

Complete Living Care 1475 Virginia Avenue Harrisonburg, VA 22802 (540) 564-3500

To: Virginia Dept. of Health Office of Licensure

and Certification

Company:

Fax Number:

Phone Number:

**Re**: Mr. Rodney Miller

From: Jonathan Hamilton

Date:

Total No. Pages:

Sender's Phone:

Sender's Fax Number:

Comments:

Dear Mr. Miller.

I'm faxing our plan of correction with gratitude to you and your survey team for all your support and guidance as we improve our service.

RECEIVED

VDH/OLC

Confidentiality Notice: The information contained in this transmission is confidential, proprietary or privileged and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act (HIPAA). The message is intended for the sole use of the individual or entity to whom it is addressed. If you are not the intended recipient, you are notified that any use, distribution or copying of the message is strictly prohibited and may subject you to criminal or civil penalties. If you received this transmission in error, please contact the sender immediately to arrange for return of the documents.

### No. 9920 PRINTED: 03/03/2016 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 4953R5 B. WING 02/18/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid MDS special focus survey was conducted 2/17/16 through 2/18/16. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #1 through #10). F 272 483.20(b)(1) COMPREHENSIVE F 272 SS=D ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following

Identification and demographic information:

Customary routine;

Cognitive patterns;

Communication;

Vision:

Mood and behavior patterns;

Psychosocial well-being;

Physical functioning and structural problems;

Disease diagnosis and health conditions:

Dental and nutritional status;

Skin conditions:

Activity pursuit

Medications:

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

TITLE

(X8) DATE

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

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/03/2016 FORM APPROVED OMB NO. 0938-0391

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	,	495385	B. WING_			02	/18/2016
	VMRC, COMPLETE LIVING CARE  (X4) ID PREFIX TAG  F 272  Continued From page 1  Special treatments and procedures; Discharge potential; Documentation of summary information regar the additional assessment performed on the careas triggered by the completion of the Minin			147	REET ADDRESS, CITY, STATE, ZIP CODE 75 VIRGINIA AVENUE ARRISONBURG, VA 22802		Tioner
PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 272	Special treatments Discharge potential Documentation of s the additional asses areas triggered by t Data Set (MDS); an	and procedures; I; summary information regarding ssment performed on the care the completion of the Minimum	F 27	72			
:	by: Based on staff interfacility document rethe facility staff failed. Assessment Summa Residents in the sar Resident #10. The Findings Included. The Findings Included. For Resident #4 complete the Care A (CAA'S) on an Adm (MDS) assessment Reference Date (AR Resident #4 was a 7 admitted on 1/12/16 included, but were n with an open reduction hypertension, syncolosteoarthritis. The most current Millocated in the clinical	4 the facility staff failed to Area Assessment Summary mission Minimum Data Set with the Assessment		2)	Care Area Assessments (CAA) is resident #4 were completed as 2/19/2016. Completion include identification of the location as CAA information. An audit of all current resident identify incomplete CAA's was completed on 2/19/2016. All residentified with incomplete CAA completed, signed and transmit 4/1/2016.	nd signed es nd date d s to ecords v's will be	of

Reference Date (ARD) of 2/9/16. The facility staff coded that Resident #4 had a Cognitive Summary

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/03/2016 FORM APPROVED OMB NO 0938-0391

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### F 272 Continued From page 2

Score of 15. The facility staff coded that Resident #4 required limited (2/2) to extensive assistance with Activities of Daily Living (ADL's). On February 18, 2016 at 8:20 a.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record produced an Admission MDS assessment with the ARD of 1/19/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 required extensive (3/3) to total nursing care (4/2) with ADL's. In Section V. Care Area Assessment (CAA'S) Resident #4 triggered for the following areas: Cognitive Loss/Dementia, Visual Function, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Behavioral Symptoms. Falls, Nutritional Status, Pressure Ulcer and Pain Review of the CAA'S revealed that the "Location." and Date of CAA Information" was not documented and that the "V. B. 1. Signature of RN (Registered Nurse) Coordinator for CAA Process and Date Signed" and "V.C. 1. Signature of Person Completing Care Plan and Date Signed" was not signed and dated. On February 18, 2016 at 9:30 a.m. the surveyor reviewed the Admission MDS with the ARD of 1/19/16 with the MDS Coordinator, who was a Registered Nurse. The surveyor pointed out that Section V. CAA'S and V.B.1 and V.C.1, were not complete and were not signed and dated. The surveyor requested a copy of the facility policy and procedure for completing MDS's. On February 18, 2016 at 10:10 a.m. the MDS Nurse hand delivered the facility policy and procedure titled, "MDS/Quarterly Assessments and Care Planning." The policy and procedure read in part ... "Purpose: The comprehensive assessment shall include all information specified

F 272

3) All interdisciplinary team members responsible for completion of the MDS will complete a review of the current RAI manual chapter 4. They will also successfully complete online learning MDS modules in the VMRC Relias learning system. These educations will be completed by 4/1/2016. A weekly face-to-face meeting of nursing, life enrichment, social services and registered dietician staff responsible for MDS section completion will begin the week of 3/14/2016. The meeting will be convened by the MDS Coordinator and/or her designee, and will review all pending MDS's for timely completion.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTER'S FOR MEDICARE & MEDICAID SERVICES.

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### F 272 Continued From page 3

in the state-approved RAI (Resident Assessment Instrument) manual. Comprehensive assessments include completion of the assessment, the CAA process, and care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change is status (SCSA) occurs, or when a previous comprehensive assessment (SCPA) needs to be corrected. Quarterly assessments are completed a minimum of 3 times annually. . . C. CAA's are completed by the disciplines associated with the MDS sections that they are responsible for ..." (sic) On February 18, 2016 at 10:45 a.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and MDS Nurse. The surveyor notified the Administrative Team (AT) that Resident #4's Admission MDS CAA'S were not complete, signed and dated. No additional information was provided prior to exiting the facility as to why the facility staff failed to complete the CAA'S on Resident #4's Admission MDS assessment with the ARD of 1/19/16.

2. For Resident #10, facility staff failed to complete the Care Area Assessment Summary (CAA) on an Admission Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) of 10/2/15 within 14 days of admission.

Resident #10 was admitted to the facility on 9/28/15 with diagnoses including atrial fibrillation, dementia, hypertension, debility, and post surgical care with colostomy. The resident scored 11/15 on the Brief Interview for Mental Status on the MDS with ARD 10/2/15 and was assessed to be without signs of delirium or psychosis.

F 272

4) The MDS Coordinator and/or her designee will monitor all MDS assessments weekly for timely completion. Any variances will be immediately corrected and the MDS Coordinator and/or her designee will provide staff education needed to prevent reoccurrence. All trends in variances will be reported to the monthly QAPI committee meeting.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 272	Continued From pa	ige 4	F 2	272		
	that the Admission signed on 10/16/15 signed 10/24/15. To completed within 14 admission (The resist to the assessment been completed 10 Version 3.0 Manual states that the Admission of later than the 14 resident's admission V0200B2) must be 14th calendar day of the signed assessment must be 14th calendar day of	rd review, the surveyor noted MDS with ARD 10/2/15 was and the CAA summary was hese items were not 4 days of the resident's sident was admitted 9/28/15, and summary should have 0/13/15). The CMS RAI I published October 2013 hission Comprehensive be completed (Item Z0500B) Ith calendar day of the mand that the CAAs (Item completed no later than the of the resident's admission, as the 14th day as the 13 calendar days.				
	completion of the a MDS coordinator stated to	ed the concern with late dmission assessment with the n 2/18/16. The MDS that she had 14 days after the noe date to complete an				
	surveyor notified the nursing that late co- assessment was a 483.20(b)(2)(i) COM		Fí	<b>273</b> .		:
	assessment of a re after admission, ex- there is no significa	luct a comprehensive sident within 14 calendar days cluding readmissions in which int change in the resident's condition. (For purposes of				

Eyent ID: 9HPQ11

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

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		ission" means a return to the emporary absence for	F 273			
	by: Based on staff inter and facility docume that the facility staff Comprehensive Add (MDS) assessment Residents in that sar and #10. The Findings Included 1. For Resident #4, complete a Comprehension with the (ARD) of 1/19/16. Resident #4 was a sadmitted on 1/12/16 included, but were rewith an open reduct hypertension, syncotosteoarthritis. The most current Molocated in the clinical Medicare MDS assered Technology and the same service of 15. The far #4 required limited (with Activities of Dai On February 18, 20 reviewed Resident # the clinical record president factors.	mission Minimum Data Set in a timely manner for 2 of 10 imple survey, Residents #4  ed: facility staff failed to hensive Admission MDS a Assessment Reference Date  77 year old male who was i. Admitting diagnoses not limited to: right hip fracture ion and internal fixation, ipe, asthma, neuropathy and inimum Data Set (MDS) al record was a 30 Day assment with an Assessment and in the companion of 2/9/16. The facility staff i. #4 had a Cognitive Summary cility staff coded that Resident 2/2) to extensive assistance	2)	were completed and signed on 2/18/2016. An audit of admissions to the Compliving Center and Transitional Care to identify other potential tardy or incomplete MDS's was completed 2/19/29016. All incomplete or tard MDS's will be completed, signed an transmitted by 4/1/2016.	olete areas  on  y  nd  MDS  nt RAI  ng  will  tly  e for the ill be	

staff coded that Resident #4 had a Cognitive

: Summary Score of 15. The facility staff also

pending MDS's for timely completion.

### Mar. 14. 2016 6:59PM PRINTED: 03/03/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 495385 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 273 Continued From page 6 F 273 coded that Resident #4 required extensive (3/3) 4) The MDS Coordinator and/or her to total nursing care (4/2) with ADL's. In Section designee will monitor all MDS V. Care Area Assessment (CAA's) Resident #4 triggered for the following areas: Cognitive assessments weekly for timely Loss/Dementia, Visual Function, ADL completion. Any variances will be Functional/Rehabilitation Potential, Urinary immediately corrected and the MDS Incontinence and Indwelling Catheter, Coordinator and/or her designee will Psychosocial Well-Being, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer and Pain. provide staff education needed to Review of the CAA'S revealed that the "Location prevent reoccurrence. All trends in and Date of CAA Information" was not variances will be reported to the documented and that the "V.B. 1. Signature of RN (Registered Nurse) Coordinator for CAA Process monthly QAPI committee meeting. and Date Signed" and "V.C.1. Signature of Person Completing Care Plan and Date Signed" as not signed and dated. On February 18, 2016 at 9:30 a.m. the surveyor reviewed the Admission MDS with the ARD of 1/19/16 with the MDS Coordinator, who was a Registered Nurse. The surveyor pointed out that

Section V. CAA'S and V.B.1 and V.C.1 were not complete and were not signed and dated. The surveyor requested a copy of the facility policy and procedure for completing MDS's. The surveyor notified the MDS Nurse that the Admission MDS assessment was not as the CAA's were not signed and that the V.B.1. and

V.C.1, were not signed and dated.

Instrument) manual. Comprehensive assessments include completion of the assessment, the CAA process, and care planning. Comprehensive assessments are

On February 18, 2016 at 10:10 a.m. the MDS
Nurse hand delivered the facility policy and procedure titled, "MDS/Quarterly Assessments and Care Planning." The policy and procedure read in part ... "Purpose: The comprehensive assessment shall include all information specified in the state-approved RAI (Resident Assessment

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F 273	Continued From pa	ige 7	F 27	73		
	significant change when a previous co	Imission, annually, and when a is status (SCSA) occurs, or omprehensive assessment			.•	
4 9 9 2 3	assessments are c times annually	e corrected. Quarterly ompleted a minimum of 3 Procedure: I. I. Frequency of	•			
,	assessments will b	essments: A. Comprehensive e commence upon admission by the fourteenth (14th) day of			;	
,	the resident's stay. by the disciplines a sections that they a On February 18, 20 team met with the	C. CAA's are completed issociated with the MDS are responsible for" (sic) 016 at 10:45 a.m. the survey Administrator (Adm), Director and MDS Nurse. The surveyor			,	
,	notified the Adminis Resident #4's Adm The surveyor notifi	strative Team (AT) that ission MDS was not complete. ed the AT that the CAA'S were hat the V.B.1. and V.C.1. were				
•	No additional informexiting the facility at to complete Reside	mation was provided prior to s to why the facility staff failed ent #4 's Admission MDS				
	complete an Admis assessment with the	o, facility staff failed to sistem Minimum Data Set (MDS) of Assessment Reference Date within 14 days of admission.			:	
	Resident #10 was 9/28/15 with diagnotementia, hyperter	admitted to the facility on oses including atrial fibrillation, asion, debility, and post colostomy. The resident				

psychosis.

scored 11/15 on the Brief Interview for Mental Status on the MDS with ARD 10/2/15 and was assessed to be without signs of delirium or

During clinical record review, the surveyor noted

### PRINTED: 03/03/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND FLAN OF CORRECTION A. BÜILDING B. WING 495385 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 273 F 273 : Continued From page 8 that the Admission MDS with ARD 10/2/15 was signed on 10/16/15 and the CAA summary was signed 10/24/15. These items were not completed within 14 days of the resident's admission (The resident was admitted 9/28/16. so the assessment and summary should have been completed 10/13/15). The CMS RAI Version 3.0 Manual published October 2013 states that the Admission Comprehensive assessment must be completed (Item Z0500B) no later than the 14th calendar day of the resident's admission and that the CAAs (Item V0200B2) must be completed no later than the 14th calendar day of the resident's admission. The manual defines the 14th day as the admission day plus 13 calendar days. Surveyors discussed the concern with late completion of the admission assessment with the MDS coordinator on 2/18/16. The MDS coordinator stated that she had 14 days after the assessment reference date to complete an assessment. During a summary meeting on 2/18/16, the surveyor notified the administrator and director of nursing that late completion of the admission assessment was a concern. F 274 : 483.20(b)(2)(ii) COMPREHENSIVE ASSESS F 274 SS=D AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive

Facility ID: VA0176

assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the

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F 274	itself without furthe implementing stand interventions, that it one area of the res	at will not normally resolve r intervention by staff or by lard disease-related clinical has an impact on more than ident's health status, and linary review or revision of the	F 27	4			
	by: Based on staff intereview, facility staff change minimum d within 14 days of di 10 residents in the Resident #9 was a and readmitted on including cerebrova prostatic hypertropi vascular disturbanciand depression. Or minimum data set a reference date 1/20 assessed as unable memory assessme assessed as exhibite behaviors toward of directed toward oth week look back per	erview and clinical record failed to complete a significant ata set (MDS) assessment scovering the change for 1 of survey sample (Resident #9).  Idmitted to the facility on 1/5/16 2/4/16 with diagnoses ascular accident, benign my with obstruction, dementia, and mainutrition, anxiety, in the significant change assessment with assessment bl/16 the resident was a to recall any items on the int. The resident was ting physical and verbal thers and other symptoms not ers on 1-3 days during the iod. The resident was hibiting signs of delirium or		·	The Significant Change MDS for resident #9 with an ARD of 1/20/2016 was signed and tron 3/8/2016.  An audit of all current reside identify other incomplete or significant change MDS asses be completed by 4/1/2016. A incomplete or tardy significal assessments will be complete and transmitted by 4/1/2016.	of ansmitte nts to tardy ssments Any nt change ed, signe	ed will ge
	surveyor noted that with assessment re	rd review on 2/18/16, the the significant change MDS ference date (ARD) 1/20/16 d or transmitted to CMS. For					

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

ARD 1/5/16, completion date would be 2/4/16.

Event ID: 9HPQ11

Fadlity ID: VA0176

If continuation sheet Page 10 of 45



DEPARTMENT OF HEALT CENTERS FOR MEDICAR					FORM APPROVED OMB NO. 0938-0391
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F 274 Continued From p	page 10	F 2	274	All interdisciplinary tear	n members
The CMS RAI Version 3.0 Manual published October 2013 states that the Significant Change Comprehensive assessment must be completed no later than the 14th calendar day after discovery of the change and that the assessment must be transmitted no later than the 14th				will complete a review of manual chapter 4. They successfully complete of	of the current RAI will also nline learning

Surveyors discussed the concern with late completion date with the MDS coordinator on 2/18/16. F 278 483.20(g) - (j) ASSESSMENT

SS=E ACCURACY/COORDINATION/CERTIFIED

calendar day after the completion date.

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

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

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

learning system. These educations will be completed by 4/1/2016. A weekly face-to-face meeting of nursing, life

enrichment, social services and

registered dietician staff responsible for

MDS section completion will begin the week of 3/14/2016. The meeting will be

convened by the MDS Coordinator and/or her designee, and will review all

pending MDS's for timely completion. 4) The MDS Coordinator and/or her designee will monitor all MDS assessments weekly for timely completion. Any variances will be immediately corrected and the MDS Coordinator and/or her designee will provide staff education needed to prevent reoccurrence. The MDS Coordinator and/or her designee will report audit results weekly to the DON and/or Administrator. All trends in variances will be reported to the monthly QAPI committee meeting.

Facility ID: VA0176

		AND HUMAN SERVICES		,	FORM APPROVED OMB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495385	B. WNG		02/18/2016			
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
VMDC C	OMPLETE LIVING C	ARE		1475 VIRGINIA AVENUE				
VIVICO, C	OMPLETE LIVING OF			HARRISONBURG, VA 22802				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE COMPLETION			
F 278	Continued From pa	ane 11	F 2	78				
:	assessment.	<b>290</b> (1		. •				
	e e e e e e e e e e e e e e e e e e e							
	Clinical disagreement material and false	ent does not constitute a	1)		S			
	THATEIRI MIN TOISE	Side Hore.		1) Resident #1: re-entry assessment was completed on 2/19/2016; 60 day assessment completed on 2/29/2016; and quarterly assessment completed on 3/1/2016.  Resident #4 admission/5 day assessment				
				·				
		NT is not met as evidenced		and quarterly assessment completed	on			
	by:	erview and clinical record	,	3/1/2016.				
	uni lista no deserci review it was deter	mined that the facility staff	:	Resident #4 admission/5 day assessm	nent			
	failed to ensure co	mplete and accurate Minimum		completed on 3/1/2016; 14 day				
	Data Set (MDS) as	sessments for 9 of 10		assessment completed on 3/1/2016;	30			
		ample survey, Resident #1,		day assessment completed on				
		lent #5, Resident #7, Resident esident #6, Resident #9 and		2/18/2016.				
	- #8, Resident #3, R - Resident #10.	esident #0, Nesident #3 and		Resident #5 admission/5 day assessm	nent			
	The Findings Inclu	ded:		and 14 day assessment completed or				
		the facility staff failed to	•	3/4/2016.				
		ry Minimum Data Set (MDS)		Resident #7 admission assessment				
		12/16. The facility staff also	•					
	tailed to sign and d	late the completion of a 60 Day sessment with an assessment	4	completed on 3/4/2016; 5 day				
		RD) of 12/30/15 and a	*	assessment completed on 3/3/2016;				
		h an ARD of 1/26/16.		discharge assessment completed on				
	Resident #1 was a	n 88 year old female who was		3/3/2016.				
	originally admitted	on 11/04/15 and readmitted on	•	Resident #8 14 day assessment, 30 day				
		diagnoses included, but were		assessment and discharge assessmer	nt			
	not limited to: cong	gestive heart failure, bilateral oothyroidism, Parkinson's,		will be completed 3/15/2016.				
		nd chronic kidney disease		Resident #3 attestation was complete	ed			

The most current MDS located in the clinical

record was a Quarterly MDS with an ARD of

had a Cognitive Summary Score of 15. The facility staff also coded that Resident #1 required

Living (ADL's). In Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator

1/26/16. The facility staff coded that Resident #1

extensive assistance (3/2) with Activities of Daily

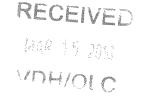
on 3/8/2016.

completed on 3/8/2016.

completed on 3/2/2016.

Resident #6 admission assessment was

Resident #10 quarterly assessment was



# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/03/2016 FORM APPROVED

		& MEDICAID SERVICES				OMB NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI.		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		495385	B, WNG			02/	18/2016
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP C	ODE	
VMRC, C	OMPLETE LIVING CA	ARE			SONBURG, VA 22802		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	D PREFU TAG	; c	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE .	(X5) COMPLETION DATE
	or dated. On February 18, 20 reviewed Resident the clinical record passessment dated the clinical record fiback into the facility Further review of the physician telephone"-Readmit to CLC orders and special Continued review of produced a History that documented the into the facility on 2 Additional review of 60 Medicare MDS 12/30/15. The facility staff also collimited (2/2) to external Additional review of facility staff also collimited (2/2) to external Additional Registered Nurse) Verifying Assessment of dated. On February 18, 20 notified the MDS N dated 1/26/16 and incomplete/inaccur the MDS's with the pointed out that Sedated indicating the	ant Completion was not signed at 2:20 p.m. the surveyor #1's clinical record. Review of produced a Discharge MDS 2/4/16. Continued review of ailed to produce a Re-entry on 2/12/15. The clinical record produced a produced a produced a produced a produced at a corder dated 2/12/16 that read a vertical record produced a procedures v." (sic) of the clinical record also and Physical dated 2/13/16 at Resident #1 was readmitted /12/16. If the clinical record produced a passessment with an ARD of ity staff coded that Resident Summary Score of 15. The ded that Resident #1 required ensive assistance (3/3) with a 0.300 and G0400 were not enably Section Z. Assessment Coordinator and Completion was not signed and a 3:10 p.m. the surveyor were that Resident #1's MDS's	F 2	3)	An audit of current reincomplete MDS asserinaccurate coding of purinary tract infection completed by 4/1/202. The MDS Coordinator designee will use select M of the current RAI remursing staff responsition wound documentation coding of those issues. Beginning 3/17/2016 for current weekly Risk Cowill include review of the skin and wounds, as worked tract infections, for accompliness.	ssments and oressure ulcers is will be 16. and/or her ctions from semanual to educe ble for skin and non accurate by 4/1/2016. the agenda of ommittee meethe MD\$ codingell as of urinar	ction cate d the ting g of

Section G 0300 and G0400 had not been done. On February 18, 2016 at 7:30 p.m. the survey

Mar. 14. 2016 7:00 PM No. 9920 P. 15 PRINTED: 03/03/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03<u>91</u> (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495385 B. WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 278 F 278 Continued From page 13 team met with the Administrator (Adm), Director of Nursing (DON), Administrator in Training (AIT), MDS Nurse. Activities Director and 2 Unit Managers. The surveyor notified the Beginning 3/14/2016 the MDS Administrative Team (AT) that the facility staff failed to ensure complete and accurate MDS's for Coordinator and/or designee will audit Resident #1. The surveyor notified the AT that weekly for 4 weeks all current resident Resident #1's Quarterly MDS with the ARD of records for accuracy of MDS coding of 12/30/15 was not signed or dated as being pressure ulcers and urinary tract complete and that Sections G 0300 and G 0400 were not done. The surveyor also notified the AT infections. Any identified inaccuracies that a Re-entry MDS had not been completed and will be corrected immediately. The MDS that Resident #1 was readmitted into the facility Coordinator and/or designee will on 2/12/16. Lastly the surveyor notified the AT that Resident #1's Quarterly MDS with the ARD of continue audits of a random selection of 1/26/16 was not signed or dated as being 5% of current resident records for complete. accuracy of MDS coding of pressure No additional information was provided prior to ulcers and urinary tract infections exiting the facility as to why the facility staff failed to ensure complete and accurate MDS's for monthly for six months. Any identified Resident #1. inaccuracies will be corrected 2. For Resident #4 the facility staff failed to immediately. Audit results will be ensure complete and accurate Minimum Data Set reported to the monthly QAPI (MDS) assessments. The MDS assessments were a 30 Day Medicare MDS assessment with committee for trend analysis. an Assessment Reference Date (ARD) of 2/9/16, a 14 Day Medicare MDS assessment with an ARD of 1/26/16 and an Admission/5 Day Medicare MDS assessment with an ARD of 1/19/16. Resident #4 was a 77 year old male who was

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osteoarthritis.

admitted on 1/12/16. Admitting diagnoses included, but were not limited to: right hip fracture with an open reduction and internal fixation, hypertension, syncope, asthma, neuropathy and

The most current Minimum Data Set (MDS) located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment

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Facility ID: VA0176

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PRINTED: 03/03/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 02/18/2016 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 14 F 278 Reference Date (ARD) of 2/9/16. The facility staff coded that Resident #4 had a Cognitive Summary. Score of 15. The facility staff coded that Resident #4 required limited (2/2) to extensive assistance with Activities of Daily Living (ADL's). Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. On February 18, 2016 at 8:20 a.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record produced a 14 Day Medicare MDS assessment with an ARD of 1/26/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 extensive assistance (3/3) with ADL's. Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. Further review of the clinical record produced the "Skin Condition Report For Selected Conditions" that documented that Resident #4 was admitted on 1/12/16 with redness on the left lower buttock. redness on the rectal area and redness on the right lower buttocks. Documentation verified that the area on the rectal area progressed to a Stage : II) pressure ulcer on 1/18/16.

Continued review of the clinical record produced an Admission/5 Day Medicare MDS assessment with an ARD of 1/19/16. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 required extensive assistance (3/3) with ADL's. In Section M. Skin Conditions the facility staff did not code/capture that Resident #4 had a Stage III

pressure ulcer. Section Z. Assessment Administration Z0500, Signature of RN

PRINTED: 03/03/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTER \$ FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 495385 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX COMPLETION **JEACH CORRECTIVE ACTION SHOULD BE** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 15 F 278 (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed. or dated. On February 18, 2016 at 9:30 a.m. the surveyor reviewed the 30 day Medicare MDS assessment with the ARD of 2/9/16 with the MDS Nurse. The surveyor pointed out that Section G 0300 and G 0400 were not completed. Additionally the surveyor notified the MDS Nurse that Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. The surveyor also reviewed the 14 Day Medicare MDS with the ARD of 1/26/16 with the MDS Nurse. The surveyor pointed out that Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. Lastly the surveyor reviewed the Skin Condition Report for Selected Conditions and the Admission /5 Day Medicare MDS assessment with the ARD of 1/19/16 with the MDS Nurse. The surveyor pointed out that the facility staff failed to code/capture the Stage [] pressure ulcer in Section M. The surveyor also pointed out that Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. On February 18, 2016 at 10:45 a.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and MDS Nurse. The surveyor notified the Administrative Team (AT) that

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Resident #4's MDS assessments were

haccurate/incomplete. The surveyor informed the AT that Resident #4's MDS's were not signed in Section Z. The surveyor also notified the AT

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Facility ID: VA0176

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Mar. 14. 2016 7:01PM No. 9920 PRINTED: 03/03/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING B. WING 495385 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 16 F 278 that the Admission/5 Day Medicare MDS with the ARD of 1/19/16 did not code/capture the Stage III pressure ulcer. The surveyor notified the AT that the 30 Day Medicare MDS assessment with the ARD of 2/9/16 was incomplete as Section G 0300 and G 0400 were not completed. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate MDS assessments for Resident #4. 3. For Resident #5 the facility staff failed to ensure a complete and accurate 14 Day Medicare Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) of 2/11/15 and an Admission/5 Day Medicare MDS assessment with an ARD of 2/4/16. Resident #5 was an 87 year old female who was admitted on 1/28/16. Admitting diagnoses included, but were not limited to: congestive heart failure, aortic stenosis and osteoarthritis. The most current MDS located in the clinical record was a 14 Day Medicare MDS assessment with an ARD of 2/11/16. The facility staff did not accurately code/capture data in Section C. Cognitive Patterns. The staff did not identify that whether or not the resident interview should have been completed, did not code/capture a Cognitive [ Summary Score or short or long term memory loss. Section D. Mood was not completed. The

Facility ID: VA0176

was not signed or dated.

facility staff coded that Resident #5 required limited assistance (2/2) with Activities of Daily Living (ADL's). However, the facility staff did not complete Section G 0300 or G 0400. Lastly, Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion

Further review of the clinical record produced an Admission/5 Day Medicare MDS assessment with

PRINTED: 03/03/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02/18/2016 B. WNG 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC. COMPLETE LÍVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION **SUMMARY STATEMENT OF DEFICIENCIES** 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 17 F 278 an ARD of 2/04/16. The facility staff coded that Resident #5 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #5 required limited assistance (2/3) with ADL's. However, Section G 0300 and G 0400 were not completed. Lastly, Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. On February 18, 2016 at 2:45 p.m. the surveyor notified the MDS Nurse that Resident #5's MDS assessments were inaccurate/incomplete. The surveyor reviewed the 14 Day Medicare MDS with the ARD of 2/11/16 with the MDS Nurse. The surveyor pointed out that Section C. Cognitive Patterns was not completed. The surveyor also pointed out that Section G 0300 and G0400 were not completed. Lastly, the surveyor pointed out that Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. The surveyor also reviewed the Admission/5 Day Medicare MDS assessment with the ARD of 2/4/16 with the MDS Nurse. The surveyor pointed that Section G. 0300 and G 0400 were not completed. Lastly, the surveyor pointed out that Section Z. Assessment Administration Z0500, Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment

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Complétion was not signed or dated.

On February 18, 2016 at 7:30 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Administrator in Training (AIT),

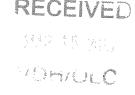
Administrative Team (AT) that the facility staff failed to ensure complete and accurate MDS's for

MD\$ Nurse, Activities Director and 2 Unit Managers. The surveyor notified the

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PRINTED: 03/03/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 02/18/2016 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 F 276 Continued From page 18 Resident #5. The surveyor notified the AT that Sections G 0300 and G 0400 were not done on Resident #5's 14 Day Medicare MDS with the ARD of 2/11/16. The surveyor also notified the AT that Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. The surveyor additionally notified the AT that Section G 0300 and G 0400 on the Admission/5 Day Medicare MDS assessment with the ARD of 2/4/16 were not completed. The surveyor also notified the AT that Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate MDS assessments for Resident #5. 4. For Resident #7 the facility staff failed to ensure complete and accurate Minimum Data Set (MDS) assessments. The assessments were an Admission MDS assessment with an Assessment Reference Date (ARD) of 2/9/16, a Discharge MDS assessment with an ARD of 1/31/16 and a 5 Day Medicare MDS assessment with an ARD of 1/29/16. Resident #7 was a 73 year old female who was originally admitted on 1/11/16 and readmitted on 2/2/16. Admitting diagnoses included, but were not limited to: metastatic colon cancer, morbid obesity, hypertension, asthma, diabetes mellitus

The most current MDS located in the clinical record was an Admission MDS assessment with an ARD of 2/9/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of

and acute renal failure.

PRINTED: 03/03/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B WING 02/18/2016 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG : DEFICIENCY) F 278 F 278 Continued From page 19 15. The facility staff also coded that Resident #7 was independent (1/2) with Activities of Daily Living (ADL's). In Section G. Functional Status the facility staff did not code/capture 0300 or 0400. Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. On February 18, 2016 at 11:15 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced an MDS, a Discharge with return anticipated, with an ARD of 1/31/16. Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. Continued review of the clinical record produced a 5 Day Medicare MDS assessment with an ARD of 1/29/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #7 required supervision (1/1) to extensive assistance (3/2) with ADL's. In Section G. Functional Status the facility staff did not completed G 0300 or G 0400. In Section Z. Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed or dated. On February 18, 2016 at 12:05 p.m. the surveyor notified the MDS Nurse that Resident #7's MDS's were incorrect. The surveyor reviewed the Admission MDS with the ARD of 2/9/16 with the MDS Nurse. The surveyor pointed out that Section G. 0300 and 0400 were not completed. The surveyor also pointed out that Section Z.

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or dated.

Assessment Administration Z0500. Signature of RN (Registered Nurse) Assessment Coordinator Verifying Assessment Completion was not signed

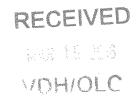
		AND HUMAN SERVICES				FORM OMB NO	0: 03/03/2016 MAPPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		TE SURVEY MPLETED
		495365	B, WING			02	/18/2016
NAME OF FI	ROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
VMRC, CO	OMPLETE LIVING CA	ARE		ı	VIRGINIA AVENUE RISONBURG, VA 22802		
(X4) ID : PREFIX : TAG :	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTIES OF THE A	D BE	(X5) COMPLETION DATE
F 278	Continued From pa	nge 20	. F 2	278			
:	Additionally the sur	veyor reviewed the Discharge					
		with the ARD of 1/31/16 with	•				;
1	the MDS Nurse. TI	he surveyor pointed out that					•
		nent Administration Z0500.					
		egistered Nurse) Assessment	•				;
	was not signed or o	ng Assessment Completion					
		r reviewed the 5 Day Medicare					
		with the ARD of 1/29/16 with		-			
		he surveyor pointed out that					
1		d 0400 were not completed.	i				į
		pointed out that Section Z					
		istration Z0500. Signature of	!	:			ŧ
		rse) Assessment Coordinator					:
	or dated.	ent Completion was not signed					:
		016 at 7:30 p.m. the survey	•				•
		Administrator (Adm), Director	•	•			; I.
		Administrator in Training (AIT),					
:	MDS Nurse, Activit	ies Director and 2 Unit					i
	Managers. The su		:				•
	Administrative Tear	m (AT) that the facility staff	ŧ				
		mplete and accurate MDS's for					
į		surveyor notified the AT that nd G 0400 were not completed	. •				
1		Assessment Administration					
İ		of RN (Registered Nurse)					•
		inator Verifying Assessment					
ļ		t signed or dated on the					1
		sessment with the ARD of		•			
		ay Medicare MDS assessment	\$	:			1
		19/16. Lastly the surveyor		•			•
		the Discharge MDS with the sonot signed or dated in					\$ : :
	Section Z.	s not signed of dated in	*				: :
		nation was provided prior to					; ;
		s to why the facility staff failed					* *
		and accurate MDS					;
	assessments for Re				-		:

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

Event ID: 9HPQ11

Facility ID: VA0175

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No. 9920 P. 23

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

PRINTED: 03/03/2016 FORM APPROVED OMB NO. 0938-0391

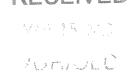
A		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII	TIPLEC	ONSTRUCTION	(X3) DA	TE SURVEY
	TOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		COMPLETED		
		495385	B. WNG			02	/18/2016
NAME OF	PROVIDER OR SUPPLIER	2		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
VARIACE C	COMPLETE LINANC C	ABE		1475	S VIRGINIA AVENUE		
VMIKC, C	COMPLETE LIVING C	ARE	I	HAF	RRISONBURG, VA 22802		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUSY BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) -COMPLETION DATE
		04	. سو	70			:
	Continued From page 21			278			
		#8 the facility staff failed to		:			1
		and accurate Minimum Data Set		:			;
		its. The MDS were a 30 Day		:			
		sessment with an Assessment	•	•			ŧ
		eference Date (ARD) of 1/22/16, a 14 Day					:
	Medicare MDS assessment with an ARD of 1/9/16 and a Discharge with Return Not			•			•
	<b></b>						:
	Anticipated MDS with an ARD of 1/29/16. Resident #8 was a 92 year old female who was						•
		on 12/15/15 and readmitted on					
		diagnoses included, but were					•
	not limited to: atrial fibrillation, anemia, hypertension, coronary artery disease,						
		disease, chronic obstructive					
		e, dementía and osteoarthritis.					
		Minimum Data Set (MDS)					1 1
		ed in the clinical record was a			•		
		MDS assessment with an					
		rence Date (ARD) of 1/22/16.					i
		oded that Resident #8 had a		í			i
		ry Score of 10. The facility staff		ī			i,
		esident #8 required limited	*				1
		ith Activities of Daily Living	ŧ	į			4
		n G. Functional Status the	i .	!			
		t complete 0300 and 0400.		,			?
	Additionally Section	n Z. Assessment	4				1
		500, Signature of RN	•				1
		e) Assessment Coordinator					
	Verifying Assessm	ent Completion was not signed					:
	or dated.						•
	On February 18, 2	016 at 4:15 p.m. the surveyor					
		t#8's clinical record. Review of			•		ŧ
		produced a Discharge with					
		ated with an ARD of 1/29/16.	٠				•
	1	ment Administration Z0500.	,				1
		Registered Nurse) Assessment					
		ing Assessment Completion		;			:
	was not signed or		5 *				
	Continued review	of the clinical record produced		1			:

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Event ID: 9HPQ11

Facility ID: VA0176

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/03/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495385	B. WING			/18/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E	
and the second second				1475 VIRGINIA AVENUE		
VMRC, C	OMPLETE LIVING CA	AKE		HARRISONBURG, VA 22802		
(X4) ID		TEMENT OF DEFICIENCIES	. ID	PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION
PREFIX TAG		YMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI		PROPRIATE	DATE
F 278	Continued From pa	ge 22	F2	278		
	· -	MDS assessment with an	, -			:
		e facility staff coded that				
		Cognitive Summary Score of				
		also coded that Resident #8				
		sistance (2/2) with ADL's. In				
		nal Status the facility staff did				1
		and 0400. Additionally	:			:
		nent Administration Z0500.				
		egistered Nurse) Assessment		,		1
		ng Assessment Completion		1		!
	was not signed or c			i		
		016 at 5:10 p.m. the surveyor		:		i I
		arge with Return Not		<u>;</u>		
		ARD of 1/29/16, the 30 Day				:
		RD of 1/22/16 and the 14 Day		•		
		ARD of 1/9/16 with the MDS	*			1
		or pointed out that Section G		•		•
		re not completed on the 30				
		the 14 Day Medicare MDS		•		
		surveyor also pointed out that nent Administration Z0500.		±		;
		egistered Nurse) Assessment				:
	· Signature or KN (K	ng Assessment Completion				*
	was not signed or o	lated on the Discharge with				
,		ited with the ARD of 1/29/16,				1
		re with the ARD of 1/22/16 and		:		•
		re with the ARD of 1/9/16.				:
		016 at 7:30 p.m. the survey		•		1
		Administrator (Adm), Director	•			:
		Administrator in Training (AIT),	•	•		:
		ies Director and 2 Unit		:		
	Managers. The su			:		•
		n (AT) that the facility staff	•			
		nplete and accurate MDS		: :		!
		esident #8. The surveyor		į		
		Sections G 0300 and G 0400		•		1
		and that Section Z.	•	:	•	:
		istration Z0500. Signature of		•		
	RN (Registered Nu	rse) Assessment Coordinator		·		į.

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Event ID: 9HPQ11

Facility ID: VA0176

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No. 9920 P. 25

PRINTED: 03/03/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 02/18/2016 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC. COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 10 (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 F 278 Continued From page 23 Verifying Assessment Completion was not signed or dated on the 30 Day Medicare MDS assessment with the ARD of 1/22/16 and the 14 Day Medicare MDS assessment with the ARD of 1/09/16. Lastly the surveyor notified the AT that the Discharge with Return Not Anticipated MDS with the ARD of 1/29/16 was not signed or dated in Section Z. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate MDS assessments for Resident #8. 6. For Resident #3, facility staff failed to ensure the quarterly minimum data set (MDS) assessment was accurately coded for diagnosis and signed within the required time frame. Resident #3 was admitted to the facility on 6/13/10 with diagnoses including obstructive uropathy with indwelling suprapubic catheter, enlarged prostate with lower urinary tract symptoms, atrial fibrillation, hyponatremia, dysphagia, and psychotic disorder. The resident scored 13/15 on the brief interview for mental status on the MDS assessment with assessment reference date (ARD) 12/22/15. During clinical record review, the surveyor noted that the resident diagnosis list on the quarterly MDS with ARD 9/22/15 was coded for obstructive uropathy at I1650. The diagnosis list on the

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quarterly MDS with ARD 12/22/15 was not coded

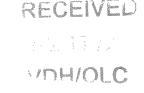
The Quarterly MDS assessment with ARD 12/22/15 was not signed until 1/19/16. The CMS RAI Version 3.0 Manual published October 2013-states that the Quarterly assessment must be

for obstructive uropathy at 11650.

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Facility ID: VA0176

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PRINTED: 03/03/2016

		H AND HUMAN SERVICES			^		APPROVED 0938-0391
		E & MEDICAID SERVICES	<b>—</b> ———			T	E SURVEY
TEMENT PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		IPLETED
		495385	B. WING			02/	18/2016
AME OF F	ROVIDER OR SUPPLIE	٦	<i>4</i>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				1475	VIRGINIA AVENUE		
MRC, C	OMPLETE LIVING	CARE		HAF	RRISONBURG, VA 22802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ΙD		PROVIDER'S PLAN OF CORRECTION	N _	(X5)
REFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDÉNTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE PRIATE	: COMPLETION : DATE
i			,	1			1
F 278			F:	278			
	completed (Item 2 calendar day after date.	20500B) no later than the 14th right the assessment reference					
	Surveyors discus	sed the concern with coding					
	diagnoses and lat	e completion of the admission					
	assessment with	the MDS coordinator on					1
	2/18/16. The MD	S coordinator stated that she					
	had 14 days after the assessment reference date		•		•		1
	to complete an as	sessment.	1	•			
	During a summar	y meeting on 2/18/16, the	:				!
	surveyor notified	the administrator and director of	4	•			1
	nursing that late of	completion of the quarterly		,			-
	assessment was	•		;			
	•		1				· •
	7. For Resident #	6, facility staff failed to	;				•
		or urinary tract infection and to	,	•			i
	complete the com	prehensive minimum data set nt. nt. within 14 days of admission.					1
	(IVIDS) assessme	III Willill 14 days of admission.					
	Resident #6 was	admitted to the facility on 9/4/15					!
	and readmitted or	n 1/28/16 with diagnoses					•
	hemiplegia, hyper	tension, dysphagia, depression,					
	and urinary tract i	nfection. Resident #6 scored					•
		nterview for mental status on		•			ī
		ange MDS assessment with	;	•			
	assessment refer	ence date (ARD) 2/3/16.		,			i
	During aliniani roc	pord ravious the surveyor noted	:	:			f :
	the regident was	cord review, the surveyor noted diagnosed with urinary tract	:	:			* ·
	, me resident was i Tinfection based of	n symptoms and urine culture on	•	:			1
	1/15/16 and treat	ed with antibiotics starting on	•	:			;
		nificant change MDS					
		assessment reference date	-	:			
	1/28/16 was not o	coded for urinary tract infection	*				!
	at 12300 Urinary 7	ract Infection (UTI) (Last 30					

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days).

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Facility ID: VA0176

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PRINTED: 03/03/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PRÓVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLEYED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 02/18/2016 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 25 F 278 Surveyors discussed the concern with coding diagnoses with the MDS coordinator on 2/18/16... During a summary meeting on 2/18/16, the surveyor notified the administrator and director of nursing that coding of the urinary tract infection was a concern. 8. For Resident #9 facility staff failed to complete minimum data set (MDS) assessments in a timely manner. Resident #9 was admitted to the facility on 1/5/16 and readmitted on 2/4/16 with diagnoses including cerebrovascular accident, benign prostatic hypertrophy with obstruction, dementia, vascular disturbance, and malnutrition, anxiety, and depression. On the significant change minimum data set assessment with assessment reference date (ARD) 1/20/16 the resident was assessed as unable to recall any items on the memory assessment. The resident was assessed as exhibiting physical and verbal behaviors toward others and other symptoms not ... directed toward others on 1-3 days during the week look back period. The resident was assessed as not exhibiting signs of delirium or psychosis. During clinical record review on 2/18/16, the surveyor noted that the Optimus EMR clinical systems list of MDS assessments documented

that The admission MDS assessment with ARD 11/4/15 was completed 11/28/15 (completion date should be within 14 calendar days of ARD or 11/18/15); A 14 day assessment with ARD 11/10/15 was completed 12/2/15 (completion date should be within 14 calendar days of ARD or

PRINTED: 03/03/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ 495385 R WING 02/18/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 Continued From page 26 F 278 11/24/15); an admission MDS with ARD 1/12/15 was not completed (completion date should be within 14 calendar days of ARD or 11/26/15). Surveyors discussed the concern with late completion dates of MDS assessments with the MDS coordinator on 2/18/16. The MDS coordinator stated that she had 14 days after the assessment reference date to complete an assessment. During a summary meeting on 2/18/16, the surveyor notified the administrator and director of nursing that late completion of MDS assessments was a concern. 9. For Resident #10, facility staff failed ensure a quarterly minimum data set (MDS) assessment was signed. Resident #10 was admitted to the facility on 9/28/15 with diagnoses including atrial fibrillation, dementia, hypertension, debility, and post surgical care with colostomy. The resident scored 11/15 on the Brief Interview for Mental Status on the MDS with assessment reference date (ARD) 10/2/15 and was assessed to be without signs of delirium or psychosis. During clinical record review on 2/18/16, the surveyor noted that the Quarterly MDS assessment with ARD 2/2/16 was not signed. The

date.

CMS RAI Version 3.0 Manual published October 2013 states that the Quarterly assessment must be completed (Item Z0500B) no later than the 14th calendar day after the assessment reference

Surveyors discussed the concern with late

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

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495385	B. WNG _		02/18/2016
	PROVIDER OR SUPPLIER	ARE		STREET ADDRESS, CITY, STAT 1475 VIRGINIA AVENUE HARRISONBURG, VA 22	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD BE COMPLETION
F 278	Continued From pa		F 27	8	; ; !
	MDS coordinator o coordinator stated	dmission assessment with the n 2/18/16. The MDS that she had 14 days after the note date to complete an			
	surveyor notified the nursing that late co- assessment was a		F 27	o.'	
F 2/9 SS=D			. F 21	9	; ; ;
		and revise the resident's	:		:
	plan for each resid objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's nd mental and psychosocial atified in the comprehensive			
	to be furnished to a highest practicable psychosocial well-t §483.25; and any some be required under due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under services that would otherwise §483.25 but are not provided is exercise of rights under the right to refuse treatment			
	under §483.10(b)(4 This REQUIREME		: :		
	by: Based on staff into Based on staff into Based on staff into	erview and clinical record		Facility ID: VA0176	If continuation sheet Page 28 of 4

MALIOIC

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	03/03/2016 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		NSTRUCTION	(X3) DATE	E SURVEY PLETED
		4953B5	B, WING			02/	18/2016
	PROVIDER OR SUPPLIER	ARE		1475 \	TADDRESS, CITY, STATE, ZIP CODE /IRGINIA AVENUE RISONBURG, VA 22802		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<b>(</b>	PROVIDER'S FLAN.OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	comprehensive cal 10 residents in the For Resident #10, the comprehensive indicated on the Casummary (CAA) of Set (MDS) assessing Reference Date (Allo of admission).  Resident #10 was 9/28/15 with diagnorm dementia, hypertersurgical care with surgical care with surgical care with surgical care with surgical care with status on the MDS assessed to be with psychosis.  During clinical recent that the Admission indicated on the Complete that Cognitive loss ADL function/rehall noontinence and incontinence and psychosocial well-status, pressure uland pain would be The care plan initialls, pressure ulcompain.	failed to complete the re plan on admission for one of survey sample (Resident #10) facility staff failed to complete e care plan for all care areas are Area Assessment in an Admission Minimum Data ment with the Assessment RD) of 10/2/15 within 14 days admitted to the facility on oses including atrial fibrillation, insion, debility, and post colostomy. The resident is with ARD 10/2/15 and was shout signs of delirium or ord review, the surveyor noted MDS with ARD 10/2/15 and was shout signs of delirium or ord review, the surveyor noted MDS with ARD 10/2/15 AA summary signed 10/24/15 AA summary signed 10/24/15 Action potential, Urinary indwelling catheter, being, activities, falls, nutritional director of the care plantated 12/22/15 did not addressed in the care plantated 12/22/15 did not addressed or psychotropic medication, or and director of nursing were cern during a summary meeting		79 1)	The plan of care for resident a updated 3/8/2016 to address care areas: falls, pressure ulco psychotropic medication and An audit of all current resider identify those for whom trigg with intent to care plan had replanned will be completed by All interdisciplinary team mer responsible for completion or complete a review of the current manual chapter 4. They will a successfully complete online modules in the VMRC Relias is system. These educations will by 4/1/2016. A weekly face-to finursing, life enrichment, so and registered dietician staff MDS section completion will week of 3/14/2016. The mean convened by the MDS Coord her designee, and will review MDS's for timely completion A monthly ongoing audit of a selected 5% of resident recoon 4/1/2016. The audit will it assessments with triggered Cointent to care plan to ensure areas are care planned. Any	the follower, pain. Intrecord: pered CAA not been A4/1/201 mbers If the MD: rent RAI also learning learning learning learning learning so-face m ocial serv responsi begin the eting will inator an v all pend a random rds will b dentify CAA's wit that tho	s to A's care 6. S will  MDS pleted eeting rices ble for e be nd/or ling ly eegin h se care

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Surveyors discussed the concern with the care

on 2/18/16.

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be immediately corrected.

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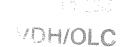
PRINTED: 03/03/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ B. WING 02/18/2016 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC, COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE TEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 279 F 279 Continued From page 29 plan with the MDS coordinator on 2/18/16. During a summary meeting on 2/18/16, the surveyor notified the administrator and director of nursing that late completion of the comprehensive care plan was a concern. F 287 F 287 483,20(f) ENCODING/TRANSMITTING SS=F RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility. must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment.

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Event ID; 9HPQ11

Facility ID: VA0176

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### PRINTED: 03/03/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XZ) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02/18/2016 B. WING 495385 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1475 VIRGINIA AVENUE VMRC. COMPLETE LIVING CARE HARRISONBURG, VA 22802 PROVIDER'S FLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) IO (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 287 F 287 . Continued From page 30 (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly 1) Resident #1: re-entry assessment was assessment. (vi) Quarterly review. completed on 2/19/2016; 60 day (vii) A subset of items upon a resident's transfer, assessment completed on 2/29/2016; reentry, discharge, and death. and quarterly assessment completed on (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that 3/1/2016. does not have an admission assessment. Resident #4 admission/5 day assessment completed on 3/1/2016; 14 day (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which assessment completed on 3/1/2016; 30 has an alternate RAI approved by CMS, in the day assessment completed on format specified by the State and approved by 2/18/2016. CMS. Resident #5 admission/5 day assessment and 14 day assessment completed on This REQUIREMENT is not met as evidenced 3/4/2016. Resident #7 admission assessment Based on staff interview and clinical record completed on 3/4/2016; 5 day review it was determined that the facility staff failed to submit/transmit Minimum Data Set assessment completed on 3/3/2016; (MDS) assessments to Centers for Medicaid and discharge assessment completed on Medicare Services (CMS) for 9 of 10 Residents in -3/3/2016. the sample survey, Resident #1, Resident #4, Resident #8 14 day assessment, 30 day Resident #7, Resident #8, Resident #2, Resident #3, Resident #6, Resident #9 and Resident #10. assessment and discharge assessment The Findings Included: will be completed 3/15/2016. 1. For Resident #1 the facility staff failed to Resident #3 attestation was completed submit multiple Minimum Data Set (MDS) on 3/8/2016. assessments to Centers for Medicaid and

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Medicare Services (CMS).

Resident #1 was an 88 year old female who was

originally admitted on 11/04/15 and readmitted on

2/12/16. Admitting diagnoses included, but were

not limited to: congestive heart failure, bilateral mastectomies, hypothyroidism, Parkinson's, pancreatic mass and chronic kidney disease.

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Resident #6 admission assessment was

Resident #10 quarterly assessment was

completed on 3/8/2016.

completed on 3/2/2016.



		AND HUMAN SERVICES					APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER			NSTRUCTION		TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER	A			T ADDRESS, CITY, STATE, ZIP	CODE	
VMRC, C	OMPLETE LIVING CA	ARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802				
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,	record was a Quart 1/26/16. The facility had a Cognitive Su facility staff also concextensive assistant Living (ADL's). On February 18, 20 reviewed Resident the clinical record paystem for Resident MDS system docur assessment with an Atransmitted to CMS On February 18, 20 notified the MDS N assessments with the 12/30/15 had not be surveyor reviewed MDS system with the pointed out that the submitted to CMS. On February 18, 20 team met with the submitted to CMS. On February 18, 20 team met with the pointed out that the submitted to CMS. On February 18, 20 team met with the pointed out that the submitted to CMS. On February 18, 20 team met with the pointed out that the submitted to submit Retimely manner. No additional informexiting the facility at to submit MDS asset #1.	IDS located in the clinical terly MDS with an ARD of y staff coded that Resident #1 mmary Score of 15. The ded that Resident #1 required the (3/2) with Activities of Daily of 6 at 2:20 p.m. the surveyor #1's clinical record. Review of produced the electronic MDS at #1. Review of the electronic mented that a Quarterly MDS in ARD of 1/25/16, a 60 RD of 12/30/15 had not been in ARD of 1/25/16 and the electronic mented that Resident #1's MDS in ARD's of 1/25/16 and the en submitted to CMS. The the Resident #1's electronic he MDS Nurse. The surveyor in MDS is had not been on the MDS nurse in the surveyor administrator (Adm), Director Administrator in Training (AIT), ties Director and 2 Unit	F 2	37	2) An audit of admissiliving Center and To identify other poincomplete MDS's 2/19/29016. All interdisciplinar responsible for convill complete a remanual chapter 4. successfully complete in the learning system. To be completed by 4 face-to-face meet enrichment, social registered dieticial MDS section completed by the fand/or her design pending MDS's for	transitional Canotential tardy of the was completed or tappeted, signed 1/2016. They will also be the Complete on the Completed on the Completed on the Complete on the Complete on the Complete on the Completed on the Completed on the Completed on the Completed on the Complete on the Co	re areas or od on ordy and ers e MDS rrent RAI rning os ns will eekly life sible for gin the g will be tor view all
	assessments to Ce	enters for Medicaid and	1	:			, 1 1

Medicare Services (CMS)



DEPARTMENT	OF HEALTH	I AND HUMAN SERVICES				: 03/03/2016  APPROVED
CENTERS FOR	MEDICARE	& MEDICAID SERVICES				. 093 <u>8-039</u> 1
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				1475 VIRGINIA AVENUE		
VMRC, COMPLE	TE LIVING C	ARE	l	HARRISONBURG, VA 22802		
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI. TAG		SHOULD BE	(X5) COMPLETION DATE
F 287 Contin	ued From na	age 32	F 2	287		
Reside admitted include with an hypert osteod The modern Medica Reference coded Score #4 requirement with Action Februsian ARI CMS. On Februsian ARI CMS. On Februsian ARI CMS. On Februsian MDS and ARI CMS. On Februsian A	ent #4 was a ed on 1/12/1 ad, but were a open reduce ension, syno- orthritis. Dest current Marchael (All the Clinical Resider of 15. The fuired limited ctivities of Date (All the Mosament Value) and the Mosament Wastern documents with 18 and not be or reviewed ystem with the dout that the dout the	77 year old male who was 6. Admitting diagnoses not limited to: right hip fracture etion and internal fixation, ope, asthma, neuropathy and dinimum Data Set (MDS) cal record was a 30 Day dessment with an Assessment RD) of 2/9/16. The facility staff at #4 had a Cognitive Summary acility staff coded that Resident (2/2) to extensive assistance ally Living (ADL's). D16 at 8:20 a.m. the surveyor #4's clinical record. Review of produced the electronic MDS at #4. Review of the electronic mented that a 14 Day Medicare with an ARD of 1/26/16 and an fledicare MDS assessment with had not been transmitted to D16 at 3:10 p.m. the surveyor urse that Resident #4's MDS the ARD's of 1/26/16 and en submitted to CMS. The the Resident #4's electronic he MDS Nurse. The surveyor of MDS's had not been D16 at 10:45 a.m. the survey Administrator (Adm), Director and MDS Nurse. The surveyor strative Team (AT) that the besubmit Resident #4's MDS's		4) The MDS Coordinatesignee will monitassessments weekl completion. Any valimmediately correct Coordinator and/or provide staff education prevent reoccurrent Coordinator and/or report audit results and/or Administrativariances will be remonthly QAPI comments.	tor all MDS  y for timely  riances will be  ted and the M  her designee  tion needed to  ce. The MDS  her designee  weekly to the  ported to the	e MDS will o will e DON

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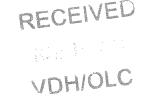
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				7. 0330-0001	
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		495385	B. WING			2/18/2016	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE		
				1475 VIRGINIA AVENUE			
VMRC, C	OMPLETE LIVING CA	ARE		HARRISONBURG, VA 22802			
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			·	1		:	
F 287	Continued From pa	age 33	F	287		:	
·		essments to CMS for Resident		:		:	
	. #4.		•	:		:	
		7 the facility staff failed to	1				
	submit multiple Mir	nimum Data Set (MDS)	,				
		enters for Medicaid and				1	
	Medicare Services	(CMS).					
	Resident #7 was a	73 year old female who was				·	
	originally admitted	on 1/11/16 and readmitted on		Y.			
	2/2/16. Admitting (	diagnoses included, but were					
		static colon cancer, morbid	Ĭ	:		1	
		on, asthma, diabetes mellitus				:	
	and acute renal fai			•		ŧ :	
		ADS located in the clinical		•		ī	
		nission MDS assessment with				1	
	an ARD of 2/9/16.	The facility staff coded that					
	: Resident #7 nad a	Cognitive Summary Score of iff also coded that Resident #7	-	•		<u> </u>	
		1/2) with Activities of Daily					
	Living (ADL's).	1/2) With Activities of Daily	,	£		i	
	On February 18 2	016 at 11:15 a.m. the surveyor	:	•			
	i reviewed Resident	#7's clinical record. Review of	i	1		į	
	the clinical record	produced the electronic MDS		!		į	
	evstem for Resider	nt #7. Review of the electronic	į	!		!	
		mented that a Re-entry MDS	*	:		į	
	assessment with a	n ARD of 2/2/16, a Discharge	:	† 			
		with an ARD of 1/31/16, a 5	1	•		!	
	Day Medicare with	an ARD of 1/29/16, a Re-entry	:			;	
	MDS assessment	with an ARD 1/22/16, a					
		ith an ARD of 1/20/16 and a 5		;		i I	
		the ARD of 1/18/16 had not					
	been transmitted to		•			• 2	
	On February 18, 2	016 at 12:05 p.m. the surveyor				1	
		Jurse that Resident #7's MDS's				•	
	had not been trans	sported to CMS in a timely	:			:	
	manner. The surv	eyor reviewed the Resident	*				
	#7's electronic MD	S system with the MDS Nurse.	1	:		į	
		ted out that the MDS's had not	:			Î	
	been submitted to		*	•		1	
	∃ On February 18-2	016 at 7:30 p.m. the survey				ł	

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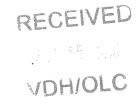
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Medicare with an ARD of 1/9/16, an Admission

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psychosis.

assessed to be without signs of delirium or

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	03/03/2016 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495385	B. WING			02/1	18/2016
	ROVIDER OR SUPPLIER	ARE		147	EET ADDRESS, CITY, STATE, ZIP CODE 5 VIRGINIA AVENUE RRISONBURG, VA 22802		
(X4) ID PREFIX TAG	/FACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEPICIENCY)	BE	(XS) COMPLETION DATE
F 287	During clinical reco that the Admission signed on 10/16/15 completed within 1 admission (The res so the assessment been completed 10 Version 3.0 Manual states that the Admission no later than the 14 resident's admission must be transmitted calendar day after facility's Optimus E the comprehensive on 11/07/15, or 25 completion date and completion date.	and review, the surveyor noted MDS with ARD 10/2/15 was in These items were not a days of the resident's sident was admitted 9/28/16, and summary should have 0/13/15). The CMS RAI I published October 2013 mission Comprehensive one completed (Item Z0500B) at a calendar day of the on and that the assessment of an olater than the 14th the completion date. The EMR clinical system indicated a assessment was transmitted days after the required and 22 days after the actual	F 2	87:			
	assessment with the 2/18/16. The MDS had 14 days after transmit it.  During a summary surveyor notified the	insmission of the admission the MDS coordinator on S coordinator stated that she completing an assessment to meeting on 2/18/16, the he administrator and director of ansmission of the admission		:			
	an amended minit	a concern. 2, facility staff failed to transmit mum data set significant chang 4 days of completion of the	e	1			

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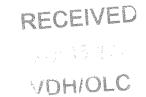
Resident #2 was admitted to the facility on 12/26/05 and re-entered the facility on 12/13/15.

assessment.

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assessment within the required time frame.

Resident #3 was admitted to the facility on 6/13/10 with diagnoses including obstructive uropathy with indwelling suprapubic catheter, enlarged prostate with lower urinary tract symptoms, atrial fibrillation, hyponatremia. dysphagia, and psychotic disorder. The resident scored 13/15 on the brief interview for mental

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		495385	B. WING				02/18/2016
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
VMRC, C	OMPLETE LIVING CA	ARE			5 VIRGINIA AVENUE RRISONBURG, VA 22802		,
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F 287	Continued From pa	ge 38	, F 2	·87			
	1	assessment with assessment	. , -			·	} ! !
	12/22/15 was not si RAI Version 3.0 Ma states that the Quarcompleted (Item Z0 calendar day after thate. The assessment 14 days of the complete that it date assessment with the 2/18/16. The MDS had 14 days after the complete an assessment with the complete and the complete a			AT MA SACE A COMPLEX CONTRACT PROPERTY AND A CONTRACT AND A CONTRA			
e en e en	surveyor notified the	meeting on 2/18/16, the administrator and director of mpletion of the quarterly concern.					
	surveyor notified the	meeting on 2/18/16, the eadministrator and director of insmission of the assessment					
,		facility staff failed to transmit MDS) assessments within the		:			

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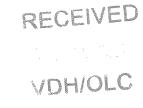
required time frame.

Resident #6 was admitted to the facility on 9/4/15 and readmitted on 1/28/16 with diagnoses

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Resident #9 was admitted to the facility on 1/5/16 and readmitted on 2/4/16 with diagnoses including cerebrovascular accident, benign prostatic hypertrophy with obstruction, dementia, vascular disturbance, and malnutrition, anxiety,

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No. 9920 P. 42

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

PRINTED: 03/03/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495385	B. WING	,	02/18/2016
NAME OF	PROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE, ZI	
				1475 VIRGINIA AVENUE	
VMRC, C	COMPLETE LIVING C	CARE		HARRISONBURG, VA 22802	
(X4) ID	; SUMMARY ST	ATEMENT OF DEFICIENCIES	. 10	PROVIDER'S PLAN OF C	
PRÉFIX TAG		CYMUST, BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE PATE
F 287	Continued From p	age 40	F 2	B7 (	
	and depression. C	n the significant change			
	minimum data set	assessment with assessment			-
		RD) 1/20/16 the resident was			į.
	assessed as unab	le to recall any items on the			•
	memory assessme	ent. The resident was			
	assessed as exhibiting physical and verbal				•
	behaviors toward others and other symptoms not				
		hers on 1-3 days during the			
	week look back pe	eriod. The resident was	•		
	assessed as not e	xhibiting signs of delirium or	-		!
	psychosis.		:	<u>:</u>	
	I During clinical rec	ord review on 2/18/16, the			†
		at the Optimus EMR clinical		\$	:
		S assessments documented		* -	
		n MDS assessment with ARD			i
		mitted 12/12/15 (transmission	`		
		hin 21 calendar days of ARD	!	1	
		lay assessment with ARD	•	i e	1
	11/10/15 was trans	smitted 12/16/15 ( completion	:	•	:
		hin 21 calendar days of ARD or	•		
		ssion MDS with ARD 1/12/16		*	
		d (transmission date should be		•	:
		days of ARD or 2/2/16).		,	/ + 1
	Currenters discussed	and the concern with late			•
		ed the concern with late s of MDS assessments with the			
		on 2/18/16. The MDS		•	
		that she had 14 days after the	1	:	
		complete an assessment.			:
	completion date to	с финувае ви возеззинена.		;	
	During a summan	meeting on 2/18/16, the	:	i	1
		he administrator and director of		:	}
		ompletion of MDS assessments	;	: }	į
	was a concern.	Surpleton of Misc adaessmenta		•	į
E 330		EGIMEN IS FREE FROM	F 3:	2 <b>a</b>	4
	UNNECESSARY I		, ,,,,		<b>(</b>
55=E	: DINIVEDESSART I	211000	,		
		•			

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

PRINTED: 03/03/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				UNID NU	7. 0930-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONS		(X3) DATE SURVEY COMPLETED	
		495385	B, WING				2/18/2016
NAME OF	PROVIDER OR SUPPLIER	1		STREET	ADDRÉSS, CITY, STATE, ZIP CO	DE	
VMRC, C	OMPLETE LIVING C	ARE			RGINIA AVENUE BONBURG, VA 22802		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	_	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
F 329	Continued From pa	ige 41	- . F:	329			!
	unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its u adverse consequel should be reduced combinations of the Based on a compressident, the facility who have not used given these drugs therapy is necessars diagnosed and record; and resider drugs receive grad behavioral interven	g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any ereasons above.  The ensive assessment of a must ensure that residents antipsychotic drug are not unless antipsychotic drug ry to treat a specific condition documented in the clinical ints who use antipsychotic unal dose reductions, and tions, unless clinically an effort to discontinue these					
	This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, and clinical record review, facility staff failed to ensure that a resident who had not used antipsychotic drugs was not given antipsychotic drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record (Resident #9).  Resident #9 was admitted to the facility on 1/5/16 and readmitted on 2/4/16 with diagnoses including cerebrovascular accident, benign			2)	The order for antipsych resident #9 was clarified practitioner on 1/22/20. The pharmacy consultate monthly audits of 100% prescribed antipsychotoappropriate diagnosis, investigated and referring physician for clarificate elimination.	ed by the num 016. Ant will cond % of residentic May variance red to the tr	rse luct ts on for ces will be reating

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	03/03/2016 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A, BUILD		CONSTRUCTION		E SURVEY IPLETED	
		495385	B. WING				18/2016	
	PROVIDER OR SUPPLIER	ARE	STREET ADDRESS, CITY, STATE, ZIP CODE  1476 VIRGINIA AVENUE  HARRISONBURG, VA 22802					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 329	vascular disturbance and depression. Or minimum data set reference date 1/20 assessed as unable memory assessme assessed as exhibited behaviors toward of directed toward of week look back perassessed as not expected assessed as not expected for "Hald (concentrate) 2 mg mg oral every 1 hophysician order data Haloperidol 1 mg Fand PRN (as need disturbance changuse for anxiety. Treport for January	hy with obstruction, dementia, be, and malnutrition, anxiety, in the significant change assessment with assessment 0/16 the resident was at the resident was at the resident was ting physical and verbal others and other symptoms not person 1-3 days during the riod. The resident was chibiting signs of delirium or ordered to the resident was chibiting signs of delirium or ordered lacted 1/5/16 on readmission to operidol lactate oral conc. I/ml (milligrams per milliliter) 1 or as needed for anxiety. A ted 1/22/16 "schedule" (by mouth)qQ2000 (8PM) are prindiagnosis please do not the resident's EMAR Monthly	F 3	3)	provide education using cur documentation standards to responsible for medication aby 4/1/2016. Education will use and documentation of a pharmacological intervention administration of pranatips medications.	rent o nurses administrati also include non- ons prior to sychotic fill continue ords of residedication wi DN and QAP linator and/ for 4 weeks as prescribed or appropriation of prin dits by the fi	ion e the the dents th or te	

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

20, 22 under the order for anxiety. The surveyor

indication, or effectiveness of the PRN medication

anxious and agitated. Attempting to call on phone : and go out doors. Haldol given X 2" without times or effectiveness documentation. The resident's EMAR Monthly report for January 2015

documented administration on January 27 and 28 : under the order for dementia with behavior disturbance. All nursing notes on 1/28/16 documented no problem behaviors noted. Nurse's notes dated 1/26/16 documented

was unable to locate documentation for time,

except for 1/22 " Resident in w/c and very

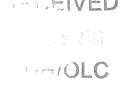
Event ID: 9HPQ11

Facility ID: VA0176

committee.

If continuation sheet Page 43 of 45

will continue with reporting to the QAPI



		AND HUMAN SERVICES  & MEDICAID SERVICES					MAPPROVED D. 0938-0391_	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495385	B. WING_			02	2/18/2016	
NAME OF F	ROVIDER OR SUPPLIER		1		ET ADDRESS, CITY, STATE, ZIP CODE			
VMRC, COMPLETE LIVING CARE					VIRGINIA AVENUE RRISONBURG, VA. 22802			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEPICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 329	Continued From pa	ine 43	· F 32	29			:	
	i administration of Haldol at 1830 for specific behavior. Effectiveness of the 1/26 Haldol was not documented.			: :				
	The surveyor discussed the concern with the anxiety as indication for PRN antipsychotic and failure to adequately document indication and effectiveness with the director of nursing on 2/18/16.		:					
F 356 SS=C	concern during a si	team was notified of the ummary meeting on 2/18/16. NURSE STAFFING	F 35	56				
	a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per s - Registered nu - Licensed prac vocational nurses ( - Certified nurse o Resident census.  The facility must po specified above on of each shift. Data o Clear and readat o In a prominent pla residents and visito  The facility must, u	and the actual hours worked regories of licensed and staff directly responsible for hift: arses. Stical nurses or licensed as defined under State law) as a defined under State law) as the nurse staffing data a daily basis at the beginning must be posted as follows: sile format.						

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

Event ID: 9HPQ11

Facility ID: VA0176

If continuation sheet Page 44 of 45

RECEIVED



TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING  NAME OF PROVIDER OR SUPPLIER  VMRC, COMPLETE LIVING CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUT AGE CROSS-REFERENCED TO THE APPRECED TO THE APPREC	O2 TION ULD BE	TE SURVEY MPLETED  //18/2016  (X5) COMPLETION DATE
NAME OF PROVIDER OR SUPPLIER  VMRC, COMPLETE LIVING CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION)  F 356 Continued From page 44  for review at a cost not to exceed the community	TION ULD BE	(X5) COMPLETION
VMRC, COMPLETE LIVING CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 356 Continued From page 44  for review at a cost not to exceed the community	TION ULD BE	(XS) COMPLETION
VMRC, COMPLETE LIVING CARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)  F 356 Continued From page 44  for review at a cost not to exceed the community	ULD BE	COMPLETION
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOT TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 356 Continued From page 44  for review at a cost not to exceed the community	ULD BE	COMPLETION
for review at a cost not to exceed the community		
for review at a cost not to exceed the community		
The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.		
This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview, and facility document review, facility staff failed to post the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:- Registered nurses;- Licensed practical nurses; - Certified nurse aides; and resident census.  During initial tour on 2/17/16, surveyors observed that nursing staffing was posted for individual units in each of the four long term care buildings, but there was no posting of resident census and aggregate nursing time for the facility as a whole.  During a summary meeting on 2/18/16, the administrator and director of nursing were notified that the expectation was that total staffing and census numbers for the facility be posted in a place accessible to residents as evidenced aggregate nursing staff hours the Oak Lea building in an are residents and visitors was init 3/14/2016.  The Post Lea building in an are residents and visitors was init 3/14/2016.  Nursing supervisors responsible collecting staffing hours are correctly an posted.  Nursing supervisors responsible collecting staffing hours data their respective totals to the secondinator who will then cor aggregate staffing hours posting of the facility be posted in a place accessible to residents and facility to post the coak Lea building in an are residents and visitors was init 3/14/2016.  The Oak Lea Front Desk receptive verify daily that the census an nursing hours are correctly are posted.  Nursing supervisors responsible collecting staffing hours data their respective totals to the secondinator who will then cor aggregate staffing hours post in the control of the facility as a whole.	in the lobes accessile trated on obtionist wind aggregated visibly obtained the staff mplete the log requires the log requirements the	bby of ible to ill rate rt e