VD PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I .	IPLE CONSTRUCTION IG	(X3) DA	D. 0938-(ATE SURVE IMPLETED
		495355	B. WING			С
VAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	04	1/22/201
RADEO	RD HEALTH AND REH	AD CENTER		700 RANDOLPH STREET	JUE	
012	VESTILEMENT AND IVER	ABCENIER	Í	RADFORD, VA 24141		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	. ID	PROVIDER'S PLAN OF COR	DECTION	
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F 000	INITIAL COMMENT	-S	F 00	o		
F 167 SS=C	survey was conduct One complaint was survey. Corrections with 42 CFR Part 48 requirements. The survey/report will fol. The census in this 9 at the time of the surcey/report will fol. The census in this 9 at the time of the surcey/report will fol. The census in this 9 at the time of the surcey/report will fol. (Residents 1 through and 6 closed record and 24 through 26). 483.10(g)(1) RIGHT READILY ACCESSION A resident has the right most recent survey federal or State survey.	O certified bed facility was 84 rvey. The survey sample ent Resident reviews 17 and 3 supplment 21-23) reviews (Residents 18-20,	F 167	The submission of the Plar Correction does not constit agreement on the part of F Health & Rehab Center no deficiencies cited within the represents deficient practic the part of the center and it The plan represents our on pledge to provide quality carendered in substantial compliance with regulatory requirements. 1. Life Safety Code survey replaced in front lobby surve on 4-20-16 2. Any resident has the poter be affected if life survey re	tute Radford r do the r report res on s staff. I-going are	
	The facility must make examination and must	re the results available for st post in a place readily nts and must post a notice of		are not posted for review. 3. Staff will be educated on n for all survey results in cursurvey cycle to be kept in the survey book in the front lot Location of survey results a discussed with patients in I resident council meeting.	eed rent he oby. will be	
at an account when the same of	by: Based on observatio	n and staff interview, the lost the results of the most surveys.		Survey ready book to be at by Administrator or designe weekly x12 weeks to ensur survey results are in binder discrepancies will be addre	ee e all : Any ssed	
a = 1000 th Managery waster .	The findings included			promptly and findings will b reported to Quality Assuran	e	
LATORY I	DIRECTOR'S OR PROVIDER	/ VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITE F		
	Extract A	Print	· w/I New	Administrator		(6) DATE
eficiency		asterisk (*) depotes a defeite which	W i 114 - 11-	on may be excused from correcting prov	<u>05-20</u>	3 - 20 (ined that s 90 days

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

Event ID:SSHU11

Facility ID: VA0161

If continuation sheet Page 1 of 119

DEPAR CENTI	RTMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 05/12/201 MAPPROVE
STATEME	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		DNSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER RD HEALTH AND REH	AB CENTER		700 R	ET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH STREET FORD, VA 24141	1, 05	#22/2016
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F 167	the business office valocated on a small taresults of the most results of the most rin the notebook on the most recent standid not include any little surveyor toured beginning at 10:33 a director. The surveyor maintenance director previous life safety surveyor discussed the	to the facility on 4/19/16 at eyor observed to the left of window in the front lobby and able, a sign that indicated the ecent surveys were available.	F 16	4.	committee for review and furth analysis of findings. 06-02-16	er	

conference on 4/22/16.

No further information regarding this issue was provided to the survey team prior to the exit

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 05/12/2016 MAPPROVED
STATEMEN	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T/Valkuu		OMB NO	D. 0938-0391
AND PLAN	OF CORRECTION .	IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECT	TION	
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F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COM ENVIRONMENT	FORTABLE/HOMELIKE	F 2			
	The facility must pro comfortable and hor the resident to use h to the extent possibl	nelike environment, allowing is or her personal belongings :		1. Air vents in rooms 215, 212, 210, 207, 204,203, 202, 201 118, 117, 115, 114, 113, 112 111, 109, 108, 107, 106, 105 104, 103, 102, and 101 were cleaned on 4/20/16.	<u>,</u> <u>2</u> , 5.	
,	by: Based on observation facility failed to ensure homelike environment on 2 of 2 units. The air vents in bathrooms were dirty unit. The facility services are directly services.	T is not met as evidenced on and staff interview, the re a clean, comfort and in 25 of 33 air vents and 25 of 33 resident room with lint on the Magnolia staff failed to ensure the infortable and sanitary on 2		The air vent in the public restroom on Dogwood, the a vents in the Janitor's closet, vents in the restorative room dust on the wheelchair scale the air vents in the storage at the air vents in the rehabilitat shower room, the air vents in community bathroom on Magnolia, the air vents in the Janitor's closet on Magnolia at the dust in the air conditioner of Resident #10s room were	the , the s, rea, ive the	
	bathrooms were dirty unit. On initial tour of the fathe surveyor observe bathrooms to have dielectory, 204, 203, 2113, 112, 111, 109, 1012 and 101. The unit manager for	25 of 33 resident room with lint on the Magnolia acility on 4/19/16 at 10 am, d the following resident rty air vents: 215, 212, 211, 02, 201, 118, 117, 115, 114, 18, 107, 106, 105, 104, 103, the Magnolia unit was with pove was observed. The Those are dirty" and		cleaned on 4/20/16. The chux, gowns, lift straps touching floor, oxygen room clutter was cleaned and/or corrected on 4/20/16. 2. Any resident room, storage room, air conditioner unit has potential to be affected if air vents are not free of dust or storage room, shower room, closets if there is clutter under shelves or items hanging on floor. Housekeeping Director designee to inspect vents are free	or	

On 4/20/16 at 5:50 pm in the end of the day conference, the administrator, director of nursing

bathroom.

dust. Administrator or designee

		H AND HUMAN SERVICES E & MEDICAID SERVICES			F	NTED: 05/12/2016 ORM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		3 NO. 0938-0391 3) DATE SURVEY COMPLETED
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t is set in on value in vitte by	documented finding No further informal surveyor prior to the 2. The facility staff was clean, comforwals. The surveyor and the walk-through of the surveyor observed to have also observed to be dust on both vental the scale itself was also observed to have also ob	were notified of the above	F 252		nent heads to ensure clean, of manner. ctor or vice on cleaning nt rooms. will be into identify be lent units. ctor or 0 patient osets, areas, as, etc. cresure st and facility e and safe, vill be and findings uality be for review	

janitor's closet on the Magnolia side also had an

DEP	ARTMENT OF HEALTH	AND HUMAN SERVICES				DDIMTE). OF (4000
CEN	TERS FOR MEDICARE	& MEDICAID SERVICES				FORM	D: 05/12/2016 MAPPROVED
1 STATEM	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU(A. BUILO		PLE CONSTRUCTION	(X3) DA), 0938-0391 TE SURVEY MPLETED
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NAME	OF PROVIDER OR SUPPLIER		S. W.(43		OTDEET ADDRESS	04	/22/2016
RADF	ORD HEALTH AND REH	AB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 790 RANDOLPH STREET RADFORD, VA 24141		The second secon
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	7 55 5	(X5) COMPLETION DATE
F 272 SS=D	closet, several of the observed to be touch Magnolia nurse's stathe wall directly acrowhere wheelchairs had the maintenance direcently been painteralways painting. Random checks of the resident's rooms were Dogwood side and the conditioner unit in Reaccumulation of dust. The surveyor discussed director which depart cleaning the air vents stated probably both maintenance should be cleaning. The surveyor informe the above concerns on the surveyor requested facility cleaning on 4/2 director of nursing. The surveyor reviewer "Miscellaneous Equipm 4/22/16. The policy reduring the day will be opposed for the proper location each do No further information exit conference on 4/2 483.20(b)(1) COMPRE ASSESSMENTS	t in the air vents. In the linent of facility lift pad straps were also the floor. At the strong, the floor. At the strong, the surveyor observed as from the nurse's station ave rubbed against the wall, ector stated the wall had and that the facility was the air conditioner units in the emade on both the emade on both the emade on both the emade on both the emade on the wall, ed with the maintenance ment was responsible for the maintenance director housekeeping and the responsible for their different the administrative staff of the administrative staff of the 4/20/16 at 5:50 p.m. and the facility policy on the facility policy titled ment, Daily Cleaning" on ad in part "Equipment used cleaned and stored in the ay." was provided prior to the 2/16. EHENSIVE	F 272	The second secon	Assessment for resident #4, #6, and # 8 was already complete and location and date of information unable to be added		
,	a comprehensive, accureproducible assessme	ect initially and periodically trate, standardized ent of each resident's			to assessment. No negative outcome identified for these residents,		

2141FWFV	#T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER'SUPPLIER/CLIA	/ya\ x a a a		FOR	D: 05/12/20 MAPPROVI <u>D. 0938-</u> 03
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU(LD)	FIPLE CONSTRUCTION NG	(X3) D4	ATE SURVEY
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F 272	Continued From page	ge 5	F 27	2:	-	4
	functional capacity.		121	2		th the state of th
	by the State. The astalent assessment by the State. The astale least the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior particular particular functioning a Continence; Disease diagnosis are Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of surface additional assessments as triggered by the Data Set (MDS); and	sident's needs, using the at instrument (RAI) specified assessment must include at mographic information; patterns; and structural problems; and health conditions; a status;		 Any resident has the potential be affected if section V is not documented on with the date and location for the CAA. Curr residents as of May 16th audit to ensure that section V has the date and location of information documented. Regional MDS Consultant or designee will educate staff responsible for completing section V on the MDS to include date and location of information used for the CAA. MDS Coordinator or designee will audit 10 of comprehensive assessments monthly x3 month to ensure that section V completed property. Any discrepancies will be addressed promptly and findings will be reported to Quality Assurance committee for review and further analysis of findings. 06-02-16 	ent ed e n	
E	y. Based on staff intervie	is not met as evidenced w and clinical record failed to document the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495355 B. WING 04/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES ID. PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 272 | Continued From page 6 F 272 date and location of clinical record documentation used to complete the comprehensive minimum data set (MDS) assessments for 3 of 26 residents (Resident #4, Resident #6, and Resident #8). The findings included: The facility staff failed to document location and date of the information used to complete Section V of the CAA (Care Area Assessment) for the significant change MDS (minimum data set) assessment with an assessment reference date (ARD) of 3/29/16 for Resident #4. The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, sacral ulcer and right lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. A review of the significant change MDS referenced above revealed Resident #4 triggered for the following areas in Section V: Delirium, Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation, Urinary Inconfinence and Indwelling Catheter, Falls, Nutritional Status. Dehydration/Fluid Maintenance, Pressure Ulcer, Psychotropic Drug Use, and Pain. For the triggered areas of Delirium and Cognition there was no documented location and date under the Location and Date column for these triggered

areas. The column only contained the words "Delirium" and "Cognition". A review of the CAA PRINTED: 05/12/2016

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 05/12/2016
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	reveal a location ar clinical record. The was 4/1/16, the data signed the CAA worksheet for deliriture and regist as the continue to monitor. Cognition read "Resimemory loss. Staff Neither of the trigge location where the inclinical record to surwere triggered. The surveyor interval to memory loss. Staff Neither of the trigge location where the inclinical record to surwere triggered. The surveyor information above finding on 4/2 No further information above finding on 4/2 No further information and date of the information of the captage of 3/10/16 for ARD) of 3/10/16 for ARD) of 3/10/16 for	um and cognition failed to ad date for information in the edate on the CAA worksheet ethe social services assistant rksheet. iewed the social services assistant rksheet. iewed the social services assistant was cation and date of the clinical oports the triggered areas of on were located in the clinical "I get it from where it triggers A worksheet." The CAA um read "Resident #4 BIM tal) (sic) fluctuates. Resident of delirium at this time. Will "The CAA worksheet for ident #4 has short term to monitor." red areas had dates or information was found in the oport the reason the areas ed the MDS staff of the 2/16. on was provided prior to the ailed to document location mation used to complete A (Care Area Assessment) for its MDS (minimum data set) assessment reference date	F 2:	72			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING (X3) DATE SUI A. BUILDING (X4) ID PROVIDER OR SUPPLIER (X4) ID PREFIX TAG (X4) ID PROVIDERS STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PROVIDER'S PLAN OF CORRECTION FREET (EACH CORRECTIVE ACTION SHOULD BE CONTAGEN TO THE APPROPRIATE	CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			Ć)	FORM APPROVE	Ď
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admitted to the facility on 5/16/12 and readmitted 3/2/16 with diagnoses that included, but not limited to anxiety, depressive disorder, urinary retention, constipation, pain, hypothyroidism, dementia with behavioral disturbances, Parkinson 's disease, diabetes mellitus type II, anemia, and enlarged prostate. Resident #6's significant change in assessment MDSs with an assessment reference date (ARD) of 3/10/16 coded the resident with a cognitive summary score of 04 out of 15 in Section C0500. A review of the significant change MDS referenced above revealed Resident #6 triggered for the following areas in Section V: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Individing Carbiteter, Falls, Nutritional Status, Dental Care, Pressure Ulcer, and Psychotropic Drug Use. For the triggered area of Cognition there was no documented location and date under the Location and Date column for the triggered area. Only the word "cognition" was written in the column. A review of the CAA worksheet for cognition failed to reveal a location and date on the CAA worksheet was 3/10/16, the date the social services assistant and registered nurse #3 on 4/22/16 at 11:50 a.m. The social services assistant was asked where the location and date for licitation of the CAA worksheet in the clinical momentum that supported the triggered area of cognitive was located in the clinical record. She stated "I get if from where it triggers on the MDS-the CAA worksheet" The CAA worksheet for cognition read "Resident #6 has a cognitive		admitted to the fact 3/2/16 with diagnost limited to anxiety, or retention, constipated dementia with behalf is disease, diabeted enlarged prostate. Resident #6's signiful MDS with an assess of 3/10/16 coded the summary score of 0 A review of the signiful referenced above refor the following are Loss/Dementia, Vistoriary Incontinence Falls, Nutritional Statusticer, and Psychotrotriggered area of Codocumented location and Date column for word "cognition" was review of the CAA with the control of the column for word "cognition" was review of the CAA with the surveyor interviews 3/10/16, the datassistant signed the The surveyor interviews assistant and registed 11:50 a.m. The social asked where the local information that suppositive was located stated "I get it from who MDS-the CAA works and the CAA works."	ses that included, but not depressive disorder, urinary don, pain, hypothyroidism, avioral disturbances, Parkinson as mellitus type II, anemia, and dicant change in assessment asment reference date (ARD) are resident with a cognitive of out of 15 in Section C0500. Ifficant change MDS avealed Resident #6 triggered was in Section V: Cognitive oual Function, Communication, and Indwelling Catheter, atus, Dental Care, Pressure opic Drug Use. For the origination there was no in and date under the Location of the triggered area. Only the swritten in the column. A corksheet for cognition failed and date for information in the date on the CAA worksheet are the social services. CAA worksheet. Ewed the social services ared nurse #3 on 4/22/16 at al services assistant was action and date of the clinical ported the triggered area of d in the clinical record. She where it triggers on the heet." The CAA worksheet	F 27	,			

DEPARTIMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/12/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 05/12/2016 FORM APPROVED OMB NO: 0938-0391
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	needed. He is assistensure that his needed. The triggered area location where the inclinical record to sure triggered. The surveyor information above finding on 4/2/16. The surveyor information above finding on 4/2/16. The facility staff from the cast on 4/22/16. The facility staff from the information acceptance of the information acceptance of 4/19/16 through 4/2/2 admitted to the facility that included, diabeth hemiplegia, hemipar disease, hypertension, depresoveractive bladder, and disease (GERD), reconstructions, postment curinary frequency, all Resident #8's annual assessment reference coded the resident with the significant and the resident with the significant and t	Staff to redirect him as sted with his care daily to ds are met." of cognition had no dates or information was found in the proof the reason the areas led the MDS staff of the 22/16. on was provided prior to the mailed to document location mation used to complete A (Care Area Assessment) for ge MDS (minimum data set) in assessment reference date. Resident #8. of Resident #8 was reviewed 2/16. Resident #8 was reviewed 2/16. Resident #8 was ty on 9/25/14 with diagnoses es mellitus type II, resis, cerebrovascular on, hypothyroidism, or episodes, ocular esive disorder, constipation, gastroesophageal reflux current urinary tract opausal atrophic vaginitis, lergic rhinitis, and anemia. I MDS assessment with an ce date (ARD) of 4/11/16 with a cognitive summary	F 272		
	score of 15 out of 15 A review of the annu	in Section C0500. al MDS referenced above			

revealed Resident #8 triggered for the following

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILO	LTIPLE CONSTRUCTION DING	(x3	OMPLETED
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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STAT 700 RANDOLPH STREET RADFORD, VA 24141	E, ZIP CODE	04/22/2010
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F 272	areas in Section Neurotional/Rehability Well-Being, Mood Nutritional Status. Psychotropic Drugtriggered areas of Mood State there and date under the these triggered areand mood were the column. A responderopic druggered allocation a clinical record. The was 4/14/16, the cassistant signed the surveyor interassistant and regional from the surveyor interassistant and regional from the cliniformation that supsychotropic drug located in the cliniform where it triggworksheet." The Charguing was read "Resident #8 Staff to monitor." Neither of the trigglocation where the clinical record to swere triggered.	V: Visual, ADL bilitation, Psychosocial di State, Activities, Falls, Dental Care, Pressure Ulcer, g Use and Pain. For the Psychosocial Well-Being and was no documented location e Location and Date column for eas. Psychosocial well-being ne only words documented in view of the CAA worksheet for use and mood state failed to and date for information in the ne date on the CAA worksheet date the social services he CAA worksheet. Triewed the social services stered nurse #3 on 4/22/16 at ocial services assistant was ocation and date of the clinical upports the triggered areas of use and mood state were cal record. She stated "I get it ers on the MDS-the CAA CAA worksheet for psychotropic esident #8 states having little e in doing things. Staff to A worksheet for mood state feeling down and feeling tired. gered areas had dates or information was found in the upport the reason the areas	F2	272		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495355	B. WING			D/A	C 04/22/2016	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 04.	12212010	
RADFOR	RD HEALTH AND REH	IAB CENTER		700 R	ANDOLPH STREET FORD, VA 24141			
(X4) ID FREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 272	Continued From pa	age 11	F 27	2				
F 279	exit on 4/22/16, 483.20(d), 483.20(l		F 27	9				
SS=D	A facility must use to develop, review a comprehensive plat. The facility must deplan for each reside objectives and time medical, nursing, a needs that are identical assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any side to the resident.	the results of the assessment and revise the resident's in of care. Evelop a comprehensive care ent that includes measurable etables to meet a resident's ind mental and psychosocial etified in the comprehensive it describe the services that are ettain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided is exercise of rights under the right to refuse treatment		3.	Resident #4's care plan update to reflect pacemaker. Any resident is at risk if their caplan does not reflect their pacemaker or interventions for care of the pacemaker. An aud of current residents as of May 16 th with pacemakers conducte to ensure care plan reflects the pacemaker. Regional MDS consultant or designee to educate MDS staff regarding updating care plans to reflect pacemakers and interventions related to care for pacemakers. Regional MDS Consultant or designee to audit residents with pacemakers monthly x3 months to ensure care plan reflects pacemaker and interventions for care of pacemaker. Any discrepancie will be addressed promptly and	it ed ir to		
	by: Based on staff intereview, the facility splan for 1 of 26 resion The findings include The facility staff fail comprehensive car Resident #4 was accompanied in the facility staff fail comprehensive car Resident #4 was accompanied in the facility staff fail comprehensive car Resident #4 was accompanied in the facility staff fail comprehensive car Resident #4 was accompanied in the facility staff fail fail fail fail fail fail fail f			5.	findings will be reported to Quality Assurance committee for review and further analysis of findings, 06-02-16	эг		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	495355	B. WING_			O ₄	C 4/22/2016
NAME OF PROVIDER OR SUP			700 1	EET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH STREET DFORD, VA 24141		Ti da da i a Co
PRÉFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	Andrew State of the State of th	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
admitted to the that included, thrive, atrial fill complications pacemaker, Be without urinary freque and right later Resident #4's MDS with an a of 3/29/16 consummary scort The clinical refered that a physician note and 1/29/16. Comprehensive current comprehensive current comprehensive current comprehensive current at the read hypertension, fibrillation), CA stents; at risk dude to ASA (and to diuretic A review of the 12/28/15 did in care plan for the surveyor if the surve	gh 4/22/16. Resident #4 was a facility on 12/21/15 with diagnoses but not limited to adult failure to orillation, diabetes mellitus without type II, coronary atherosclerosis, PH (benign prostate hypertrophy) yobstruction, esophageal reflux, ncy, cellulitis, edema, sacral ulcer al foot ulcer. Significant change in assessment assessment reference date (ARD) ded the resident with a cognitive e of 05 out of 15 in Section C0500. Cord of Resident #4 revealed the pacemaker documented in the s of 12/28/15, 12/31/15 and 1/8/16, The surveyor reviewed the current e care plan initiated 12/31/15. The ehensive care plan had the focus "Resident #4 has diagnosis of hyperlipidemia, A. Fib (atrial aD (coronary artery disease) with for bleeding and excessive bruising aspirin) use; at risk for dehydration use." The comprehensive care plan dated of include the development of a ne cardiac pacemaker or any or the care of the pacemaker. Informed the administrative staff of ing on 4/22/16.		1-	Care plan for resident #1, #10 #14, #13, #12, #2 updated to reflect non-pharmacological interventions for pain. Care p for resident #3 updated to ref	lan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495355	B. WING		•	0.4	C //22/2016
MAME DE	PROVIDER OR SUPPLIEF	<u> </u>	I	ero	EET ADDRESS, CITY, STATE, ZIP CODE	04	HZZIZU10
INPAINIC OF I	FREW VIDER ON SOFFEE	`			RANDOLPH STREET		
RADFOF	RD HEALTH AND REI	HAB CENTER			DFORD, VA 24141		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFU TAG	X	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 280	Continued From p	-	F 2	80			
	incapacitated unde	er the laws of the State, to			non-pharmacological		
	participate in plant	ning care and treatment or		ļ	interventions for depression.		Ì
	changes in care a	nd treatment.			Care plan for resident #7		1
	Accordance			i	updated to reflect non-		AND COLUMN TO THE PARTY OF THE
		care plan must be developed			pharmacological interventions	;	
		the completion of the			related to a fall. Care plan for		
		sessment; prepared by an		İ	resident #4 updated to reflect		
	interdisciplinary team, that includes the attending physician, a registered nurse with responsibility				non-pharmacological		
		ared norse with responsibility and other appropriate staff in		ĺ	interventions for pain and		
	1	rmined by the resident's needs,			anxiety. Care plan for residen	t #6	
		practicable, the participation of			updated to reflect non-		
		esident's family or the resident's	,		pharmacological interventions	for	
		e; and periodically reviewed			anxiety.		
		eam of qualified persons after		12	. Any resident has the potential	Ю	
	each assessment.				be affected if care plan is not updated with non-		1
		and the second s			phamacological interventions	for	-
					pain, anxiety, depression, or	10.	,
	•				falls. Current residents as of N	<i>l</i> lav	:
	TI' DECLIDENT				16 th audited to ensure care pla		
		NT is not met as evidenced		ì	reflective of non-pharmacolog		1
	by:	serious olinical record regions		:	interventions for pain, anxiety.		
		erview, clinical record review ent review, the facility staff			depression, and falls if		
		e comprehensive care plan for	i		applicable.		
		in the survey sample		3	9		
		7,12,13,4,6,10,14, and #1).			licensed nursing staff on		•
		aff failed to update the			updating care plans with non-		
		re plan as related to		i	pharmacological interventions		
	non-pharmacologic	cal interventions for pain for			when residents have new pair	1,	
	Resident #2.				anxiety, depression, or falls.	to	
		aff failed to update the		4	 MDS Coordinator or designee audit 10 of care plans monthly 		deceased of the second
		re plan as related to		:	months to ensure care plans thoraing		İ
		cal interventions for depression		ĺ	reflective of non-pharmacolog		į
	for Resident #3.				interventions for pain, anxiety		!
		ed to update the		Very continuous page	depression, and falls. Any		· .
	comprehensive ca				discrepancies will be address	ed	1 1
	non-pharmacologic falls for Resident#	cal interventions as related to 7.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON A. BUILDING				TE SURVEY MPLETED			
		495355	B, WING			0.4	C
NAME OF I	PROVIDER OR SUPPLIE	<u> </u>	<u> Т</u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 04	1/22/2016
	· · · · · · · · · · · · · · · · · · ·	•			RANDOLPH STREET		
RADFOR	RD HEALTH AND RE	HAB CENTER			FORD, VA 24141		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From p	page 14	F 2	80			
F 280	4. The facility stacomprehensive canon-pharmacolog Resident #12. 5. The facility stacomprehensive canon-pharmacolog Resident 13. 6. The facility the current comprehensive to facility the current comprenon-pharmacologic Resident #6. 8. The facility the current comprenon-pharmacologic Resident #10. 9. The facility the current comprenon-pharmacologic Resident #10. 9. The facility the current comprenon-pharmacologic #14's pain.	aff failed to update the are plan as related to ical interventions for pain for aff failed to update the are plan as related to ical interventions for pain for a staff failed to review and revise then sive care plan to include ical interventions for pain and	F 2	5.	promptly and findings will be reported to Quality Assurance committee for review and furth analysis of findings. 06-02-16		
· · · · · · · · · · · · · · · · · · ·	the current compre	ehensive care plan to include cal interventions for Resident					
	comprehensive canon-pharmacologic Resident #2. Resident #2 was re 2/20/16 with the folimited to diabetes chronic obstructive	ded: off failed to update the ore plan as related to cal interventions for pain for eadmitted to the facility on ollowing diagnoses of, but not dementia, enlarged prostrate, pulmonary disease, major er, anemia and heart failure.		The state of the s			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION	COMPLETED			
		495355	B. WING		C 04/22/201	16		
NAME OF F	PROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE	,			
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		l	700 RANDOLPH STREET				
RADFOR	D HEALTH AND REI	HAB CENTER		RADFORD, VA 24141				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C				
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		OTHE APPROPRIATE DAT			
F 280	Continued From p	age 15	F 2	280				
	On the resident 's	MDS (Minimum Data Set, an						
	assessment proto	col) with an ARD (Assessment						
		of 3/17/16, Resident #2 was	!		:			
		BIMS (Brief Interview for						
		ore of 6 out of a possible score						
		nt was also coded as requiring						
		ice of 2 or more staff members		\$ 5	!			
		ersonal hygiene. Resident #2	l I	Ex.Com	•			
		nt on staff for bathing.			1			
		of the clinical record by the						
	care plan was not	oted that the comprehensive						
		cal interventions that staff can	İ	1 3				
		ministration of a pain		ALL CONTRACTOR OF THE PROPERTY	•			
		nost recent updated care plan		TAC TANADAM	1			
		16 which stated, under the						
		irdiac Chest Pain " , the						
		ions: " Administer medication						
*	for nerve pain as o	orderedAdminister pain		AAAAAAAA				
		eredFollow up with Dr. (name		Assert 4.4				
		dered/neededObserve for an			4			
		runrelieved and report to the			ļ.			
	physician as need				§			
		rsing was notified of the above						
		ngs on 4/21/16 and again on			, and the second			
		veyor. The director of nursing						
	stated on 4/22/16	at approximately 2:45 pm, " I			A A A A A A A A A A A A A A A A A A A			
	plan it see any ou plan besides medi	ner interventions on the care			4			
		ition was provided to the		·				
		ne exit conference on 4/22/16.		b				
		iff failed to update the			<u>}</u>			
		are plan as related to						
		cal interventions for depression						
	for Resident #3.							
		admitted to the facility on						
		ollowing diagnoses of, but not	:					
	limited to heart fail	lure, high blood pressure,						
		on, asthma, respiratory failure,						

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495355	B. WING			C 04/22/2016
NAME OF F	ROVIDER OR SUPPLIEF	<u> </u>		STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
				700 RANDOLPH STR	EET	
RADFOR	D HEALTH AND RE	HAB CENTER		RADFORD, VA 241	141	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		('S PLAN OF CORRECTION ECTIVE ACTION SHOULD	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		ECTIVE ACTION SHOOLD ENCED TO THE APPROPE DEFICIENCY)	
24.20mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40mm24.40		***************************************	7			3
F 280	Continued From p	age 16	F 2	280		
	muscle weakness	, difficulty in walking and	!			F
		h. The resident was coded on	1			
		n Data Set, an assessment				
		ARD (Assessment Reference				
		s having a BIMS (Brief	İ	1		
		al Status) score of 15 out of a		· · · · · · · · · · · · · · · · · · ·		
		15. Resident #3 was also		\$		The state of the s
	coded as requiring	a extensive assistance from one				
	staff person for dr	essing, personal hygiene and				!
	bathing.					
	During the review	of the clinical record by the				
	surveyor, it was no	oted that the comprehensive		1.000		
	care plan was not	updated with				į.
	non-pharmacolog	ical interventions that staff can	1			į.
	use prior to the ac	Iministration of a depression				
	medication. The r	most recent updated care plan				
		16 which stated, under the				.*
		psychoactive medications				
		ion " , the following))
		dminister medications as	1			
		for side effects and	1			[
		nedications, Conduct				
		en reviews monthly by				* ;
		acist. Observe for target		İ		
		ease or escalation that may	1			
		medication review. "	Lamborator			; ; ;
		rsing was notified of the above	1			
		ngs on 4/21/16 and again on				
		veyor. The director of nursing				
		at approximately 2:45 pm, "1	İ			
		her interventions on the care				
	plan besides med					E E
		ation was provided to the	į			1
		he exit conference on 4/22/16.	-	And the second s		
	3). The facility fai		1	1		
	comprehensive ca					
		ical interventions as related to	!	•		
	falls for Resident			į		İ
	Resident #7 was,r	readmitted to the facility on	:.			

Event ID: SSHU11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/ IDENTIFICA	SUPPLIER/CLIA TION NUMBER:		TIPLE CONSTRUCTI		(X	3) DATE SE COMPLE	
		4.0	9535 5	B. WING			D	C	***
A K		<u> </u>	33333		ETDEET ADDOCC	O OITH STATE 710 O	OPE	04/22/	2016
NAME OF I	ROVIDER OR SUPPLIER					SS, CITY, STATE, ZIP O	ODE		
RADFOR	D HEALTH AND REI	IAB CENTER			700 RANDOLPH				
TRI KENT SPIT					RADFORD, VA	A 24141			
(X4) ID	SUMMARY ST	ATEMENT OF DEF	ICIENCIES	10	FRO'	VIDER'S PLAN OF COR	RECTION	:	(X5)
PREFIX	(EACH DEFICIENC			PREFIX		CORRECTIVE ACTION		- :	DATE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING	INFORMATION)	TAG	UNU33-N	REFERÉNCED TO THE. DEFICIENÇY)	APPROPRIA	E	WAIL.
								-	.
<u>.</u>					100			8 8	
F 280	Continued From pa	age 17		F 2	80				
	11/17/15 with the fe	ollowing diagn	oses of, but not						
	limited to high bloo	id pressure, de	ementia, anxiety,					:	
	osteoarthritis and t	ransient ische	mic attack. The						
	resident was code	d on the MDS	(Minimum Data					1	
	Set, an assessmer	nt protocol) wit	h an ARD					i	
	(Assessment Refe	rence Date) of	2/15/16 as					:	
	having a BIMS (Bri	ief Interview fo	r Mental Status)						
	score of 0 out of a							,	
	#7 was also coded	as requiring e	extensive		i				
	assistance of 1 sta				İ				
	toilet use and pers		·		1				
	During review of R		clinical record by						
	the surveyor, it was							:	
	care plan dated for							1	
	each of the resider							*	
	1/4/16, 1/24/16 and							1	
	interventions put in						s#1	in the second	
	surveyor upon revi							:	
	The director of nur								
	4/22/16 at approxim				; 1			4	
	don 't see where t							j	
	with interventions a				į				
	expected to do. "		,		and a second sec				
	No further informat	tion was provid	led to the						
	surveyor prior to th								
	4). The facility sta				:				. `
	comprehensive car								
	non-pharmacologic	•							
	Resident #12.	2.2			il read			ĺ	
	Resident #12 was	readmitted to t	he facility on						`
	12/7/15 with the fo							;	
	limited to: heart fa							:	į
	vascular disease, I				*				l
	disorder, depression								
	lower extremities,	•	-					1	
	insomnia, Resider				Sans Sansan			;	
	quarterly MDS (Mir								
	assessment protoc			•	!				
	Reference Date) o			**				-	
						1 -		<u> </u>	
ORM OMS.25	567(02-99) Previous Version:	s Obsolete	Event ID: S5HU1	1	Facility ID: VA0161	If co	intinuation s	neet Page	18 of 119

	<u> </u>	3 1412 2 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2		. F GOMOTOMOTOM	(X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LE CONSTRUCTION	COMPLETED	
WIND LEWIN C	F CZONNEOTION	IDELY IN TOTAL YORK DEVE	A. BUILDING		c	1
		185058	B. WING		04/22/2016	
		495355	1	STREET ADDRESS, CITY, STATE, ZIP CODE	04/22/2010	-
NAME OF I	PROVIDER OR SUPPLIER					-5.00
RADEOR	D HEALTH AND REF	IAB CENTER	1	700 RANDOLPH STREET		-
MAD) OF	E	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		RADFORD, VA 24141		
(X4) ID PREFIX	AT A OUR POPULATION OF	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	DBE COMPLETION	TO COLUMN COLUMN
TAG	(= 1 × 1 × 1 = 1	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE	an experience and a second
FFA. \$4.	`		\$ }	·		and an area
F 280	Continued From pa	age 18	F 280	ס	e e	
	(Brief Interview for	Mental Status) score of 10 out				-
		of 15. The resident was also			i i	
	_	ally dependent on staff			2 8	
		sing, personal hygiene and				
	; bathing.	of the elimination and by the				
		of the clinical record by the				
		6, it was noted that the staff medication, "Percocet 5 -325	1			
		t 2043 (8:43 pm) and again on			i :	
		1:33 pm) as documented on			2 1 4	
		dication Administration Record			•	
	(MAR). The surve	yor reviewed the nurses '	1			
		tes and times and there were				
		macological interventions				
	documented by the					
	administration of F Resident #12.	Percocet, a pain medication, to	and a constraint of the constr		6°	
		ed for 2/5/16, for Resident #12,	:			
		by the surveyor on 4/22/16.				
	The resident was	care planned for a focus of "				
	Pain " with the fol	lowing interventions noted on it:				
		nedications and medication for				
		orderedObserve for an		1		
	increase in s/s (sig	gns and symptoms) or c/o				
		relieved pain and report to the				
	physician as need	eo. rsing was notified of the above				
		ngs on 4/22/16 at 2:30 pm. The				
		stated "Let me review the		1		
	notes myself and	then I can get with you about			,	
	this."		-		E .	
	No further informa	ition was provided to the			Advantage of the second	
	surveyor prior to the	ne exit conference on 4/22/16.5.				
	5). The facility sta	off failed to update the			; 	
	comprehensive ca	are plan as related to	:		* ADDRESS ** ********************************	
		ical interventions for pain for			•	
	Resident 13.					
	⊣ Resident #13 was	admitted to the facility on			į	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495355	B. WING			04	/22/2016
NAME OF E	PROVIDER OR SUPPLIE			STR	EET ADDRESS, CITY, STATE. ZIP CODI		
	D HEALTH AND RI				RANDOLPH STREET DFORD, VA 24141		
(X4) ID PREFIX TAG	(EACH DEFICIE)	BTATEMENT OF DEFICIENCIES NCY MUSY BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 280	limited to muscle weakness on on left side, uncontrand high blood particles and high blood particles and high blood particles and assessm completed was a Section A completed was a Section A completed was a Section A completed administration of the following Administration of the following Administer pain Administer top Observe for s/ (complaints of) in Notify physician The director of the documented find 4/22/16 by the stated on 4/22/1 didn't see any oplan besides menor to form the facility state of the current components of the current currents of the current currents of the current currents of the current currents of the current currents of the current currents of the current currents of the current currents of the current currents of the current currents of the current currents of the currents of	following diagnoses of, but not weakness, difficulty in walking, a side after a stroke affecting the olled insulin dependent diabetic, ressure. At the time of the 6, the only MDS (Minimum Data ent protocol) that had been a 5 day admission with only eted. ensive care plan with admission the surveyor noted there were not a pain medication to Resident area of "pain" on the care plan interventions in the staff prior to the farea of "pain" on the care plan interventions that stated, "medication as ordered ical pain medication as ordered in the staff of the above director of nursing 6 at approximately 2:45 pm, "I to ther interventions on the care the exit conference on 4/22/16. Itaff failed to review and revise orehensive care plan to include original interventions for pain and		280			
<u>.</u>	admitted to the that included, but thrive, atrial fibri	facility on 12/21/15 with diagnoses at not limited to adult failure to llation, diabetes mellitus without pe II, coronary atherosclerosis,	5				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY . MPLETED C
		495355	B. WING		04	/22/2016
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 700 RANDOLPH STREET RADFORD, VA 24141	CODE	
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CEEEEEELOCE TO TE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	urinary obstruction frequency, cellulicateral foot ulcer. (a) Resident #4's assessment MDS date (ARD) of 3/d cognitive summates Section C0500. Understand other Resident #4 was in Section E. Resident #6 revealed no sched	page 20 state hypertrophy) without en, esophageal reflux, urinary tis, edema, sacral ulcer and right significant change in S with an assessment reference 29/16 coded the resident with a ery score of 05 out of 15 in Resident #4 was assessed to es usually and was understood, assessed to have no behaviors sident #4's pain assessment eduled pain medication regimen, eny prn (whenever necessary) did not receive any enterventions for pain. Resident d pain during the look back t #4 rated his pain level as 8 out	F 2	280		
	order that read " (Hydrocodone-A mouth every 6 he April 2016 medic (MARs) were rev (as needed) pair April 2016 on 4/3 4/18/16, 4/19/16 The current com 12/31/15 includes "Resident #4 has and buttocks." I medication as or	hysician order sheet included an Norco Tablet 5-325 mg cetaminophen) Give 1 tablet by burs as needed for pain." The cation administration records viewed. Resident #4 received profit medications eight (8) times in 2/16, 4/5/16, 4/9/16, 4/15/16, (x2), and 4/20/16. Apprehensive care plan initiated a focus area that read a focus area that read a generalized pain with legs, feet, interventions: "Administer pain redered. Nursing to assist with ort. Observe for increase s/s stoms) of pain or unrelieved pain, as needed."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED C	
		495355	B. WING		04	/22/2016
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD, VA 24141			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	COMPLETION DATE
₩ 280	non-pharmacolog medication admir (9:44 p.m.) The read "Acetaminophy mouth every 4 and hips aching, Tylenol." Tylenol time the note was (9:38 p.m.) programon-pharmacolog #4 when the resk The 4/18/16 21:3 read "C/o (complano documented reprior to the admir at 21:37 (9:37 p.m.) progress note read is sacrum and be documented non prior to the admir at 10:51 a.m. The read "RSD said if wound." Resider 8:00 a.m. There interventions prior pain medication of the surveyor discomprehensive of with registered in The current comone non-pharma R.N. #3 stated the "Standards of Privould normally by would normally by the surveyor with registered in the current comone non-pharma R.N. #3 stated the "Standards of Privould normally by the surveyor surveyor discomprehensive of the current comone non-pharma R.N. #3 stated the "Standards of Privould normally by the surveyor surveyor discomprehensive of the current comone non-pharma R.N. #3 stated the "Standards of Privould normally by the surveyor surveyor surveyor discomprehensive of the surveyor discomprehensive	ogress notes did not reveal gical interventions prior to histration on 4/2/16 at 21:44 4/13/16 21:30 (9:30 p.m.) note of the tablet 325 mg Give 1 tablet hours as needed for pain back repositioned and gave printed at the same swritten. The 4/15/16 21:38 less note did not include gical interventions for Resident dent complained of back pain. 7 (9:37 p.m.) progress notes ain of) all over pain." There was non-pharmacological intervention histration of the pain medication m.). The 4/19/16 at 10:51 ad "RSD (resident) states pain in eack 8/10." There were no epharmacological interventions histration of the pain medication of a 4/20/16 08:00 progress note he is having pain in his sacral at #4 received pain medication at were no non-pharmacological or to the administration of the care plan for Resident #4 curse #3 on 4/22/16 at 10:00 a.m. prehensive care plan identified cological intervention for pain. In the care plan identified cological intervention for pain. In the care plan identified cological intervention for pain. In the care plan identified cological intervention for pain. In the care plan identified cological intervention for pain. In the care plan identified cological intervention for pain.		280		
	medication. One repositioning. R.	example she gave; turning and N, #3 stated these would be sident prior to giving medications.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495355	B. WING		0	C 4/22/2016		
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP C 700 RANDOLPH STREET				
RADFOR	RD HEALTH AND RE	HAB CENTER		RADFORD, VA 24141				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 280	R.N. #3 stated into ther areas of the to look at all of the asked R.N. #3 if the asked R.N. #3 if the asked R.N. #3 if the part "Yanax table (Alprazolam) Give hours as needed. The April 2016 prace Resident #4 was (milligrams) six (6 days: 4/2/16, 4/5 and 4/18/16. The current comparison of the determination for determination for determination as ore (signs/symptoms Notify physician and The current comparison of the use of the theory for the use of the theory for the use of the theory for the use of the theory for the use of the theory for the use of the theory for the use of the theory for the the use of the theory for the use of the theory for the use of the theory for the use of the theory for the use of the theory for the the use of the theory for the the use of the theory for the the use of the theory for the use of the theory for the use of the theory for the theory for the use of the theory for the use of the theory for the use of the theory for the use of the theory for the use of the use o	e facility "charted by exception." erventions might be found in e care plan and stated you have e problems. The surveyor he facility knew what Resident ement would include besides ort." No answer was given. 5 physician order sheet read in t 0.25 mg (milligram) e 1 tablet by mouth every 6 for anxiety." ogress notes were reviewed. administered Xanax 0.25 mg b) times in April on the following /16, 4/9/16, 4/15/16, 4/17/16; orehensive care plan initiated esident #4 receives psychotropic epression with adult failure to ad insomnia, at risk for side entions "Administer psychotropic dered. Observe for increase s/s) of depression and anxiety. es needed."		80				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3), DATE SURVEY COMPLETED		
		495355	495355 B. WING			C 04/22/2016		
	PROVIDER OR SUPPLIER (DI-HEALTH AND RE	3	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP C D RANDOLPH STREET ADFORD, VA 24141			
(X4) ID PREFIX TAG	(EACH DEFICIENT	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	4 SHOULD BE	COMPLETION DATE	
F 280	Continued From p	page 23	F	280			5	
	smacks, fluids, rep	es of 4/6/16 8:32 read "Offered positioning, boosting into bed, to Redirection ineffective."	a de venere e e e e					
	read "Xanax 0.25 every 6 hours as in hollering help me, standing @ (at) b	7 (10:27 p.m.) progress note mg Give 1 tablet by mouth needed for anxiety. Anxiety, help me while nurse is edside resident stated he	1	And the second s			and the state of t	
	with anxiety, denice administered Xan p.m.). Resident # a non-medication			com to one or a control of the form of the control	er.		• Committee and the state of th	
		rmed the administrative staff of on 4/22/16 at 10:00 a.m.					· v	
	from the director policy titled "Pain Care Setting" real 1. Assess the res	uested the facility policy for pain of nursing on 4/21/16. The Management in the Long Term d in part "Procedure: sident for pain on admission,					Andrews - Market Company of the Comp	
	other times as ap (electronic medic Form.	rterly, change of condition, or at propriate. Use the EMR ation record) Pain Assessment location, quality, duration, and						
	intensity of pain. pain, however will b. Assist the rest	a. Some residents will deny I describe feelings of discomfort dent to describe the quality of th such words as throbbing,		And the second s				
	stabbing, burning will relate pain or certain times of d	and aching c. Some residents discomfort in connection with ay or specific movement or the resident to use the intensity	· · · · · · · · · · · · · · · · · · ·	:	: · · · · · · · · · · · · · · · · · · ·	-	-	
		hev are most comfortable. e						

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		40.5255	B. WING			1	C /22/2016
	PROVIDER OR SUPPLIER		0. 7.110	700	REET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH STREET DFORD, VA 24141	1 04/	22/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	should involve the observations of the reactions. 3. Document presiby the resident for a medications bo the counter) be alto positioning, heat at the treatment by effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of effectiveness of pain and the each. 6. Utilize the pain interdisciplinary can determine the ademanagement, and appropriate." No further informate exit conference of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current compression of the current current compression of the current compression of the current compression of the current current compression of the current current compression of the current current current compression of the current curr	rimpaired resident, the nurse family as appropriate, or make e resident's behavior and sent and past treatments utilized the treatment of pain, include: the prescription and OTC (over emative treatments such as and cold applications c. specify each site of pain d. record the ach treatment ciffic care plan to address all the appropriate treatment for assessments in are planning meetings to equacy of the resident's pain if revise the plan of care as ation was provided prior to the a 4/22/16. Aff failed to review and revise ehensive care plan to include ical interventions for anxiety for d of Resident #6 was reviewed /22/16. Resident #6 was cility on 5/16/12 and readmitted bees that included, but not depressive disorder, urinary tured humerus, congestive stipation, pain, hypothyroidism, navioral disturbances, Parkinson tes mellitus type II, anemia, and		280		· .	

Event ID: SSHU11

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. (X2) MUL)	RPLE CO	ONSTRUCTION	(X3) DAT	DATE SURVEY COMPLETED	
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:					C	
		495355	B. WING		ET ADDRESS, CITY, STATE, ZIP CO		/22/2016	
NAME OF F	ROVIDER OR SUPPLIER				RANDOLPH STREET			
RADFOR	RD HEALTH AND REF	IAB CENTER		RAD	FORD, VA 24141			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	Resident #6 was a usually understood. There were no iss in Section E. Resident #6's currinitiated 11/29/12 identified cognitive diagnosis of deme Interventions: ass (speech therapy) #6 to make decisi provide a consisteral so received psylanxiety and depredementia with belifocus area: Admiras ordered, MD (reconsultant to revier egularly, monitor GDR (gradual documless otherwise increase in report depression or any as needed, observed izziness, drowsi rapid heart rate, vand report to the The comprehensinclude interventil however, there were section is supported to the comprehensinclude interventil however, there were section in the comprehensinclude interventil however, there were section in the comprehensinclude interventil however, there were section in the comprehensinclude interventil however, there were section in the comprehensinclude interventil however, there were section in the comprehensinclude interventil however, there were section in the comprehensi	the resident with a cognitive 04 out of 15 in Section C0500. Issessed with speech clarity, it, and usually understands. It was documented for behaviors ent comprehensive care plan with revisions on 2/8/16 behavior as a focus due to entia, history of behaviors. It is needed, consult ST as needed, encourage Resident ons daily regarding care, and ent environment. Resident #6 chotropic medication due to ssion; at risk for side effects; naviors. Interventions for the nister psychotropic medication medical doctor) and pharmacy ew meds (medications) for side effects and attempt se reduction) as indicated contraindicated, observe for an ed s/s (signs/symptoms) of kiety and report to the physician ve for s/s drug toxicity and sician as needed, observe for eport to the physician as for side effects such as ness, high BP (blood pressure), weight gain, or tardive dyskinesis physician as needed. Ive care plan dated 3/15/16 did ons for Resident #6's confusion; vere no non-pharmacological anxiety on the current						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	RIPLE CONSTRUCTION NG	COMPLETED
		495355	B. WING		04/22/2016
	PROVIDER OR SUPPLIES TO HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP CO 700 RANDOLPH STREET RADFORD, VA 24141	ODE
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 280	Continued From p	page 26	F 2	80	
	"Ativan tablet 0.5	ysician order sheet read in part mg (Lorazepam) Give 1 tablet hours as needed for			: :
	identified Resider 4/4/16, 4/7/16, 4/8	edication administration record at #6 received Ativan on 4/3/16, 3/16, 4/10/16, 4/11/16, 4/15/16, and 4/20/16-ten (10) times in	an age of the large and the la		:
	2016 progress no	cumentation in any of the April tes that Resident #6 was nacological interventions prior to n of Ativan.)		
	The surveyor info	rmed the administrative staff of on 4/22/16.	1		
	No further inform exit conference o	ation was provided prior to the n 4/22/16.	**************************************		
	the current comp non-pharmacolog Resident #10. The clinical recor 4/19/16 through 4 admitted to the fa 4/9/16 with diagn to hypertension, s chronic kidney di hyperlipidemia, o type II, and hypor Resident #10's si (minimum data s	aff failed to review and revise rehensive care plan to include pical interventions for pain for d of Resident #10 was reviewed 1/22/16. Resident #10 was acility 4/3/15 and readmitted coses that included but not limited status post pacemaker insertion sease, atrial fibrillation, steoarthritis, diabetes mellitus hyroidism. gnificant change in MDS et) assessment with an rence date (ARD) of 8/17/15	d		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILD!	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C
		495355	8. WING		04/22/2016
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL	
RADEOR	D HEALTH AND RE	HAB CENTER		700 RANDOLPH STREET	
77,157,01	O (ILLICITIONIS INC.			RADFORD, VA 24141	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 280		_	F2	80	
	that Resident #10 medication, receive medications or wanot receive any no pain. Resident #10's cuidentified the diagratisease) and DDE history of fracture care plan was reviewed; observantelieved pain anneeded and follow ordered/needed. Resident #10's phread in part "Perce (Oxycodone-Acetamouth every 6 houdate: 4/9/16." The April 2016 mewere reviewed. Resident #10's phread in part "Perce (Oxycodone-Acetamouth every 6 houdate: 4/9/16." The April 2016 mewere reviewed. Ras follows: 4/9/16 mewere reviewed.	s: administer pain medication we for an increase in pain or ad report to the physician as you with MD as you with MD as you with MD as you with MD as you with MD as you with MD as you will be a tablet 10-325 mg aminophen) Give 1 tablet by wirs as needed for pain. Start you will will will be a tablet will be a tablet as needed for pain. Start you will be a tablet will be a table			
	revision for Reside The surveyor requ	ent #10's surgical procedure. lested the facility policy for pain of nursing on 4/21/16. The			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MÜL' A. BUILDI	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED C
		495355	B. WING		04	/22/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 700 RANDOLPH STREET RADFORD, VA 24141		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From p	age 28	F 2	280		
	Care Setting" read 1. Assess the reside readmission, quar other times as apply (electronic medical Form. 2. Document the intensity of pain. a pain, however will be Assist the reside pain by queing with stabbing, burning will relate pain or occurrent times of deactivity deactivity deactivity should involve the observations of the reactions.	Management in the Long Term I in part "Procedure: ident for pain on admission, terly, change of condition, or at propriate. Use the EMR thion record) Pain Assessment docation, quality, duration, and as Some residents will deny describe feelings of discomfort lent to describe the quality of the such words as throbbing, and aching a commercial with any or specific movement or the resident to use the intensity mey are most comfortable as impaired resident, the nurse family as appropriate, or make a resident's behavior and		X.		
	by the resident for a. medications both the counter) b. alto positioning, heat at the treatment by eleffectiveness of each. 6. Utilize the pain interdisciplinary cat determine the ademanagement, and appropriate."	cific care plan to address all ne appropriate treatment for assessments in are planning meetings to quacy of the resident's pain revise the plan of care as				
		off failed to review and revise		-		I L

STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		 DING		re survey MPLETED
		495355	B. WING		04	/22/2016
	PROVIDER OR SUPPLIE	R	~~	STREET ADDRESS, CITY, STATE, ZIF 700 RANDOLPH STREET RADFORD, VA 24141	CODE	
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	the current compinon-pharmacolog #14's pain. Resident #14's c 4/21/16 through admitted to the fa 7/17/15 with diaglimited to osteoachyperlipidemia, ogastroesophage prostate, insomn Resident #14's sassessment with (ARD) of 7/29/18 cognitive summa Section C Summa The current com 2/10/16 identified needs varied with due to osteoarth second focus are diagnosis of OA immobility." Intearthritic medication as ordered, obseunrelieved pain a needed.	rehensive care plan to include gical interventions for Resident dinical record was reviewed 4/22/16. Resident #14 was acility 3/24/14 and readmitted moses that included but not rethritis, hypertension, depression, anxiety, anemia, al reflux disease, enlarged ia, and spondylosis. ignificant change in MDS an assessment reference date assessed the resident with a ary score of 15 out of 15 in mary Score. prehensive care plan dated that Resident #14 assistance in ADLs (activities of daily living) ritis (OA); joint replacements. A sea read "Resident #14 has and chronic pain syndrome, rventions/tasks: administer on as ordered, administer as ordered, administer pain redered, encourage use of brace erve for an increase in pain or and notify the physician as	F :	280		
	identify any non- the administration. The April 2016 profollowing: Oxyo- 5 mg Give 1 tab needed for pain. The surveyor ob- pour on 4/19/16	prehensive care plan did not medication interventions prior to on of pain medications. Shysician orders included the odone HCL (hydrochloride) tablet let by mouth every 4 hours as served a medication pass and at 4:50 p.m. with licensed \$1. Resident #14 complained of				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NNG		(X3) DATE \$U COMPLE	
		495355	B. WING			C 04/22 //	2016
NAME OF I	ROVIDER OR SUPPLIES	₹		STREET ADDRESS, CITY, STATE, ZI 700 RANDOLPH STREET	P CODE	~~~	A CONTRACTOR OF THE PARTY OF TH
RADFOR	D HEALTH AND RE	HAB CENTER		RADFORD, VA 24141			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD I HE APPROPR	BE CC	(X5) IMPLETION DATE
F 280	of 10. L.P.N. #1 p Resident #14 oxy were no non-med prior to the admin Resident #14 did	ain and rated the pain an 8 out proceeded to administer codone 5 mg at this time. There ication interventions offered istration of the medication. however, have a care plan for	F 2	280			
	identified. The surveyor disc #14's pain medica of nursing on 4/21 The surveyor requ from the director of policy titled "Pain Care Setting" read 1. Assess the res readmission, qual other times as ap (electronic medical Form. 2. Document the	sed 4/14/16 with 7 interventions bussed the issue of Resident ations with the assistant director 1/16 at 7:20 a.m. uested the facility policy for pain of nursing on 4/21/16. The Management in the Long Term of in part "Procedure: sident for pain on admission, rterly, change of condition, or at propriate. Use the EMR ation record) Pain Assessment location, quality, duration, and a. Some residents will deny			.a.		
	pain, however will b. Assist the resipain by cueing wistabbing, burning will relate pain or certain times of dactivity d. Teach scale with which the for the cognitively should involve the observations of the reactions. 3. Document preby the resident for a medications bother counter) b. alto.	describe feelings of discomfort dent to describe the quality of th such words as throbbing, and aching c. Some residents discomfort in connection with ay or specific movement or the resident to use the intensity hey are most comfortable e. I impaired resident, the nurse of family as appropriate, or make the resident's behavior and the treatment of pain, include: the prescription and OTC (over ternative treatments such as and cold applications c. specify					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NING	(×		SURVEY LETED
			/ = =			С	
		495355	B. WING				2/2016
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE		
PARECE	RD HEALTH AND REH	AB CENTER	ĺ	700 RANDOLPH STREET			
MULOR	(D TICALITY AND KET	AD CENTER		RADFORD, VA 24141			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BI E APPROPRIA		(XS) COMPLETION DATE
F 280	Continued From pa	nge 31	F 2	280			
		ech site of pain id, record the		•		AAAAAA	
	effectiveness of ea	ch treatment	1			!	
	4. Develop a speci	ific care plan to address all					
		e appropriate treatment for	1	i f		ļ	
	each.		i	-		1	
	6. Utilize the pain a					e de che	
		e planning meetings to)		1	
		uacy of the resident's pain	:				
	appropriate."	revise the plan of care as		1		4	
		ion was provided prior to the				<u> </u>	
	exit conference on					į	
		ff failed to review and revise				COLORIDA A	
		hensive care plan to include					
		al interventions for anxiety for					
	Resident #1.		1	:		1	
	ì	of Resident #1 was reviewed <				3	
		22/16. Resident #1 was	E .	i			
		lity on 5/15/14 and readmitted	:				
		gnoses that included, but not	Ì				
		nigh blood pressure, dementia,		•			Side
		, asthma, and osteoarthritis.				:	
		ecent MDS (minimum data ompleted on this resident was					
	a quarterly assessn					And seems	
		ence date) of 02/22/16. Section		•		·	
		ns) of this assessment scored				,	average and a second
		of a possible 15 points					
		ent was cognitively intact.				į	3
		e resident to understand and	1				
		n section N she was coded to	1				AAAAAA
	have received ant	ianxiety medication.					
	The March and Ann	il 2016 physician order sheet		,		į	
		tablet 0.5 mg (milligram)					
		outh every 24 hours as needed		:			
	for anxiety."	and overy 2 i more do notated				-	
						1	
	The March and Apr	il 2016 medication	1				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	COM	E SURVEY PLETED
		495355	B. WING			1	22/2016
	### A95355 ### OF PROVIDER OR SUPPLIER ### DFORD HEALTH AND REHAB CENTER ### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### Was administration records were reviewed. Reside ## was administred Xanax 0.5 mg on Wednesday 3/23/16 and on Monday 4/18/16 f anxiety. The current comprehensive care plan initiated 12/31/15 read "Resident #1 receives psychotr medication for anxiety and depression; at risk side effects: Interventions; Administer psychotropic medication as ordered. Observe increase s/s (signs/symptoms) of depression anxiety. Notify physician as needed." The current comprehensive care plan did not include any non-pharmacological interventions prior to the use of Xanax. The progress notes for March and April did not have any documentation related to the administration of the xanax. There were no non-pharmacological interventions prior to the administration of the Xanax documented. The surveyor informed the administrative staff the above finding on 4/22/16 at 10:00 a.m. No further information was provided to the surveyor prior to the 4/22/16 exit related to the non-pharmacological interventions. 483.20(x)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facing must meet professional standards of quality. This REQUIREMENT is not met as evidence.			700 R	T ADDRESS, CITY, STATE, ZIP CODE ANDOLPH STREET ORD, VA 24141		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	- Laboratory	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Continued From	page 32	F 28	0			!
	administration red #1 was administe Wednesday 3/23	cords were reviewed. Resident ered Xanax 0.5 mg on	:	- A 500 IN 17 ' A			
	1 2/31/15 read "R medication for ar side effects: Inter psychotropic med increase s/s (sign	esident #1 receives psychotropic exiety and depression; at risk for ventions; Administer dication as ordered. Observe for es/symptoms) of depression and		Average of the second s			
	include any non-	pharmacological interventions		TO THE TAXABLE PROPERTY WHEN THE PROPERTY WHEN T	,u		
	have any docume administration of non-pharmacolog	entation related to the the xanax. There were no gical interventions prior to the		7 8 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
				3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			
F 281 SS=D	surveyor prior to non- pharmacolo 483.20(k)(3)(i) S	the 4/22/16 exit related to the egical interventions ERVICES PROVIDED MEET	F 28	31 1.	Labs for residents #4 and #14 had already been obtained without order. No negative		
				2.	outcome identified. Any resident is at risk if a lab obtained without a physician's order. DON or designee to au	S	
	This REQUIREM	MENT is not met as evidenced	And the second s		labs for current residents obtained as of May 16 th to ensure physicians order.		

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRU		COV	(X3) DATE SURVEY COMPLETED			
		495355	B. WING				C /22/2016
RADFOF	PROVIDER OR SUPPLIER RD HEALTH AND RE		10	700 R	T ADDRESS, CITY, STATE, ZIP CODI ANDOLPH STREET FORD, VA 24141 FROVIDER'S PLAN OF CORRE	ECTION	(XS)
(X4) ID PREFIX TAG	(FACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE PROPRIATE	COMPLETION DATE
F 281	review, and clinical failed to follow propractice for writing residents (Resided The findings included). The facility state order for a BMP of #4. The clinical record 4/19/16 through 4 admitted to the fat that included, but thrive, atrial fibrilla complications type BPH (benign producinary obstruction frequency, cellulial lateral foot ulcer. Resident #4's sige MDS with an assof 3/29/16 coded summary score of The surveyor four 3/21/16 in the election surveyor reviewed 2016 but was uncorder. The surveyor information of the surveyor information order for the surveyor information order for the surveyor information order for the surveyor information or the failure of the BMP on 4/21/16.	terview, facility document al record review, the facility staff ofessional standards of nursing g physician orders for 2 of 26 ont #4 and Resident #14).			DON or designee to education licensed nursing staff of the need to obtain a physician order prior to obtaining a latent Unit Manager or designee audit labs that are obtained (M-F) x4 weeks and weeks weeks to ensure physician order was obtained prior to obtaining the lab. Any discrepancies will be addromorphy and findings will reported to Quality Assuracommittee for review and analysis of findings. 06-02-16	ne 's ab. to d daily ly x8 as essed be	

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		495355	B. WING		04/22/2	2016
NAME OF I	R ONDER OR SUPPLIER	3	1.	STREET ADDRESS, CITY, STATE, ZIP CODE		participate and a second secon
		· · · · · · · · · · · · · · · · · · ·	1	700 RANDOLPH STREET		
RADFOR	D HEALTH AND RE	HAB CENTER		RADFORD, VA 24141	-	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOUL)	NO DBE CO	(%5) IMPLETION
PREFIX TAG		A BUILDING CONN. 495355 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD, VA 24141 MIMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE ATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRIATE	DATE		
F 281	Continued From p	page 34	F 281		:	
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	them.	doi illion aradio ana green te	I		ſ	
		ewed the facility's standard of		1		
			: :			
			1	4 (
	"Verbal orders car	n be taken by licensed nurse,			i	
					and and and and and and and and and and	
				1	•	
	record immediate	ly by the licensed nurse. These			- Yaka	
	orders will be cou	ntersigned by the physician as				
	soon as his/her si	gnature can be obtained."	1			
	No further informa	ation was provided prior to the			1	
	exit conference of	n 4/22/16.			M. Andrewson	
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			and an artist and a state of the state of th		- AMMAL	
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			t 1	; 		
	hyperlipidemia, de	epression, anxiety, anemia,	1			
	gastroesophagea	I reflux disease, enlarged	1			
	prostate, insomni	a, and spondylosis.				
	Resident #14's si	gnificant change in MDS	1			
				:		
	Section C Summ	ary Score.			Accounts to	
	The surveyor revi	ewed the miscellaneous section	ļ		·	
		clinical record. The clinical			Manu personal	
	record revealed t	he results of a urinalysis and a				
	urine bilirubin obt	ained 4/18/16. The surveyor				
	reviewed the Apri	2016 physician orders but was				
		physician orders for the two	į.			
	aforementioned la	aporatory tests.	1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	COMPLETED C		
		495355	B. WING	i		04	V/22/2016
	PRO VIDER OR SUPPLIE			70	TREET ADDRESS, CITY, STATE, ZIP CODE 00 RANDOLPH STREET RADFORD, VA 24141	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	COMPLETION DATE
F 281	a ssistant director a.m. The ADON obtained and the lab will automatic determine the se "The nurse docu having burning u note of 4/18/16. order for the urin from the routine The surveyor rev practice with reg 4/22/16. The po Orders" read "Ve licensed nurse, p physician's verb recorded in the r the licensed nurse countersigned b signature can be During the end of administrative st corporate nurse nurses should w given to them. No further inform exit conference 483.25 PROVID HIGHEST WEL Each resident m provide the neco or maintain the mental, and psy	uested the assistance of the of nursing on 4/22/16 at 8:20 stated when urinalyses are tube has no sex or birthday, the cally do a urine bilirubin to x of the resident. ADON stated mented Resident #14 was pon urination in the progress. The nurse needed to write the alysis. The nurse took the order standing orders." riewed the facility's standard of ard to physician orders on licy titled "Physician's Verbal erbal orders can be taken by charmacist, or physician. All all and telephone orders are nedical record immediately by se. These orders will be y the physician as soon as his/her obtained." If the day meeting with the aff on 4/21/16 at 4:20 p.m., the registered nurse #4 stated yes rite an order when orders are nation was provided prior to the on 4/22/16. E CARE/SERVICES FOR L BEING Thus treceive and the facility must essary care and services to attain highest practicable physical, chosocial well-being, in the comprehensive assessment.		309	1. Resident #1, #3, and #6 h negative outcome identified not having a bowel mover more than 3 days. Reside #15, #12, #4, #14, had not negative outcome identified to non-pharmacological interventions not being proprior to the administration medications.	ed after ment for ints ed due rovided	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY COMPLETED		
ND PLAN O	D PLAN OF C OFRECTION IDENTIFICATION NUMBER:		A. BUILD	ING			c	
			B. WING			04/22/2016		
NAME OF F	PRO VIDER OR SUPPLIER				REET ADORESS, CITY, STATE, ZIP CODI			
					RANDOLPH STREET			
RADFOR	D HEALTH AND REI	HAB CENTER		RA	DFORD, VA 24141)	
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F 309	Continued From p	age 36	F	309				
	Based on staff intaind facility documed facility documed failed to provide in interventions for property of the findings inclusion. The findings inclusion of the facility stander of the clinical reconsistance of the facility of the clinical reconsistance of the facility				 Any resident is at risk if physician's standing order not followed when a patier gone greater than 3 days having a bowel movement Current residents as of Manudited to ensure that physician's standing order followed if resident has go greater than 3 days without bowl movement in the last days. Any resident is at risnon-pharmacological interventions are not used to administering pain medications. DON or destonaudit current patients to audit current patients to audit current patients to audit current patients to administering pair of the prior to administering pair protocol for patients who gone greater than 3 days a bowel movement and of documenting non-pharmacological interventions. DON or designee will audit administering pair medications. DON or designee will audit administerions pair medications. DON or designee will audit administerions. DON or designer interventions. DON or designed will audit 24 hour clinical 	nt has without t. ay 16 th rs one ut a t 30 sk if d prior ignee o ical inted in meds, cate g facility have without on dit 10 ks to nger wel esignee		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			C 04/22/2046		
495355	B. WING	***	04/22/2016		
		700 RANDOLPH STREET RADFORD, VA 24141			
CY MUST BE PRÉCEDED BY FULL			SHOULD BE COMPLETIC		
Aris/16 through 4/10/16 and again hrough 4/20/16. ation with Resident #1 she was als moved regularly. She said "can't remember when I had my reent comprehensive care plant identified that Resident #1 to on to prevent constipation. and in part read "Administer ed, follow RSO (routine standing I (bowel movement) in 3+ days, the record of bowel movements." Ilectronic physician orders read in gnesia Suspension 400 mg (milliliter) (Magnesium 30 ml by mouth every 24 hours constipation Start date 9/14/15." Ilectronic medication ecords (eMARs) were reviewed. In documentation that the ed medication MOM had been by in April 2016. In Movement on 4/22/16. The last: "Provide a record of, and esident's bowel movements to eation. Procedure: ement activity/inactivity is to be oth shift in the CCR software."		daily (M-F) x4 weeks, the weekly x8 weeks to ensemble pharmacological interversare documented prior to administering pain medits. Any discrepancies will be addressed promptly and will be reported to Quality Assurance committee for and further analysis of for 5. 06-02-16	ure non- ntions cations. e i findings ty or review		
	HAB CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RISC IDENTIFYING INFORMATION) Dage 37 1/3/16 through 4/10/16 and again through 4/20/16. ation with Resident #1 she was els moved regularly. She said " can't remember when I had my rent comprehensive care plan is identified that Resident #1 to on to prevent constipation. ed in part read "Administer ed, follow RSO (routine standing A (bowel movement) in 3+ days, ite record of bowel movements."	HAB CENTER TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RUSC IDENTIFYING INFORMATION) Dage 37 1/3/16 through 4/10/16 and again hrough 4/20/16. ation with Resident #1 she was els moved regularly. She said "can't remember when I had my Trent comprehensive care plant of identified that Resident #1 to be fine part read "Administer ed, follow RSO (routine standing of the word in part read "Administer ed, follow RSO (routine standing of the word in 3+ days, the record of bowel movements." Ilectronic physician orders read in genesia Suspension 400 mg I (milliliter) (Magnesium 30 ml by mouth every 24 hours constipation Start date 9/14/15." Decords (eMARs) were reviewed. In a documentation that the ed medication MOM had been by in April 2016. Viewed the facility protocol titled I Movement on 4/22/16. The last: "Provide a record of, and esident's bowel movements to eation. Procedure: ement activity/inactivity is to be ch shift in the CCR software	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) Dage 37 ### Aproach April 20/16 atton with Resident #1 she was also moved regularly. She said "can 't remember when I had my identified that Resident #1 to on to prevent constipation. Bed in part read "Administer ed, follow RSO (routine standing M (bowel movements) in 3+ days, the record of bowel movements." ###################################		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
495355			B. WING		04/22/2016
NAME OF PROVIDER OR SUPPLIER RADFORD HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP (700 RANDOLPH STREET RADFORD, VA 24141	CODE
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		NISHOULD BE COMPLÉTION
F 309	the CCR software occur. 3. Each time a re the results are doc program. Docume bowel movements 4. The charge nu movement status a of the CCR softwar that were triggered movement in the lanurse will create a accordingly. 5. If the resident loy the third day, the resident's orders to or suppository ordefurther orders from indicated, the residential suppository per phywill be documented accordingly."	sident has a bowel movement, umented in the CCR software ntation to include: a. Size of (small, medium, large). It is checks the bowel alerts from the dashboard view to program for any residents for not having had a bowel last three days. The charge laxative /suppository list that has not had a bowel movement to charge nurse checks the make sure there is a laxative er. If not, the nurse will obtain the resident's physician. If lent may be given a laxative or ysician 's orders. If given, it don the resident 's EMAR	F3	309	
	ensure the non- ph	15 the facility staff failed to armacological interventions the administration of pain	The state of the s		
	order that read "No (Hydrocodone-Ace mouth every 6 hou	rsician order sheet included an orco Tablet 5-325 mg taminophen) Give 1 tablet by rs as needed (PRN) for pain." dication administration records wed.	THE RELEASE OF THE PROPERTY OF CHARGE OF CHARG		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C 04/22/2016	
		495355	B. WING		04		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, Z 700 RANDOLPH STREET RADFORD, VA 24141	······································	distance in the engineering	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DÉFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 309	4/11/16 included a #15 has pain; inder Has diagnosis inder pain: End stage reserved. Hypertension, and "Administer pain responsible Encourage position Encourage hand die and elevated to needed. Observed symptoms) of pair physician as needed. A 4/13/16, 15:41 phon-pharmacological #15 nor did it indictivas. The next not 16:52. On 4/14/16 note read: " residente next note at 9 mg, Give 1 tablet opain. PRN medical 4/14/16 16:25: " In back " the next note of pain. PRN medical Hydrogen PRN medi	prehensive care plan initiated a focus area that read "Resident ex finger injured during activity. licating possible presence of enal disease, diabetes. emia. "Interventions: medication as ordered. on changes as possible relief, up on a pillow as ordered. Apply o left hand as ordered and as for increase s/s (signs and nor unrelieved pain. Notify	F3	309			
	1 tablet every 6 ho (complain of pain)	":Norco tablet 5-325 mg, Give ours as needed for pain C/O in his back. " the next note at tablet 5-325 mg, Give 1 tablet					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495355			(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		B. WING	3	0/	C 04/22/20 16	
	NAME OF PROVIDER OR SUPPLIER RADFORD HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 700 RANDOLPH STREET RADFORD, VA 24141	DDE	HZZ(ZV)U
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 309	medication was e On 4/17/16 16:06 back " the next r 5-325 mg, Give 1 for pain. PRN med 4/19/16 10:57 pro states pain is in hiread; Norco tablet 6 hours as needed ineffective There was no door intervention prior to medication for any when Resident #1 The surveyor disc #15's pain medicat of nursing on 4/22 The surveyor requirements of the director of policy titled "Pain to Care Setting" react 1. Assess the resident times as app (electronic medicat Form. 2. Document the lintensity of pain. a pain; however will b. Assist the resident	reeded for pain. PRN ffective. " resident states pain is in his note at 9:12 read; Norco tablet tablet every 6 hours as needed dication was effective. gress notes read: " resident is back " the next note at 12:24 to 5-325 mg, Give 1 tablet every d for pain. PRN medication was sumented non-pharmacological to the administration of the pain of the above dates and time 5 complained of pain. seed the issue of Resident stions with the assistant director /16 at 11:20 a.m. sested the facility policy for pain of nursing on 4/21/16. The Management in the Long Term I in part "Procedure: ident for pain on admission, terly, change of condition, or at propriate. Use the EMR attorn record) Pain Assessment location, quality, duration, and a. Some residents will deny describe feelings of discomfort lent to describe the quality of	F	309		
THE PROPERTY OF THE PROPERTY O	stabbing, burning a will relate pain or o	n such words as throbbing, and aching -c. Some residents liscomfort in connection with y or specific movement or		· ·		1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495355	B. WING		04/22/2016		
	D HEALTH AND RE			STREET ADDRESS, CITY, STATE, ZIP COU 700 RANDOLPH STREET RADFORD, VA 24141			
(X4)∃D PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		HOULD BE	(X3) COMPLETION DATE	
F 309	activity d. Teach scale with which the scale with which the For the cognitively should involve the observations of the reactions. 3. Document preserved by the resident for a medications both the counter) be alto positioning, heat at the treatment by eleffectiveness of each. 4. Develop a speciates of pain and the each. 6. Utilize the pain interdisciplinary can determine the ade management, and appropriate." The failure of the finance	the resident to use the intensity ney are most comfortable—e. Impaired resident, the nurse family as appropriate, or make excited and past treatments utilized the treatment of pain, include: The prescription and OTC (over emative treatments such as and cold applications—c. specify ach site of pain—d. record the ach treatment offic care plan to address all the appropriate treatment for assessments in the planning meetings to quacy of the resident—is pain revise the plan of care as acility to provide non interventions for resident—was discussed with the fon 4/22/16 prior to exit. It tion was provided prior to the 4/22/16. Aff failed to follow physician men Resident #3 had no bowel lays. In diagnoses of, but not	F3				
	arthritis, depressio muscle weakness, shortness of breath the MDS (Minimum	ure, high blood pressure, n, asthma, respiratory failure, difficulty in walking and h. The resident was coded on n Data Set, an assessment RD (Assessment Reference					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495355	B. WING		04	C 04/22/2016	
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, 700 RANDOLPH STREET RADFORD, VA 24141			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	COMPLETION DATE	
F 309	Date) of 2/28/16 Interview for Mer plossible score of coded as requirir sitaff person for de bathing. During the review by the surveyor, had no bowel me 4/12/16 through Unit 2 Manager f has no bowel me Manager gave th physician 's star am. The standing Standing Order' Constipation (No (Milk of Magnesi dose. B. If no re rectal suppositor presence of stoce indicated. D. If enemaix 1 enem physician for furf reviewed the nur medication admit and there were re made by the star the above interviewed the nur medication admit and there were re documented for administrative star the record and I movements documents documents documents of the record and I movements documents documents documents of coded as requiries.	page 42 as having a BIMS (Brief stal Status) score of 15 out of a 15. Resident #3 was also ag extensive assistance from one ressing, personal hygiene and of the clinical record on 4/19/16 at was noted that Resident #3 avements documented from 4/15/16. The surveyor asked or the protocol for a resident that avement for 3 days. The Unit 2 are surveyor a copy of the adding orders on 4/20/16 at 8:10 ag order sheet titled "Routine astated the following" BM for 3 days) A. Give MOM am) 30 cc by mouth x (times) 1 asuits in 8 hours, give Dulcolax by x 1 dose. C. Check for all in rectum. Remove manually if an results in 8 hours, give fleets an E. If no results, notify the an their orders. "The surveyor areses' notes and the resident's anistration record for April, 2016 and documentation or entries and the clinical record as any of antions being given to the anowel movements and the resident service of a my of antions being given to the and the stated, "I looked through and the stated, "I looked through and the stated, "I looked through and the tresident of any bowel are the stated, "I looked through and the tresident and the resident and the resident and the stated, "I looked through and the tresident of any bowel are the tresident and th		309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	NG	(X3) DATE SURVEY COMPLETED		
		495355	B. WING		04/22/2016		
	NAME OF PROVIDER OR SUPPLIER RADFORD HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP COE 700 RANDOLPH STREET RADFORD, VA 24141)E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION		
F 309	Continued From		F3	09			
	The director of numotified of the above Resident #3 on 4 conference. No further inform surveyor prior to 4). The facility stonon-pharmacolog to the administra Resident #12. Resident #12 was 12/7/15 with the firmited to: heart vascular disease disorder, and dellower extremities insomnia. Resident #12 was provided for the extremities in the firmited to: heart vascular disease disorder, and dellower extremities in somnia. Resident #10 was extremities in somnia. Resident #10 was extremities in somnia. Resident #10 was extremities in somnia. Resident #10 was extremities in somnia. Resident #10 was extremities in somnia. Resident #10 was extremities in somnia. Resident #10 was extremities in somnia. Resident #10 was extremities in a was extremited #10 was extremited #	ursing and administrator were ove documented findings on /20/16 in the end of the day ation was provided to the the exit conference on 4/22/16. aff failed to implement gical interventions for pain prior tion of pain medication to sereadmitted to the facility on following diagnoses of, but not failure, anemia, peripheral, high cholesterol, and anxiety pression, bilateral amputation of yet yet yet yet yet yet yet yet yet yet					
	the resident's M (MAR). The sun notes for these of no noted non-ph documented by	(11:33 pm) as documented on fedication Administration Record veyor reviewed the nurses lates and times and there were armacological interventions he staff prior to the Percocet, a pain medication, to					

AND PLAN OF CORRECTION (X1) PROVIDERS OPPLIER CLIA IDENTIFICATION NUMBER: 495355		1 ' '		CONSTRUCTION	COMPLETED		
		495355	B. WING			C 04/22/2016	
	PROVIDER OR SUPPLIER THE HEALTH AND RE			STI	REET ADDRESS, CITY, STATE, ZIP CODE NANDOLPH STREET NDFORD, VA 24141	_ 1 0	412212010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACTION		JLD BE	(X5) COMPLETION DATE
F 309	The care plan date was also reviewed The resident was a Pain " with the foll " Administer pain in phantom pain as a increase in s/s (sig (complaints of) uniphysician as need. The director of nursing notes myself and this. " No further informa surveyor prior to the surveyor prior to the clinical record 4/19/16 through 4/19/16 through 4/19/16 with diagnolimited to anxiety, or etention, left fractional with behing dementia with behins disease, diabete enlarged prostate. Resident #6's sign MDS with an asset of 3/10/16 coded to summary score of Resident #6 was a usually understood Section & Function	ded for 2/5/16, for Resident #12, by the surveyor on 4/22/16. care planned for a focus of "lowing interventions noted on it: medications and medication for orderedObserve for an gns and symptoms) or c/o relieved pain and report to the ed. "rsing was notified of the above gs on 4/22/16 at 2:30 pm. The stated "Let me review the hen I can get with you about tion was provided to the ne exit conference on 4/22/16. If failed to follow the physician's rotocol [Milk of Magnesia 30 ml 4 hours as needed for	F3				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495355				TIPLE CON	C 04/22/2016		
		B. WING					
NAME OF PROVIDER OR SUPPLIER RADFORD HEALTH AND REHAB CENTER				700 RA			TADORESS, CITY, STATE, ZIP CODE NDOLPH STREET ORD, VA 24141
(X4) ID PREFIX TAG			ID PREFI TAG	REFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO TH		ON SHOULD BE IE APPROPRIATE	
F 309	assessed Resident bowel. Resident #6's curre initiated 11/29/12 widentified that Resident as ordification. Intentified that Residentified that Residentified that Resident as ordification and the surplement as ordification as of the April 2016 electron and the April 2016 electron as needed for constitution as needed for constitution as needed for constitution and the past 30 the past two months.	Section H Bladder and Bowel #6 to be always incontinent of ent comprehensive care plan with revisions on 3/15/16 dent #6 received a laxative for eventions listed in part read eras ordered, administer ered for diarrhea, encourage vise indicated, follow RSO rders) for no BM (bowel ays, and keep accurate record	F3	609	DEFICIENCY)		
	used for MDS (min for March 2016 and The March 2016 Bl Resident #6 had no 3/4/16 through 3/8/ and 3/19/16 through documentation reverse.)	ated the BM documentation imum data set) assessments if April 2016. M documentation revealed bowel movements from 16, 3/13/16 through 3/16/16, in 3/27/16. The April 2016 BM caled Resident #6 had no from 4/9/16 through 4/18/16.					
ا	The March 2016 an	nd April 2016 electronic					1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495355		(X2) MUI A. BUILO			(X3) DATE SURVEY COMPLETED C 04/22/2016			
		B. WING						
NAME OF	PROVIDER OR SUPPLIE		L	STR	EET ADDRESS, CITY, STATE, ZIP CODE			
-					RANDOLPH STREET			
RADFORD HEALTH AND REHAB CENTER			:		DFORD, VA 24141			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE	
F 309	Continued From p	page 46	F:	309			:	
	medication admin reviewed. The eN that the physician been administere	istration records (eMARs) were MARs had no documentation ordered medication MOM had dany in April 2016. There were reconstipation administered in						
		nat was an issue. She stated C. Diff (Clostridium difficile) nea.		A HARMONIA AND A SANCTON A SANCTON AND A SANCTON AND A SANCTON AND A SANCTON A SANCTON A SANCTON A S				
·	The surveyor required bowel movements licensed practical	ested the facility's policy for and the facility protocol from nurse #3.						
		med the administrative staff of on 4/21/16 at 4:20 p.m.		The state of the s				
	"Record of Bowel policy read in part monitor, each resi prevent constipation." Bowel movemented each	ewed the facility protocol titled Movements" on 4/22/16. The "Provide a record of, and dent's bowel movements to on. Procedure; ent activity/inactivity is to be shift in the CCR software NAs (certified nursing		The supply and the second seco				
	 When a reside movement during the CCR software occur. Each time a rethe results are docured program. Docume bowel movements The charge numovement status. 	ent does not have a bowel the shift, it is documented in program that one did not esident has a bowel movement, cumented in the CCR software entation to include: a. Size of (small, medium, large). Irse checks the bowel elerts from the dashboard view re program for any residents		The second secon				
~		re program for any residents I for not having had a bowel						

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FOF	ED: 05/12/201 RM APPROVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
	495355		B. WING			C 04/22/ 2016	
NAME OF	PROVIDER OR SUPPLIER	-			TREET ADDRESS, CITY, STATE, ZIP CODE		14/ZZ/ZU10
RADEOE	RD HEALTH AND REH	AD PERTUR			00 RANDOLPH STREET		
10301 (7)	CO TRACTI AND RED	AB CENTER			ADFORD, VA 24141		
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F 309	movement in the last nurse will create a last accordingly. 5. If the resident his by the third day, the resident's orders to or suppository order further orders from tradicated, the resides suppository per physically."	st three days. The charge axative /suppository list as not had a bowel movement charge nurse checks the make sure there is a laxative. If not, the nurse will obtain he resident 's physician. If nt may be given a laxative or sician 's orders. If given, it on the resident 's EMAR	F 3	39			
	assessment with nor interventions for pair. The clinical record of 4/19/16 through 4/22 admitted to the facilit that included, but not thrive, atrial fibrillatic complications type II, BPH (benign prostate urinary obstruction, effrequency, cellulitis, elateral foot ulcer. (a) Resident #4's signate (ARD) of 3/29/10 cognitive summary set.	of for Resident #4. FResident #4 was reviewed 1/16. Resident #4 was you not not not not not not not not not not					

understand others usually and was understood. Resident #4 was assessed to have no behaviors in Section E. Resident #4's pain assessment revealed no scheduled pain medication regimen,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COR 700 RANDOLPH STREET RADFORD, VA 24141			
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F 309	Continued From page	age 48	F 30	9	,		
	did not receive any medications and d non-medication int #4 frequently had period. Resident # of 10.	y prn (whenever necessary) id not receive any erventions for pain. Resident pain during the look back f4 rated his pain level as 8 out					
	order that read "No (Hydrocodone-Ace mouth every 6 hou April 2016 medical (MARs) were revie (as needed) pain n	rsician order sheet included an orco Tablet 5-325 mg etaminophen) Give 1 tablet by ars as needed for pain." The tion administration records awed. Resident #4 received princedications eight (8) times in 16, 4/5/16, 4/9/16, 4/15/16, 4/20/16, and 4/20/16.					
,	12/31/15 included "Resident #4 has of and buttocks." Into medication as order position of comfort	ehensive care plan initiated a focus area that read generalized pain with legs, feet, erventions: "Administer pain ered. Nursing to assist with Observe for increase s/s ms) of pain or unrelieved pain. a needed."			·		
	non-pharmacologic medication admini- (9:44 p.m.). The n back and BLE (bila- next entry dated 4/ medication was eff	gress notes did not reveal cal interventions prior to stration on 4/2/16 at 21:44 ote read "c/o (complained of) ateral lower extremities)." The /3/16 05:41 read "PRN fective." Resident #4 had lone 5-Acetaminophen 325 mg).					
	"Acetaminophen ta	(9:30 p.m.) note read ablet 325 mg Give 1 tablet by irs as needed for pain back and				-	

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER RD HEALTH AND REI		STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD, VA 24141				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	Continued From p	age 49	F 309				
	Tylenol was admin note was written. The 4/15/16 21:38 not include non-ph Resident #4 when back pain. The 4/18/16 21:37 read "C/o (compla no documented no prior to the administ 21:37 (9:37 p.m.) The 4/19/16 at 10: (resident) states pain 10: There were non-pharmacological points with the states paints at 21:37 (9:37 p.m.)	51 progress note read "RSD, ain in his sacrum and back					
	The 4/20/16 08:00 he is having pain in #4 received pain in There were no nor prior to the adminison 4/20/16. The surveyor disconformer one non-pharmacourrent comprone non-pharmacours, #3 stated the "Standards of Practication." One edication.	progress note read "RSD said in his sacral wound." Resident nedication at 8:00 a.m. "In-pharmacological interventions stration of the pain medication assed the current re plan for pain for Resident #4 se #3 on 4/22/16 at 10:00 a.m. ehensive care plan identified allogical intervention for pain. facility wouldn't document stice" on the care plan— what tried prior to the use of example she gave: turning and . #3 stated these would be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		I LAIPO I U
RADFOR	D HEALTH AND REH	AB CENTER			RANDOLPH STREET DFORD, VA 24141		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 309	R. N. #3 stated the R. N. #3 stated interpretation of the content	ent prior to giving medications. facility "charted by exception." eventions might be found in care plan and stated you have problems. The surveyor efacility knew what Resident then would include besides the No answer was given. The stated the facility policy for pain a nursing on 4/21/16. The lanagement in the Long Term in part "Procedure: dent for pain on admission, and, change of condition, or at repriate. Use the EMR ion record) Pain Assessment to describe feelings of discomfort and to describe the quality of such words as throbbing, and aching a c. Some residents is comfort in connection with a representation of the resident to use the intensity ey are most comfortable and the treatment of pain, include: a prescription and OTC (over mative treatments such as ad cold applications a c. specify ach site of pain d, record the	F	309			
	effectiveness of ea	ch neatment					<u>.</u>

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495355 B. WING 04/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 309 Continued From page 51 F 309 Develop a specific care plan to address all sites of pain and the appropriate treatment for each. Utilize the pain assessments in interdisciplinary care planning meetings to determine the adequacy of the resident's pain management, and revise the plan of care as appropriate." The failure of the facility to not offer/use non pharmacological interventions for resident complaints of pain was discussed with the administrative staff on 4/21/16 at 4:20 p.m. No further information was provided prior to the exit conference on 4/22/16. 7). The facility staff failed to complete a pain assessment with non-pharmacological interventions for Resident #14's pain. Resident #14's clinical record was reviewed 4/21/16 through 4/22/16. Resident #14 was admitted to the facility 3/24/14 and readmitted

Section C Summary Score.

7/17/15 with diagnoses that included but not limited to osteoarthritis, hypertension, hyperlipidemia, depression, anxiety, anemia, gastroesophageal reflux disease, enlarged prostate, insomnia, and spondylosis. Resident #14's significant change in MDS assessment with an assessment reference date (ARD) of 7/29/15 assessed the resident with a cognitive summary score of 15 out of 15 in

The current comprehensive care plan dated 2/10/16 identified that Resident #14 assistance needs varied with ADLs (activities of-daily living) due to osteoarthritis (OA); joint replacements. A second focus area read "Resident #14 has

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO: 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED C 495355 B. WING 04/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 309 | Continued From page 52 F 309 diagnosis of OA and chronic pain syndrome, immobility." Interventions/tasks: administer arthritic medication as ordered, administer muscle relaxant as ordered, administer pain medication as ordered, encourage use of brace as ordered, observe for an increase in pain or umrelieved pain and notify the physician as needed. The current comprehensive care plan did not identify any non-medication interventions prior to the administration of pain medications. The April 2016 physician orders included the following: Oxycodone HCL (hydrochloride) tablet 5 mg Give 1 tablet by mouth every 4 hours as needed for pain. The surveyor observed a medication pass and pour on 4/19/16 at 4:50 p.m. with licensed practical nurse #1. Resident #14 complained of stomach "belly" pain and rated the pain an 8 out of 10. L.P.N. #1 proceeded to administer Resident #14 oxycodone 5 mg at this time. There were no non-medication interventions offered prior to the administration of the medication. Resident #14 did however, have a care plan for constipation revised 4/14/16 with 7 interventions identified. The surveyor discussed the issue of Resident #14's pain medications with the assistant director of nursing on 4/21/16 at 7:20 a.m. The surveyor requested the facility policy for pain from the director of nursing on 4/21/16. The policy titled "Pain Management in the Long Term

Form.

Care Setting" read in part "Procedure:

 Assess the resident for pain on admission, readmission, quarterly, change of condition, or at

Document the location, quality, duration, and

other times as appropriate. Use the EMR (electronic medication record) Pain Assessment

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495355	B. WING_			Į.	C /22/2016
	PROVIDER OR SUPPLIER	AB CENTER		700 F	ET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH STREET FORD, VA 24141		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Abstract & seconds	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	pain; however will of b. Assist the reside pain by cueing with stabbing, burning a will relate pain or dicertain times of day activity d. Teach t scale with which the For the cognitively is should involve the fobservations of the reactions. 3. Document preservations both the counter) b. alterpositioning, heat and the treatment by earffectiveness of each. 6. Utilize the pain and the each. 6. Utilize the pain and the each. 6. Utilize the pain and the each. 7. The failure of the farmanagement, and rappropriate." The failure of the farmanacological interministrative staff. No further informatic exit conference on a stable pain and the each.	Some residents will deny lescribe feelings of discomfort ent to describe the quality of such words as throbbing, and aching c. Some residents scomfort in connection with or specific movement or the resident to use the intensity ey are most comfortable e. impaired resident, the nurse amily as appropriate, or make resident's behavior and ent and past treatments utilized the treatment of pain, include: prescription and OTC (over mative treatments such as discold applications c. specify ch site of pain id. record the entreatment for experience the plan to address all appropriate treatment for essessments in explanning meetings to usely of the resident is pain evise the plan of care as cility to not offer/use non erventions for resident was discussed with the on 4/21/16 at 4:20 p.m. on was provided prior to the 4/22/16.	F 30	1	Nurse who disposed of lancet improperly was educated on 4-		
	483.25(h) FREE OF HAZARDS/SUPER\		F 32:	3 :	20-16 regarding proper sharps disposal.	Annual Company	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CLIA (X2) MULTIPLE CONSTRUCTION ER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(X4) 'D PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO	N SHOULD BE	(X5) COMPLETION DATE
F 323	environment rema as is possible; and adequate supervise prevent accidents. This REQUIREMED by: Based on observed document review facility staff failed container during a 1 of 26 residents (The findings including the facility staff fato obtain an accude medication pass a The surveyor observed the surveyor observed the commedication cart. Finger with the land results, then place then put the gloves then disposed of the surveyor interrupon completion of the surveyor interrupon completi	ensure that the resident ains as free of accident hazards deach resident receives sion and assistance devices to ation, staff interview, facility and clinical record review, the to dispose of sharps in a sharps a medication pass that affected (Resident #22), ded: ailed to dispose of a lancet used check on Resident #22 during a land pour observation, erved a medication pass on m. with registered nurse #1. Igned physician orders for April "Accuchecks ac (before meals) or DM (diabetes mellitus)." R.N. dent #22's medication then munity glucometer from the R.N. #1 pricked Resident #22's cet, obtained the blood sugar ed the lancet in the gloves and s in the water cup. R.N. #1 he cup with the lancet in the d to the medication cart. Viewed R.N. #1 immediately of Resident #22's medication	F3	2. Any resident/staff has to potential to be affected or sharps are not disposare properly. 3. DON or designee to edicensed nursing staff or disposal of lancets/shares. 4. Unit Manager or designate randomly observe 5 nurveck x12 weeks disposal ancets/sharps to ensurred disposal of lancet/sharps discrepancies will be accommitted to Quality Assist committee for review are analysis of findings. 5. 06-02-16	if lancets sed of ucate in proper rps. nee to rses a sing of re proper os. Any ddressed vill be urance	
	where lancets sho stated "In the share	ne surveyor asked R.N. #1 ould be disposed. R.N. #1 rps container." rmed the administrative staff of				·

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 0 495355 B. WING 04/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 55 F 323 the above finding on 4/20/16 at 5:50 p.m. The surveyor requested the facility policy for disposal of sharps on 4/21/16. The surveyor reviewed the facility policy titled "Sharps Disposal" on 4/22/16. The policy read in part under POLICY: "A. NO sharps (needles, sharp instruments, razors, broken glass, etc.) are to be discarded in waste baskets, anywhere." Resident #22 was admitted to the facility 4/11/16 with diagnoses that included but not limited to muscle weakness, lack of coordination, diabetes mellitus, hypertension, hyperlipidemia, constipation, and hypothyroidism. Resident #22's admission minimum data set (MDS) assessment had not yet been completed. No further information was provided prior to the exit conference on 4/22/16. 483.25(k) TREATMENT/CARE FOR SPECIAL F 328 F 328 **NEEDS** SS≃D 1. Oxygen sats for resident #6 were The facility must ensure that residents receive unable to be obtained as they proper treatment and care for the following were missed in March, No. special services: negative outcome identified. Injections: Oxygen adjusted to 2 I/min for Parenteral and enteral fluids; resident #2 as soon as it was Colostomy, ureterostomy, or ileostomy care; identified that the oxygen was Tracheostomy care: not on the correct setting. No Tracheal suctioning: negative outcome identified. Respiratory care: 2. Any resident has the potential to Foot care: and be affected if O2 sats are not Prostheses.

by:

This REQUIREMENT is not met as evidenced

for respiratory care were followed for 2 of 26

Based on observation and clinical record review, the facility staff failed to ensure physician's orders

obtained per physician order.

DON or designee will audit
current patients on oxygen as of

May 16th to ensure O2 sats have

been documented as ordered for

the last 30 days. Any resident has the potential to be affected if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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The findings included. The facility staff saturation (O2 sater physician for Resident The clinical record 4/19/16 through 4/19	Int #6 and Resident #2). Ided: If failed to obtain oxygen Is) levels as ordered by the Ident #6. In of Resident #6 was reviewed Ident #6. Ident #6 was reviewed Ident #6 was Ility on 5/16/12 and readmitted Ident ses that included, but not Idepressive disorder, urinary Identification, pain, hypothyroidism, Identification with a cognitive Identification with a cognitive Identification orders read Identification orders read Identification orders read Identification orders with a cognitive Identification orders read Identification orders read Identification orders with a cognitive Identification orders read Identification orders read Identification orders read Identification orders and Vitals Identification administration Identification administration Identification administration Identification administration Identification orders read Identification orders and Vitals Identification administration Identification administration Identification administration Identification orders read	F 328	their oxygen is not on the correct setting. Unit Manager designee to check current patients as of May 16 th to ensi oxygen is on correct setting. 3. DON or designee will educate licensed nursing staff on documenting O2 sats per physician order and on properl setting patient O2 on the corresetting. 4. Unit manager or designee will audit patients on oxygen daily (M-F) x4 weeks, then weekly x weeks to ensure oxygen is documented per physician order Unit Manager or designee will randomly check 5 patients on oxygen weekly x12 weeks to ensure oxygen is set to correct setting. Any discrepancies will be addressed promptly and finding will be reported to Quality Assurance committee for review and further analysis of findings. 5. 06-02-16	ly sot be gs		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)·MULTIPLE CONSTRUCTION A. BUILDING		(>	(X3) DATE SURVEY COMPLETED	
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F 328	stated the staff we results on the eM sometimes in the sometimes on the sometimes on the sometimes on the sometimes on the sometimes on the sometimes on the sometimes on the sometimes of the facility standard cannula at a minute (I/min) for The findings included. The facility standard cannula at a minute (I/min) for Resident #2 was 2/20/16 with the folimited to diabetes chronic obstructive depressive disord On the resident to coded as having a Mental Status) so of 15. The reside extensive assistant for dressing and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotally dependent states and pristotal	els. The director of nursing ill sometimes document the AR or the vitals signs sheet, nurses notes and then a 24 hour sheet. In saturation levels were provided onference on 4/22/16, off failed to administer oxygen by the prescribed rate of 2 liters per Resident #2. In second the prescribed rate of 2 liters per Resident #2. In second the prescribed rate of 2 liters per Resident #2. In second the prescribed rate of 2 liters per Resident #2. In second the prescribed rate of 2 liters per Resident #2. In second the prescribed rate of 2 liters per Resident #2. In second the prescribed rate of 2 liters per Resident #2. In second with an ARD (Assessment of 3/17/16, Resident #2 was a BIMS (Brief Interview for one of 6 out of a possible score int was also coded as requiring ince of 2 or more staff members personal hygiene. Resident #2 into no staff for bathing. In sitting at the nurses is station on the which time the surveyor ident is oxygen setting at 1.5 inula, a linical record review performed in 4/20/16, it was noted that a chated on 3/16/16 stated, "O2 in via (by) nasal cannula.	F3	328			
÷	Licensed practical	nurse (LPN) #2 was asked by	-	1 (

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SS=E	the surveyor on 4/20 make sure the oxyg Resident #2. LPN # portable oxygen tan be at 2 l/min. "LPN the oxygen setting to The administrator and notified of the above 4/20/16 at the end of No further information surveyor prior to the 483.25(l) DRUG REGUNNECESSARY DESEACH	of the day conference on 4/22/16. If the day conference on 4/22/16. If the conference of the existence of the day conference on was provided to the exit conference on 4/22/16. If the day conference on 4/22/16.	F 329				

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	Based on staff into review, and clinical failed to ensure 5 of unnecessary drugs Resident #1, Resident #1, Resident #1, Resident #1, Resident #1, Resident #1, Resident #1, Resident #1, Resident #1, Resident #2, and failed to provide the anxiolytic medication of the non-pharmacologic administration. The the targeted behavior and failed to provide the anxiolytic was a The clinical record #19/16 through #1/2 admitted to the facilithat included, but not thrive, atrial fibrillatic complications type BPH (benign prostaurinary obstruction, frequency, cellulitis, right lateral foot ulco Resident #4's signiff MDS with an assess of 3/29/16 coded the summary score of CR Resident #4 was as usually and was uncomplication and control of the summary score of CR Resident #4 was as usually and was uncomplication and control of the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncomplications the summary score of CR Resident #4 was as usually and was uncompleted the summary score of CR Resident #4 was as usually and was uncompleted to the summary score of CR Resident #4 was as usually and was uncompleted to the summary score of CR Resident #4 was as usually and was uncompleted to the summary score of CR Resident #4 was as usually and was uncompleted to the summary score of CR Resident	erview, facility document record review, the facility staff of 26 residents were free of (Resident #4, Resident #6, lent #9, and Resident #7). ed: failed to monitor Resident #4's e administration of an on Xanax. Resident #4 was (as needed) Xanax without e attempt to use all interventions prior to the efacility staff failed to identify for for the use of the prn Xanax e evidence of monitoring when administered. Of Resident #4 was reviewed (2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident with a cagnitive edema, and sacral ulcer and er. icant change in assessment sment reference date (ARD) resident with a cognitive (1/2/16. Resident with a cognitive (1/2/16. Resident #4 was reviewed (1/2/16. Resident with a cognitive (1/2/16. Resident with a cognitive (1/2/16. Resident with a cognitive (1/2/16. Resident with a cognitive (1/2/16. Resident with a cognitive (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was reviewed (1/2/16. Resident #4 was	F	5.	hour clinical report daily (M-F) weeks, then weekly x8 weeks ensure behavior monitoring an non-pharmacological interventions are attempted pri to administering anxiolytic medications. Any discrepancie will be addressed promptly and findings will be reported to Quality Assurance committee freview and further analysis of findings.	x4 to d ior s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 329	The April 2016 phy "Xanax tablet 0.25 Give 1 tablet by more for anxiety." The April 2016 pro Resident #4 was a (milligrams) six (6) days: 4/2/16, 4/5/2 and 4/18/16. The current comproduction for depthrive, anxiety, and effects." Intervent medication as order (signs/symptoms) Notify physician as The current comprinclude any non-phyrior to the use of the current comprinciple and the current comprise and the current comprise and the current current comprise and the current comprise and the current comprise and the current current comprise and the current comprise and the current current comprise and the current cur	rsician order sheet read in part mg (milligram) (Alprazolam) outh every 6 hours as needed gress notes were reviewed. Idministered Xanax 0.25 mg times in April on the following 16, 4/9/16, 4/15/16, 4/17/16, rehensive care plan initiated sident #4 receives psychotropic ression with adult failure to hisomnia, at risk for side tions "Administer psychotropic red. Observe for increase s/s of depression and anxiety." Inherence are plan did not harmacological interventions Xanax. 10:22 p.m.) progress note read in ineffective. Xanax 1 tablet hours as needed for anxiety." Is administered at 22:15 (10:15 no non-pharmacological to the administration of the Redirection ineffective."		9		
	read "Xanax 0.25 r	(10:27 p.m.) progress note ng Give 1 tablet by mouth seded for anxiety. Anxiety,				

BTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 329	standing @ (at) be doesn't need anythe with anxiety, denied administered Xan p.m.). Resident # a non-medication. The surveyor review monitoring of Residents record did contain antidepressant menomonitoring for Xanax-an antianx. The facility staff fabehavior for Residentary for Residents record and the potential for medications. The surveyor review "Anxiolytics" on 4/ "Residents receive the intendand the potential for medication is door medical record and for the resident. 3 therapy is initiated.	help me while nurse is edside resident stated he ching, increased restlessness as pain." Resident #4 was ax 0.25 mg at 22:27 (10:27 f4 medicated without the use of intervention. ewed the clinical record for ident #4's behavior. The clinical monitoring for Resident #4's edication but the surveyor found the use of the prin medication iety medication. alled to identify the targeted dent #4's Xanax use, failed to rior and failed to incorporate ical interventions prior to the	F	29				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 329	and the presence Non-pharmacologic belin nursing notes in resident care plant reviewed by the phassessing the resident or, if nursiwarranted, in the oresident or other stresident or other stresident or other stresident's best interesident's best interesident's best interesident's best interesident's prior to the anxiolytic medication of the att non-pharmacologic administration. The targeted behavior prior to the anxiolytic was administration. The targeted behavior prior to the anxiolytic was administration. The targeted behavior prior to the anxiolytic was administration. The targeted behavior prior to the anxiolytic was administration. The targeted behavior prior to the anxiolytic was a The clinical record 4/19/16 through 4/2 admitted to the fact 3/2/16 with diagnost limited to anxiety, or retention, left fractuleart failure, constituted to the fact anxiolytic with behaviors disease anemia, and enlarged and enlarg	of adverse effects. C. ic behavioral modification effects, as well as the effect of navior modifiers, are addressed the resident's chart and in the ning. These records are systician in the process of dent's response to therapy. 5. ons ordered on a "prn" basis only at the request of the ng judgement indicates it is asse of a non-communicative tuation where its use is in the rest." I failed to monitor Resident #6's e administration of an an Ativan. Resident #6 was (as needed) Ativan without any empt to use all interventions prior to the effacility staff failed to identify for for the use of the prn Ativan e evidence of monitoring when administered. Of Resident #6 was reviewed 22/16. Resident #6 was reviewed 22/16. Resident #6 was lity on 5/16/12 and readmitted ses that included, but not epressive disorder, urinary red humerus, congestive pation, pain, hypothyroidism, ovioral disturbances, et diabetes mellitus type II,	F 32	29		

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	MDS with an asses of 3/10/16 coded to summary score of Resident #6 was as usually understood. There were no issuant Section E. Resident #6's curred initiated 11/29/12 wordentified cognitive diagnosis of demer Interventions: assist (speech therapy) as #6 to make decision provide a consistent also received psychamiciately and depress dementia with behalfocus area: Adminitiately and depression of anxiety and depression of anxiety and depression of anxiety and depression of anxiety and deserved increase in reported depression or anxiety and report to the physicis side effects and represent and report to the physicis and report to the phy	sement reference date (ARD) he resident with a cognitive 04 out of 15 in Section C0500. In Seessed with speech clarity, and usually understands, es documented for behaviors on 2/8/16 behavior as a focus due to the history of behaviors. In the start as needed, consult ST is needed, encourage Resident in a daily regarding care, and the environment. Resident #6 totropic medications due to sion; at risk for side effects; viors. Interventions for the ster psychotropic medication edical doctor) and pharmacy of medical doctor) and pharmacy of medical doctor) and attempt reduction) as indicated entraindicated, observe for an exist (signs/symptoms) of the ster psychotropic medicated effects and attempt reduction) as indicated entraindicated, observe for an exist (signs/symptoms) of the physician as needed, observe for ort to the physician as side effects such as side effects such as side effects such as side effects and dyskinesia ysician as needed.	F	329			
-	include interventions	care plan dated 3/15/16 did for Resident #6's confusion; no non-pharmacological tiety.		The second secon	·	TENTO - ASSESSMENT ASSESSMENT	-

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUI A. BUILD	ETIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 329	"Ativan tablet 0.5 by mouth every 4 agritation/anxiety." The April 2016 me identified Resider 4/4/16, 4/7/16, 4/8/16 a April. There was no doo progress notes the behavior that Reside non-pharmacolog administration of administration of administration of administration of administration received and residency anxiety/omonitored and residency anxiety/omonitored and residency document fit Date-03/25/16 19 reviewed all entrie found check mark boxes for both the and the 7:00 p.m.	hysician order sheet read in parting (Lorazepam) Give 1 tablet hours as needed for edication administration record at #6 received Ativan on 4/3/16, 8/16, 4/10/16, 4/11/16, 4/15/16, and 4/20/16-ten (10) times in edication in the April 2016 hat identified the targeted ident #6 exhibited prior to the the Ativan. There was no any of the April 2016 progress at #6 was offered ical interventions prior to the	F3	329			
		dence in the progress notes to Ativan. There was no	_				

PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495355 B, WING 04/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 Continued From page 65 F 329 evidence in the clinical record of any targeted behaviors the Ativan had been administered to control, no non-medication intervention prior to the use of the Ativan, and no follow-up after the Ativan had been administered. The surveyor informed the administrative staff of the above finding on 4/21/16 at 4:20 p.m. The surveyor requested the facility policy on anxiolytic mredications. The surveyor reviewed the facility policy titled "Anxiolytics" on 4/22/16. The policy read in part "Residents receive anxiolytic medications only when medically necessary. Every effort is made to ensure that residents who use anxiolytics receive the intended benefit of the medications and the potential for unwanted effects is minimized. Procedure 1. The reason for the medication is documented in the resident's medical record and included in the care planning for the resident. 3. Monitoring: When anxiolytic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and the presence of adverse effects. C. Non-pharmacologic behavioral modification activities and their effects, as well as the effect of pharmacologic behavior modifiers, are addressed in nursing notes in the resident's chart and in the resident care planning. These records are reviewed by the physician in the process of assessing the resident's response to therapy, 5.

resident's best interest."

Anxiolytic medications ordered on a "prn" basis are administered only at the request of the resident or, if nursing judgement indicates it is warranted, in the case of a non-communicative resident or other situation where its use is in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 329	exit conference on 3. The facility staff in on-pharmacologic Resident #1. The clinical record 4/19/16 through 4/2 admitted to the facilion 12/1/14 with diadirmited to anemia, hanxiety, depression Resident #1 most in set) assessment refere C (cognitive pattern the resident 14 out indicating the reside Section B coded that to be understood. In have received antic The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March and Apread in part "Xanax (Alprazolam) Give 1 hours as needed for The March	from was provided prior to the 4/22/16. failed to provide ral interventions for anxiety for of Resident #1 was reviewed 22/16. Resident #1 was lity on 5/15/14 and readmitted gnoses that included, but not high blood pressure, dementia, a sethma, and osteoarthritis. ecent MDS (minimum data empleted on this resident was nent with an ARD race date) of 02/22/16. Section as) of this assessment scored of a possible 15 points ent was cognitively intact, are resident to understand and a section N she was coded to anxiety medication. Til 2016 physician order sheet tablet 0.5 mg (milligram) tablet by mouth every 24 ranxiety."	F3	29			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED C495355 B. WING 04/22/2016 NAME OF PROVIDER OR SUPPLIFE STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION m (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 | Continued From page 67 F 329 anxiety. Notify physician as needed." The current comprehensive care plan did not imclude any non-pharmacological interventions prior to the use of Xanax. The progress notes for March and April did not have any documentation related to the administration of the xanax. There were no non-pharmacological interventions prior to the administration of the Xanax documented.

The surveyor reviewed the facility policy titled "Anxiolytics" on 4/22/16. The policy read in part "Residents receive anxiolytic medications only when medically necessary. Every effort is made to ensure that residents who use anxiolytics receive the intended benefit of the medications and the potential for unwanted effects is minimized. Procedure 1. The reason for the medication is documented in the resident's medical record and included in the care planning for the resident. 3. Monitoring: When anxiolytic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and the presence of adverse effects. C. Non-pharmacologic behavioral modification activities and their effects, as well as the effect of pharmacologic behavior modifiers, are addressed in nursing notes in the resident's chart and in the resident care planning. These records are reviewed by the physician in the process of assessing the resident's response to therapy. 5. Anxiolytic medications ordered on a "prn" basis are administered only at the request of the

resident or, if nursing judgement indicates it is

The surveyor informed the administrative staff of the above finding on 4/22/16 at 10:00 a.m.

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STATEMEN	T OF DEFICIENCIES	(X4) PROVINCE PROPERTY.	T		<u>— ОМВ ИС</u>	<u>. 0938-039</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	ECONSTRUCTION		TE SURVEY MPLETED
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F 329	resident or other s resident's best inte	case of a non-communicative illustion where its use is in the erest."	F 329			
	surveyor prior to the non-pharmacology. The facility staft non-pharmacological administration of A Resident #9 was resident #9 was resident #9 was resident #9 was resident #9 was continuous for more staff members on a possible score of 1 coded as requiring or more staff members on all hygiene a During the review of Administration Recisurveyor noted that "Ativan 0.5 mg (mill every 24 hours as resident #9 more staff members on a possible score of 1 coded as requiring or more staff members on a possible score of 1 coded as requiring or more staff members on a possible score of 1 coded as requiring or more staff members on a possible score of 1 coded as requiring or more staff members on a possible score of 1 coded as requiring the review of 1 tablet by more and 8 pm on 4/13/1 The surveyor review Resident #9 for 4/13 for pharmacological staff of the surveyor sed befores the staff of the surveyor review Resident #9 for 4/13 for pharmacological staff of the surveyor sed befores the surve	failed to use cal interventions prior to the ativan for Resident #9. eadmitted to the facility on llowing diagnoses of, but not ure, coronary artery disease, od pressure, anxiety, holesterol and muscle annual MDS (Minimum Data at protocol) with an ARD rence Date) of 2/22/16, oded as having a BIMS (Brief all Status) score of 14 out of a 5. The resident was also the extensive assistance of 1 pers for dressing, toilet use,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	CIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 329	The surveyor also updated care plar #9 on 4/19/16. The some of the focus interventions to be psychotropic med as ordered. Obsesymptoms of or cofor side effects relimedications and needed. Physician needed. Physician needed to review. There were no no noted on the care. On 4/19/16 at the administrator and of the above docuas ked the director non-pharmacologisthe staff prior to the Ativan that was given about this. "No further informas urveyor prior to the surveyor prior to the	reviewed the most recent adated for 2/26/16 on Resident he care plan listed. "Anxiety" is areas with the following e followed, "Administer fications and sleep medication erve for an increase in amplaints of anxiety Observe ated to psychotropic direport to the physician as an and Pharmacy consultants as medications regularly" in-pharmacological interventions plan as well. end of the day conference, the director of nursing were notified mented findings. The surveyor of nursing what cal interventions were used by a administration of the "prn" wen to Resident #9 on 4/13/16 ctor of nursing stated, "I'll in notes myself and get back to tion was provided to the ne exit conference on 4/22/16.	F 32	29			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
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F 329 F 332 SS≃E	assistance of 1 state to ilet use and person During the review of Administration Reconsurveyor noted that Ativan 0.5 mg (milling every 6 hours as nearesident was given dates and times, as 4/6/16 at 1931 (7:3 pm), 4/9/16 at 1609 (8:24 pm), 4/13/16 at 2035 (8:35 pm), 4/1 4/18/16 at 1900 (7 pm). The surveyor review Resident #7 for the times that the Ativan non-pharmacological being used befor prin " (as needed) A and times by the state of the above documn asked the director of non-pharmacological the staff prior to the Ativan that was give documented dates a nursing stated, "I'myself and get back No further informatic surveyor prior to the 483.25(m)(1) FREE	as requiring extensive f member with bed mobility, anal hygiene. If the April 2016, Medication and of Resident #7, the the resident was given " gram) Give 1 tablet by mouth beded for anxiety". The the Ativan on the following documented on the MAR, " I pm), 4/7/16 at 2046 (8:46 (4:09 pm), 4/10/16 at 2024 at 2014 (8:14 pm), 4/14/16 at 5/16 at 2045 (8:45 pm) and amount." I wed the nurses ' notes of above documented dates and a was given. There were no all interventions documented the the administration of the " ativan dose on these dates aff. and of the day conference, the frector of nursing were notified ented findings. The surveyor of nursing what all interventions were used by administration of the " prn" and to Resident #9 on above and times. The director of and times. The director of and times. The director of and times. The director of and times. The director of and times to review the notes and times. The director of and times to review the notes and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times. The director of and times to review the notes and times to review the notes and times. The director of	F 33		nen

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This REQUIREMED by: Based on observate document review, a facility staff failed to rate of less than 5% 33 opportunities for 21.21% that affects #21, Resident #22, #8). The findings included 1. The facility staff #21's medication was administered Metforwithout food. R.N. Metformin per their administer with food The surveyor observation with 4/19/16 at 4:18 p.m. medications for Resideations administer Metformin 1000mg, Prilosec 40 mg, and medications were a water. The surveyor reconnadministered with the for April 2016. The manufacturer's production of nursing of the manufacturer's Metformin, received pharmacist, read in	NT is not met as evidenced tion, staff interview, facility and clinical record review, the ensure a medication error 6. There were 7 errors out of a medication error rate of a 4 of 26 residents (Resident Resident #23, and Resident at the meals. Resident #21 was rmin 1000 mg (milligram) #1 failed to administer manufacturer's instructions to	F 33	outcome was identified fresident #8 when resident was not held shut after administration of eye drowhen Voltaren gel was napplied per physician ordinegative outcome identification of Nasa 2. Any resident is at risk of medications are not administration of Nasa 2. Any resident is at risk of medications are not administration of Nasa 3. DON or designee will edicensed nursing staff regiollowing physicians order administering medication 4. Unit Manager or designer randomly observe 5 nursimedication passes week weeks to ensure that medications are administration passes week weeks to ensure that medications are administration passes will be add promptly and findings will reported to Quality Assur committee for review and analysis of findings. 5. 06-02-16	ops or look ops or look ops or look of look of look ops or look ops or look ops or look ops or look ops of look ops of look ops ops ops ops ops ops ops ops ops ops		

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F 332	combination with a sulfonylurea) or ins (regular-release tal Initially, 500 mg (m daily or 850 mg po The evening meal served by 4:25 p.m. R.N. #1 stated in a package labeling he package the medic read to administer. The surveyor interviacility's contract pla.m. Other #4 state recommendations on 4/19/16 and 4/21 Resident #21 was a with diagnoses that systolic heart failure hypertension, atrial reflux disease, and 3. No further informatic exit conference on 2. The facility staff of #22's medication wadministered Metfo without food. R.N. Metformin per the madminister with food the surveyor obserpour observation with 4/19/16 at 4:28 p.m. medication for Resiperformed an accurate and the surveyor observation with a surveyor observation for Resiperformed an accurate and the surveyor observation of the surveyor observation for Resiperformed an accurate and the surveyor observation of the surveyor observation for Resiperformed an accurate and the surveyor observation of the surveyor observation accurate and the surveyor observation accurate and the surveyor observation accurate and the surveyor observation accurate and the surveyor observation accurate and the surveyor observation accurate and the surveyor observation accurate and the surveyor observation accurate accurate and the surveyor observation accurate and the surveyor observation accurate accurate and the surveyor observation accurate	in insulin secretogue (e.g., sulin: Oral dose plets or oral solution): Adults: illigrams) po (by mouth) twice once daily, given with meals." on the skilled unit had not been on 4/19/16. In interview on 4/20/16 that the ad not been read. The ations were removed from Metformin with food. Hewed other #4 (one of the narmacist) on 4/20/16 at 10:03 and the manufacturer's state "Give with food." In the medication observation of the narmacist of the national state administrative staff of the narmacist of the national state of the	F :	332			

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B + D 5 D B	in the Atmatematical States	AD OFFICE		700 RA	NDOLPH STREET		
RADFOR	RD HEALTH AND REH	IAB CENTER		RADF	ORD, VA 24141		
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E 332	Continued From pa	voa 73	F3	122			
1 332	•	_	i fa	132			Ì
		nciled the medications	:	, and the second			1
,		he physician's signed orders	***				
		surveyor requested the	i i	i			1
		duct information from the	ļ	i			i
		on 4/20/16 at 10:10 a.m. s product information for					1
		d from the facility's contract	! ! !	İ			à E
		part "For treatment of type 2	e e	-			
		for monotherapy or for use in	4				
		n insulin secretoque (e.g.,	İ				i
	sulfonylurea) or ins	9 \ 9.					
		olets or oral solution): Adults:	and the same of th				8 8 F
		illigrams) po (by mouth) twice					and the state of t
		once daily, given with meals."		į.			1
		on the skilled unit had not been	1	Acceptance			:
	served by 4:32 p.m		İ				
		n interview on 4/20/16 that the					
	package labeling h	ad not been read. The					
		ations were removed from					A A A A A A A A A A A A A A A A A A A
	read to administer	Metformin with food.		Anna			
	The surveyor interv	riewed other #4 (one of the					
	facility's contract pt	narmacist) on 4/20/16 at 10:03					
	a.m. Other #4 state	ed the manufacturer 's					
	!	state "Give with food."		Î			
		ned the administrative staff of	į	1			2000
		g the medication observation					
		0/16 on 4/20/16 at 5:50 p.m.					
		admitted to the facility 4/11/16		*			
		t included but not limited to					
		lack of coordination, diabetes					5
	mellitus, hypertens						
		ypothyroidism. Resident #22's		ļ			too room in
	t .	n data set (MDS) assessment					
	had not yet been co						The second second
		ion was provided prior to the	i				The state of the s
	exit conference on		-			-	1
		failed to administer Resident					
	#23's with meals. I	resident #25 was ormin 1000 mg (milligram)		1			
	; aurimisereu weno	rimir (900 mg (miligram)					<u> </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
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F 332	Continued From p	age 74	F 332			1	
	without food. R.N Metformin per the administer with food. The surveyor observation via 4/19/16 at 4:40 p.r. medications for Rewere Metformin 50 and Glimperide 2 administered at 4:2 administered with The surveyor reconstructurer administered with for April 2016. The manufacturer's prodirector of nursing The manufacturer's prodirector of nursing The manufacturer' Metformin, receive pharmacist, read in diabetes mellituse combination with a sulfonylurea) or insulfonylurea) or insulfonylurea or ins	. #2 failed to administer manufacturer 's instructions to od. erved a medication pass and with registered nurse #2 on m. R.N. #2 prepared three (3) esident #23. The medications 00 mg, Vitamin D3 1000 units, mg. The medication was 48 p.m. The medication was a cup of water. Incided the medications the physician's signed orders esurveyor requested the oduct information from the on 4/20/16 at 10:10 a.m. is product information for the facility 's contract in part "For treatment of type 2 for monotherapy or for use in minsulin secretogue (e.g., sulin: Oral dose blets or oral solution): Adults: hilligrams) po (by mouth) twice once daily, given with meals." on the skilled unit had not been in on 4/19/16. Vailable for an interview on viewed other #4 (one of the pharmacist) on 4/20/16 at #4 stated the manufacturer 's state "Give with food." med the administrative staff of the medication observation 0/16 on 4/20/16 at 5:50 p.m. admitted to the facility 2/18/16	. 332				
	with diagnoses tha muscle weakness,	t included but not fimited to diabetes mellitus,					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 332	hypertension, hyperhypothyroidism. No further informate exit conference on 4. (a) The facility s#8 in the use of Nafacility staff failed to eye drops were ad keep the eyelids get to Resident #8. (d) Tadminister physiciato Resident #8. The surveyor obsepour observation won 4/20/16 beginning prepared the follow #8: Escitalopram 150 mg, Tamsulosim 25 mg, Ativan 0.5 mg, Ativan 0.5 mg, Ativan 0.5 mg, Ativan 0.5 mg, Ativan 0.5 mg,	tion was provided prior to the 4/22/16. Staff failed to instruct Resident isacort nasal spray. (b) The compress the tear duct after ministered for one minute or to ently closed for three minutes. The facility staff failed to apply physician ordered location for the facility staff failed to an ordered Ocean Nasal Spray rived a medication pass and with licensed practical nurse #6 and at 8:10 a.m. L.P.N. #6 wing medications for Resident 10 mg (Lexapro), Nitrofurantoin (Flomax) 0.4 mg, Metoprolol mg, Levemir flex pen 35 units, and say, Sodium Chloride onic) eye drops (Muro 128) and 1%. Bered the medications to 8 a.m. L.P.N. #6 administered sacort nasal spray into each of strils. Prior to the see Nasacort, L.P.N. #6 failed to 8 to blow her nose as an the manufacturer's arecommendations for any, requested from the director read in part "Patient e: Using the Spray: 6. Gently		332		
		nstruct Resident #8 to blow				

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				R/	ADFORD, VA 24141		
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F 332	Continued From p	áge 76	. F3	132			
		ff failed to compress the tear	1	į			
		os were administered for one					
		ed Resident #8 to keep her					and the same of th
	eyelids closed for		Í				
		one (1) drop of Sodium					,
		ic (hypertonic) eye drops (Muro		į			
		f Resident #8's eyes. After the	1	-			
		en administered to Resident #8,	•				
		ssue and dabbed the corners of	i F				
		tear duct briefly, L.P.N, #6	1	!			
	failed to press the	tear duct for 1 minute after the	i į				
	medications were	administered or Instruct	i I				
	Resident #8 to kee	ep eyes closed for	1	1			
	approximately thre	e minutes.	İ	1			
		ed by the facility's contract		LAW STATE OF THE S			
*		ed 4/22/16 read "If the_	i •	ļ			
		e potential to produce systemic		ĺ			
		ssure should be applied to the	ļ				1
	1	for 30-60 seconds."	1	1			
		mation was obtained from the					
		Manual and read under		-			DOM:
		stration: "Eye Contact: The					
		he dropper, must make full		į			
		onjunctival sac and then be					
		ye when the resident closes		!			
		fficient Contact Time: The eye					
		the eye for a sufficient period					
:		next eye drop is instilled. The					
		e drop absorption is	İ	!			
	approximately 3 to	5 minutes. (It should be		i			
	encouraged that w	then the procedures are	1	1			
		effects of eye medications can ssing the tear duct for one					
		rop administration or by gentle	4				
		proximately three minutes after				,	The second
1		-	1				:
	the administration	-		Police of	-		<u>[</u>
	(c) The facility stat	f failed to apply Voltaren gel to		ļ			The state of the s
		red location for Resident #8.	! .		•		

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F 332	Continued From p	page 77	, F3	332		
	with licensed prace 8:10 a.m., L.P.N.; she wanted the Vo#8 stated left knee	ation pass and pour observation tical nurse #6 on 4/20/16 at #6 asked Resident #8 where oltaren Gel applied. Resident e. L.P.N. #6 applied Voltaren at #8 's left knee and both				
	administered with orders. Resident: Voltaren: "Voltare transdermally two Administer 2 gm ((twice a day) and)	nciled the medications the signed April 2016 physician #8's physician orders read for n Gel 1% Apply 1 application times a day to elbows. grams) topically to elbows bid Voltaren Gel 1%-Apply 1 ermally two times a day for pain				
		as applied to the left knee and ring the medication pass.		:		
	#6 when the medicompleted at 9:35	viewed licensed practical nurse cation pass had been a.m. She reviewed the order uld let the physician know and fed.				
	Nasal Spray to Re	f falled to administer Ocean sident #8 on 4/20/16 during the nd pour observation.				
American services and the services are the services and the services and the services and the services and the services and the services and the services are the services and the services and the services are the services and the services are the services and the services are the services and the services are the services and the services are the services are the services and the services are the services and the services are t	administered with surveyor identified spray that read " (Nasal Moisturizer	liation of the medications the medications ordered, the a physician order for nasal Docean Ultra saline Mist Solution Combination) 2 spray in both a day related to Allergic				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION		E SURVEY MPLETED
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F 332	Continued From (page 78	F 33:	2			1 1 1
		o administer the Ocean Nasal medication pass and pour when erved.					
	9:35 a.m. L.P.N.	rviewed L.P.N. #6 on 4/20/16 at #6 stated she realized she didn ' back and gave them after the		S comments of the second secon			
		not observe L.P.N. #6 ean nasal spray during the and pour.		And a comment of the			
	the medication pa	rmed the administrative staff of iss and pour concerns during meeting on 4/20/16 at 5:50		The state of the s	un.		
an and an and an an an an an an an an an an an an an	The surveyor requiredication admin	uested the facility policy on istration.					
	Medication Admin "4. Open the med book/eMAR to the the first medicatio responsible for no Medication Admin 5. Read the label the medication. If	General Guidelines for istration" read in part: ication administration appropriate resident and note in to administer. The nurse is sting: a. Any changes on the istration record (MAR), three times before preparing the medication for proper		Albert 17		The second secon	
F 371 SS=F	exit conference or 483,35(i) FOOD F	1	F 371		The air vents in the kitchen were cleaned on 4-20-16. Boxes and)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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considered satisfact authorities; and (2) Store, prepare, under sanitary cond	om sources approved or tory by Federal, State or local distribute and serve food litions	F 37	carton of milk on freeze were removed on 4-19- pan that was wet was re from the clean dishes at back for cleaning on 4-1 The trash can at the end tray line had a lid placed 4-19-16. Expired hotdog were removed on 4-19- refrigerators that were ic as dirty were cleaned on 16. Applesauce that was	16. The emoved nd placed 9-16, d of the fount on it on the fount of th		
by: Based on observatifacility document reto store, prepare an sanitary manner in tin the pantry refriger. The findings include 1. The initial tour of 4/19/16 at 10:10 am a tour of the kitchen that the ceiling air verefrigerators and free the walk-in-freezer b sitting on the floor. To carton of milk sitting the floor. Multiple pans were of dietary manager statistorage rack. The panother. The surveyor to pick up the individing			labeled was removed from refrigerator on 4-20-16. 2. Any resident is at risk if the not cooked and stored in sanitary manner. Dietary manager audited refriger the center to ensure they clean and food prepared kitchen is labeled with its contents. 3. Dietary manager or designed educate dietary staff on a policy for food storage, and sanitat practices in the kitchen. 4. Administrator or designed inspect the kitchen week weeks to ensure that food labeled and stored proper clean dishes are stored pland proper sanitation is be practiced. Dietary managed designee to audit common refrigerators daily (M-F) x weeks, then weekly x8 weeks, then weekly x8 weeks.	food is a a rators in / are by the gnee to center lean ion e to ly x12 d is rly, roperly, reing er or n area 4		

DEPAR TMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/12/20-FORM APPROVE STATEMENT OF DEFICIENCIES OMB_NO. 0938-035 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (D PROVIDER'S FLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 371 Continued From page 80 F 371 table was a large black trash can without a lid. ensure refrigerators are clean and the food placed in them is The dietary manager took the surveyor to the dry labeled properly. . Any storage area. Lying on the floor was paper and discrepancies will be addressed an individual package of crackers. There were no promptly and findings will be dates listed on the powdered cake icing, turkey reported to Quality Assurance gravy mix or brownie mix. The surveyor asked committee for review and further how the rotation of the dry food was done without analysis of findings a date. She said as the supplies came in they 06-02-16 were rotated back to front. However, there were no dates to determine if this process was being followed by the staff. It was also noted on the bread rack there were 2 packages of hot dog buns that had expired dates of use on them. On 4/20/16 at 11:25 am, the surveyor returned to the kitchen and asked the cook to check the tray line temperatures. The temperatures on the tray line were maintained at 140 degrees and greater. However, the cook leaned the food thermometer against the wall of the pan that contained pork chops and quickly removed it as the surveyor stepped closer to the tray line. As the cook served the food on to the plates she let the gravy ladle touch the pork chops and she used the ladle to mash the potatoes down and then poured the gravy over the top. The surveyor also noted that the cook spilled gravy into a bowl of corn sitting on a plate then using her gloved hand wiped the gravy off the dish edge. The bowl still had gravy mixed in the corn. The surveyor informed the dietary manager who had the bowl replaced. On 4/21/16 at 4:20 pm, the administrator, director

kitchen.

of nurse and other administrative staff were informed of the issues and concerns found in the

The surveyor reviewed the facility policy titled

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/20: CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE STATEMENT OF DEFICIENCIES OMB NO. 0938-039 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED C495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PRÉFIX 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 371. Continued From page 81 F 371 "Food and Supply Storage" on 4/21/16. The policy read in part "Food and supplies will be stored under sanitary and secure conditions according to approved State and Federal standards. Procedure 1. Food service products will be placed in appropriate storage areas that have been designated for each product. All storage areas should be well-lit, well ventilated. clean, dry and organized. Appropriate temperatures must be maintained. Attachment a Food and Supply Storage Guidelines for Leftovers 1. Leftovers must be labeled, dated, and stored in NSF (National Sanitation Foundation) approved containers, zip lock bags or wrapped in plastic wrap. They can be frozen or refrigerated." Prior to exit on 4/22/16 the surveyor was not provided further information related to the above issues 2. The facility staff failed to ensure food delivered from the kitchen to the "Resident Designated Refrigerators" was labeled and the refrigerators in all three designated "resident refrigerators" were clean. The surveyor observed the refrigerator in the "The Parlor" on 4/19/16 at 3:40 p.m. The surveyor noted an accumulation of liquids on the bottom shelves just above the pull-out drawers. The surveyor toured the facility with the maintenance director on 4/20/16 beginning at10:33 a.m. "The Parlor"s resident designated refrigerator was checked. The surveyor observed fourteen (14) covered bowls of food. The bowls

were dated but none contained a label that identified the contents of the bowl. The cover on the bowls was not clear; therefore, the contents of the bowls could not be seen. The surveyor also

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) D	(X3) DATE SURVEY COMPLETED	
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	area on the botton. The surveyor and the "Resident Des Twelve Oaks day recontained twelve (no label on the bowas not clear; ther could not be seen. The surveyor and designated for the an accumulation of shelf. The surveyor aske which department of the refrigerator. The dietary." The surveyor interveyor interveyor that came from an ager stated statement of the refrigerated the daily. The dietary moften spilled food an out of the refrigerate the dietary policy or items and the clean out of the refrigerate the dietary policy or items and the clean The surveyor review "Food and Supply Spolicy read in part "I stored under sanital according to approvistandards. Proceduril be placed in apphave been designate storage areas shouldean, dry and organtemperatures must be contained and supply storage areas shouldean, dry and organtemperatures must be contained and supply storage areas shouldean, dry and organtemperatures must be contained and supply storage areas shouldean, dry and organtemperatures must be contained and supply storage areas shouldean, dry and organtemperatures must be contained and supply supply storage areas shouldean, dry and organtemperatures must be contained and supply	in shelf of the refrigerator. Imaintenance director observed ignated Refrigerator" in the room. The refrigerator also (12) bowls of covered food but (13) bowls of covered food but (14) bowls of covered food but (15) bowls of covered food but (16) bowls of the contents of the bowls of the maintenance director relator in the rehab unit residents. The refrigerator had fliquids on the bottom of the of the maintenance director was responsible for cleaning the maintenance director stated (16) at 2:00 p.m. The dietary of the were to label and date food on the kitchen. The dietary refrigerators were cleaned from an ager stated the residents and drinks when they got them for. The surveyor asked for a labeling and dating food ing of the refrigerators. Wed the facility policy titled itorage" on 4/21/16. The food and supplies will be the yeard secure conditions the difference of the conditions of the refrigerator of the conditions of the refrigerator of the facility policy titled itorage" on 4/21/16. The food and supplies will be the yeard secure conditions of the refrigerator of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage of the facility policy titled itorage.	F3	71				

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d total part of the total part	Leftovers 1. Leftor and stored in NSF Foundation) approver or wrapped in plast or refrigerated." The surveyor information the above findings on the Assamatic Conference on 483.40(c)(1)-(2) FROF PHYSICIAN VISTA The resident must be once every 30 days admission, and at lefthereafter. A physician visit is contracted than 10 day required. This REQUIREMENT by: Based on staff interreview, the facility staff physician visited at lefthereafter as required. The findings included the facility staff faile	vers must be labeled, dated, (National Sanitation red containers, zip lock bags ic wrap. They can be frozen ned the administrative staff of on 4/21/16 at 4:20 p.m. on was provided prior to the 4/22/16. EQUENCY & TIMELINESS SIT re seen by a physician at least for the first 90 days after last once every 60 days. Onsidered timely if it occurs as after the date the visit was after the date the visit was reast every 30 days for the least every 30 day	F 387	1	ed physician mable to coutcome sk of not seen sery 30 days as required, or audit of May 16th ave been for the first educate f and coatients by a ays for the esignee to		
	90 days as required. The clinical record of 4/19/16 through 4/22 admitted to the facilit that included, but not	Resident #4 was reviewed /16. Resident #4 was reviewed /16. Resident #4 was y on 12/21/15 with diagnoses limited to adult failure to n, diabetes mellitus without	a nonzana ha na na na na na na na na na na na na na	months to ensure pat seen by physician even for first 90 days. Any discrepancies will be promptly and findings reported to Quality As	ery 30 days , addressed s will be	1966 - 19	

DEPAR TMENT OF HEALTH AND HUMAN SERVICES

CENTE RS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/12/20 FORM APPROVI STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-03 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 1 COMPLETED 495355 C B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFOR D HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (XS)TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE DEFICIENCY) F 387 Continued From page 84 F 387 complications type II, coronary atherosclerosis, BPH (benign prostate hypertrophy) without committee for review and further urinary obstruction, esophageal reflux, urinary analysis of findings. frequency, cellulitis, edema, sacral ulcer and right 5. 06-02-16 Lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. Resident #4 was assessed to understand others ursually and was understood. Resident #4 was assessed to have no behaviors in Section E. Resident #4's pain assessment revealed no scheduled pain medication regimen, did not receive any prn (whenever necessary) m edications and did not receive any non-medication interventions for pain. Resident #4 frequently had pain during the look back period. Resident #4 rated his pain level as 8 out of 10. The surveyor reviewed Resident #4's physician progress notes. Resident #4 was seen by the physician on 12/28/15, 12/31/15, 1/8/16, and 1/29/16. The next physician progress note was 3/21/16. The surveyor discussed the progress note visits with the minimum data set nurse (L.P.N. #2) on 4/20/16 at 3:30 p.m. L.P.N. #2 reviewed the progress notes and stated she would research the concern. She stated when Resident #4 was no fonger skilled, the progress notes were not done every 30 days. "I can't believe he wasn't seen. The doctors are in here all the time." The surveyor informed the administrative staff of the above finding on 4/22/16 prior to the exit conference on 4/22/16. No further information was provided prior to the exit conference on 4/22/16.

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) I	(X3) DATE SURVEY COMPLETED	
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	483.60(a),(b) PHAI ACCURATE PROCE The facility must prodrugs and biological them under an agree §483.75(h) of this punicensed personnel away permits, but on supervision of a lice. A facility must provide (including procedur acquiring, receiving administering of all the needs of each realicensed pharmace.	RMACEUTICAL SVC - CEDURES, RPH ovide routine and emergency als to its residents, or obtain element described in eart. The facility may permit held to administer drugs if State by under the general ensed nurse. de pharmaceutical services es that assure the accurate drugs and biologicals) to meet esident. aploy or obtain the services of ist who provides consultation is provision of pharmacy	F4	3	 Expired medications, open insulin pens that were not d and laboratory tubes were discarded on 4-19-16 Any patient is at risk of expireds and laboratory tubes and laboratory tubes and discarded properly and timely. DON or designee to medication rooms and carts ensure that there are no expendications, opened insulin pens with no date, or laboratubes. DON or designee to educate licensed nursing staff regard proper disposal of expired medications and laboratory in promptly after they expire and dating insulin pens when the have been opened. Unit Manager or designee to audit medication rooms and 	red are audit to bired tory e ding tubes ad ey		
	by: Based on observati document review, th dispose of expired n tubes on 2 of 2 units The findings include The surveyor toured assistant director of at 10:00 a.m. Upon rooms, the surveyor com on the Dogwoosurveyor observed th	the Dogwood unit with the nursing (ADON) on 4/19/16 completion of the resident checked the medication of unit with the ADON. The		5.	weekly x12 weeks to ensure there are no expired medical or laboratory tubes and that insulin pens have been date once opened. Any discrepar will be addressed promptly a findings will be reported to Quality Assurance committed review and further analysis of findings.	tions d ncies nd		

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top laboratory tubes with an				:
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GM (gram) with an expiration				
powder for Resident #6 with 3/13/16			ļ	
ved the medication carts on The following concerns were	1000		2	, e
OVolog 100 tmit/1 mittiliter	ocean de la company de la comp			Series Proposed and Company and American Americans
al/box/package-No date			and a minute of the state of th	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/201€ 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 C 495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

The surveyor observed the medication room on the Magnolia unit with the unit manager registered nurse #5 on 4/19/16 at 11:35 a.m. The following issues were observed:

Vancomycin 1 GM (gram) with expiration date of 4/14/16

Gabapentin 250 mg (milligram) / 5 ml (milliter) bottle No date when opened

The unit manager registered nurse #5 stated she tried to check the refrigerator for expired medications every day.

The surveyor informed the administrative staff of the above concerns and requested the facility policy on medication storage on 4/20/16 at 5:50 p.m.

The surveyor reviewed the facility policy titled "General Guidelines for Medication Storage" on 4/20/16. The policy read in part "Policy The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members authorized to administer medications. Procedure 11. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction, and reordered from the Pharmacy, if replacements are needed."

A second facility policy titled "Discontinuation and Disposal of Controlled Substances C11-V" read "Procedure 6. Nursing staff is responsible for removing all discontinued medications from the cart and/or storage areas."

Special Expiration Dating Requirements: Insulin

PRINTED: 05/12/2016 FORMAPPROVEE OMB NO. 0938-039

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	Humalog-Wher Lantus-When o Levemir-When	Opened 28 days	F 42	25		
	(miscellaneous)	lating Requirements: Misc vith preservative-30 days				
	If the date of oper cannot be determine	with these items: ing should be documented on ning is not documented or d, the date dispensed may te after opening for stability				
F 431	A83.60(b), (d), (e) DE LABEL/STORE DRUGE The facility must emp a licensed pharmacis of records of receipt a controlled drugs in su accurate reconciliation records are in order a controlled drugs is mareconciled. Drugs and biologicals	loy or obtain the services of twho establishes a system and disposition of all fficient detail to enable an and that an account of all intained and periodically used in the facility must be with currently accepted, and include the and cautionary	F 431	 Ointment was removed fro bedside on 4-19-16. The Voltaren gel was re-ordere the pharmacy so the correctinstructions were on the medication. Refrigerator or Dogwood and Magnolia has locked boxes that could not removed from the refrigerational placed in them for the storal narcotics. Any resident is at risk if ointments are left at the bed Unit Manager or designee the audit patient rooms to ensuredicated ointments are at bedside. Any resident is at resident is at resident. 	ed from ct n ed t be tor age of dside, o re no	

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTIO G		(X3) DATE SURVEY COMPLETED	
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F 431	Continued From pa	age 89	F 43	1	0		4
	facility must store a locked compartme controls, and perm have access to the The facility must propermanently affixed controlled drugs lis Comprehensive Drabuse, except whe package drug distriction.	ovide separately locked, I compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can		the proper label. Un to audit properly designeed from refronces properly. 3. DON or collicensed from medicate medication volterantics instruction.	designee to educate staff on keeping do intrent in their on cart, on ensuring Gel has the proper ns on the label, and the	ee el ons at d	
	by: Based on observat document review th safe and secure sto to provide separate compartments for s 2 of 2 units. The fact the medication labe instructions for app 1. The facility staff (Calmoseptine Oint area for Resident # The findings include Resident #3 was ac 2/21/16 with the foll limited to heart failu arthritis, depression	failed to store a medication ment) in a safe and secure 3.		per cente 4. Unit Mana audit 10 p F) x4 wee weeks to ointments bedside. designee Volteran g to ensure on the lab designee rooms da	are secured properly or policy. ager or designee to patient rooms daily (Maks, then weekly x8 ensure medicated are not left at the Unit Manager or to audit patients on gel weekly x12 weeks proper instructions are lel. Unit Manager or to audit medication ily (M-F) x4 weeks the weeks to ensure that	re en	

	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER RADFORD HEALTH AND REHAB CENTI	=	T. Constitution of the Con	700	RAN	ADDRESS, CITY, STATE, ZIP CODE NDOLPH STREET ORD, VA 24141	1 04	ZZIZOJO
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE P TAG REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFI TAG		C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 6E	(X5) COMPLETION DATE
Shortness of breath. The resisted MDS (Minimum Data Set protocol) with an ARD (Assest Date) of 2/28/16 as having a Interview for Mental Status) is possible score of 15. Reside coded as requiring extensive staff person for dressing, perbathing. During the initial tour of the fato:20 am, the surveyor obser Calmoseptine Ointment "was bathroom laying on the count The Unit 2 Manager was with initial tour when this was obseasked if this was the proper pointment to be kept. The Unit "No, it really shouldn't be in locked up with the other medinesident." The Unit Manage ointment out to the medication in the resident 's bin with the for this resident. The administrator and director notified of the above documed 4/20/16 at the end of the day director of nursing was asked where storage medications or be kept for the residents. The care nurse stated, "If the oin cream, then it can be kept at surveyor asked the corporate to let the surveyor know if the barrier or medicated cream. On 4/21/16 at the end of the corporate wound care nurse saurveyor when asked, that the the bathroom on initial tour was surveyor when asked, that the the bathroom on initial tour was surveyor when asked, that the	an assessment sement Reference BIMS (Brief core of 15 out of a nt #3 was also assistance from one sonal hygiene and wellity on 4/19 /16 at ved that a tube of "s in the resident's er beside the sink, the surveyor on erved. The surveyor lace for this t 2 Manager stated, here. It should be cations for this r took the tube of n cart and placed it other medications or of nursing were noted findings on conference. The by the surveyor ointments should a corporate wound the two a barrier the bedside. "The wound care nurse cream was a lay conference, the stated to the cointment found in	• ·	and the second s	; ; () ()	narcotics are secured per cen policy. Any discrepancies will addressed promptly and findings will be reported to Quality Assurance committee review and further analysis of findings. 06-02-16	be for	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	• • • • • • • • • • • • • • • • • • • •	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STAYE, 700 RANDOLPH STREET RADFORD, VA 24141		T San Bas San San San San San San San San San San	
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F 431	No further informs surveyor prior to to a urveyor prior to to a urveyor prior to to a urveyor prior to to a urveyor prior to to a urveyor pour observation on 4/20/16 beging prepared the follow #8: Escitalopram 50 mg, Tamsulosi 25 mg, Ativan 0.5 Nasacort nasal spophthalmic (hyper 5%, and Voltaren During the medica with licensed prace 8:10 a.m., L.P.N.; she wanted the Voltaren to Resident elbows. The surveyor recondinistered with orders. Resident a Voltaren: "Voltare transdermally two Administer 2 gm (stwice a day) and application transde Apply to right leg."	ation was provided to the he exit conference on 4/22/16. If failed to ensure the on Resident #8's Voltaren gel ect instructions for application. Erved a medication pass and with licensed practical nurse #6 ing at 8:10 a.m. L.P.N. #6 wing medications for Resident 10 mg (Lexapro), Nitrofurantoin (Flomax) 0.4 mg, Metoprolol mg, Levemir flex pen 35 units, eray, Sodium Chloride tonic) eye drops (Muro 128) gel 1%. In a sked Resident #8 where obtaren Gel applied. Resident e. L.P.N. #6 applied Voltaren in the signed April 2016 physician eras a day to elbows. In grams) topically to elbows bid voltaren Gel 1% Apply 1 application times a day to elbows bid voltaren Gel 1% Apply 1 aprimally two times a day for pain	F 4	131			

STATEMEN	T OF DEFICIENCIES	(V4) 270/4550(0) 155 (5)	γ		<u>. — ОМВ NO.</u>	<u> 0938-039</u>	
AND FLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIEF		70	TREET ADDRESS, CITY, STATE, ZIP CO DO RANDOLPH STREET ADFORD, VA 24141		22/2016	
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	#6 when the medic completed at 9:35 licensed practical rathe Voltaren Gel pal "Resident #8's name physician's name, (drug enforcement number, and with the use: Apply topically two times a day." The label did not in the elbows. She reviewed the of the physician know. The surveyor informative above concernated of the day mee and of the day mee and of the day mee accordance with Starbellow Remedication labeling. The policy titled "Me" Policy Remedications accordance with Starbellow accordance with Starbellow and package or label in a Federal regulations. The warning information auxiliary sticker. 6. sealed, damaged, owith or soiled should pharmacy should be	viewed licensed practical nurse cation pass had been a.m. The surveyor and nurse #6 reviewed the label on ackage. The label read he, Voltaren Gel 1%, resident's room number, DEA agency number) account he following instructions for y to right leg and right knee clude instructions to apply to order and stated she would let and get the order clarified. The defined the administrative staff of with medication labeling in the ting on 4/20/16 at 5:50 p.m. sted the facility policy on edication Labeling" read in particles medications dispensed in late and Federal regulations, ent medications will have at aformation printed on the accordance with State and o. Directions as required by a appropriate, cautionary or will be printed or added by Any item improperly labeled, appearing to be tampered be rejected and the notified immediately. 7. The ection and administers	F 431				



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	IAB CENTER		STREET ADDRESS, CITY, STATE, Z 700 RANDOLPH STREET RADFORD, VA 24141	DIP CODE	04/22/2016	
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	printed on the label a dose that can be supply, the nurse we the product indicating to indicate that directly and the product indicate that directly and the product indicate that directly and the product of the facility failed permanently affixed controlled drugs on During the initial tour resident units, the sign medication rooms. The surveyor obsentine Dogwood unit we nursing on 4/19/16 and observed a locked in a fallowing and sixteen (16) syringes of AHBR get (Ativan Reglan) for an unsampled resident and sixteen (16) syringes of AHBR get and sixteen (16) syringes of the controlled in a separate. The surveyor observe the Magnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit wit registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with registered nurse #5 of the surveyor observed the fagnolia unit with the surveyor observed the fagnolia unit with the surveyor observed the fagnolia unit with the surveyor observed the fagnolia unit with the surveyor observed the fagnolia unit with	and the directions are and the directions change to administered from the existing fill affix an auxiliary sticker to ag "See MAR" or comparable ctions have changed." on was provided prior to the 4/22/16. It to provide separately locked, compartments for storage of 2 of 2 units. It of both of the facility's urveyor observed both wed the medication room on the the assistant director of at 10:00 a.m. The surveyor efrigerator. The locked did three (3) vials of Ativan (1) in a plastic bag, 8 syringes, Haldol, Benadryl, and appled resident, six (6) all for an unsampled resident, nges of Ativan gel 1 mg/1 ml sident. The refrigerator was did to the floor and was able to trolled medications were not compartment.	F4	431			
į	narcotic box; howeve	er, the shelf the medication could be removed from the					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 431	the above finding o	age 94 med the administrative staff of on 4/20/16 at 5:50 p.m. and ity policy on medication	F 43	1			
,	Medication Storage medication supply personnel, pharma authorized to admill medications are permanently affixed Schedule III-V (3-5 along with non-con	eneral Guidelines for e" read in part "Policy The is accessible only to licensed by personnel or staff members nister. Procedure 7. Schedule stored in a separate, diarea and are double lock.) medications may be stored trolled drugs, but may be torage controls at the Facility's					
F 441 SS=E	exit conference on	ion was provided prior to the 4/22/16. I CONTROL, PREVENT	F 441				
***************************************	Infection Control Pr safe, sanitary and of to help prevent the of disease and infe- (a) Infection Control The facility must es Program under which	l Program tablish an Infection Control		 Infection control log has be updated to reflect if infection community acquired or far acquired, identify of the organism/culture results, of infection has been resolved ongoing. The nurse who fall clean the bell of her stethed prior to obtaining a blood pressure was educated or proper cleaning of equipment. 	ion was cility or if the ed or is ailed to oscope		
	(2) Decides what pr should be applied to	ocedures, such as isolation, an individual resident; and ord of incidents and corrective		The nurse who failed to cl			

STATEMEN AND PLAN (TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	determines that a reprevent the spread isolate the resident (2) The facility mustom direct contact direct contact will tropy. The facility mustom direct contact will tropy and after each direct contact will tropy and after each direct contact will tropy. This REQUIREMENT of the facility statement of the tropy. This REQUIREMENT of the facility statement of the tropy and rection control guic Resident #8 and Resid	ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. I require staff to wash their rect resident contact for which licated by accepted e. Indie, store, process and les to prevent the spread of T is not met as evidenced view and facility document laff failed to ensure an entrol program regarding entation; failed to follow lelines for 2 of 26 Residents esident #22); and failed to enree ice machines in the eity were maintained in a loted infection control lachines in each of the est did not have proper air	F 441	glucometer before and affixed equipment. The ice may were fixed to have the progaps. 2. Any resident is at risk if infections are not logged at tracked properly. DON to a May infection control log to ensure infections are bein tracked and logged proper patient is at risk if staff do clean equipment properly and/or after use. Any resid at risk if ice machines do in have proper air gaps in the Maintenance director to chacility ice machines to ensure proper air gaps. 3. DON or designee to educate infections. DON or designee educate nursing staff on procleaning of equipment before and/or after use. Administrates designee to educate Maintenance Director on ensuring ice machines have proper air gap in them. 4. DON or designee to audit infection control log monthly months to ensure infections logged and tracked properly Manager or designee to audit infections.	cleaning chines oper air and audit o g rly, Any not before dent is not em. neck sure ate ng ee to oper ore ator or e y x3 s are y, Unit

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			PRINTE	D: 05/12/201
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h for hear or you are		495355	B. WING_		0.	\$/22/2016
MAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	*122120 TO
RADFOR	D HEALTH AND REH	AB CENTER		700 RANDOLPH STREET RADFORD, VA 24141		
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i i i i i i i i i i i i i i i i i i i	Ine surveyor request list (tracking form for past year from the at When the infection of provided to the surveyor and the infection of the form was incompline listing form titled and provide information of the organism of the surveyor request control policy from the surveyor interview of the surveyor interview of the body and the body and the body and the body and the formation of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the surveyor information of the deans in part: The facility fection control programitary, and comfortate of the deans in the surveyor information of the deans in the surveyor information of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of the deans in the surveyor of	ted the infection control line of facility infections) for the dministrator. Control line listing was eyor by the director of nurses ation control registered nurse, colete. The infection control Residents Illness Log did on if the infection was or facility acquired, the send of a was ongoing, and the facility infection e DON on 4/20/16. When the DON and the stered nurse on 4/22/16. The einformed the surveyor on on was done. The surveyor of the infection control nurse and pointed out the form did on if the infection was or facility acquired, the m/culture results or if the solved or was ongoing. If the infection was or facility acquired, the m/culture results or if the solved or was ongoing. If the infection was ongoing of the administrator, the dother administrator, the dother administrator, the dother administrator at the following policy and ion control Program that the following policy and ion control Program that the povides a safe, able environment to help evelopment and on and/or outbreaks. The	F 44	staff members randor equipment weekly x1 ensure equipment is a before and/or after us Maintenance director designee to audit ice monthly x3 months to proper air gaps. Any discrepancies will be a promptly and findings reported to Quality As committee for review analysis of findings 5. 06-02-16	2 weeks to cleaned e. or machines ensure addressed will be surance	

achieve the goals through monitoring and

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION :	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER RADFORD HEALTH AND REHA	AB CENTER	STI 700	REET ADDRESS, CITY, STATE, ZIP CODE RANDOLPH STREET DFORD, VA 24141	04/22/2	016
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including the interdiscontrol practices. No further informatic exit conference on 4 2. The facility staff facontrol guidelines dupour observation that licensed practical nuthe stethoscope priopressure of Resident bell of the stethoscope pressure of Resident The surveyor observation with on 4/20/16 beginning prepared the followin #8: Escitalopram 10 50 mg, Tamsulosin (face) 125 mg, Ativan 0.5 mg, Nasacort nasal spray ophthalmic (hyperton 5%, and Voltaren gel After licensed practice Resident #8's medication cart but was tethoscope. She look walked toward the nureturned with a stethocheck resident #8's informed the surveyor and proceeded to admedications. L.P.N. #6 did not cleat before it was used on blood pressure had before surveyor discussed.	fied problems or issues sciplinary team 's infection on was provided prior to the /22/16, ailed to follow infection using a medication pass and that affected Resident #8. The rese failed to clean the bell of the affect to obtaining the blood that and failed to clean the perior affect to clean the perior to obtaining the blood that and failed to clean the perior to obtaining the blood that and failed to clean the perior to obtaining the blood that and failed to clean the perior to obtaining the blood that and failed to clean the perior to obtain the	F 441			

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: SSHU11 Facility ID: VA0161

If continuation sheet Page 98 of 119



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FREFIX TAG REGULATORY OR ISC DENTIFYING INFORMATION) F 441, Continued From page 98 nursing on 4/21/16 at 1:30 p.m. The director of nursing on 4/21/16 at 1:30 p.m. The director of nursing stated she would expect staff to clean the stethoscope after use. She would expect anything that touches a resident to be cleaned. The surveyor requested the facility policy on cleaning equipment on 4/21/16. No further information was provided prior to the exit conference on 4/22/16. 3. The facility staff failed to clean the glucometer before and after use during a medication pass and pour observation on 4/19/16 that affected Resident #22. The surveyor observed a medication pass and pour observation with registered nurse #1 on 4/19/16 at 4:28 p.m. R.N. #1 prepared one (1) medication for Resident #22 por 4/19/16 and performed an accucheck. The medication was administered at 4:32 p.m. The medication was administered with a cup of water. The surveyor removed the community accucheck and performed an accucheck on Resident #22. When R.N. #1 returned to the medication cart, the glucometer was cleaned with an alcohol pad and placed back in the medication drawer. The glucometer was not cleaned before use with a disinfectant. The surveyor informed the administrative staff of the above finding and requested the manufacturer's product information for cleaning the glucometer in the end of the day meeting on 4/20/16 at 5:50 p.m. The infection control nurse/assistant director of nursing was asked how she would expect the glucometer to be cleaned. She stated "Use disinfectant wipes in between residents" — The surveyor requested the facility of the day meeting on the produced of the day meeting on the produced of the produced of the day meeting on the produced of the produced of the day meeting on the produced of the produced of the day meeting on the produced of the produced of the produced of the produced of the produced of the produced of the produced of the produced of the produced of the produced of the produced of the produced of the p					700 RANDOLPH STREET		<u>04/22/2016</u>	
nursing on 4/21/16 at 1:30 p.m. The director of nursing stated she would expect staff to clean the stethoscope after use. She would expect anything that touches a resident to be cleaned. The surveyor requested the facility policy on cleaning equipment on 4/21/16. No further information was provided prior to the exit conference on 4/22/16. 3. The facility staff failed to clean the glucometer before and after use during a medication pass and pour observation on 4/19/16 that affected Resident #22. The surveyor observed a medication pass and pour observation with registered nurse #1 on 4/19/16 at 4:28 p.m. R.N. #1 prepared one (1) medication for Resident #22 on 4/19/16 and performed an accucheck. The medication was administered at 4:32 p.m. The medication was administered with a cup of water. The surveyor removed the community accucheck and performed an accucheck on Resident #22. When R.N. #1 returned to the medication cart, the glucometer was cleaned with an alcohol pad and placed back in the medication drawer. The glucometer was not cleaned before use with a disinfectant. The surveyor informed the administrative staff of the above finding and requested the manufacturer's product information for cleaning the glucometer in the end of the day meeting on 4/20/16 at 5:50 p.m. The infection control nurse/assistant director of nursing was asked how she would expect the glucometer to be cleaned. She stated "Use disinfectant wipes in between residents -before and after each resident." The surveyor requested the facility	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE	
policy on cleaning glucometers.		nursing on 4/21/16 nursing stated she stethoscope after anything that touck. The surveyor requirements conference on 3. The facility staff before and after us and pour observat Resident #22. The surveyor observation of 4/19/16 at 4:28 p.n medication for Resperformed an accuradministered at 4:3 administered with a the surveyor removant performed an accuradministered with a the surveyor removant performed an included back in glucometer was and placed back in glucometer was not disinfectant. The surveyor information and performed an amulfacturer's prothe glucometer in the 4/20/16 at 5:50 p.m nurse/assistant directions and state between residents.	at 1:30 p.m. The director of would expect staff to clean the use. She would expect hes a resident to be cleaned, lested the facility policy on at on 4/21/16. It ion was provided prior to the 4/22/16. If alled to clean the glucometer se during a medication passion on 4/19/16 that affected exved a medication pass and with registered nurse #1 on a. R.N. #1 prepared one (1) sident #22 on 4/19/16 and scheck. The medication was a cup of water, wed the community accucheck accucheck on Resident #22, and to the medication cart, is cleaned with an alcohol paddithe medication drawer. The trace to the administrative staff of and requested the duct information for cleaning are end of the day meeting on the infection control ector of nursing was asked ect the glucometer to be di "Use disinfectant wipes in before and after each	F 4	41			
The manufacturer's user instruction manual for the blood glucose monitoring system named		the glucometer in the 4/20/16 at 5:50 p.m. nurse/assistant direction she would expedeaned. She state between residents resident." The survection on cleaning gathe manufacturer's	ne end of the day meeting on the infection control ector of nursing was asked ect the glucometer to be diffuse disinfectant wipes in before and after each reyor requested the facility plucometers.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/201 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVEL OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED (495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 441 Continued From page 99 F 441 GLUCOCARD ® Vital TM was reviewed 4/21/16. The product information titled "Caring for your GLUCOCARD ® Vital TM Blood Glucose Meter" read: "Cleaning the Meter The GLUCOCARD ® Vital TM Blood Glucose Meter is a precise instrument, Please handle with care. Clean the outside of the meter with a damp cloth only. Dirt, dust, blood, control solution, or water entering the meter could cause damage. Your GLUCOCARD Wital TM Blood Glucose Meter should not need decontamination as no blood or control solution should come into contact with the meter if the instructions are followed correctly." The surveyor interviewed the director of nursing and the assistant director of nursing/Infection Control nurse on 4/21/16 at 1:15 p.m. The surveyor asked about the policy on cleaning the glucometer. The ADON stated the glucometers used between patients needed to be cleaned in between the residents-before and after use with alcohol or disinfectant towelettes. The glucometers then would be stored in the medication cart. The ADON stated the facility would follow the CDC (Centers for Disease Control) guidelines. The surveyor reviewed the Infection Control Program policy on 4/21/16. The policy read in part "The program develops and implements appropriate infection control policies and procedures and the training of staff that reflects the current Centers for Disease Control (CDC) Guidelines." The surveyor reviewed the facility policy titled "Blood Glucose Monitoring, Fingerstick " on 4/22/16. The policy read in part

wipe."

"12. Cleanse glucometer monitor between residents by wiping off outside case with alcohol

The CDC guidelines accessed 4/21/16 read in part "Blood Glucose Meters Blood glucose

495355 8. WING 04/	E SURVEY MPLETED C 22/2016
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NAME OF PROVIDER OR SUPPLIER	**************************************
RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD, VA 24141	22/2016
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
meters are devices that measure blood glucose levels. Whenever possible, blood glucose neters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. A simple rute for safe care: If shared, blood glucose meters should be cleaned and disinfected then it should not be shared. A simple rute for safe care: If shared, blood glucose meters should be cleaned and disinfected after every use." Resident #22 was admitted to the facility 4/11/16 with diagnoses that included but not limited to muscle weakness, lack of coordination, diabetes mellitus, hypertension, hypertipidemia, constipation, and hypothyroidism. Resident #22's admission minimum data set (MDS) assessment had not yet been completed. No further information was provided prior to the exit conference on 4/22/16. 4. The facility staff failed to ensure each of the three ice machines in the dayrooms in the facility were maintained in a manner which promoted infection control practices. The ice machines in each of the resident 's dayrooms did not have proper air agas. The surveyor and the maintenance director toured the facility on 4/20/16 at 10:33 a.m. Each day room contained an ice machine. The pipe that drained the ice machine (potable water line) was observed to be in close proximity to the waste line pipe. This did not allow for an air gap between the ice machine drainage pipe and the main drainage system. The surveyor asked the maintenance director if there was a back-up in the waste line, what the circumstances might be for contamination of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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drinking water/ice material director stated the pater The maintenance of the length of the pipidentified. At the time of the sumachines were functive residents. US Food and Drug Ale www.fda.gov http://gaps.as : An air gapinlet and the flood le fixture, equipment, cat least twice the diainlet and may not be The surveyor information exit conference on 4. F 504 483.75(j)(2)(i) LAB SORDERED BY PHYSORDERED BY P	tential for the water to flow mixing and contaminating the machine. The maintenance potential would be a concernificator stated he could adjust the and correct the problem providing its and correct the problem providing and providing its to administration accessed at a www.fda.gov> described air between the water supply vel rim of the plumbing prononfood equipment shall be a meter of the water supply less than 25 mm (1 inch). The distribution accessed at a water supply well rim of the plumbing prononfood equipment shall be a meter of the water supply less than 25 mm (1 inch). The was provided prior to the water supply was provided prior to the water supply less than 25 mm.	F 44		ome ib is i's audit lace		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 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 495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFOR**D HEALTH AND REHAB CENTER** 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY: F 504 Continued From page 102 F 504 current residents labs obtained The finding included: as of May 16th to ensure labs obtained timely per physician 1. For Resident #11 the facility staff failed to obtain physicians orders for laboratory test; a order. 3. DON or designee to educate complete blood count (CBC). Resident #11 was admitted to the facility 6/25/15 licensed nursing staff the need to obtain a physician's order prior to with diagnoses that included but not limited to dementia, high blood pressure, heart failure, obtaining a lab and on obtaining seizure disorder, and esophageal reflux disorder. labs timely per physician order. 4. Unit Manager or designee to A review of Resident #11's clinical record audit labs that are obtained daily revealed on the most recent minimum data set (M-F) x4 weeks and weekly x8 (MDS) with an assessment reference date of weeks to ensure physicians 2/8/16, the facility staff assessed the resident to order was obtained prior to understand and to be understood. She was obtaining the lab and that labs assessed to have a cognitive summary score of are obtained timely per physician 15. order. Any discrepancies will be addressed promptly and findings Resident #11's clinical record was reviewed will be reported to Quality 4/20/16 and revealed the results of a CBC done Assurance committee for review on 10/8/15. However, the surveyor could not and further analysis of findings. locate a corresponding order. On 4/20/16 at 5. 06-02-16 2:15pm the assistant director of nurses was asked to assist in locating the orders for the labs. On 4/21/16 at 3:15pm, the assistant director of nurses informed the survey team she did not have the order. On 4/21/16 at approximately 4:20 pm, the administrative staff was made aware of the CBC obtained without an order.

physician for Resident #2.

Prior to exit no further information was provided related to the lab test CBC without an order.

2. The facility staff failed to obtain a laboratory testing in a timely manner as ordered by the

Resident #2 was readmitted to the facility on

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(×3) D	(×3) DATE SURVEY COMPLETED C	
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	chronic obstructive depressive disorder On the resident 's assessment protoc Reference Date) of coded as having a Mental Status) scored of 15. The resident extensive assistant for dressing and period that Resident During the clinical moted that Resident physician. "Draw a an antibiotic) peak of 00 (6 am) on 11/minutes before four 11/4/15. "The restrough for 11/4/15 colinical record. How laboratory results, the cord, for the above with a date of 11/5/10 on 4/21/16, the assign (ADON) was asked results of the above for 11/4/15. They were 11/4/15. "The AD for these labs dated 11/4/15. They were 11/4	Allowing diagnoses of, but not a dementia, enlarged prostrate, a pulmonary disease, major er, anemia and heart failure. MDS (Minimum Data Set, an exol) with an ARD (Assessment of 3/17/16, Resident #2 was BIMS (Brief Interview for re of 6 out of a possible score of 8 out of a possible score of 2 or more staff members ersonal hygiene. Resident #2 on staff for bathing. The record review, the surveyor of the tall the following dent (Gentamycin, which is 1 hour after the fourth dose at 14/15. Draw a Gent trough 30 of the dose at 0430 (4:30 am) on ealts for a Gent peak and ould not be found in the elinical edocumented physician order.	F	504				

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

Event ID:55HU11

Facility ID: VA0161

If continuation sheet Page 104 of 119





DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 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 \cap 495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREEIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 504 : Continued From page 104 F 504 panel) on 3/21/16 for Resident #4. The clinical record of Resident #4 was reviewed 4/19/16 through 4/22/16. Resident #4 was admitted to the facility on 12/21/15 with diagnoses that included, but not limited to adult failure to thrive, atrial fibrillation, diabetes mellitus without complications type II, coronary atherosclerosis. BPH (benign prostate hypertrophy) without urinary obstruction, esophageal reflux, urinary frequency, cellulitis, edema, and sacral ulcer and right lateral foot ulcer. Resident #4's significant change in assessment MDS with an assessment reference date (ARD) of 3/29/16 coded the resident with a cognitive summary score of 05 out of 15 in Section C0500. The surveyor found the results of a BMP obtained 3/21/16 in the electronic clinical record. The surveyor reviewed the physician orders for March 2016 but was unable to locate the physician order. The surveyor informed the director of nursing and registered nurse #3 of the BMP obtained 3/21/16 and that the surveyor was unable to locate the physician order for the 3/21/16 lab test on 4/20/16 at 4:00 p.m. The director of nursing stated the BMP obtained was requested by the pharmacy when Resident #4 received Gentamycin. The director of nursing stated to the surveyor on 4/22/16 at 8:03 a.m. that the staff was unable to locate the physician order for the BMP obtained on 3/21/16.

exit conference on 4/22/16.

No further information was provided prior to the

4. The facility staff failed to obtain a physician order prior to obtaining a urinalysis and a urine

bilirubin on 4/18/16 for Resident #14. Resident #14's clinical record was reviewed 4/21/16 through 4/22/16. Resident #14 was

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 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 IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED $^{\circ}$ 495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID m PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 504 | Continued From page 105 F 504 admitted to the facility 3/24/14 and readmitted 7/17/15 with diagnoses that included but not limited to osteoarthritis, hypertension, hyperlipidemia, depression, anxiety, anemia, gastroesophageal reflux disease, enlarged prostate, insomnia, and spondylosis, Resident #14's significant change in MDS assessment with an assessment reference date (ARD) of 7/29/15 assessed the resident with a cognitive summary score of 15 out of 15 in Section C Summary Score. The surveyor reviewed the miscellaneous section of the electronic clinical record. The clinical record revealed the results of a urinalysis and a urine bilirubin obtained 4/18/16. The surveyor reviewed the April 2016 physician orders but was unable to locate physician orders for the two aforementioned laboratory tests. The surveyor requested the assistance of the assistant director of nursing on 4/22/16 at 8:20 a.m. The ADON stated when urinalyses are obtained and the tube has no sex or birthday, the lab will automatically do a urine bilirubin to determine the sex of the resident. ADON stated "The nurse documented Resident #14 was having burning upon urination in the progress note of 4/18/16. The nurse needed to write the order for the urinalysis. The nurse took the order from the routine standing orders." No further information was provided prior to the exit conference on 4/22/16. Lab result placed in resident #2's F 507 483.75(j)(2)(iv) LAB REPORTS IN RECORD chart on 4/21/16 F 507 SS=D LAB NAME/ADDRESS 2. Any resident is at risk if lab results are not in the clinical The facility must file in the resident's clinical record, DON or designee to audit

laboratory.

record laboratory reports that are dated and

contain the name and address of the testing

labs obtained for current patients

as of May 16th to ensure lab

results are in the clinical record

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 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 \Box 495355 B. WING 04/22/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 700 RANDOLPH STREET RADFORD HEALTH AND REHAB CENTER RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 507 Continued From page 106 F 507 DON or designee to educate licensed nursing staff and This REQUIREMENT is not met as evidenced medical records to ensure that by: lab results are placed in the Based on staff interview and clinical record clinical record. review, the facility staff failed to ensure that a Unit Manager or designee to aboratory test result was available in the clinical audit patient labs daily x4 weeks, record (Resident #2). The findings included: then weekly x8 weeks to ensure that lab results are filed in the Resident #2 was readmitted to the facility on clinical record. Any 2/20/16 with the following diagnoses of, but not limited to diabetes, dementia, enlarged prostrate, discrepancies will be addressed promptly and findings will be chronic obstructive pulmonary disease, major reported to Quality Assurance depressive disorder, anemia and heart failure. On the resident 's MDS (Minimum Data Set, an committee for review. 5. .06-02-16 assessment protocol) with an ARD (Assessment Reference Date) of 3/17/16, Resident #2 was coded as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 or more staff members for dressing and personal hygiene. Resident #2 is totally dependent on staff for bathing. During the clinical record review on 4/20/16, the surveyor noted the following physicians ' order dated for 4/8/16 which stated "...INR recheck 4/11/16. " The surveyor could not find the results of this laboratory testing in the clinical record. On 4/21/16 at 8:05 am, the assistant director of nursing (ADON) was asked to find the results of the above ordered INR on Resident #2. The ADON stated. "It should be in the nurses! notes or on the MAR (Medication Administration Record). " The ADON could not find the results

Coumadin Review Log ".

in either of these two places in the clinical record. The ADON stated "it may be in the unit.'s

At 8:15 am, the ADON provided the surveyor a copy of the Coumadin Review Log that was on

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/20-CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVE STATEMENT OF DEFICIENCIES OMB NO. 0938-039 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER-(X3) DATE SURVEY A. BUILDING COMPLETED 495355 C B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 507 | Continued From page 107 F 507 the nursing unit for Resident #2. On this log, there was no INR result for 4/11/16. However, there was noted by the surveyor, a notation that stated " 4 mg re (with check mark) 4/15/16. The ADON stated "it was in the log book but not in the nurses ' notes or on the MAR for April. ' The administrator and director of nursing were notified of the above documented findings on 4/21/16 in the end of the day conference. No further information was provided to the surveyor prior to the exit conference on 4/22/16. F 513 483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT F 513 SS=D IN RECORD-SIGN/DATED 1. Diagnostic study result placed in resident #4's chart on 4/21/16 The facility must file in the resident's clinical 2. Any resident is at risk if record signed and dated reports of x-ray and diagnostic study results are not other diagnostic services. in the clinical record, DON or designee to audit diagnostic studies completed for current This REQUIREMENT is not met as evidenced patients as of May 16th to ensure study results are in the clinical Based on staff interview and clinical record record review, the facility staff failed to ensure physician DON or designee to educate ordered diagnostic studies were maintained in the licensed nursing staff and clinical record for 1 of 26 residents (Resident #4). medical records to ensure that The findings included: diagnostic study results are The facility staff failed to ensure that the results of placed in the clinical record. a physician ordered Doppler study was contained Unit Manager or designee to in the clinical record for Resident #4, audit patient diagnostic study The clinical record of Resident #4 was reviewed results daily (M-F) x4 weeks. 4/19/16 through 4/22/16. Resident #4 was then weekly x8 weeks to ensure admitted to the facility on 12/21/15 with diagnoses that lab results are filed in the that included, but not limited to adult failure to clinical record. Any

thrive, atrial fibrillation, diabetes mellitus without

complications type II, coronary atherosclerosis,

urinary obstruction, esophageal reflux, urinary

frequency, cellulitis, edema, sacral ulcer and right

BPH (benign prostate hypertrophy) without

5. 06-02-16

discrepancies will be addressed

promptly and findings will be

committee for review.

reported to Quality Assurance

STATEMEN AND PLAN	VT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 513	MDS with an assess of 3/29/16 coded the summary score of 0. The clinical record recorder dated 1/6/16 to arm-r/o (rule out) DV CBC (complete block metabolic panel), Bi in am (morning)." The surveyor review record and was unatoppler. The physician visit pread in part "Doppler DVT."	ficant change in assessment sment reference date (ARD) ne resident with a cognitive 05 out of 15 in Section C0500. The vealed a signed physician that read "Doppler of left VT" (deep vein thrombosis), and count), BMP (basic NP (B-type natriuretic peptide) and the electronic medical ble to locate the results of the progress note dated 1/8/16 of left arm was negative for	F 513	3			
S\$≃E│	the above concern of On 4/22/16, the survey of the Doppler study director of nursing string the chart. No further information exit conference on 4, 483.75(f)(1) RES RECORDS-COMPLE LE The facility must main resident in accordance standards and practic accurately document systematically organic.	etelaccurate/accessib ntain clinical records on each ce with accepted professional ces that are complete; ed; readily accessible; and zed.	F 514	1. Resident # 11's bowel movements that were not documented were from March, unable to correct in medical record. No negative outcome identified. Resident #10's progress notes were corrected and wrong note removed from the chart by the nurse on 4/21/16. Resident #4's missing output documentation was from February and was unable to be			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/12/2016 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVEE 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 \mathbf{C} 495355 B. WING NAME OF PROVIDER OR SUPPLIER 04/22/2016 STREET ADDRESS, CITY, STATE, ZIP CODE RADFORD HEALTH AND REHAB CENTER 700 RANDOLPH STREET RADFORD, VA 24141 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 109 F 514 resident's assessments; the plan of care and corrected. No negative outcome services provided; the results of any identified. Resident #6's missing preadmission screening conducted by the State; O2 sat documentation was from and progress notes. March and was unable to be corrected. No negative outcome This REQUIREMENT is not met as evidenced identified. Resident # 3's missing intake and output documentation Based on staff interview and clinical record was from February and was review, the facility staff failed to ensure a unable to be corrected. No negative outcome identified. complete and accurate clinical record for 6 out of 27 Resident's (Residents # 11, #10, #4, #6,# 2 Resident #3's missing behavior monitoring was from March and and #7). The facility staff failed to maintain accurate April and was unable to be documentation to indicate that facility staff was corrected, no negative outcome identified. Resident # 7's falls monitoring Resident #11 's bowel movements. that did not have proper Resident #11 was admitted to the facility 6/25/15 documentation occurred in January and February and was with diagnoses that included but not limited to dementia, high blood pressure, heart failure, unable to be corrected. No seizure disorder, and esophageal reflux disorder. negative outcome identified. Any resident is at risk if bowel A review of Resident #11's clinical record movements are not documented revealed on the most recent minimum data set in the clinical record. DON or (MDS) with an assessment reference date of designee to audit current 2/8/16, the facility staff assessed the resident to patients as of May 16th to ensure understand and to be understood. She was bowel movements documented assessed to have a cognitive summary score of in medical record. Any resident is 15. at risk if the wrong progress note is placed in his or her medical Resident #11 was interviewed on 4/22/16; she record. DON or designee to audit was asked how often her bowels moved. current patients as of May 16th to Resident #11 said, "About every few days." ensure correct progress notes

Further review of the resident's clinical record

revealed her physician's orders showed she had

scheduled Colace 1 capsule 100 mg (milligram) twice a day as a stool softener. The facility standing orders read as follows: Constipation or

are in patient charts. Any

documented in the medical

resident is at risk if output is not

STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Tassing		NAR MO	<u>. 0938-039</u>
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION NG_		E SURVEY MPLETED
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NAKAE OF		495355	B. WING _		1	/22/2016
MAINE OF	PROVIDER OR SUPPLIEF	A.		STREET ADDRESS, CITY, STATE, ZIP CODE		
RADFO	RD HEALTH AND RE	HAB CENTER		700 RANDOLPH STREET		
		41		RADFORD, VA 24141		
(X4) ID PREFIX	SUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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F 514	Continued From p	page 110	F 514	4	· · · · · · · · · · · · · · · · · · ·	
		vement) for 3 days. Give 30 ml	, 31-			1
	(milliliters) MOM (r	milk of magnesia) by mouth, x 1				İ
	dose; if no results	Dulcolax rectal suppository x 1	i	record. DON or designee to au	ıdit	-
	dose check for pr	resence of stool in rectum.	-	current patients as of May 16th		
	Remove manually	if indicated. If no results in 8	l	with output monitoring to ensur	re	1
	hours give fleets e	enema x1 enema. If no results,		output is documented in the		3
	notify MD for further	er orders.		chart. Any resident is at risk if (D 2	
				sats are not documented in the	<u>.</u>	
	The surveyor did n	not find documentation in the	i	medical record. DON or		
	clinical record to st	how if the resident had bowel		designee to audit current	į	
,	movements. The s	Surveyor asked the unit		patients as of May 16 th on		
į	manager if there wa	vas documentation in the		oxygen to ensure O2 sats		
į	clinical record for b	powel movements. She said "		documented in the medical	•	
40000000	the CNA's docume	ent in the electronic clinical		record. Any resident is at risk if		
1	record and showed	d the surveyors the area of		intake and output is not	1	
***	documentation for	all ADL (activity of daily living).		documented in the medical	1	
,				record. DON or designee to aud	dit !	
2	Review of the ADL	(activity of daily living) work		current patients as of May 16 th		
į	sheets for the dates	s 3/5/16 through 3/12/16.		with intake and output monitoring	na j	
	showed no BM doc	cumentation. For the dates		to ensure intake and output is	1	
1	3/21/16 through 3/2	25/16 there was no		documented in the medical	1	
1	documentation rela-	ated to BM 's. The following		record. Any resident at risk if		
	dates 3/30/16 throu	igh 4/5/16 showed no related		behavior monitoring is not		
	documentation for E	BM's.		documented in the medical	ĺ	
j				record. DON or designee to aud	lit	
***	The absence of dor	cumentation to indicate that		current patients as of May 16th	1	
-	the facility staff were	re monitoring and treating	ļ	with behavior monitoring to	i	
100	concerns related to	Resident #11's bowel function	î	ensure behavior monitoring is	(1	
	was discussed with	the facility's administrator and	ļ	documented in the medical	*	
í	director of nursing.			record. Any resident is at risk if	1	
1				falls are not properly		
	During an end of the	e day meeting with the		documented in the chart. DON of	or .	
İ	administrative staff t	they were notified that		designee will audit current	***************************************	
	Resident #11 did no	of have a documented BM for		patients as of May 16 th who have	e	
	extended periods in	March and April 2016. The	ļ	had falls in the last 30 days to		
· .	survey team request	sted the facility	-	ensure proper falls		
1		documentation in regards to		}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PREFIX (EACH DEFICIENCY	AB CENTER TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, 700 RANDOLPH STREET RADFORD, VA 24141 PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	F CORRECTION (XS) CTION SHOULD BE COMPLETIO THE APPROPRIATE DATE
documented each s program by the CN/2. When a resident movement, during the CCR software proceur. Prior to exit on 4/22/2 was provided to the 2. The facility staff f #10's progress notes record. The clinical record of 4/19/16 through 4/22 admitted to the facility 4/9/16 with diagnose to hypertension, static chronic kidney diseat hyperlipidemia, osteotype II, and hypothymous Resident #10's signiff (minimum data set) as assessment reference assessed the resider score of 15 out of 15 Score. Section J Heath at Resident #10 remedication, received medications or was one not receive any non-repain. The progress note of read "Resident is rest Took all meds as ordered and accepted. Has treated the desk with staff. We have the desk with staff. We have the desk with staff. We have the desk with staff. We have the desk with staff.	redure read as follows in part: nt activity/inactivity is to be shift in the CCR software A's. It does not have a bowel he shift it is documented in rogram that one did not In the further information survey team. It is is desident swere accurate in the clinical of Resident #10 was reviewed as the clinical of Resident #10 was the stat included but not limited as post pacemaker insertion, se, atrial fibrillation, carthritis, diabetes mellitus poidism.	F 5	documentation is in record. 3. DON or designee to licensed staff on pro documentation of bo movements, progres output, O2 sats, intal output, behavior mor falls. 4. Unit Manager or des audit 10 patients dail weeks then weekly x ensure bowl moveme documented properly notes, output, O2 sat and output, behavior and falls are docume properly. Any discrep be addressed prompt findings will be report Quality. 5. 06-02-16	educate oper owel os notes, ke and nitoring, and ignee to ly (M-F) x4 8 weeks to ents are of, progress ts, intake monitoring, ented pancies will tly and

DEPAR CENTE	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 05/12/2016 FORM APPROVED
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	PROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 700 RANDOLPH STREET RADFORD, VA 24141	
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	made him to have sabd (abdomen) soft in reach." The above note four record was informated above note four record was informated. The surveyor information. The ADON stanote was the only perinformation. The ADON was password protection information. The ADON was password protection the nurse of the surveyor interview of the surveyor interview of the note on the corrected. The note on the corrected the note on the corrected the documentation of the district conference on 4/19/16 through 4/22/16 admitted to the facility hat included, but not hrive, atrial fibrillation complications type II, BPH (benign prostate in information, esternal foot ulcer. Resident #4's significations type II, and the signification was accurately that included, but not have a strial fibrillation complications type II, and the signification was accurately that included, but not have a strial fibrillation complications type II, and the signification was accurately that included, but not have a strial fibrillation was accurately that included, but not have a strial fibrillation was accurately that included, but not have a strial fibrillation was accurately that included, but not have a strial fibrillation was accurately that included, but not have a strial fibrillation was accurately that included, but not have a strial fibrillation was accurately that included in the facility has a strial fibrillation was accurately that included in the facility has a strial fibrillation was accurately that included in the facility has a strial fibrillation was accurately that included in the facility has a strial fibrillation was accurately that included in the facility has a strial fibrillation was accurately that included in the facility has a strial fibrillation was accurately that included in the facility has a strial fibrillation was accurately that the facility has a strial fibrillation was accurately that the facility has a strial fibrillation was accurately that the facility has a strial fibrillation was accurately that the facility has a strial fibr	urgery. Lungs are clear and and non-tender. Call light is and in Resident #10's clinical fon describing Resident #6. ed the assistant director of concern on 4/21/16 at 3:00 ted the nurse who wrote the rson who can strike out the ON stated the information cted. She stated she would be concern. ewed licensed practical nurse a.m. L.P.N. #6 stated the L.P.N. #5 stated she wrote ct resident when she was on was incorrect. In was provided prior to the 22/16. illed to ensure Resident #4's and documented in the clinical Resident #4 was reviewed 16. Resident #4 was r	F 51	RECE VOHV	9%

DEPA CENT	RTMENT OF HEALTH	HAND HUMAN SERVICES			ı	PRINTE:	D: 05/12/201 MAPPROVE
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	F PROVIDER OR SUPPLIER DRD HEALTH AND REF	IAB CENTER		700	REET ADDRESS, CITY, STATE, ZIP CODE D RANDOLPH STREET ADFORD, VA 24141	1 02	1/22/ 2 016
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	The April 2016 phys Resident #4 had ord shift that started 12/reviewed the electrorecord (eTAR) for Foundained "holes", tildocumentation that been completed. The February 2016 p.m7:00 a.m. shift. The surveyor informative lack of document 2/8/16 on 4/21/16 at The director of nursing document on assigning of the clinical record, provided the surveyor total for 2/8/16. The worksheet was part or esponded no. No further information exit conference on 4/4. 4. The facility staff factoxygen saturation leviclinical record. The clinical record of 4/19/16 through 4/22/admitted to the facility 3/2/16 with diagnoses limited to anxiety, dep	ne resident with a cognitive 05 out of 15 in Section C0500. Sician orders were reviewed. Hers for urinary output every 21/15. The surveyor onic treatment administration ebruary 2016. The eTARs mes when there was no the ordered treatments had eTAR had holes for the 7:00 on 2/8/16. Bed the administrative staff of ted output for Resident #4 on 4:20 p.m. Ing stated the staff will ment sheets that are not part. The director of nursing on 4/22/16 with the output surveyor asked if the of the clinical record and she of the clinical record and she had supported to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16. It was provided prior to the 22/16.	F 5	14			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
dankalaska popularia o popularia popularia popularia popularia popularia popularia popularia popularia popular		495355	B. WING	;			C
NAME OF	PROVIDER OR SUPPLIER		_	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 0,	4/22/2016
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	anemia, and enlarg Resident #6's signif MDS with an assess of 3/10/16 coded the summary score of 0 The April 2016 signed "Apply O2 @ (at) 2L below 90% per stan O2. Start date 3/21/The surveyor review Summary Report" for and the electronic marecords for March 20 surveyor was unabled levels for 3/21/16, 3/21/16, 3/21/16, 3/21/16, 3/21/16, 3/21/16, 3/21/16, 3/21/16, 3/21/16, 3/23/16 7:00 a.m. to 10 The director of nursing stated the 3/23/16 7:00 p.m. to 10 for nursing stated the 3/23/16 and 3/23/16 v. the directs the staff use divas asked if these were asked if the	evioral disturbances, e., diabetes mellitus type II, ed prostate. Ficant change in assessment sment reference date (ARD) he resident with a cognitive of out of 15 in Section C0500. Find the decident with a cognitive of out of 15 in Section C0500. Find physician orders read of the compact of	F	514			

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F 514	Continued From pa	ge 115	F 5	514			•	7-
	prior to the exit contours. The facility stand Outputs in the contours and Outputs in the contours. The facility staff failed behavior that was be record of Resident # 5a. The facility Intake and Outputs in Resident #3. Resident #3. Resident #3. Resident #3 was liking and shortner was coded on the an assessment protoc (Assessment Reference of 15 out of a president #3 was also extensive assistance dressing, personal hy During the surveyor noted that of the extension of the surveyor standard that of the extension of the extension of the extension of the extension of the resident of the extension	aff failed to document Intake dinical record of Resident #3. Determined to document the specific geing monitored in the clinical to document in the clinical record for ent #3 was admitted to the the following diagnoses of, art failure, high blood expression, asthma, uscle weakness, difficulty in est of breath. The resident ent MDS (Minimum Data Set, etc.) with an ARD expression of 2/28/16 as Interview for Mental Status) cossible score of 15. Decoded as requiring from one staff person for regiene and bathing. In clinical record review, the in 2/25/16 7 am-7 pm shift documented on the resident ministration Record). The Decome to do the conductions of the above documented.						
*	surveyor prior to the e	ation was provided to the exit conference on 4/22/16. ity staff failed to document		No. of Control of Control		-		

the specific behavior that was being monitored in

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1		ONSTRUCTION		TE SURVEY MPLETED
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F 514	Continued From pa		F 5	14			
	Resident on 2/21/16 with the not limited to heart arthritis, depressior muscle weakness, shortness of breath the MDS (Minimum protocol) with an AFDate) of 2/28/16 as interview for Menta possible score of 18 coded as requiring staff person for dresbathing. During this surveyor noted that MARs (Medication of M	#3 was admitted to the facility following diagnoses of, but failure, high blood pressure, a, asthma, respiratory failure, difficulty in walking and. The resident was coded on Data Set, an assessment RD (Assessment Reference having a BIMS (Brief I Status) score of 15 out of a 65. Resident #3 was also extensive assistance from one asing, personal hygiene and e clinical record review, the on the March and April, 2016 Administration Record) the ank: "Behaviors- Monitor for					
	4/22/16. 6. The fa	acility staff failed to accurately the nurses ⁻¹ note of Resident		1	VDH/		

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		ATE SURVEY OMPLETED
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	on 11/17/15 with the not limited to high anxiety, osteoarthe attack. The reside (Minimum Data Sewith an ARD (Asse 2/15/16 as having Mental Status) sociof 15. Resident #7 extensive assistant mobility, toilet use During the Surveyor, the surveyor asked the director the Policy on Falls received this documentsing on 4/21/16. The policy titled "STEPS TO FOLLO IS FOUND ON THIS section STEPS, it is documented thoroumedical record) systematical record and the floor by the CN. Also include the resident found on the floor by the CN. Also include the resident found and the floor by the CN. Also include the resident found on the floor by the CN. Also include the resident found on the floor by the CN. Also include the resident found on the floor by the CN. Also include the resident found on the floor by the CN. Also include the resident found on the floor by the CN. Also include the resident found on the floor by the CN. Also include the resident found on the following: "RSD (It after another RSD rabout this incidence aware. MD (Medica "Another nurses" in Another nurses" in Another nurses" in the It another nurses and the residence aware. MD (Medica "Another nurses" in the It another nurses and the residence aware. MD (Medica "Another nurses" in the Italian another nurses and the Italian another nurses and the Italian another nurses and the Italian another nurses and the Italian another nurses another nurses and the Italian another nurses and the Italian another nurses and the Italian another nurses and the Italian another nurses and the Italian another nurses another	age 117 #7 was readmitted to the facility be following diagnoses of, but blood pressure, dementia, bitis and transient ischemic ent was coded on the MDS et, an assessment protocol) essment Reference Date) of a BIMS (Brief Interview for or of 0 out of a possible score of was also coded as requiring ce of 1 staff member with bed and personal hygiene, he clinical record review by the eyor noted that Resident #7 anuary, 2016. The surveyor of nursing to provide a copy of for the facility. The surveyor mentation from the director of at approximately 2:30 pm. SAFETY FALLS-INITIAL OW IF A RESIDENT FALLS OR E FLOOR ". Under the stated, "6. The fall must be ughly in the EMR (electronic stem under Interdisciplinary details of the fall, not just the floor or resident eased to A (Certified Nursing Assistant). Sults of the full body st not apparent injury "note dated and timed for 13 pm) that was reviewed by clinical record stated the Resident) found on the floor reported to the nurses desk et CCP was called and made all Doctor) also made aware ote dated and timed for 130) pm was reviewed by the	F 514			

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DAT	/_ U938-U39 FE SURVEY MPLETED
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F 514	Resident found sit	nical record which stated " ting in the floor beside her bed. ying to get into the hed. No	F 514			
	director of nursing documented findin reviewed the docu this documentation supposed to be wrogarding a fall. It	approximately 2:30 pm, the was notified of the above gs. The director of nursing mentation and stated, "No, is not complete in what is itten in the nurses' notes doesn't give you a clear spened to the resident."				
	No furth surveyor prior to th	er information was given to the e exit conference on 4/22/16.				
						The state of the s
		i			4 / 1 mm	
· · · · · · · · · · · · · · · · · · ·				RECEI	VED	
			· The state of the	9/8.23	1.	
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F 000 Initial Comments	,		F 000		
survey and biennia was conducted 4/1 complaint was inve Corrections are red CFR Part 483 Fede requirements and V	Medicare/Medicald sta Il State Licensure Insp 9/16 through 4/22/16 estigated during the su juired for compliance eral Long Term Care /irginia Rules and Re Nursing Facilities. T	pection . One urvey. with 42		The submission of the F Correction does not con agreement on the part of Health & Rehab Center deficiencies cited within represents deficient pra	stitute of Radford nor do the the report

The census in this 90 certified bed facility was 84 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents 1 through 17 and 3 supplment 21-23) and 6 closed record reviews (Residents 18-20, and 24 through 26).

F 001 Non Compliance F 001

> The facility was out of compliance with the following state licensure requirements:

Safety Code survey/report will follow.

This RULE: is not met as evidenced by: 12 VAC 5-371-300. Pharmacy Services. 12 VAC 5-371-300 (J.3) Cross reference to F-431.

12 VAC 5-371-180. Infection Control. 12 VAC 5-371-180 (A,B,C) Cross reference to F-441.

12 VAC 5-371-370. Physical Environment. 12 VAC 5-371-370 (b) Cross reference to F-456. 12 VAC 5-371-360. Clinical Records 12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514 .12 VAC 5-371-340. Dietary Services. 12 VAC 5-371-340 (A) Cross reference to F-371.

12 VAC 5-371-220. Quality of Care.

represents deficient practices on the part of the center and its staff. The plan represents our on-going pledge to provide quality care rendered in substantial compliance with regulatory requirements.

RECEIVED

12 VAC 5-371-300. Pharmacy services. 12 VAC 5-371-180 (ABC) Cross Reference to F-431, pages 89-91

12 VAC 5-371-180. Infection Control. 12 VAC 5-371-180 (A,B,C) Cross reference to F-441, see pages 95-97

12 VAC-5-371-370. Physical Environment 12 VAC 5-371-370 (b) Cross reference to 252, see pages page3-4

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

inistrator

(X6) DATE

If continuation sheet 1 of 2

TATE FORM

PRINTED: 05/11/2016 ΈD

State of	^F Virginia						:D: 05/11/20 RM APPROV
STATEMENT OF DEFICIENCIES (X1) PRO AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIEDENTIFICATION N	JER/CLIA (XZ) MULTIPLE CONSTRUCTION UMBER: A. BUILDING			(X3) DATE	SURVEY PLETED
		49535	Ę		January Vandada and American		
NAME OF	PROVIDER OR SUPPLIER			6 WING	TATE TICA DO COM	04/	22/2016
RADFOR	RD HEALTH AND REHA	AB CENTER	700 RAN	IDOLPH STRE RD, VA 24141			
(X4) ID PREFIX TAG	REGULATORY OR L	TEMENT OF DEPICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORN	ES V Strick	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETE DATE
F 001	Continued From Pa	ge 1		F [*] 001			
	12 VAC 5-371-220 (F-328.	(A, B) Cross referer	ice to				
	12 VAC 5-371-220. 12 VAC 5-371-250. 12 VAC 5-371-250. 12 VAC 5-371-250 (F-280. 12 VAC 5-371-220. 12 VAC 5-371-220. 15 VAC 5-371-220. 16 F-309.	B) Cross reference Resident assessme F, H, I) Cross Refer Quality of Care	ent and Tence to		12 VAC 5-371-360, CI Records 12 VAC 5-371-360 (A, Cross Reference to F-pages 109-112 12 VAC 5-371-340 Die Services 12 VAC 5-371-340 (A) reference to F-371, sec 79-81 12 VAC 5-371-220, Qu Care 12 VAC 5-371-220 (A, Ereference to F-328, see 56-57 12 VAC 5-371-220 (B) Cr reference to F-329, see 59-60 12 VAC 5-371-250, Res assessment and care pl 12 VAC 5-371-250 (F, H Reference to F-280, see 13-15 12 VAC-5-371-220, Qua Care 12 VAC 5-371-220, Qua Care 12 VAC 5-371-220, Qua Care 12 VAC 5-371-220, Qua Care	etary Cross e pages ality of ross pages sident fanning. "I) Cross pages	
					Cross reference to F-309 pages 36-38		
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