegation of compliance of aspects of this plan of corrections.	et is being will be or 4 weeks, and then esignee will sident and kly for 12 ang will enitoring to for review enduration	

If continuation sheet Page 33 of 65

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DEPARTMENT OF HE						(FORM	04/14/20 APPROV . 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER 495134				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 03/31/2016	
NAME OF PROVIDER OR SUP	PLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE			
RIDGECREST MANOF	R NURSING &	REHABILI		DSS CART	TER BOULEVARD 14244			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY TAG OR LSC IDENTIFYING INFORMATION)				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETIO DATE
assistant direc findings during 3/30/16 at 4:0	ator, director o ctor of nursing g a meeting wit	were inform th the surve	ed of the	F 312			1 2 2 2 3	
F 315 483.25(d) NO SS=D RESTORE BL		PREVENT U	TI,	F 315				

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow the physician order for monthly Foley catheter changes for 1 of 24 residents (Resident #11). The findings included:

The facility staff failed to change Resident #11's indwelling Foley catheter in January 2016. The clinical record was reviewed 3/30/16 and 3/31/16. Resident #11 was admitted to the facility 4/25/14 with diagnoses that included but not limited to rectocele/cystocele without uterine prolapse, diabetes mellitus type 2, urine retention, senile dementia, nephritis and nephropathy, diabetic retinopathy, hypertension, congestive heart failure, pain, and osteoporosis. Resident #11's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/1/16 assessed the resident with a

- 1. Resident # 11's Foley catheter was changed on 3-30-2016. The resident has shown no adverse effects from this delay.
- All residents with catheters have had their orders reviewed and the MAR checked to ensure that there have been no others affected by this issue.
- Licensed nursing staff have been reeducated concerning the responsibility to follow physician orders as written.

The nurses are now required to document a review of the MAR at change of shift during the shift to shift report to identify any variance from the policy. The nurses must sign the form in the MAR book attesting that they have completed this review and that all medication administration has been completed according to the policy.

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

If continuation sheet Page 34 of 65

Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
495134				le unue			C 31/2016
	PROVIDER OR SUPPLIER	1			TATE, ZIP CODE		
RIDGE	CREST MANOR NUF	RSING & REHABILIT		SS CARTE LD, VA 24:	ER BOULEVARD		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES		· · · · · · · · · · · · · · · · · · ·		CCTION!	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST	T BE PRECEDED BY FULL REENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 315	Continued From page 1	age 34	:	F 315			
F 315	cognitive summary H Bladder and Bow catheter (H0100). marked "9" (not rate H0300. The January 2016 previewed 3/30/16. the Foley catheter the needed with an 18 belloon. The surveyor review medication administication and the surveyor review progress notes with on 3/30/16 at 3:30 photocontain document had been changed in Resident #11 had be room on 1/9/16. She could have been changed in the surveyor information and the surveyor requestions are surveyor requestions. The surveyor requestions are surveyor requestions and the facility didicatheter changes and was not changed at the surveyor and the surveyor and the surveyor requestions are surveyor requestions.	score of 12 out of 15. Wel was marked for indurinary continence was ed, resident had a cathological process. The control of th	welling s neter) in ers for and as illiter)). An cheter of the ne not hanged erstated ency neter staff of for for followeter.		I. The Director of Nursing or or review the documentation week for 4 weeks, 3 days a weeks, and then weekly for The Director of Nursing will results of the monitoring to committee monthly for revirecommendations. The allegation of compliance aspects of this plan of correct 29, 2016	5 days a week for 4 8 weeks. report the the QAPI ew and	
		GIMEN IS FREE FROI	VI	F 329		· · · · · · · · · · · · · · · · · · ·	
	Each resident's drug	regimen must be free	from	í			

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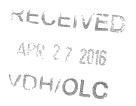
If continuation sheet Page 35 of 65



Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1			URVEY ETED	
	i	495134		B. WING		<u> </u>	C 1/2016
	PROVIDER OR SUPPLIER CREST MANOR NUR	1	157 RO		TATE, ZIP CODE ER BOULEVARD 1244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	BULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	unnecessary drugs. drug when used in eduplicate therapy); of without adequate mindications for its us adverse consequents should be reduced combinations of the Based on a comprehensident, the facility who have not used a given these drugs untherapy is necessary as diagnosed and do record; and resident drugs receive gradual behavioral interventic contraindicated, in addrugs.	An unnecessary drug excessive dose (including or for excessive duration on for excessive duration on for excessive duration on for excessive duration on the presence of the excessive discontinued; or any excessive and excessive and excessive and excessive assessment of must ensure that reside antipsychotic drugs are an excessive and exc	ng n; or equate f dose a ents not dition al c hese	F 329	notified of the missi- listed. There were notified. There were notified as who had ordered to be taken administration of met for this issue. 3. Licensed nursing state reeducated concerning responsibility to follow as written. The nurses are now notified as written.	on new orders. Inve blood pressure prior to the edication are at risk If have been ing the ow physician orders required to of the MAR at g the shift to shift y variance from the ust sign the form in ing that they have w and that all	
:	Based on staff interv review, the facility sta ordered parameters antihypertensive med (Resident #13). The findings include: The facility staff failed		cian f an dents		medication administr completed according		
	the antihypertensive (Coreg). The physici medication if the syst than 110. The clinical record of	medication Carvedilol ian had ordered to hold tolic blood pressure was Resident #13 was revien 13 was admitted to the factorial for the factorial	the s less ewed	;		:	

If continuation sheet Page 36 of 65



Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CLIA	,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495134	E	B. WING			C 03/31/2016	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRES	SS, CITY, ST	ATE, ZIP CODE		***************************************	
RIDGECREST MANOR NU	RSING & REHABILIT	157 ROS		R BOULEVARD 244			
PRÉFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE DENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 329: Continued From r	page 36		F 329		***************************************	<u> </u>	
limited to hyperten pituitary gland neo hyperlipidemia, va disturbances, major hallucinations, resi Resident #13's qua (MDS) assessmen reference date (AF resident with a cogo of 15 in Section C Resident #13's cur revised on 11/17/15 hypertension and reference of the force orthostatic hypoten (tachycardia) and e weights as ordered The March 2016 sign the following order Carvedilol (Coreg): (milligrams) tablet for by mouth twice daily pressure) less than The surveyor review medication administrates.	oses that included but resion, Alzheimer's disea plasm, type 2 diabetes scular dementia with been depressive disorder, allessness and agitation. For the administration for the administration of the	se, mellitus, ehavioral visual et d the of 13 out re plan for this. I on as ons as rt rate s and oncluded end/or		 The Director of Nursing or de monitor that the sign in sheet signed daily. This monitoring documented 5 days a week for 3 days a week for 4 weeks, an weekly for 4 weeks. The Director of Nursing or deserview the MARs for each residocument their findings week weeks. The Director of Nursing report the findings of the morther monthly QAPI committee and recommendations for the of the monitoring process. The allegation of compliance caspects of this plan of correctize, 29, 2016 	t is being will be or 4 weeks, and then signee will ident and ally for 12 g will nitoring to for review duration		
p.m. The surveyor of Vitals Summary form were no blood press above dates for 9:00 interviewed licensed 3/30/16 at 2:30 p.m.	27/16, and 3/28/16 at 9: reviewed the Weights a m for March 2016. The sures documented on the p.m. The surveyor I practical nursing #5 or L.P.N. #5 provided the for March 2016 vital sig	nd ; re ; ne ;					

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If continuation sheet Page 37 of 65

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Printed: 04/14/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		l` ′		(X	X3) DATE S COMPL	ETED .
	495134		B. WING _			03/3	C 31/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD				***************************************	***************************************
RIDGECREST MANOR NUR	SING & REHABILIT		OSS CART		BOULEVARD 4		· · · · · · · · · · · · · · · · · · ·
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE I BE PRECEDED BY FULL F NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	77.21	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329 Continued From pa	 age 37	ŧ	F 329				
•	oressure listed above	had	:	!			
been obtained and of At 2:36 p.m., L.P.N. not done."	documented on thesa. #1 stated "Blood promed the administrative	e forms. essures	: : : :	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
the failure of the fac pressures prior to th antihypertensive Ca	cility staff to obtain blo ne administration of the prvedilol (Coreg) on 3	ood					
conference on 3/31/		he exit	1				: : : : : : : : : : : : : : : : : : : :
F 333 483.25(m)(2) RESID SS=E SIGNIFICANT MED		T T T T T T T T T T T T T T T T T T T	F 333				
The facility must ens any significant medic	sure that residents ar cation errors.	re free of		1.	The physician has been notified concerning the medication errors Residents #11, #16, #20, and #5.	There	
Based on staff interval and clinical record re	s not met as evidence view, facility documer eview, the facility staf 4 residents in the sar	nt review, ff failed		2.	were no new orders at that time. Residents receiving medication ar risk for this issue.		
survey were free from errors (Resident #11 #20, and Resident #4 The findings included 1. The facility staff fatordered insulin (Lantand failed to obtain a 6:00 a.m.	m significant medical, Resident #16, Resi 5). d: ailed to administer ph tus) nine times in Ma an accucheck on 3/23	ntion ident nysician arch 2016 3/16 at		3.	Licensed nursing staff have been reeducated concerning the policy procedure of medication administration/documentation, including the responsibility to follophysician orders as written. The nurses are now required to	low	
	systocele without uter nellitus type 2, urine ro phritis and nephropatl hypertension, congest nd osteoporosis.	ne facility not rine retention, hy, estive			document a review of the MAR at change of shift during the shift to report to identify any variance fro policy. The nurses must sign the for the MAR book attesting that they completed this review and that all medication administration has becompleted according to the policy	shift om the form in have II	
assessment with an a					completed according to the policy	/-	

If continuation sheet Page 38 of 65



FIIII. 04/14/2010 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I '	LE CONSTRUCTION (X3) DATE SURY COMPLETE C		ETED
		495134	B. WING_		03/3	1/2016
	PROVIDER OR SUPPLIER REST MANOR NUI	RSING & REHABILI7 157		STATE, ZIP CODE TER BOULEVARD 24244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATOR ENTIFYING INFORMATION)	ID Y PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 333	cognitive summary. The March 2016 p. 3/30/16. Two insularead: "Lantus 100 units/a units subcutaneous 100 units/1 ml vl In meals and at bedti sugar: 0-50=0 unit (medical doctor); 571-150=0 units; 15 units; 251-300=6 u. 351-400=10 units f. The surveyor revier medication adminis. There were blanks. Lantus insulin on 3 blanks on 3/15/16 at 9:00 p.m., blanks on 3/26/16 at 9:00 p.m. The sliding scale in the blood sugar ware a.m. The surveyor review March 2016 medication why the insulins we blood sugar obtained notes were reviewed evidence why Residuals on 3/30/16 at 3:0 L.P.N. #2 the March the scheduled and state of the surveyor interview of the surveyor interview of the surveyor interview of the scheduled and state of	sessed the resident with a score of 12 out of 15. hysician orders were reviewed in orders were written and I ml (milliliter) vl (vial) Inject 10 sly twice daily" and "Humalog ject subcutaneously before me per sliding scale for blood s, house protocol and call MD 1-70=0 units & house protocol; 1-200=2 units; 201-250=4 nits; 301-350=8 units; or DM (diabetes mellitus)." wed the March 2016 stration records (MARs). for the administration of /3/16 and 3/4/16 at 9:00 p.m., at 9:00 p.m., blanks on 3/17/16 at n 3/23/16 at 9:00 a.m., blanks a.m., and blanks on 3/30/16 at sulin entry had no evidence is obtained on 3/23/16 at 6:00 wed the reverse side of the ation administration records. mentation as to the reason re not administration records. mentation as to the reason re not administered or the add. The March 2016 progress das well. There was no dent #11 did not receive insulin l sugar as ordered. iewed licensed practical nurse 03 p.m. The surveyor showed in 2016 MAR and specifically sliding scale insulin e surveyor asked L.P.N. #2	F 333	 The Director of Nursing or demonitor that the sign in shee signed daily. This monitoring documented 5 days a week for 3 days a week for 4 weeks, arweekly for 4 weeks. The Director of Nursing or dereview the MARs for each residocument their findings weeks. The Director of Nursing will refindings of the monitoring to monthly QAPI committee for recommendations for the durathe monitoring process. The allegation of compliance caspects of this plan of corrections 29, 2016 	will be or 4 weeks, and then signee will be dident and kly for 12 deport the treview and ation of date for all	

(X2) MULTIPLE CONSTRUCTION

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

C2N611

If continuation sheet Page 3°



FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		495134		B. WING		03/	/31/2016
NAME OF !	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, ST	FATE. ZIP CODE		
		RSING & REHABILIT			ER BOULEVARD		
KIDGLO	KEST WANTON HON	(SING OF LET IVENERAL		ELD, VA 242			
	C. MALADA C.				PROVIDER'S PLAN OF C	OPPECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL RI ENTIFYING INFORMATION)	S EGULATORY	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 333	Continued From pa	age 39		F 333			
		.N. #2 stated when me	edications	•			
		hey are initialed. L.P.N		İ			
	stated there were h	blanks on the March 20	.016				
	MAR.						*
	The surveyor interv	viewed the director of r	nursing				ŧ
	on 3/31/16 at 1:20 p	p.m. The surveyor as	sked the				l I
	DON when medicat	ations aren't administer	red, what				\$
	would the standard	d of practice be. The D	DON				:
	stated to circle the r	medication and put the	ne ·				1 5
		ations weren't adminis					
	the reverse side of	the MAR or chart in th	ne	4			1
	nurse's notes. The surveyor requested the facility			4			:
		of nursing practice for	•	4			F.
	medication adminis		· •				#
		wed the facility standa		‡ •			
	nursing practice for	r medication administra	ation				
	titled "6.0 General L	Dose Preparation and	- .	!			8
	Medication Adminis	stration" on 3/31/16. T	he	9 - -			
	policy read in part	"Applicability: The Poli	ICY b.u	÷			11
	sets forth the proce-	edures relating to gene	eral dose				
	preparation and me	edication administration	n.				
		medication administra					:
		I take all measures red		i .			
	Facility policy and A	Applicable Law, includiouslicable Applicable Law, includiouslicable Applicable Applicable	ng, but				
	not limited to the rol	ion administration/trea	ntment	ě			
		hat is) when medicatio		!			1
		lications are given, inje		1			1
		n, if medications are re					3
		essary) medications,	ilusou,	1			
	application sight] or	n appropriate forms."		- - - -			I
		w with the DON, the su	irvevor				F
		priate forms" were. Th					
	stated "on the rever	rse side of the MAR or	r in the	•			i
	chart."						
		ned the administrative	staff of	É			
		n 3/31/16 at 3:20 p.m.		4			,
		ion was made available					i ·
	to the exit conference						d)
		ailed to follow physicia	an orders				

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C2N611

If continuation sheet Page 40 of 65

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APR 27 2016

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495134	B. WING		03/	31/2016
	DER OR SUPPLIER ST MANOR NUI	RSING & REHABILIT 157 RC				
(X4) ID PREFIX (EAC TAG	H DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
for res Re 10/ lim dep CC The ass qua refe pat 14 res the	sident #16 was 108/14. Diagnosited to, seizure oression, anxieto PD (chronic observant expenses and the sessment comparterly assessment erence date) of the session of this as out of a possible resident to und	admitted to the facility on es included, but were not disorder, chronic pain, y, heart failure, diabetes and structive pulmonary disease). IDS (minimum data set) leted on this resident was a ent with an ARD (assessment 03/04/16. Section C (cognitive sessment scored the resident e 15 points indicating the tively intact. Section B coded erstand and to be understood.	F 333			
: 3/9 res inte /or sug	/16. The care plident was an inserventions included or all medications.	e care plan was reviewed on lan contained a focus area the sulin dependent diabetic. The ded to administer insulin and as ordered, obtain blood report to physician any BS de parameters.				
phy ord foll sub and "If I 15' 20' 25' 30'	ysician orders da ler for administr ows: "Novolog					

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C2N611

If continuation sheet Page 41 of 65

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APR 27 2016

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				APPROVE 0. 0938-039
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE S COMPLE	
495134		495134	B. WING		03/3	1/2016
NAME OF	PROVIDER OR SUPPLIER		RESS, CITY, ST		<u> </u>	
RIDGE	CREST MANOR NUR		OSS CARTE ELD, VA 242	R BOULEVARD 244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 333	Continued From pa	age 41	F 333			
	March 2016, was a	ministration record (MAR) for lso reviewed. On 3/21/16 there tion for a blood sugar.				
	The nursing notes we contain any docume as to why the blood obtained/document	were reviewed and did not entation to provide a reason sugar was not ed.	1 1 2			
	following order Nov	f the MAR revealed the olog Mix 70-30 units/ml vial utaneously twice daily with er (6am and 5pm).	:			
	times no documenta	on the following dates and ation to support that the insulin t 5pm, 3/6/16 at 6am, 3/20/16 s/16 at 5pm.	;			
	look at the MAR and	p.m., LPN #1 was asked to d tell the surveyor if the insuling red after looking she said "I hey aren't mine."	:			!
	In the afternoon of 3 director of nurses w medication errors.	3/31/16 the administrator and ere informed of the insulin				
,	was provided to the The survey team was standard of nursing administration titled Preparation and Me 3/31/16. The policy The Policy 6.0 sets	practice for medication " 6.0 General Dose dication Administration " on read in part " Applicability: forth the procedures relating	!		; ; ;	
	to general dose pre	paration and medication	1		1	

administration. Procedure: 6. After medication administration, Facility staff should take all

/ED <u> 391</u>

DEPAR	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERV & MEDICAID SERV	ICES ICES				M APPROV D. 0938-03
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	1 '	E CONSTRUCTION	(X3) DATE S COMPL	
		495134		B. WING		03/	31/2016
NAME OF	PROVIDER OR SUPPLIER				ATE, ZIP CODE		
RIDGE	CREST MANOR NUR	RSING & REHABILIT		OSS CARTE ELD, VA 242	R BOULEVARD 244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F INTIFYING INFORMATION)	S	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
E 33'	Continued From pa	age 42		F 333			
F 33.		by Facility policy and					1
	Applicable Law inc	luding, but not limited	to the	1			
	following 6.1 Doc	ument necessary me	dication	E .			1
	administration/treat	ment information [e.	a (that	1			
	is) when medication	ns are opened, when	, (4			ţ
	medications are giv	en, injection site of a		,			1
	medication, if medic	cations are refused, p	orn	:			1
	(whenever necessa	ry) medications, app	lication				1
	sight] on appropriat						
		0, facility staff failed t	to follow				
		actice for medication		;			1
	administration for in	nsulin.		, ;			
	10/20/10 and readn		n 6/12/13				997 6.
	cardionulmonary dis	sease, and insulin de	pendent				i
	diabetes mellitus T	he resident scored 1	5/15 on	1			1
		or mental status on th					1
	minimum data set a	issessment with asse	essment				
	reference date 3/12						*
		rd review on 3/31/16,	the	4			i
	surveyor noted on the	he medication admin	istration	i			i
	record (MAR) for M	arch 2016 that the sign	anatures	i i			
		100 units per 1 ml inj		V man			1
		ly at bedtime for DMI					
	scheduled for 9 PM	were circled every d	ate	i			t
	except 3/18, which	was blank. Humalog	100 units				*
	/ 1 ml (milliliter) inie	ct subcutaneously be	efore	8			
	meals and at bedtin	ne per sliding scale for	or blood				3
	sugar 70-140 units	= 0; 141-180=1 units	;	:			•

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181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather

C2N611

If continuation sheet Page 43 of 65



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION AND PROVIDER OR SUPPLIER RIDGECREST MANOR NURSING & REHABILIT SUMMARY STATEMENT OF DEFICENCIES OR SUPPLIER (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) TAG CONSTRUCTION A BUILDING SUMMARY STATEMENT OF DEFICENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY) TAG CONSTRUCTION OR LSC IDENTIFYING INFORMATION FREERY TAG CONSTRUCTION A BUILDING STATE APPROPRIATE STRUCTURE AND CORRECTION A BUILDING SUMMARY STATEMENT OF DEFICENCIES SUMMARY STATEMENT OF DEFICENCIES SUMMARY STATEMENT OF DEFICENCY DEFICIENCY WAS 18E PRECEDED BY FULL REGULATORY DOR LSC IDENTIFYING INFORMATION FREERY TAG CONSTRUCTION A BUILDING STRUCTION A BUILDING STRUCTION A BUILDING CONSTRUCTION A BUILDING CONSTRUCTION A BUILDING CONSTRUCTION COMMETTED PREFIX FROSS CARTER BOULEVARD DUFFIELD, VA 24244 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY MATERIAL ACTION SHOULD BE CROSS REFERENCES OF THE APPROPRIATE F 333 Continued From page 43 than the ordered dose. No explanations were documented on the backs of the MARA or in nurses progress notes. There was no record of the physician being notified that the insulin had been refused, or administered, or administered, or administered in a dose other than ordered. On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing susperiors and director of nursing about the omitted medications. The unit manager indicated that the resident had been refusing insulin for years because he thought his blood sugar went too low between the effects of the insulin and the hemodialsys. On 3/31/16, at approximately 12:30 PM, the DON reported discussing the Lantus insulin with the physician and obtaining an order to discontinue the medication with the physician was in the resident had been refused that the resident had not received Lantus insulin in the properted discussing the Lantus insulin with the physician was in the resident had been refused to the physician of the order to th	DEPART CENTER	IMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERV & MEDICAID SERV	/ICES /ICES				M APPROVE O. 0938-039	
NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NURSING & REHABIL. A SUMMARY STATEMENT OF DEFICIENCY MAY 124244	STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE	R/CLIA	1			LETED	
### SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OF LECH DEFICIENCY OF LECH DEFIC			495134	ŀ	B. WING		03/	i .	
DUFFIELD, WA 24244 MAJID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION CRACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE				1					
PREFIX TAG EACH DEFICIENCY WIST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 333 Continued From page 43 than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered. On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. The unit manager indicated that the resident had been refusing insulin for years because he thought his blood sugar went too low between the effects of the insulin and the hemodialysis. On 3/31/16, at approximately 12:30 PM, the DON reported discussing the Lantus insulin with the physician and obtaining an order to discontinue the medication. She stated that the record indicated that the resident had not received Lantus insulin in 4 months. Staff were accustomed to the resident refusing the medication and had stopped mentioning it to the physician. During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most	RIDGEC	REST MANOR NUR	RSING & REHABILIT						
than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered. On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. The unit manager indicated that the resident had been refusing insulin for years because he thought his blood sugar went too low between the effects of the insulin and the hemodialysis. On 3/31/16, at approximately 12:30 PM, the DON reported discussing the Lantus insulin with the physician and obtaining an order to discontinue the medication. She stated that the record indicated that the resident had not received Lantus insulin in 4 months. Staff were accustomed to the resident refusing the medication and had stopped mentioning it to the physician. During a summary meeting on 3/30/16, the director of nursing reported that the policy for documentation of medication omission was for the nurse to document the reason on the back of the MAR and notify the physician of the omission. She said she considered the medication administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most	PRÉFIX	(EACH DEFICIENCY MUST	BE PRECEDED BY FULL	REGULATORY.	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION	
4. For Resident #5, facility staff failed to follow physician orders for medication administration for	F 333	than the ordered do documented on the nurse's progress not the physician being consistently been readministered in a documented in a documentation of manager indicated refusing insulin for y blood sugar went to the insulin and the happroximately 12:30 discussing the Lant and obtaining an ormedication. She stathat the resident havin 4 months. Staff we resident refusing the mentioning it to the During a summary redirector of nursing redocumentation of mathematical mathem	se. No explanation backs of the MAR of the Second that the insuffused, not administed ose other than order eximately 11:30, the sing supervisor and of mitted medications. That the resident had years because he the properties of	or in record of ulin had ered, or ed surveyor director of The unit I been ought his ffects of 31/16, at rted hysician e indicated ind	F 333				

Resident #5 was admitted to the facility on 3/31/11 with diagnoses including hypertension,

FORM APPROVED OMB NO. 0938-0391

			(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		COMPLETED	
	495134			B. WING0			C 31/2016	
	PROVIDER OR SUPPLIE REST MANOR NU	JRSING & REHABILI	157 RC		TATE, ZIP CODE ER BOULEVARD 244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIE IST BE PRECEDED BY FULL F DENTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 333	diabetes mellitus disorder. The resinterview for men set assessment of without symptom behavior issues. Clinical record relative insulin 30 documented as a administration record for explanation for explana	anxiety, depression, a sident scored 13/15 on tal status on the minim dated 2/5/16, and was a s of delirium, psychosis view on 3/30/16, reveal units twice per day was dministered on the mecord (MAR) at 9 AM on or the omission was four	the brief um data assessed s, or led that s not dication 3/26/16.	F 333				
F 367 SS=D	during a summar director of nursing documentation of the nurse to docu the MAR and noti She said she con administration po practice for the fa physician was in to days. 483.35(e) THERA BY PHYSICIAN	reported to administrally meeting on 3/30/16. To reported that the policing reported that the policing medication omission with the reason on the fixed the physician of the sidered the medication licy the nursing standardility. She stated that the building for part of report of the prescribed by must be prescribed by	The cy for vas for e back of omission. The cy for the c	1 367				
	This Requirement Based on observat document reviewt facility staff failed	t is not met as evidence ation, staff interview, far and clinical record revito ensure the resident ered therapeutic diet font #16).	cility ew, the received		 Resident #16 now recefrom the kitchen as sh All residents capable of been asked if they predecaffeinated coffee them. Their preference honored. 	e wishes. of interview have of caffeinated or o be served to	:	

C2N611

If continuation sheet Page 45 of 65



Resident #16 was purchasing coffee with caffeine

FORM APPROVED OMB NO. 0938-0391

MULTIPLE CONSTRUCTION JILDING	
O3/31/2016 CITY, STATE, ZIP CODE ARTER BOULEVARD /A 24244 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) O3/31/2016 (X5) COMPLETED DATE	
ARTER BOULEVARD /A 24244 PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLET DATE DATE DEFICIENCY)	
COMPLET COMPLET COMPLET COMPLET DATE COMPLET DATE COMPLET DATE DATE COMPLET DATE DATE COMPLET DATE DATE DATE COMPLET DATE DAT	
 3. The Dietary manager has been reeducated concerning the contents of the therapeutic diets. Resident preferences will be reviewed quarterly and as a resident brings up an issue. The Dietary Manager will create a list for the Administrator of the latest preference interview with each resident and the date of the next interview. 4. The Administrator will audit 25% the completion of resident preference interviews monthly for 3 months. The Administrator will report the findings of the monitoring to the monthly QAPI committee for the duration of the monitoring period for review and recommendations. 	
 The allegation of compliance date for all aspects of this plan of correction is April 29, 2016 	
	reeducated concerning the contents of the therapeutic diets. Resident preferences will be reviewed quarterly and as a resident brings up an issue. The Dietary Manager will create a list for the Administrator of the latest preference interview with each resident and the date of the next interview. 4. The Administrator will audit 25% the completion of resident preference interviews monthly for 3 months. The Administrator will report the findings of the monitoring to the monthly QAPI committee for the duration of the monitoring period for review and recommendations. 5. The allegation of compliance date for all aspects of this plan of correction is April

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her. Resident #16 was asked if she knew she was on a cardiac diet. She stated "I've drunk regular coffee for well over 30 years and don't

C2N611

If continuation sheet Page 46 of 65



DEPART	MENT OF HEALTH	AND HUMAN SERVI & MEDICAID SERVI	CES CES					M APPROVE O. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA	1		NSTRUCTION	(X3) DATE COMPI	
		495134		B. WING _			03/	31/2016
	PROVIDER OR SUPPLIER		STREET ADDR					
RIDGEC	REST MANOR NUR	SING & REHABILI		SS CART LD, VA 24		DULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL R NTIFYING INFORMATION)	S EGULATORY	ID PREFIX TAG	(CR	PROVIDER'S PLAN OF EACH CORRECTIVE AC OSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 367	(LPN) #1 on 3/30/1 about Resident #16 me she didn't like s brew her coffee a asked why she was caffeine she said "LPN was asked if the been notified. She she cardiac therapeutic After the document Chapter 5:Diets for surveyor reviewed in did not restrict caffer on the morning of a sked about the cardiac the standard. Some tolerance to caffeine and we do procedure that addit the standard. Some tolerance to caffeine blood pressure or caffeine and we do procedure that addit the standard. Some tolerance to caffeine blood pressure or caffeine surveyor inform director of nursing, nurse of the above	iewed licensed praction of at 10:00 a.m. When it is coffee she said "decaf. The night shift and fill her thermos." It is receiving the coffee it is her right to have the resident is physicial and it is physicial if it is provided with the cardiovascular Healt and determined that it is and determined that it is and it is and it does not addition thave a policy and ress it either. It has just a people will develop a ge and it doesn't affect.	she told C.N.A. ' She was with e it. The an had py of the facility. e title of the the diet vas ress st been a ct the the jistered 3:20 p.m.	F 367				
F 371 SS=F	483.35(i) FOOD PR STORE/PREPARE/ The facility must - (1) Procure food fro considered satisfac authorities; and	SERVE - SANITARY om sources approved tory by Federal, State distribute and serve fo	or local	F 371	2. A a 3. T	he meat in question oon as the Director otified. Il opened food mus ccordance to policy he Dietary Manager	of Nursing was t be kept in and staff have	
			!			nd procedure for sto has been opened.	orage of food after	

D 91

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVE B NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ATE SURVEY OMPLETED C
	495134	B. WING		03/31/2016
NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NUI	RSING & REHABILIT 157 R			
DREELY FACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
F 371 Continued From p	age 47	F 371		
Based on observal staff failed to label food and ensure it date. During initial tour of 6:15 on 3/29/16, the foil-wrapped packar unlabeled. The seen tour conducting the tour She said that the penal baseled it 3/23. She staff for the unlabeled packar labeled it 3/23. She staff for the unlabeled packar labeled it 3/23.	is not met as evidenced by: ion and staff interview, facility and date stored ready to eat was discarded by its use-by If the kitchen at approximately e surveyor observed 2 iges of a pink meat. One was cond was labeled "layed 3/16". If the dietary staff member of what "layed 3/16" meant. ackages were ham and that it im the freezer on 3/16. She put itage in a Ziploc bag and e said she knew it was opened was the last time they had		 The Administrator will inspect the kitchen to identify any variance from policy and procedure for the storage food after it is open. The administrativill address any violation. This inspection will be documented days a week for 2 weeks and then weekly x 6 weeks. The Administrator will report the findings of the inspection to the QAR committee monthly meeting for the duration of the monitoring period for review and recommendations. The allegation of compliance date for aspects of this plan of correction is A 29, 2016 	e of tor 3 Pl r
dietary manager. longer in the refrige said it was gone. So on the ham in the refriger was discarded, so policy. The policy of Nutrition and Die Guide Reference h	If, the surveyor interviewed the The ham dated 3/16 was no erator. The dietary manager She stated that the 3/23 date refrigerator should be accurate, ong ham should be kept before the said she would check the she offered from The Academy retetics listed, Under Use By righlighted Potentially 3 day rule-meats. She stated			

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the interview (30-23=7).

that the ham would be discarded after 3 days.

The surveyor calculated that the ham dated 3/16 had been kept in the refrigerator for 13 days (29-16=13) and the ham labeled 3/23 would have been in the refrigerator for 7 days at the time of

C2N611

If continuation sheet Page 48 of 65

RECEIVED APR 2.7 2016 VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERV	CES			OMB NO	O. 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	R/CLIA	1	PLE CONSTRUCTION	(X3) DATE S COMPL	
		495134		B. WING		03/3	31/2016
	PROVIDER OR SUPPLIER			•	TATE, ZIP CODE		
RIDGEC	REST MANOR NUF	RSING & REHABILIT		OSS CARTI ELD, VA 24	ER BOULEVARD 1244		
(X4) ID PREFIX TAG	(FACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	Continued From pa	age 48		F 371			
F 425	notified of the conc on 3/30/16.	and director of nursing ern during a summar	y meeting	F 425			
55=D	The facility must prodrugs and biological them under an agre §483.75(h) of this punicensed personal law permits, but on supervision of a licensed proceduracquiring, receiving administering of all the needs of each of the facility must enable a licensed pharmacent of the facility must enable the second of the second of the facility must enable the second of the sec	rovide routine and emals to its residents, or eement described in part. The facility may nel to administer drug ly under the general ensed nurse. Ide pharmaceutical series that assure the act, dispensing, and drugs and biologicals resident. Inploy or obtain the secist who provides cone provision of pharmaceutical series and biologicals resident.	permit s if State ervices curate s) to meet ervices of sultation		 The physician was no medication availabilit Residents # 16 and #8 were given at that tin All residents receiving risk for this issue. Licensed nursing staff reeducated concernir for Unavailable Medic The nurses are now redocument a review or change of shift during report to identify any policy. The nurses muthe MAR book attesticompleted this review medication administr 	ey issues for B. No new orders ne. It may be an any the facility policy cations. equired to f the MAR at g the shift to shift evariance from the list sign the form in any that they have by and that all	y
	Based on staff inter and clinical record in to ensure the control available for admin	is not met as evidence review, facility docume review, the facility state olled medication Ativatistration for 1 of 24 refailed to ensure scon	nt review, ff failed an was sidents,		completed according	to the policy.	

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The findings included:

was available for 1 of 24 residents Resident #8.

1. The facility staff failed to ensure the resident's

C2N611

If continuation sheet Page 49 of 65

RECEIVED APR 27 2016 VDH/OLG

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SU COMPLE	TED
		495134	B. WING _		i	C 1/2016
	PROVIDER OR SUPPLIER CREST MANOR NU	RSING & REHABILIT 157 RC		STATE, ZIP CODE FER BOULEVARD 4244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 42!	administration on 3/19/16 at 6 a.m. a Resident #16 was 10/08/14. Diagnos limited to, seizure depression, anxiet COPD (chronic ob The most recent Nassessment comp quarterly assessment comp quarterly assessment eater) of patterns) of this as 14 out of a possibl resident was cogn the resident to unconsider the resident for the resident was cogn the resident #16 's place signed and dated 0.5 mg one every with the work of acility nursing staff 3/18/16 at 2:00 p.m. again at 2 p.m. in the medication Ativan. #1 had written on 3 (nurse practitioner pharmacy. " The Addinistration; she to the note on the pharmacy would near the sident would near the sident would near the sident was asked why the administration; she to the note on the pharmacy would near the sident would near the sident was asked why the administration; she to the note on the pharmacy would near the sident was asked why the administration; she to the note on the pharmacy would near the sident was asked why the administration; she to the note on the pharmacy would near the sident was asked why the administration; she to the note on the pharmacy would near the sident was asked why the administration; she to the note on the pharmacy would near the sident was asked why the administration; she to the note on the pharmacy would near the sident was a sident was asked why the administration; she to the note on the sident was a	Ativan was available for 3/18/16 at 2:00 p.m. and on and again at 2 p.m. admitted to the facility on es included, but were not disorder, chronic pain, y, heart failure, diabetes and structive pulmonary disease). ADS (minimum data set) leted on this resident was a ent with an ARD (assessment 03/04/16. Section C (cognitive sessment scored the resident e 15 points indicating the litively intact. Section B coded lerstand and to be understood. Aysicians summary of orders 3/4/16 had the order for Ativan eight hours for seizures. Be current MAR's (medication ords) it was noted that the fad circled their initials on and on 3/19/16 at 6 a.m. and the administration blocks for the On the back of the MAR, LPN 3/18/16, "need hard script NP) aware not available from ativan was not available for a said "I wrote that (referring back of the MAR) the ot send it without a hard script. I wrote that (referring back of the MAR) the ot send it without a hard script.	F 425	monitor that the signed daily. This right documented 5 days a week for weekly for 4 week. The Director of Noreview the MARS document their fill weeks. The Director of Noreview the monthly QAPI correcommendation the monitoring process.	ys a week for 4 weeks, 4 weeks, and then iss. Sursing or designee will for each resident and indings weekly for 12 wrsing will report the ponitoring to the immittee for review and is for the duration of	

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

C2N611

If continuation sheet Page 50 of 65

APR 2.7 2016
VDH/OLC

(X1) PROVIDER/SUPPLIER/CLIA

FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` ′		(X3) DATE SURVEY COMPLETED		
		495134		B. WING		03/	C 31/2016	
	PROVIDER OR SUPPLIEF REST MANOR NU	₹ JRSING & REHABILI1	157 RC	ADDRESS, CITY, STATE, ZIP CODE ROSS CARTER BOULEVARD FIELD, VA 24244				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MU	STATEMENT OF DEFICIENCIE IST BE PRECEDED BY FULL I DENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 425	medication was in nurse the day bef know. At 3:20pm the ad the medication the administration. Prior to exit no fur related to the una 2. The facility staf Scopolamine was Resident #8. Resident #8 was 2/25/15 with diagranemia, pressure myocardial infarct syndrome, stroke artery disease. The current quart with a reference or resident with a co. The resident was assistance of 2 petransfers, dressin hygiene. The clinical record mad written a telep Scopolamine 1.5rear q 72 hours (chad written a telep Scopolamine 1.5rear q 72 hours (chad written a telep Scopolamine 1.5rear q 72 hours (chad written a telep Scopolamine 1.5rear q 72 hours (chad written a telep Scopolamine 1.5rear q 72 hours (chad written a telep Scopolamine 1.5rear q 72 hours (chad written a telep Scopolamine 1.5rear q 72 hours (chad written a telep Scopolamine patch back of the MAR is Scopolamine patch pharmacy was away	ministration team was at was not available for ther information was pavailable Ativan. If failed to ensure medical available for administration admitted to the facility noses of respiratory fair along, hypertension, post, atrial fibrillation, and control of the facility	notified of r provided ication of ration for on ilure, xiety, t-polio coronary it (MDS) ed the of "15" otal otal of the of "15" otal otal otal otal otal otal otal otal	F 425				

(X2) MULTIPLE CONSTRUCTION

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

C2N611

If continuation sheet Page 51 of 65



FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED A. BUILDING **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION 495134 B. WING 03/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 157 ROSS CARTER BOULEVARD RIDGECREST MANOR NURSING & REHABILIT **DUFFIELD, VA 24244** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 425 F 425 Continued From page 51 nursing (DON) was also informed and stated that insurance did not cover the medication. There was no documentation in the clinical record regarding this information. The DON provided the facility policy for Unavailable Medications. The policy stated if the medication was not covered then the facility should collaborate with the pharmacy and physician to determine a suitable alternative. The administrator, DON, assistant DON, unit manager, and corporate nurse were informed of the findings during a meeting with the survey team on 3/30/16 at 4:40 p.m. F 431 483.60(b), (d), (e) DRUG RECORDS, F 431 SS=D LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of

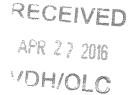
 The bottle of medication was discarded prior to any further dose of this medication to the resident.

- 2. All residents receiving liquid medication are at risk for this issue.
- Licensed Nursing staff has been reeducated concerning the appropriate wasting of liquid medication.
- 4. The Director of Nursing or designee will randomly observe and document the observation of one medication administration pass to ensure proper wasting 3 days weekly for 4 weeks. The Director of Nursing will report the findings of the monitoring to the monthly QAPI committee meeting for the duration of the monitoring for review and recommendations.
- The allegation of compliance date for all aspects of this plan of correction is April 29, 2016

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

C2N611

If continuation sheet Page 52 of 65



FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	LETED
		495134	B. WING		03/	C 31/2016
NAME OF	PROVIDER OR SUPPLIER	•	DRESS, CITY, S			
	REST MANOR NUF		ROSS CARTE IELD, VA 24	ER BOULEVARD 244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATOR' ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 431	controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except when package drug distri	ted in Schedule II of the ug Abuse Prevention and and and other drugs subject to the facility uses single unit bution systems in which the hinimal and a missing dose can	F 431			
	Based on observation document review a facility staff failed to medications for 1 on The findings included the facility staff fail medication during a observation on 3/30 registered nurse possible. Resident #18 was a and readmitted 12/4 included but not liming with tracheostomy, diabetes mellitus, not depression, anxiety encephalopathy, hy obstructive pulmon surgery. Resident #18's ann assessment with an (ARD) of 2/5/16 had long term memory cognitive skills for on the surveyor observations.	ed to properly discard wasted a medication pass and pour 0/16 for Resident #18. The bured the unused liquid ciferol back into the original admitted to the facility 5/22/13 6/15 with diagnoses that lited to acute respiratory failure osteoporosis, aphasia, type 2 norbid obesity, epilepsy, anoxic brain damage, pertension, chronic ary disease, and bariatric ual minimum data set (MDS) in assessment reference date dash marks for short and and severely impaired				

Resident #18: Ferrous sulfate 5 milliliters [220



FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495134	B. WING		03/	/31/2016	
	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
RIDGEC	REST MANOR NU		ELD, VA 24	ER BOULEVARD 244			
(X4) ID PREFIX TAG	FACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 431	Ergocalciferol 1 m Sulfate and Zantamedication cups. measure 1 ml of the syringe was not lomedication into the then poured an unapple of the poured and then poured to draw R.N. #1 then return the surveyor required in the surveyor required in the surveyor required back into the surveyor inter 4:00 p.m. R.N. #1 unused medication original bottle. The surveyor informs the above concerned the surveyor informs the above concerned in the surveyor informs and the surveyor informs are defined as merefused that required in pare defined as merefused that required in the surveyor informs	Zantac 10 ml (150 mg), and I. R.N. #1 poured the Ferrous c at eye level into plastic R.N. #1 used a syringe to the Ergocalciferol; however, the ing enough to draw the element because amount of a plastic medication cup and wup 1 ml of the medication. The medications together and into Resident #18. The medications from the director into its possibility policy on a medications should not be the bottle but discarded. The wasted R.N. #1 on 3/30/16 at stated she was not aware that the could not be returned to the medications the stated she was not aware that the scould not be returned to the medication and a text and a new bottle. The facility policy titled inside the Pharmacy and cart "13. "Wasted medications" dications contaminated or redisposal. Facility should not dications back in their original attion was provided prior to the	F 431				
F 514 SS=E	483.75(I)(1) RES RECORDS-COMF	PLETE/ACCURATE/ACCESSIB	F 514				

(X2) MULTIPLE CONSTRUCTION

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

C2N611

If continuation sheet Page 54 of 65



FORM APPROVED

DEPART CENTER	IMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVIC & MEDICAID SERVIC	JES JES). 0938-039
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME	CLIA	1 ' '	PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		495134		B. WING _		03/3	1/2016
	PROVIDER OR SUPPLIER REST MANOR NUR	1	157 RC		STATE, ZIP CODE ER BOULEVARD 4244		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE NTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	age 54	:	F 514			
	resident in accorda professional standa complete; accurate accessible; and sys The clinical record information to ident resident's assessm services provided; the preadmission screet and progress notes. This Requirement is Based on staff internant clinical record into ensure complete for 6 of 24 residents (Resident #11, Resident #11, Resident #11, Resident #11's Note administration record times when there wordered medications. The clinical record wordered medications. The clinical record wordered medications. The clinical record wordered medications imited to rectocelest prolapse, diabetes in senile dementia, ne diabetic retinopathy heart failure, pain, a	and practices that by documented; readily tematically organized. must contain sufficient ify the resident; a recordents; the plan of care is he results of any ining conducted by the series, the facility document with the sample survey dent #16, Resident #2 and accurate clinical is in the sample survey dent #16, Resident #2 and Resident #2 and Resident #3 and Resident #3 and Resident #4 as no documentation to had been given. Was reviewed 3/30/16 as no documentation to had been given. Was reviewed 3/30/16 as no documentation to had been given. Was reviewed 3/30/16 as no documentation to had been given. Was reviewed 3/30/16 as no documentation to had been given. Was admitted to the sest that included but recystocele without uterinellitus type 2, urine rephritis and nephropath, hypertension, conges	are / brd of the and e State; ed by: t review, failed records 20, 15). n oles", that the and e facility not ne etention, ny, stive		 There is no remedy for the mistakes of documentation been found in the clinical residents' #11, #16, #20, #15. All residents are at risk for Licensed nursing staff have reeducated concerning the administration/document. This includes when to not physician and responsible issue. The nurses are now required document a review of the change of shift during the report to identify any variation policy. The nurses must sithe MAR book attesting the completed this review and medication administration completed according to the complete completed according to the complete complete complete completed according to the complete compl	n that have records of #5, #3, and this issue. e been e medication ation policy. ify the party of an red to MAR at shift to shift iance from the ign the form in hat they have d that all n has been	

If continuation sheet Page 55 of 65



assessment with an assessment reference date (ARD) of 3/1/16 assessed the resident with a cognitive summary score of 12 out of 15.

The March 2016 physician orders were reviewed

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DEPART	MENT OF HEALTH. RS FOR MEDICARE	AND HUMAN SERV & MEDICAID SERV	ICES ICES			F OME	ORM. NO.	APPROVE 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	1 ' '		CONSTRUCTION (X3) DA	MPLET	
		495134		B. WING _				/2016
NAME OF P	ROVIDER OR SUPPLIER REST MANOR NUR	SING & REHABILIT			ER	BOULEVARD 4		
(X4) ID PREFIX TAG	<i>(EACH DEFICIENCY MUST</i>	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I NTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
F 514	read: "Lantus 100 units/1 units subcutaneous 100 units/1 ml vl Inj meals and at bedtir sugar: 0-50=0 units (medical doctor); 5/ 71-150=0 units; 15/ units; 251-300=6 ur 351-400=10 units for The surveyor review medication adminis There were blanks Lantus insulin on 3/ blanks on 3/15/16 at 9:00 p.m., blanks 9:00 a.m., blanks o on 3/26/16 at 9:00 a 9:00 p.m. The sliding scale in the blood sugar war a.m. The surveyor review March 2016 medica There was no docu why the insulins we blood sugar obtaine notes were reviewe evidence why Resid as ordered or blood The surveyor interv #2 on 3/30/16 at 3:0	ml (milliliter) vl (vial) sly twice daily" and "heet subcutaneously me per sliding scale for house protocol and 1-70=0 units & house 1-200=2 units; 201-2 units; 301-350=8 units or DM (diabetes mellowed the March 2016 stration records (MAF for the administration (3/16 and 3/4/16 at 9:00 p.m., blanks of son 3/20/16 and 3/2 in 3/23/16 at 9:00 a.m., and blanks on sulin entry had no expected the reverse side atton administration rementation as to the interest of the March 2016 at 3 well. There was dent #11 did not received.	Inject 10 dumalog before for blood d call MD e protocol; 50=4 ; itus)." Rs). n of :00 p.m., on 3/17/16 1/16 at n., blanks 3/30/16 at ridence 6 at 6:00 of the ecords. reason or the progress s no ive insulin ical nurse or showed	F 514	4.	The Director of Nursing or designee we monitor that the sign in sheet is being signed daily. This monitoring will be documented 5 days a week for 4 wee 3 days a week for 4 weeks, and then weekly for 4 weeks. The Director of Nursing or designee were were with MARs for each resident and document their findings weekly for 1 weeks. The Director of Nursing will report results of the monitoring to the monitory of the monitory of the monitory. The allegation of compliance date for aspects of this plan of correction is A 29, 2016	cs, vill dd 2	

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the scheduled and sliding scale insulin

what nurses do when medications are

documentation. The surveyor asked L.P.N. #2

administered. L.P.N. #2 stated when medications are administered they are initialed. L.P.N. #2 stated there were blanks on the March 2016

C2N611

If continuation sheet Page 56 of 65



DEPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERVI	ICES CES				M APPROVED O. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM	R/CLIA	` '	E CONSTRUCTION	(X3) DATE S COMPL	
		495134		B. WING		03/	31/2016
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, ST			
	REST MANOR NUR	SING & REHABILIT		OSS CARTE ELD, VA 242	R BOULEVARD 244		
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	age 56	<u></u>	F 514			
1 014	MAR.	.90 00					
		iewed the director of	nursing				
	on 3/31/16 at 1:20 r	o.m. The surveyor a	sked the				
	DON when medicat	tions aren't administe	red. what				1
	would the standard	of practice be. The	DON				
	stated to circle the r	medication and put th	ne				1
	reasons the medica	itions weren't admini	stered on				
	the reverse side of	the MAR or chart in t	he :	1			i
	nurse's notes. The	surveyor requested	the facility	:			411
	policy on standard of	of nursing practice fo	r !				
	medication adminis			1			
	The surveyor reviev	ved the facility standa	ard of				
	nursing practice for	medication administ	ration	i I			
	titled "6.0 General D	Pose Preparation and	1	1	•		3
	Medication Adminis	tration" on 3/31/16.	The	Ę			,
	policy read in part "/	Applicability: The Po	licy 6.0	1			:
	sets forth the proce	dures relating to gen	eral dose	1			
	preparation and me	dication administration	on.				
	Procedure: 6. After	medication administr	ation,				
	Facility staff should	take all measures re	quirea by	1			;
1	Facility policy and A	pplicable Law, includ	ing, but				
	not limited to the fol	lowing: 6.1 Docume	etmont :				1
		on administration/tre					
	energed when modi	nat is) when medicati ications are given, inj	ection :				:
	site of a medication	, if medications are r	efused				
	prn (whenever nece		oracoa,	4			
i	application sight] on	appropriate forms."		*			1
	During the interview	with the DON, the s	urveyor				
į	asked what "approp	riate forms" were. T	he DON				
	stated "on the rever	se side of the MAR of	or in the	1			
3	chart."			•			
	The surveyor inform	ned the administrative	e staff of	1			
	the above finding or	n 3/31/16 at 3:20 p.m	•				:
	No further information	on was made availab	le prior	3			1
	to the exit conference	ce on 3/31/16.	-	5			
	2. The facility staff fa	ailed to document the	e reasons				
		administered to Res	ident				
į	#16.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ELE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	495134	B. WING		03/	31/2016
NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NU	RSING & REHABILIT 157 RC		TATE, ZIP CODE ER BOULEVARD 1244		
PREEIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES BY BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
10/08/14. Diagnos limited to, seizure depression, anxie COPD (chronic ob The most recent Massessment compared quarterly assessment compared quarterly assessment compared the resident was cognitive resident was cognitive resident to undersident was an interventions inclured for oral medication sugars as ordered (blood sugar outsion order for administration orders of the clinical record physician orders o	admitted to the facility on the sincluded, but were not disorder, chronic pain, by, heart failure, diabetes and ostructive pulmonary disease). MDS (minimum data set) bleted on this resident was a tent with an ARD (assessment 03/04/16. Section C (cognitive seesment scored the resident le 15 points indicating the itively intact. Section B coded derstand and to be understood. We care plan was reviewed on alan contained a focus area the sulin dependent diabetic. The ded to administer insulin and as ordered, obtain blood report to physician any BS de parameters. I was reviewed on 3/31/16. The lated 12/19/15 included an ration of sliding scale insulin as 100 Unit/ML vial inject er slicing scale before meals llows: 0-150=0 units	F 514			
The medication ac	dministration record (MAR) for				

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March 2016, was also reviewed. On 3/21/16 there

was no documentation for a blood sugar.

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If continuation sheet Page 58 of 65

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DEPAR*	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				M APPROVE O. 0938-039
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	LE CONSTRUCTION	(X3) DATE S COMPL	
		495134	B. WING		03/	31/2016
	PROVIDER OR SUPPLIER CREST MANOR NUR	SING & REHABILIT 157 R	ORESS, CITY, ST OSS CARTE ELD, VA 242	R BOULEVARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	age 58	F 514			
	The nursing notes of contain any docume as to why the blood obtained/document. Continued review of following order Novinject 25 units subcontained and dinner the MAR revealed times no document was given: 3/4/16 at 6am, and on 3/26 look at the MAR and had been administed can't speak to that the speak to	were reviewed and did not entation to provide a reason sugar was not ed. If the MAR revealed the olog Mix 70-30 units/ml vial utaneously twice daily with er (6am and 5pm). on the following dates and ation to support that the insulin t 5pm, 3/6/16 at 6am, 3/20/16 6/16 at 5pm. p.m., LPN #1 was asked to d tell the surveyor if the insulin ered after looking she said "I hey aren't mine."				
		3/31/16 the administrator and ere informed of the insulin				
	surveyors related to completely and accurate. 3. For Resident #20	on was provided to the the staff failure to document urately. O, facility staff failed to the medication administration.				
	10/20/10 and readm with diagnoses inclu- with hemodialysis, h gastroesophageal re- cardiopulmonary dis- diabetes mellitus. TI					

minimum data set assessment with assessment

FORM APPROVED OMB NO. 0938-0391

MAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NURSING & REHABILI PAGE 10 SUMMARY STATIMENT OF DEFICIENCES THEFET WAS A CACHE DEFICIENCE OF THE PROPERTY OF THE APPROPRIATE TAG FOR ISC IDENTIFYING INFORMATION) F. 514 Continued From page 59 reference date 3/12/16. During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signatures for Lantus (insulin) 100 units per 1 m inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units 1/1 ml (millillate) inject subcutaneously before meals and at bedtime per siding scale for blood sugar 70-140 units = 0, 141-180-1 units, 181-220=2units, 221-260-3units, 261-300- 4units; 301-340-5 sinits, 341-400-6 cunits for diabetes contained blanks on 3/5, 14, 18, and 23, 3/24, 26, and 27) a units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered. 4 For Resident #20, facility staff failed to accurately document medication administered, or administered in a dose other than ordered. 4 For Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis. hypertension, gastroscophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment with assessment reference data 8/12/16.		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
RIDGECREST MANOR NURSING & REHABILI A4 IID DUFFIELD, WA 24244 A5 IID PROVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION PREFIX PROVIDERS PLAN OF CORRECTION PROGRAST PROVIDER			495134	B. WING		03/		
DUFFIELD, VA 24244 SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION COMMERCENT PROVIDERS PLAN OF COMMERCE			1					
(EACH DEFICIENCY MIST RE-PRECEDED BY FULL REGULATORY TAGE) F 514 Continued From page 59 reference date 3/12/16. During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bettime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units 1/1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-280=3units; 261-300=4units; 301-340=5units; 341-600=6units for diabetes contained blanks on 3/51, 41, 81, and 23, 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered in a dose other than ordered. 4 For Resident #20, facility staff failed to accurately document medication administration for insulin and antibiotics. Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodallysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment	KIDGE	CREST MANOR NO						
reference date 3/12/16. During clinical record review on 3/31/16, the surveyor noted on the medication administration record (MAR) for March 2016 that the signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (millilliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0, 141-180=1 units, 181-220=2units; 221-260=3units; 261-300= 4units; 301-340= 5units; 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23, 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had consistently been refused, not administered, or administered, or administered in a dose other than ordered. 4 For Resident #20, facility staff failed to accurately document medication administered. 5 Resident #20 was admitted to the facility on 10/20/10 and readmitted to the facility on 6/12/13 with diagnoses including end stage renal disease with hemodialysis, hypertension, gastroesophageal reflux disease, cardiopulmonary disease, and insulin dependent diabetes mellitus. The resident scored 15/15 on the brief interview for mental status on the minimum data set assessment	PREFIX	(EACH DEFICIENCY MUS	T BE PRECEDED BY FULL REGULATO	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE HE APPROPRIATE	COMPLETION	
I GIOLOGIO MUIO VI I III I V	F 514	During clinical reco surveyor noted on record (MAR) for M for Lantus (insulin) units subcutaneous scheduled for 9 PM except 3/18, which / 1 ml (milliliter) inje meals and at bedti sugar 70-140 units 181-220=2units; 22 4units; 301-340= 5 diabetes contained 3/24, 26, and 27 hai indicating not admi 27, 28, and 29, 2 uthan the ordered do documented on the nurse's progress not the physician being consistently been readministered in a di 4 For Resident #20 accurately docume for insulin and antib Resident #20 was a 10/20/10 and readministered in a di Resident #20 was a 10/20/10 and readministered in a di with diagnoses including with hemodialysis, in gastroesophageal reading diabetes mellitus. The brief interview for minimum data set a	ord review on 3/31/16, the the medication administration farch 2016 that the signatures 100 units per 1 ml inject 10 sly at bedtime for DMII were circled every date was blank. Humalog 100 units ect subcutaneously before me per sliding scale for blood = 0; 141-180=1 units; 21-260=3units; 261-300= units; 341-600= 6units for blanks on 3/5, 14, 18, and 23 ad times which were circled, nistered. On 3/17, 18, 20, 26, nits were administered rather bese. No explanations were a backs of the MAR or in ones. There was no record of a notified that the insulin had refused, not administered, or one other than ordered. O, facility staff failed to not medication administration protects. admitted to the facility on an intended to the facility on 6/12/13 unding end stage renal disease the resident scored 15/15 on our mental status on the assessment with assessment					

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If continuation sheet Page 60 of 65



FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING AND PLAN OF CORRECTION 495134 B. WING 03/31/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER RIDGECREST MANOR NURSING & REHABILIT 157 ROSS CARTER BOULEVARD **DUFFIELD. VA 24244** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 514 F 514: Continued From page 60 During clinical record review on 3/31/16, the surveyor reviewed the medication administration record (MAR) for March 2016. Bactrim DS 1 tab PO (by mouth) BID (by mouth) X 5 days ordered 3/24/16. Two times per day for 5 days required 10 doses. The MAR had only 9 spaces indicated for documentation of administration of Bactrim, with staff documenting 2 doses on 3/25, 26, 27, and 28. Only one dose was documented on 3/29/16. The space for the second dose on 3/29 was X'd out. There was no documentation to indicate that a 10th dose of Bactrim had been administered. The signatures for Lantus (insulin) 100 units per 1 ml inject 10 units subcutaneously at bedtime for DMII scheduled for 9 PM were circled every date except 3/18, which was blank. Humalog 100 units / 1 ml (milliliter) inject subcutaneously before meals and at bedtime per sliding scale for blood sugar 70-140 units = 0; 141-180=1 units; 181-220=2units; 221-260=3units; 261-300= 4units: 301-340= 5units: 341-600= 6units for diabetes contained blanks on 3/5, 14, 18, and 23. 3/24, 26, and 27 had times which were circled, indicating not administered. On 3/17, 18, 20, 26, 27, 28, and 29, 2 units were administered rather than the ordered dose. No explanations were documented on the backs of the MAR or in nurse's progress notes. There was no record of the physician being notified that the insulin had

consistently been refused, not administered, or administered in a dose other than ordered..

On 3/31/16 at approximately 11:30, the surveyor interviewed the nursing supervisor and director of nursing about the omitted medications. Both counted the doses of Bactrim administered and agreed that only 9 had been administered. They acknowledged that the insulin had not been documented administered as ordered.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED C	
		495134		B. WING		03/	03/31/2016	
	ROVIDER OR SUPPLIER				TATE, ZIP CODE			
RIDGEC	REST MANOR NUR	SING & REHABILIT		DSS CARTE ELD, VA 24	ER BOULEVARD 244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 514	Continued From pa	age 61		F 514			:	
į		meeting on 3/30/16,		!				
:		reported that the police nedication omission was a contract of the contract o					1	
		ent the reason on the						
;	the MAR and notify	the physician of the	omission.					
		dered the medication					\$	
2		y the nursing standar ity. She stated that t						
		e building for part of r		:			í	
	days.		1				1	
:	On 3/31/16 at appro	oximately 11:30, the s	urvevor	:				
!	interviewed the nurs	sing supervisor and d	irector of				;	
		mitted medications. That the resident had		1				
***		rears because he tho		1				
	blood sugar went to	o low between the ef	fects of				1	
:		nemodialysis. On 3/3) PM, the DON repor					1	
		us insulin with the ph		; #				
1	and obtaining an ord	der to discontinue the		1				
		ated that the record in I not received Lantus		1			1	
		vere accustomed to t		i :				
1	resident refusing the	medication and had		:			1	
	mentioning it to the	physician.	1				1	
	During a summary n	neeting on 3/30/16, t	ne	:			1	
1	director of nursing re	eported that the polic	y for				* *	
		edication omission w ent the reason on the		1				
		the physician of the c					!	
		ered the medication					1	

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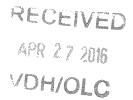
days.

administration policy the nursing standard of practice for the facility. She stated that the physician was in the building for part of most

5. For Resident #5, facility staff failed to follow accurately document medication administration

C2N611

If continuation sheet Page 62 of 65



RM APPROVED O. 0938-0391

(X5) COMPLETION DATE

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				M APPRO O. 0938-	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 03/31/2016	
		495134			03/		
	PROVIDER OR SUPPLIER			TATE, ZIP CODE			
RIDGEC	REST MANOR NUR	(01110 0112111	DSS CARTE ELD, VA 24	ER BOULEVARD 244			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL REGULATORY INTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECONDERSE OF THE AP CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5 COMPLE DAT	
F 514 Continued From page 62			F 514			1	
	for insulin.					1	
	3/31/11 with diagnodiabetes mellitus, a disorder. The residinterview for menta set assessment datwithout symptoms obehavior issues. Clinical record reviet Lantus insulin 30 urdocumented as adradministration record No explanation for fourse's progress not dispersional diagrams.						
	during a summary r director of nursing r documentation of m the nurse to docum the MAR and notify She said she conside administration policity practice for the facily physician was in the days.	eported to administrative staff meeting on 3/30/16. The reported that the policy for medication omission was for ent the reason on the back of the physician of the omission. Idered the medication y the nursing standard of ity. She stated that the e building for part of most mailed to ensure a complete					

C2N611

If continuation sheet Page 63 of 65

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epilepsy and pressure ulcer.

and accurate clinical record for Resident #3. Resident #3 was admitted to the facility on 8/31/12 with diagnoses of subarachnoid hemorrhage, hepatitis C, cirrhosis, traumatic brain injury, paraplegia, malnutrition, depression,

The Minimum Data Set (MDS) with a reference date of 1/20/16 assessed the resident with a cognitive score of "15" of "15". The resident was assessed requiring total assistance of 2

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION B. WING 03/31/2016 495134 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 157 ROSS CARTER BOULEVARD RIDGECREST MANOR NURSING & REHABILIT **DUFFIELD, VA 24244** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 F 514 Continued From page 63 persons for bed mobility, dressing, toileting, bathing, and hygiene. The current physician recertification orders signed 3/4/16 contained orders to, "Apply Duoderm to sacrum change every 5-7 days until healed " . A second order stated to, " Apply Collagen to sacral wound every day " The unit manager (RN#3) was asked about the wound care on 3/30/16 at 9:00 a.m. and stated she would find out. A telephone order dated 2/8/16 noted to discontinue the duoderm to the sacrum. The facility failed to remove the order from the current physician recertification orders. The administrator, DON, assistant DON, unit manager, and corporate nurse were informed of the findings during a meeting with the survey team on 3/30/16 at 4:40 p.m. 7. The facility staff failed to ensure a complete clinical record for Resident #15. Resident #15 was admitted to the facility on 1/5/14 with diagnoses of fracture pubis, skin cancer, dysphagia, anemia, hypertension, Gastro-esophageal reflux disease, chronic obstructive pulmonary disease, dementia, anxiety, coronary artery disease, and arthritis. The significant change Minimum Data Set (MDS) with a reference date of 11/23/15 assessed the

notified of the refusal.

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resident with a cognitive score of "9" of "15". The resident was assessed requiring total assistance of 2 persons for bed mobility,

transfers, dressing, eating, toileting, bathing, and

The medication administration record (MAR) for March 2016 was reviewed. The nurses had documented on the front of the MAR the resident had refused the suppository every evening from

The nurses also circled their initials from 3/18/16

3/1/16 through 3/16/16. There was no documentation the physician/ RP had been

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING_ AND PLAN OF CORRECTION C 495134 B. WING 03/31/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 157 ROSS CARTER BOULEVARD RIDGECREST MANOR NURSING & REHABILIT **DUFFIELD, VA 24244** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 F 514 Continued From page 64 through 3/29/16 indicating the medication was not given. There was no documentation the physician/ RP had been notified of the refusal. There was no documentation on the back of the MAR for reason the medication was not given. The nursing notes were reviewed and no documentation was evidenced the physician/ RP were notified of the medication not administered.

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