STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/4/18 through 4/6/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to establish and maintain a complete	E 001	**E001** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice** Immediately conducted a review of our current emergency preparedness plan to assure that our program included all necessary components that would not put residents at risk. Started planning next steps to enhance the needed components to fulfill the comprehensiveness of the emergency preparedness program. **How facility will identify other residents having the potential to be affected by the same deficient practice** Immediately conducted a review of our current emergency preparedness plan to assure that our program included all necessary components that would not put any residents at risk. Started planning next steps to enhance the needed components to fulfill the comprehensiveness of the emergency preparedness program. **Measure or system change to ensure the deficient practice will not recur** Emergency preparedness program will be further revised to assure comprehensiveness.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	5-4-18

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

RECEIVED

VDH/OLC

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

E 001 Continued From page 1

emergency preparedness plan.

The facility staff failed to establish and maintain a comprehensive emergency preparedness program that meets the requirements of these regulations.

The findings include:

On 4/5/18 at 3:45 p.m. and 4/6/18 at 9:13 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #3 (the director of environmental services). Review of the facility's emergency preparedness plan failed to evidence a comprehensive plan that meets the requirements of these regulations. On 4/6/18 at 9:55 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of this concern.

No further information was presented prior to exit.

E 035 LTC and ICF/IID Sharing Plan with Patients
SS=C CFR(s):483.73(c)(8)

[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document

E 001

How the facility plans to monitor its performance to make sure that solutions are sustained
Administrator, Director of Environment Services, or designee will conduct a 'learning after doing' exercise following any facility emergency or drill in the monthly Quality Assurance Performance Improvement (QAPI) to assure the emergency is sufficiently addressed in the emergency preparedness program.

All corrective actions complete by 5-21-18.

E 035

E035
How corrective action will be accomplished for those residents found to have been affected by the deficient practice
Reviewed and determined there was not a negative impact for a resident. Determined that we would expand our current communication forum (Resident Council), expand our emergency communication, and more comprehensively document that communication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE

E 035 Continued From page 2

review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to provide evidence of documentation that the communication plan includes a method for sharing information from the emergency plan with residents or clients and their families or representatives.

The findings include:

On 4/5/18 at 3:45 p.m. and 4/6/18 at 9:13 a.m., the facility's emergency preparedness plan was reviewed with OSM (other staff member) #3 (the director of environmental services). Review of the facility's emergency preparedness plan failed to evidence documentation that the communication plan includes a method for sharing information from the emergency plan with residents or clients and their families or representatives. On 4/6/18 at 9:55 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of this concern.

No further information was obtained prior to exit.

E 039 EP Testing Requirements
SS=C CFR(s): 483.73(d)(2)

(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:

*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan atleast annually, including

E 035 **How facility will identify other residents having the potential to be affected by the same deficient practice**

Reviewed and determined there was not a negative impact for any resident. Determined that we would expand our current communication forum (Resident Council), expand our emergency communication, and more comprehensively document that communication.

Measure or system change to ensure the deficient practice will not recur

Implement revised process where a designated Resident Council meeting at a minimum one time per year will include an emergency preparedness program review, with comprehensive minutes, delivered or mailed to all residents/representatives.

How the facility plans to monitor its performance to make sure that solutions are sustained

E 039 Director of Environment Services or designee will report out annually to Quality Assurance Performance Improvement (QAPI) when resident/representative communication on emergency preparedness program has occurred.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

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E 039 Continued From page 3

unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]

(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
(ii) Conduct an additional exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based.
(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following:
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set

E 039 **E039**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

Immediately conducted a review of our current emergency preparedness plan to assure that our program included all necessary components that would not put resident at risk. Continuing with current plans of a full-scale, individual facility-based exercise of a disaster drill by May 1, 2018.

How facility will identify other residents having the potential to be affected by the same deficient practice

Immediately conducted a review of our current emergency preparedness plan to assure that our program included all necessary components that would not put any residents at risk. Continuing with current plans of a full-scale, individual facility-based exercise of a disaster drill by 5-1-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

E 039 Continued From page 4

of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.

The facility staff failed to provide evidence of documentation of the annual tabletop and full-scale exercises and documentation of the facility's exercise analysis, response, and how the facility updated its emergency program based on the exercise analysis.

The findings include:

On 4/5/18 at 3:45 p.m. and 4/6/18 at 9:13 a.m., a review of the facility's emergency preparedness plan was conducted with OSM (other staff member) #3 (the director of environmental services). Review of the facility's emergency preparedness plan failed to evidence documentation of the annual tabletop and full-scale exercises and documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. On 4/6/18 at 9:55 a.m., ASM (administrative staff member) #1 (the administrator) was made aware of this concern.

No further information was obtained prior to exit.

E 039 **Measure or system change to ensure the deficient practice will not recur**

1) New annual full-scale community-based (or individual based) exercise to be added to our current emergency preparedness program.
2) New annual table-top exercise to be added to our current emergency preparedness program.
3) New table-top exercise to be conducted, with appropriate analysis and response, and any additions to be added to our emergency preparedness program as appropriate.

How the facility plans to monitor its performance to make sure that solutions are sustained

Director of Environment Services or designee will report out upon any facility actual emergency, facility emergency exercise, or emergency drill to Quality Assurance Performance Improvement (QAPI) for any needed response or updates to our current emergency preparedness program.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	**INITIAL COMMENTS** An unannounced Medicare/Medicaid standard survey was conducted 4/4/18 through 4/6/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 20 certified bed facility was 15 at the time of the survey. The survey sample consisted of 12 current resident reviews (Residents# 9, 61, 10, 4,112, 1, 6, 8, 3,111, 2 and 115) and two closed record reviews (Residents # 12 and 11).	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.1O(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.1O(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550	**F550** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice** Social worker to meet with residents affected. Provide emotional support. Implement resident-centered service by offering resident choice on preference of living room seating vs. dining seating prior to breakfast. **How facility will identify other residents having the potential to be affected by the same deficient practice** Social worker to meet with remaining residents on neighborhood. Provide emotional support. Implement resident-centered service by offering resident choice on preference of living room seating vs. dining seating prior to breakfast.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6	F 550	**Measure or system change to ensure the deficient practice will not recur**	

residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.1O(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.1O(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide dignity for six of 14 residents in the survey sample, Residents #1, #3, #4, #6, #9 and #61.

The facility staff failed to provide breakfast to all residents seated at the dining room table at the same time on 4/4/18. Residents #1, #3, #4, #6, #9 and #61 were placed at the dining room table with no food while another resident was observed eating.

The findings include:

Resident #1 was admitted to the facility on 6/26/17. Resident #1's diagnoses included but were not limited to diabetes, chronic kidney

Implement new practice whereby all residents who do not require assistance with drinking at the breakfast table or whom it is their preference will be offered a drink at the table while waiting for their breakfast meal. Residents who require assistance with a drink or whom is their preference will be assisted to the living room until breakfast time. All nursing to be educated on new practice and re-educate on dignity.

How the facility plans to monitor its performance to make sure that solutions are sustained
Audit to be completed 2 times per month by Director of Nursing or designee to ensure compliance and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 7	F 550		

disease and major depressive disorder. Resident #1's most recent MOS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/18, coded the resident's cognition as severely impaired. Section G coded Resident #1 as requiring supervision with setup help only with eating.

Resident #2 was admitted to the facility on 12/29/17. Resident #2's diagnoses included but were not limited to high blood pressure, high cholesterol and anxiety disorder. Resident #2's most recent MOS, an annual assessment with an ARD of 12/29/17, coded the resident as cognitively intact. Section G coded Resident #2 as requiring supervision with setup help only with eating.

Resident #3 was admitted to the facility on 7/15/17. Resident #3's diagnoses included but were not limited to difficulty swallowing, anxiety disorder and high blood pressure. Resident #3's most recent MOS, a significant change in status assessment with an ARD of 1/19/18, coded the resident's cognition as moderately impaired. Section G coded Resident #3 as requiring limited assistance of one staff with eating.

Resident #4 was admitted to the facility on 2/26/16. Resident #4's diagnoses included but were not limited to muscle weakness, high cholesterol and major depressive disorder. Resident #4's most recent MOS, a quarterly assessment with an ARD of 2/4/18, coded the resident's cognition as severely impaired. Section G coded Resident #4 as requiring extensive assistance of one staff with eating.

Resident #6 was admitted to the facility on 9/9/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 8	F 550		

Resident #6's diagnoses included but were not limited to dry eye syndrome, difficulty swallowing and major depressive disorder. Resident #6's most recent MOS, a significant change in status assessment with an ARD of 3/12/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #6 as being totally dependent on one staff with eating.

Resident #9 was admitted to the facility on 3/15/17. Resident #9's diagnoses included but were not limited to pain, muscle weakness and vitamin deficiency. Resident #9's most recent MOS, a quarterly assessment with an ARD of 3/21/18, coded the resident's cognition as severely impaired. Section G coded Resident #9 as being totally dependent of one staff with eating.

Resident #61 was admitted to the facility on 3/26/18. Resident #61's most recent MOS, an admission assessment with an ARD of 4/2/18 (completed but not yet submitted to the Centers for Medicare and Medicaid Services), coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #61 as requiring extensive assistance of one staff with eating.

On 4/4/18 at 8:25 a.m., a dining observation was conducted in the long-term care dining room. Four square tables were pushed together to create one long table. Resident #2 was observed feeding himself at the dining room table. Resident #3 was observed sitting at the table drinking a beverage. Resident #61 was observed sitting at the table with her husband. Resident #61's husband was assisting her with a beverage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING ___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 9	F 550		

Neither Resident #3 nor Resident #61 had food at the table. On 4/4/18 at 8:37 a.m., Resident #6 was wheeled to the table. On 4/4/18 at 8:39 a.m., Resident #1 was wheeled to the table. On 4/4/18 at 9:00 a.m., Resident #9 was wheeled to the table. At this time, the only resident observed with food was Resident #2. Also at this time, an interview was conducted with OSM (other staff member) #6 (the Chaplain who was observed talking with residents sitting at the dining room table). OSM #6 was asked who was responsible for serving food to residents at the dining room table. OSM #6 stated the cook usually makes food and brings it out to the unit. When asked why residents were not yet being served, OSM #6 stated some residents need assistance from care staff so she thought they were waiting to serve residents at the table when care staff was available to assist them. OSM #6 stated the care staff is typically getting residents ready to come out to the dining room. On 4/4/18 at 9:03 a.m., Resident #4 was wheeled to the dining room table. On 4/4/18 at 9:05 a.m., Resident #61 and her husband were served breakfast. On 4/4/18 at 9:16 a.m., Residents #3 and #1 were served breakfast then Residents #4, #6 and #9 were served and assisted with breakfast.

During the above observations, staff was not observed offering food to the above residents until the times documented above.

On 4/5/18 at 2:16 p.m., an interview was conducted with CNA (certified nursing assistant) #2 (a CNA working on the long-term care unit on 4/4/18). CNA #2 was asked about the process for serving meals to residents. CNA #2 stated many of the residents needed assistance with feeding so the CNAs try to get all the residents up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 550	Continued From page 10	F 550		

and bring them out to the dining room at once so they can help each one of them with breakfast in the mornings. CNA #2 was asked if residents are brought to the dining room table while other residents are eating. CNA #2 stated Residents #2, #3 and #1 like to eat earlier so they get their breakfast first and the CNAs do sometimes push other residents up to the table. CNA #2 stated the residents are placed in the living room at other times. When asked why residents are sometimes placed in the living room versus the dining room table, CNA #2 stated, "I thought it wasn't good to put them at the table while others are eating so they aren't watching others eating." When asked how she would feel if she was at a table where someone else was eating and had to wait fifteen or more minutes to eat, CNA #2 stated, "That would probably make youinpatient." CNA #2 stated a majority of residents require two-person assistance with ADLs (activities of daily living). CNA #2 stated there was one CNA on the rehab (rehabilitation) unit and two CNAs on the long-term care unit so it takes longer to get residents up in the morning.

On 4/5/18 at 5:11 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the administrative support clerk) and OSM (other staff member) #3 (the director of environmental services) were made aware of the above concern.

The facility policy titled, "Quality of Life- Dignity" documented, "Each resident and guest shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality." The policy did not specifically document information regarding meal service.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE

F 550 Continued From page 11

No further information was presented prior to exit.

F 622 Transfer and Discharge Requirements
SS=D CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)

§483.15(c) Transfer and discharge-
§483.15(c)(1) Facility requirements-
(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided, by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or

F 550

F 622 **F622**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

Assessed resident cases; no negative outcome due to not providing the care plan document for Residents #3 and #8.

How facility will identify other residents having the potential to be affected by the same deficient practice

Assessed other residents and other resident facility-initiated transfers. No other facility-initiated transfers since 4-6-18, therefore, no negative outcomes due to not providing the care plan document.

Measure or system change to ensure the deficient practice will not recur

Education to be provided to all nurses, social workers, community outreach liaison on the newly updated Transfer or Discharge Notice Policy outlining the inclusion of the care plan document as a required document upon a facility-initiated transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 12	F 622	**How the facility plans to monitor its performance to make sure that solutions are sustained**	

discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including

Social Services Manager or designee to conduct a 10% chart audit on a monthly basis, on residents who had a facility-initiated transfer or discharge to ensure proper documentation and notification was completed, and to report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 13	F 622		

contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to have the required documentation of a facility-initiated transfer for two of 14 residents, Resident #3 and #8.

1. For Resident #3, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 1/5/18.

2. For Resident #8, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer.

The findings include:

1. Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 14	F 622		

Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's clinical record revealed that she went out to the hospital on 1/5/18. The following nursing note was documented, "Guest fell this AM (morning) 0745 (7:45 a.m.) in bathroom witnessed by CNA (certified nursing assistant). Hit head on toilet and implemented neuro (neurological) checks. 0940 (9:40 a.m.) resident sitting in DR (dining room) per her request for breakfast and stated her vision was blurry. BP (blood pressure) 72/42, HR (heart rate) 67, T (temperature) 97.4. Resident diaphoretic (sweaty) and clammy. Assisted back to bed x 2 assist and BP rechecked 88/52. MD (medical doctor) made aware and given orders to send resident to ER (emergency room) for eval (evaluation), S/P (status/post) fall with head injury. Left facility at 1030 (10:30 a.m.) am with x 3 EMS (emergency services) personnel. Alert to voice and speech clear at the time. Able to answer all questions appropriately."

Further review of Resident #3's clinical record revealed that she was admitted to the hospital with diagnoses of dehydration and a urinary tract infection (UTI). Resident #3 arrived back to the facility on 1/7/18.

There was no evidence that all the required information; Resident #3's advanced directives, responsible party contact information, and Resident #3's care plan was provided to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING ___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 15	F 622		

hospital for the facility-initiated transfer.

On 4/5/18 at 4:42 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, the only nurse on the unit. When asked what documentation was sent with residents who were being transferred to the hospital, LPN #1 stated that she would send their advanced directives, a medication list, and any other pertinent information for the hospital staff. When asked if she would send the resident's care plan, LPN #1 stated she had never heard of nurses sending the care plan with the resident to the hospital. LPN #1 stated she was new to the unit and had not yet sent anyone out to the hospital. When asked if it should be documented that certain documentation was sent with the resident to the hospital, LPN #1 stated that she would write a general statement that all paperwork was sent out with the resident. LPN #1 stated she probably wouldn't specify which paperwork was sent with the resident. LPN #1 stated there was no way of knowing what paperwork was sent out with Resident #3 for her transfer on 1/5/18.

On 4/6/18 at approximately 8:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. ASM #2 handed this writer a checklist of items that are usually sent with every resident during a hospital transfer. The following was documented: "Acute Care Transfer List, copies and documents sent with the patient (check all that apply): Patient transfer form, personal belongings identified on Patient Transfer Form are enclosed, Face sheet, Current Medication List or Current MAR (medication administration record), SBAR (situation, background, assessment, recommendation) and or other change in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

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F 622	Continued From page 16	F 622		

condition progress note, advance directives, advance care orders. Send these documents if available: Most recent history and physical, recent hospital discharge summary, recent MD/NP (nurse practitioner)/PA (physician's assistant) and Specialist orders, flow sheets, relevant lab (laboratory) results, Relevant X-Rays and other Diagnostic Test Results, Nursing Home Capabilities. Emergency Department: Please ensure that these documents are forwarded to the hospital unit if the patient is admitted. Thank you." ASM #2 could not evidence what was sent to the hospital with Resident #3. ASM #2 stated the care plan was also something that wasn't typically sent with the resident to the hospital. ASM #2 stated she was going to update her transfer checklist to include the care plan.

On 4/5/18 at 5:10 p.m., ASM #1, the administrator, ASM #2 and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Transfer or Discharge notice," did not address the above concerns.

No further information was presented prior to exit.

2. For Resident #8, facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer.

Resident #8 was admitted to the facility on 10/9/17 and readmitted on 2/6/18 with diagnoses that included but were not limited to atrial fibrillation, hypothyroidism, muscle weakness, high blood pressure, Parkinson's disease and pneumonia. Resident #8's most recent MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 622	Continued From page 17	F 622		

(minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/17/18. Resident #8 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #S's clinical record revealed he had been transferred to the hospital on 2/4/18. The following was documented in a nursing note: "Around 0400 (4:00 a.m.), CNAs (certified nursing assistants) alerted this writer that guest was cold to the touch. This writer assessed the guest and the tympanic temp (temperature) read 91.0. Multiple blankets were added over top of him. Blood sugar was taken and resulted at 47. Guest was slow to respond and had a blank stare on the wall. Guest was able to drink a cup of orange juice. BS was checked 15 minutes later to result at 41. He then has another cup of orange juice and BS was checked another 15 minutes later to result 33. This writer then called (Name of physician) around 4:30 a.m., who gave orders to send him out to the hospital. The DON (Director of Nursing) was also called. Vitals upon EMS arrival were: blood sugar 51, BP 70/38, respirations 14, HR (heart rate) 58 and irregular and temp 95.0."

The next note dated 2/4/18 documented the following: "POA (power of attorney), (Name of POA) updated on resident condition and being sent out to the hospital. In agreement with plan."

Further review of the clinical record revealed that Resident #8 was admitted to the hospital with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 18	F 622		

diagnoses of lactic acidosis (1) and sepsis (2).

There was no evidence that all the required information; Resident #S's advanced directives, responsible party contact information, and Resident #*B's* care plan was provided to the hospital for the facility-initiated transfer. Resident #8 arrived back to the facility on 2/6/18.

On 4/5/18 at 4:42 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, the only nurse on the unit. When asked what documentation was sent with residents who were being transferred to the hospital, LPN #1 stated that she would send their advanced directives, a medication list, and any other pertinent information for the hospital staff. When asked if she would send the resident's care plan, LPN #1 stated she had never heard of nurses sending the care plan with the resident to the hospital. LPN #1 stated she was new to the unit and had not yet sent anyone out to the hospital. When asked if it should be documented that certain documentation was sent with the resident to the hospital, LPN #1 stated that she would write a general statement that all paperwork was sent out with the resident. LPN #1 stated she probably wouldn't specify which paperwork was sent with the resident. LPN #1 stated there was no way knowing what paperwork was sent out with Resident #8 for his transfer on 2/4/18.

On 4/6/18 at approximately 8:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the Director of Nursing. **ASM** #2 handed this writer a checklist of items that are usually sent with every resident during a hospital transfer. The following was documented: "Acute Care Transfer List, copies and documents sent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 19	F 622		

with the patient (check all that apply): Patient transfer form, personal belongings identified on Patient Transfer Form are enclosed, Face sheet, Current Medication List or Current MAR (medication administration record), SBAR (situation, background, assessment, recommendation) and or other change in condition progress note, advance directives, advance care orders. Send these documents if available: Most recent history and physical, recent hospital discharge summary, recent MD/NP (nurse practitioner)/PA (physician's assistant) and Specialist orders, flow sheets, relevant lab (laboratory) results, Relevant X-Rays and other Diagnostic Test Results, Nursing Home Capabilities. Emergency Department: Please ensure that these documents are forwarded to the hospital unit if the patient is admitted. Thank you." ASM #2 could not evidence what was sent to the hospital with Resident #8. ASM #2 stated the care plan was also something that wasn't typically sent with the resident to the hospital. **ASM #2** stated she was going to update her transfer checklist to include the care plan.

On 4/5/18 at 5:10 p.m., ASM #1, the administrator, ASM #2 and ASM #3, the administrative support clerk were made aware of the above concerns.

Facility policy titled, "Transfer or Discharge notice," did not address the above concerns.

No further information was presented prior to exit.

(1) Lactic acidosis is a buildup of lactic acid in the blood. This information was obtained from The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 20 National Institutes of Health. https:l/search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=lactic+acidosis. (2) Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This information was obtained from The National Institutes of Health. https://medlineplus.gov/sepsis.html	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.	F 623	**F623** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice** Assessed resident cases; no negative outcome due to not notifying in writing the representative and long term ombudsman for the facility-initiated transfer for Residents #3 and #8. **How facility will identify other residents having the potential to be affected by the same deficient practice** Assessed other resident cases and other resident facility-initiated transfers. No other facility-initiated transfers since 4-6-18, therefore, no negative outcomes due to not notifying in writing the representative and long term ombudsman for a facility-initiated transfer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 623 Continued From page 21

(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)**(i)(C)** of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D} An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c}(5} Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email} and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for

F 623 **Measure or system change to ensure the deficient practice will not recur**

Education to be provided to all nurses, social workers, community outreach liaison on updated Transfer or Discharge Notice Policy; implementation of new Notice of Transfer or Discharge form; and notification and required documentation of a facility initiated transfer or discharge.

Implement new process of providing Notice of Transfer or Discharge form to resident representatives and to long term care ombudsman by Social Work monthly.

How the facility plans to monitor its performance to make sure that solutions are sustained

Social Services Manager or designee to conduct a 10% chart audit on a monthly basis, on residents who had a facility-initiated transfer or discharge to ensure proper documentation and notification was completed, and to ensure long term care ombudsman was notified, and to report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 623	Continued From page 22	F 623		

the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(1).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide written notification to the resident representative and the long term care ombudsman for a facility-initiated transfer for two of 14 residents in the survey sample, Resident #3 and #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 23	F 623		

1. The facility staff failed to provide written notification to the resident representative and ombudsman when Resident #3 was transferred to the hospital on 1/5/18.

2. The facility staff failed to provide written notification to the resident representative and ombudsman when Resident #8 was transferred to the hospital on 2/4/18.

The findings include:

1. Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's clinical record revealed that she went out to the hospital on 1/5/18. The following nursing note was documented, "Guest fell this AM (morning) 0745 (7:45 a.m.) in bathroom witnessed by CNA (certified nursing assistant). Hit head on toilet and implemented neuro (neurological} checks. 0940 (9:40 a.m.) resident sitting in DR (dining room) per her request for breakfast and stated her vision was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 24	F 623		

blurry. BP (blood pressure) 72/42, HR (heartrate) 67, T (temperature) 97.4. Resident diaphoretic (sweaty) and clammy. Assisted back to bed x 2 assist and BP rechecked 88/52. MD (medical doctor) made aware and given orders to send resident to ER (emergency room) for eval (evaluation), S/P (status/post) fall with head injury. Left facility at 1030 (10:30 a.m.) am with x 3 EMS (emergency services) personnel. Alert to voice and speech clear at the time. Able to answer all questions appropriately."

Further review of Resident #3's clinical record revealed she was admitted to the hospital with diagnoses of dehydration and a UTI (urinary tract infection). Resident #3 arrived back to the facility on 1/7/18.

Further review of Resident #3's clinical record revealed that she was admitted to the hospital with diagnoses of dehydration and a urinary tract infection (UTI). Resident #3 arrived back to the facility on 1/7/18.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, regarding the nurses' role when a resident is transferred out to the hospital. LPN #1 stated she would first assess the resident, and obtain vital signs to determine the need for the resident to be sent out. LPN #1 stated she would then call the physician to obtain an order to send the resident out to the hospital. LPN #1 stated she would also call the administrator, family or POA (power of attorney) and then the ambulance. When asked how she would notify the family, LPN #1 stated it is usually verbally over the phone. When asked if she would provide written notification to the family explaining the reason for resident transfer, LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 25	F 623		

#1 stated, "I haven't sent anyone to the hospital over here." LPN #1 stated she usually works in assisted living. When asked if nurses should be sending written notification to the long term care ombudsman regarding a resident's transfer to the hospital, LPN #1 stated, "I will have to get verification on that one."

On 4/5/18 at 3 p.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that she did not notify the long term care ombudsmen with every facility initiated transfer to the hospital.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #1 and ASM #2 stated they were not aware the resident's representative was to be notified in writing of the reason for transfer. ASM #1 and ASM #2 were also not aware the long term care ombudsman had to be provided written notification for every facility-initiated transfer to the hospital.

The facility policy titled, "Transfer or Discharge notice," did not address the above concerns.

No further information was presented prior to exit.

2. The facility staff failed to provide written notification to the resident representative and ombudsman when Resident #8 was transferred to the hospital on 2/4/18.

Resident #8 was admitted to the facility on 10/9/17 and readmitted on 2/6/18 with diagnoses that included but were not limited to atrial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 26	F 623		

fibrillation, hypothyroidism, muscle weakness, high blood pressure, Parkinson's disease and pneumonia. Resident #S's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/17/18. Resident #8 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #S's clinical record revealed he had been transferred to the hospital on 2/4/18. The following was documented in a nursing note: "Around 0400 (4:00 a.m.), CNAs (certified nursing assistants) alerted this writer that guest was cold to the touch. This writer assessed the guest and the tympanic temp (temperature) read 91.0. Multiple blankets were added over top of him. Blood sugar was taken and resulted at 47. Guest was slow to respond and had a blank stare on the wall. Guest was able to drink a cup of orange juice. BS was checked 15 minutes later to result at 41. He then has another cup of orange juice and BS was checked another 15 minutes later to result 33. This writer then called (Name of physician) around 4:30 a.m., who gave orders to send him out to the hospital. The DON (Director of Nursing) was also called. Vitals upon EMS arrival were: blood sugar 51, BP 70/38, respirations 14, HR (heart rate) 58 and irregular and temp 95.0."

The next note dated 2/4/18 documented the following: "POA (power of attorney), (Name of POA) updated on resident condition and being sent out to the hospital. In agreement with plan."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 623	Continued From page 27	F 623		

Further review of the clinical record revealed Resident #8 was admitted to the hospital with diagnoses of lactic acidosis (1) and sepsis (2). Resident #8 arrived back to the facility on 2/6/18.

Further review of Resident #S's clinical record failed to evidence the RP (responsible party) was notified in writing of the reason for Resident #S's transfer to the hospital, and that the ombudsman received a copy of this written notification.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, regarding the nurses' role when a resident is transferred out to the hospital. LPN #1 stated she would first assess the resident, and obtain vital signs to determine the need for the resident to be sent out. LPN #1 stated she would then call the physician to obtain an order to send the resident out to the hospital. LPN #1 stated she would also call the administrator, family or POA (power of attorney) and then the ambulance. When asked how she would notify the family, LPN #1 stated it is usually verbally over the phone. When asked if she would provide written notification to the family explaining the reason for resident transfer, LPN #1 stated, "I haven't sent anyone to the hospital over here." LPN #1 stated she usually works in assisted living. When asked if nurses should be sending written notification to the long term care ombudsman regarding a resident's transfer to the hospital, LPN #1 stated, "I will have to get verification on that one."

On 4/5/18 at 3 p.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated she did not notify the long term care ombudsmen with every facility initiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 623 Continued From page 28 F 623

transfer to the hospital.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #1 and ASM #2 stated they were not aware the resident's representative was to be notified in writing of the reason for transfer. ASM #1 and ASM #2 were also not aware the long term care ombudsman had to be provided written notification for every facility-initiated transfer to the hospital.

The facility policy titled, "Transfer or Discharge notice," did not address the above concerns.

No further information was presented prior to exit.

(1) Lactic acidosis is a buildup of lactic acid in the blood. This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=lactic+acidosis.

(2) Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This information was obtained from The National Institutes of Health. https://medlineplus.gov/sepsis.html

F 624 Preparation for Safe/Orderly Transfer/Dschrg F 624
SS=D CFR(s): 483.15(c)(7)

§483.15(c)(7) Orientation for transfer or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 624 Continued From page 29

discharge.
A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to orient, prepare, and document the same, a resident for transfer to the hospital for two of 14 residents in the survey sample, Resident #3 and #8.

1. The facility staff failed to document that Resident #3 was properly oriented and prepared for a hospital transfer that occurred on 1/5/18.

2. The facility staff failed to document that Resident #8 was properly oriented and prepared for a hospital transfer that occurred on 2/4/18.

The findings include:

1. Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the **BIMS** (Brief Interview for

F 624 **F624**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice
Late entries have been noted in the chart to reflect that Resident #3 and #10 were oriented and prepared for the transfer to the hospital; Resident #3 could not recall which day;

Resident #8 did indicate that he thought the staff did tell him why he was going to the hospital prior to his transfer.

How facility will identify other residents having the potential to be affected by the same deficient practice
Began communication of the need to document when staff provide orientation to residents upon a transfer to hospital; No hospital transfers occurred 4-5-18 or 4-6-18 during survey.

Measure or system change to ensure the deficient practice will not recur
Education to applicable team members regarding documentation compliance with orienting and preparing a resident for transfer to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 624 Continued From page 30

Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's clinical record revealed that she went out to the hospital on 1/5/18. The following nursing note was documented, "Guest fell this AM (morning) 0745 (7:45 a.m.) in bathroom witnessed by CNA (certified nursing assistant). Hit head on toilet and implemented neuro (neurological) checks. 0940 (9:40 a.m.) resident sitting in DR (dining room) per her request for breakfast and stated her vision was blurry. BP (blood pressure) 72/42, HR (heart rate) 67, T (temperature) 97.4. Resident diaphoretic (sweaty) and clammy. Assisted back to bed x 2 assist and BP rechecked 88/52. MD (medical doctor) made aware and given orders to send resident to ER (emergency room) for eval (evaluation), S/P (status/post) fall with head injury. Left facility at 1030 (10:30 a.m.) am with x 3 EMS (emergency services) personnel. Alert to voice and speech clear at the time. Able to answer all questions appropriately."

Further review of Resident #3's clinical record revealed she was admitted to the hospital with diagnoses of dehydration and a UTI (urinary tract infection). Resident #3 arrived back to the facility on 1/7/18.

There was no documentation in the clinical record evidencing the resident was oriented and prepared for 1/5/18 facility-initiated transfer to the hospital.

On 4/5/18 at approximately 12:15 p.m., an interview was conducted with Resident #3. She

F 624 **How the facility plans to monitor its performance to make sure that solutions are sustained**

Director of Nursing, Clinical Quality and Performance Leader, or designee will audit 10% of all Readmissions to ensure compliance of documentation of resident orientation and preparation of transfers and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING ___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 31	F 624		

could not recall the day she was transferred to the hospital on 1/5/18.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, regarding the nurses' role when a resident is transferred out to the hospital. LPN #1 stated she would first assess the resident, and then obtain vital signs to determine the need for the resident to be sent out. LPN #1 stated she would then call the physician to obtain an order to send the resident out to the hospital. LPN #1 stated she would also call the administrator, family or POA and then the ambulance. When asked about the documentation for a hospital transfer, LPN #1 stated that should document everything in a nurse's note such as the resident's vital signs, the change in condition, who she had contacted etc. When asked if nurses should be documenting if the resident was oriented and prepared for the transfer, LPN #1 stated, "I believe so." When asked why this should be documented, LPN #1 stated, the resident should be oriented to the transfer so they know what is going on and it gives the resident a chance to refuse the transfer.

On 4/5/18 at 5:10 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Transfer or Discharge notice," did not address the above concerns.

2. The facility staff failed to document that Resident #8 was properly oriented and prepared for a hospital transfer that occurred on 2/4/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 32	F 624		

Resident #8 was admitted to the facility on 10/9/17 and readmitted on 2/6/18 with diagnoses that included but were not limited to atrial fibrillation, hypothyroidism, muscle weakness, high blood pressure, Parkinson's disease and pneumonia. Resident #S's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/17/18. Resident #8 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #S's clinical record revealed he had been transferred to the hospital on 2/4/18. The following was documented in a nursing note: "Around 0400 (4:00 a.m.), CNAs (certified nursing assistants) alerted this writer that guest was cold to the touch. This writer assessed the guest and the tympanic temp (temperature) read 91.0. Multiple blankets were added over top of him. Blood sugar was taken and resulted at 47. Guest was slow to respond and had a blank stare on the wall. Guest was able to drink a cup of orange juice. BS was checked 15 minutes later to result at 41. He then has another cup of orange juice and BS was checked another 15 minutes later to result 33. This writer then called (Name of physician) around 4:30 a.m., who gave orders to send him out to the hospital. The DON (Director of Nursing) was also called. Vitals upon EMS arrival were: blood sugar 51, BP 70/38, respirations 14, HR (heart rate) 58 and irregular and temp 95.0."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING ___ ___ ___ B. WING ___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 624	Continued From page 33	F 624		

The next note dated 2/4/18 documented the following: "POA (power of attorney), (Name of POA) updated on resident condition and being sent out to the hospital. In agreement with plan."

Further review of the clinical record revealed that Resident #8 was admitted to the hospital with diagnoses of lactic acidosis (1) and sepsis (2). Resident #8 arrived back to the facility on 2/6/18.

There was no documentation in the clinical record evidencing the resident was oriented and prepared for 2/4/18 facility-initiated transfer to the hospital.

On 4/5/18 at 12:56 p.m., an interview was conducted with Resident #8. Resident #8 stated he thought the staff did tell him why he was going to the hospital prior to his transfer on 2/4/18.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, regarding the nurses' role when a resident is transferred out to the hospital. LPN #1 stated she would first assess the resident, and then obtain vital signs to determine the need for the resident to be sent out. LPN #1 stated she would then call the physician to obtain an order to send the resident out to the hospital. LPN #1 stated she would also call the administrator, family or POA and then the ambulance. When asked about the docum ntation for a hospital transfer, LPN #1 stated that should document everything in a nurse's note such as the resident's vital signs, the change in condition, who she had contacted etc. When asked if nurses should be documenting if the resident was oriented and prepared for the transfer, LPN #1 stated, "I believe so." When asked why this should be documented, LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

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F 624 Continued From page 34 F624

stated, theresident should be oriented to the transfer so they know what is going on and it gives the resident a chance to refuse the transfer.

On 4/5/18 at 5:10 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Transfer or Discharge notice," did not address the above concerns.

(1) Lactic acidosis is a buildup of lactic acid in the blood. This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=lactic+acidosis.

(2) Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This information was obtained from The National Institutes of Health. https://medlineplus.gov/sepsis.html

F 625 SS=D Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) F 625

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 625 Continued From page 35

(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under§ 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a written bed hold notice for a facility initiated transfer for two of 14 residents in the survey sample, Residents #3 and #8.

1. The facility staff failed to provide Resident #3 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 1/5/18.

2. The facility staff failed to provide Resident #8 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 2/4/18.

F 625 F625

How corrective action will be accomplished for those residents found to have been affected by the deficient practice
Assessed resident cases; no negative outcome due to not providing a written bed hold notice for the facility initiated transfer for Residents #3 and #8.

How facility will identify other residents having the potential to be affected by the same deficient practice
Assessed all other resident cases; No other facility-initiated transfers since 4-6-18, therefore, no negative outcome due to not providing a written bed hold notice for a facility initiated transfer.

Measure or system change to ensure the deficient practice will not recur
New process implemented whereby the "Notice of Bed Hold Policy" form will be reviewed upon admission effective April 27, 2018.
All residents who are transferred due to a facility initiated transfer will be provided the written "Notice of Bed Hold Policy" form at the time of transfer, by the nurse. If the resident has a resident representative, that person will be provided with the written form.
Education to be provided to all nurses, social workers, community outreach liaison on the new "Notice of Bed Hold Policy" form and associated process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE

F 625 Continued From page 36

The finding include:

1. Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's clinical record revealed that she went out to the hospital on 1/5/18. The following nursing note was documented, "Guest fell this AM (morning) 0745 (7:45 a.m.) in bathroom witnessed by CNA (certified nursing assistant). Hit head on toilet and implemented neuro (neurological) checks. 0940 (9:40 a.m.) resident sitting in DR (dining room) per her request for breakfast and stated her vision was blurry. BP (blood pressure) 72/42, HR (heart rate) 67, T (temperature) 97.4. Resident diaphoretic (sweaty) and clammy. Assisted back to bed x 2 assist and BP rechecked 88/52. MD (medical doctor) made aware and given orders to send resident to ER (emergency room) for eval (evaluation), S/P (status/post) fall with head injury. Left facility at 1030 (10:30 a.m.) am with x 3 EMS (emergency services) personnel. Alert to voice and speech clear at the time. Able to answer all questions appropriately."

F 625 **How the facility plans to monitor its performance to make sure that solutions are sustained**

Social Services Manager or designee to conduct a 10% chart audit on a monthly basis, on residents who had a facility-initiated transfer to ensure compliance with the "Notice of Bed Hold Policy", and to report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 37	F 625		

Further review of Resident #3's clinical record revealed she was admitted to the hospital with diagnoses of dehydration and a UTI (urinary tract infection). Resident #3 arrived back to the facility on 1/7/18.

A bed hold policy signed by the representative on 6/22/17 was found in Resident #3's chart.

Further review of the clinical record failed to evidence a copy of the written bed hold notice for the facility-initiated transfer to the hospital on 1/5/18.

Review of the January 2018 social worker notes failed to evidence that the bed hold policy was discussed with the resident or representative for the 1/5/18 facility-initiated transfer to the hospital.

On 4/5/18 at approximately 12:15 p.m., an interview was conducted with Resident #3. She could not recall the day she was transferred to the hospital on 1/5/18.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (Licensed practical nurse) #1, regarding the nurses' role when a resident is transferred out to the hospital. When asked who was responsible for offering the bed hold policy at the time of a transfer, LPN # 1 stated that she was not sure about bed holds. LPN #1 stated she has never sent anyone out to the hospital on the nursing unit. LPN #1 stated that she normally works for assisted living.

On 4/5/18 at 3 p.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that when a resident is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 625	Continued From page 38	F 625		

sent to the hospital, the nurse is supposed to ask them about the bed hold. OSM #7 stated the nurses should go over the bed hold policy that was signed by the resident and/or resident representative upon admission to the facility, at the time of transfer. OSM #7 stated if the resident is admitted to the hospital, she will follow up with the family member about whether they want to hold the bed. OSM #7 stated she would notify them over the telephone and get a verbal confirmation. When asked if she writes a note that she went over the bed hold policy with the family, OSM #7 stated, "Typically yes." When asked if the resident is provided written notification of the bed hold policy during the time of transfer, **OSM** #7 stated, "They get the bed hold policy on admission. The resident or resident representative signs the policy and it is placed in their chart. Admissions goes over the bed hold policy during the resident's admission. At the time of transfer, the nurses go over that form with the resident." OSM #7 confirmed residents do not receive written bed hold notification at the time of transfer to the hospital.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns. No further information was provided prior to exit.

Review of the facility's "Bed Hold Policy" documents in part the following: "You are being sent to the hospital today. If your stay is covered by Medicare, Medicaid or a private insurance carrier, your insurance will not pay to hold your room while you are in the hospital. Additionally, private pay residents must continue to pay for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 39	F 625		

room while at the hospital to reserve the room. If you do not wish to pay for your room while you are in the hospital, there is a possibility that someone else may be admitted to that room..."

2. The facility staff failed to provide Resident #8 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 2/4/18.

Resident #8 was admitted to the facility on 10/9/17 and readmitted on 2/6/18 with diagnoses that included but were not limited to atrial fibrillation, hypothyroidism, muscle weakness, high blood pressure, Parkinson's disease and pneumonia. Resident #8's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/17/18. Resident #8 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the **BIMS** (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #8's clinical record revealed he had been transferred to the hospital on 2/4/18. The following was documented in a nursing note: "Around 0400 (4:00 a.m.), CNAs (certified nursing assistants) alerted this writer that guest was cold to the touch. This writer assessed the guest and the tympanic temp (temperature) read 91.0. Multiple blankets were added over top of him. Blood sugar was taken and resulted at 47. Guest was slow to respond and had a blank stare on the wall. Guest was able to drink a cup of orange juice. BS was checked 15 minutes later to result

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTIONSHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 40	F 625		

at 41. He then has another cup of orange juice and BS was checked another 15 minutes later to result 33. This writer then called (Name of physician) around 4:30 a.m., who gave orders to send him out to the hospital. The DON (Director of Nursing) was also called. Vitals upon EMS arrival were: blood sugar 51, BP 70/38, respirations 14, HR (heart rate) 58 and irregular and temp 95.0."

The next note dated 2/4/18 documented the following: "POA (power of attorney), (Name of POA) updated on resident condition and being sent out to the hospital. In agreement with plan."

Further review of the clinical record revealed that Resident #8 was admitted to the hospital with diagnoses of lactic acidosis (1) and sepsis (2). Resident #8 arrived back to the facility on 2/6/18.

A bed hol.d policy signed by the representative on 12/13/17 was found in Resident #S's chart.

Further review of the clinical record failed to evidence a copy of the written bed hold notice for the facility initiated transfer to the hospital on 2/4/18.

Review of the February 2018 social worker notes failed to evidence that the bed hold policy was discussed with the resident or representative.

On 4/5/18 at 12:56 p.m., an interview was conducted with Resident #8. Resident #8 could not recall being offered a bed hold policy prior to transfer.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (Licensed practical nurse)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 41	F 625		

#1, regarding the nurses' role when a resident is transferred out to the hospital. When asked who was responsible for offering the bed hold policy at the time of a transfer, LPN # 1 stated that she was not sure about bed holds. LPN #1 stated she has never sent anyone out to the hospital on the nursing unit. LPN #1 stated that she normally works for assisted living.

On 4/5/18 at 3 p.m., an interview was conducted with OSM (other staff member) #7, the social worker. OSM #7 stated that when a resident is sent to the hospital, the nurse is supposed to ask them about the bed hold. OSM #7 stated the nurses should go over the bed hold policy that was signed by the resident and/or resident representative upon admission to the facility, at the time of transfer. OSM #7 stated if the resident is admitted to the hospital, she will follow up with the family member about whether they want to hold the bed. OSM #7 stated she would notify them over the telephone and get a verbal confirmation. When asked if she writes a note that she went over the bed hold policy with the family, OSM #7 stated, "Typically yes." When asked if the resident is provided written notification of the bed hold policy during the time of transfer, OSM #7 stated, "They get the bed hold policy on admission. The resident or resident representative signs the policy and it is placed in their chart. Admissions goes over the bed hold policy during the resident's admission. At the time of transfer, the nurses go over that form with the resident." OSM #7 confirmed residents do not receive written bed hold notification, at the time of transfer to the hospital.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, **ASM #2,** the DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 625 Continued From page 42

(Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns. No further information was provided prior to exit.

(1) Lactic acidosis is a buildup of lactic acid in the blood. This information was obtained from The National Institutes of Health. https://search.nih.gov/search?utf8=%E2%9C%93&affiliate=nih&query=lactic+acidosis.

(2) Sepsis is a serious illness. It happens when your body has an overwhelming immune response to a bacterial infection. The chemicals released into the blood to fight the infection trigger widespread inflammation. This information was obtained from The National Institutes of Health. https://medlineplus.gov/sepsis.html

F 625

F 657 Care Plan Timing and Revision
SS=D CFR(s):483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).

F 657 **F657**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

Care plan was immediately revised on 4-4-18 to reflect the fall on 1-5-18 and the compression fracture on 1-15-18.

How facility will identify other residents having the potential to be affected by the same deficient practice

Audit of all care plans was completed immediately by MDS/QAPI Manager. All applicable revisions were addressed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 43	F 657	**Measure or system change to ensure the deficient practice will not recur**	

An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for one of 14 residents in the survey sample, Resident #3.

1a. The facility staff failed to review or revise Resident #3's comprehensive care plan following a fall on 1/5/18.

1b. The facility staff failed to revise Resident #3's comprehensive care plan when an L2 (lumbar spine) compression fracture was found on 1/15/18.

The findings include:

1a. Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure.
Resident #3's most recent MOS (minimum data

New process implemented for MDS/QAPI Manager to revise care plans post incidents, on admission, and whenever there is a change in condition.

New process implemented for documenting a note that a care plan revision occurred.

How the facility plans to monitor its performance to make sure that solutions are sustained
MDS/QAPI Manager or designee will audit 10% of all care plans monthly to ensure accuracy and compliance, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

All corrective actions complete by 4-20-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 44	F 657		

set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's clinical record revealed that she went out to the hospital on 1/5/18. The following nursing note was documented, "Guest fell this AM (morning) 0745 (7:45 a.m.) in bathroom witnessed by CNA (certified nursing assistant). Hit head on toilet and implemented neuro (neurological) checks. 0940 (9:40 a.m.) resident sitting in DR (dining room) per her request for breakfast and stated her vision was blurry. BP (blood pressure) 72/42, HR (heart rate) 67, T (temperature) 97.4. Resident diaphoretic (sweaty) and clammy. Assisted back to bed x 2 assist and BP rechecked 88/52. MD (medical doctor) made aware and given orders to send resident to ER (emergency room) for eval (evaluation), S/P (status/post) fall with head injury. Left facility at 1030 (10:30 a.m.) am with x 3 EMS (emergency services) personnel. Alert to voice and speech clear at the time. Able to answer all questions appropriately."

Further review of Resident #3's clinical record revealed she was admitted to the hospital with diagnoses of dehydration and a UTI (urinary tract infection). Resident #3 arrived back to the facility on 1/7/18.

Review of Resident #3's fall care plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 45	F 657		

6/20/17 and revised 10/24/17 failed to evidence the care plan was reviewed or updated following her 1/5/18 fall. Review of Resident #3's fall report dated 1/5/18 failed to evidence that an intervention was put into place to prevent future falls.

On 4/5/18 at 9:52 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (director of nursing), regarding the process staff follows when a resident has a fall. ASM #2 stated, when a resident falls, a nurse would add an intervention at the time of the fall to prevent future falls. ASM #2 stated therapy will also evaluate a resident. When asked if the intervention that is put into place should be on the care plan, ASM #2 stated that it should. When asked about the importance of a fall intervention being added to the care plan, ASM #2 stated that it was important for the care plan to reflect the fall so everyone was in the loop and aware of the fall or any change in condition. When asked who had access to the care plan, ASM #2 stated that all team members have access to the care plan. ASM #2 stated the floor nurses and the MOS nurse could update the care plan. ASM #2 confirmed she did not see where the care plan was reviewed or updated after Resident #3's 1/5/18 fall. ASM #2 also viewed the incident report and confirmed that she did not see an intervention put into place after the 1/5/18 fall.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Care Plans" documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 657	Continued From page 46	F 657		

in part the following: "An comprehensive, person-centered care plan that included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...The Care Planning/Interdisciplinary team is responsible for the review and updating care plans: a. when there has been a significant change in the resident's condition. b. When the desired outcome is met. c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment."

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

No further information was provided prior to exit.

1b. The facility staff failed to revise Resident #3's comprehensive care plan when an L2 (lumbar spine) compression fracture was found on 1/15/18.

Review of Resident #3's clinical record revealed that she went out to the hospital on 1/5/18. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 47	F 657		

following nursing note was documented, "Guest fell this AM (morning) 0745 (7:45 a.m.) in bathroom witnessed by CNA (certified nursing assistant). Hit head on toilet and implemented neuro (neurological) checks. 0940 (9:40 a.m.) resident sitting in DR (dining room) per her request for breakfast and stated her vision was blurry. BP (blood pressure) 72/42, HR (heart rate) 67, T (temperature) 97.4. Resident diaphoretic (sweaty) and clammy. Assisted back to bed x 2 assist and BP rechecked 88/52. MD (medical doctor) made aware and given orders to send resident to ER (emergency room) for eval (evaluation), S/P (status/post) fall with head injury. Left facility at 1030 (10:30 a.m.) am with x 3 EMS (emergency services) personnel. Alert to voice and speech clear at the time. Able to answer all questions appropriately."

Further review of Resident #3's clinical record revealed she was admitted to the hospital with diagnoses of dehydration and a UTI (urinary tract infection). Resident #3 arrived back to the facility on 1/7/18.

Further review of Resident #3's clinical record revealed that Resident #3 started to complain of increased back pain following her fall. An x-ray was ordered on 1/15/18. The x-ray dated 1/15/18, documented the following: "Age-indeterminate mild to moderate L2 compression fracture. CT (computed tomography) is recommended."

A nursing note dated 1/17/18 documented that Resident #3's responsible party had declined the CT scan.

Review of Resident #3's care plan dated 6/20/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING___	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 48	F 657		

and revised 4/5/18 did not evidence her L2 compression fracture.

On 4/5/18 at 9:52 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (director of nursing). When asked if Resident #3's L2 fracture should be reflected on her care plan. ASM #2 stated that it should be. ASM #2 stated she would expect the fracture to be on the care plan so that facility staff know how to transfer the resident and know how to monitor and manage the resident's pain. When asked who had access to the care plan, ASM #2 stated that all team members have access to the care plan. ASM #2 stated the floor nurses and the MOS nurse could update the care plan. ASM #2 confirmed she did not see where the care plan was updated after the discovery of Resident #3's L2 compression fracture.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON and ASM #3, the administrative support clerk were made aware of the above concerns. No further information was provided prior to exit.

F 684 Quality of Care
SS=D CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced

F 684

F684

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

The order was clarified immediately on 4-5-18.

How facility will identify other residents having the potential to be affected by the same deficient practice

Audit of all pain medication orders was completed immediately by Director of Nursing and MDS/QAPI Manager. All applicable orders were clarified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 49

by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 14 residents in the survey sample, Resident #3.

The facility staff failed to clarify Resident #3's pain medication orders with the physician.

The findings include:

Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's most recent POS (physician order summary) revealed the following pain medication orders:

1) "Acetaminophen (Tylenol) (1)Tablet 325 mg (milligrams) Give 2 tablets by mouth every 6 hours as needed for pain." This order was initiated on 1/8/18.

2) "Tylenol Extra Strength 500 MG Give 1 tablet

F 684 **Measure or system change to ensure the deficient practice will not recur**
Re-educate nurses on pain medication orders. New process implemented whereby MDS/QAPI Manager or Director of Nursing will review all pain medication orders from last twenty four hours to ensure order entry accuracy and parameters for pain.

How the facility plans to monitor its performance to make sure that solutions are sustained
MDS/QAPI Manager or Director of Nursing will audit 10% of all pain medication orders monthly to ensure compliance and accuracy, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-15-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 684	Continued From page 50	F 684		

by mouth every 6 hours as needed for pain." This order was initiated on 3/5/18.

3) "Tramadol (2) HCL (hydrochloride) Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for pain." This order was initiated on 1/16/18.

Review of Resident #3's March 2018 MARS (Medication Administration Record) revealed Resident #3 received Tramadol 50 MG on 3/12/18 and Tylenol Extra Strength 500 mg on 3/16/18, 3/20/18, 3/22/18.

There were no parameters or instructions on the above orders on when to give each pain medication.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked how she would know which medication to give if a resident had three different orders for pain medication, LPN #1 stated she would call the medical director and clarify the orders. LPN #1 stated the pain medication orders should have pain scales attached to them to determine when to give each one. When asked if nurses were able to determine which medication to give at their own discretion, LPN #1 stated, **"No.** Nurses are not allowed to determine which medication to give when." LPN #1 stated she doesn't normally work on the skilled nursing unit and that she was not a nurse who administered the above pain medication.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 51	F 684		

the above concerns.

No further information was provided prior to exit.

The facility policy titled, "Orders and Order Clarification" did not address the above concerns.

According to Potter and Perry's, Fundamentals of Nursing, 7th edition, page 268 documents the following statements: "Clarifying an order is competent nursing practice, and it protects the client and members of the health care team. When you carry out an incorrect or inappropriate intervention, it is as much your error as the person who wrote or transcribed the original order."

(1) Tylenol is used to treat minor aches and pains and reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

(2) Tramadol is an analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer F 686
SS=D CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 52	F 686	**F686**	

demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide treatment and services to promote the healing and prevent infection of a pressure sore for one of 14 residents in the survey sample, Resident #3.

The facility staff failed to wash hands after removing Resident #3's pressure wound dressing and prior to donning new gloves, worn to perform wound care.

The findings include:

Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the **BIMS** (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

a) Director of Nursing immediately educated LPN #1 regarding proper hand hygiene and proper procedure for dressing change on 4-5-18. Resident #3 had no negative effect related to the stated observation.

b) Checked and verified that Resident #3's skin interventions and wound healing measures still in place including -- air mattress, zinc and calcium therapy, pain medications, turning and repositioning schedule, wound clinic appointments, Braden scale assessments, and med pass supplement.

How facility will identify other residents having the potential to be affected by the same deficient practice

Nurses will have a wound dressing change validation skills and proper hand hygiene re-education session.

Measure or system change to ensure the deficient practice will not recur

Education began on 4-5-18 and will continue for nurses regarding proper hand hygiene and wound dressing change validation skills. Education to occur for C.N.A.'s on 'prevention of skin breakdown'.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 53

Review of Resident #3's clinical record revealed she had a stage three-pressure sore (1) pressure sore* on her left buttock.

Review of Resident #3's most recent POS (physician order summary) revealed the following order: "Cleanse left buttock with soap and water, then cleanse with NS (normal saline) if wound has a dry bed. Apply Santyl (2) cover with Meplix border dressing daily." This order was initiated on **3/23/18.**

On 4/5/18 at 3:39 p.m., wound care observation was conducted with LPN (licensed practical nurse) #1. LPN #1 had set up her supplies before calling this writer in for the observation. LPN #1 with her gloves on removed Resident #3's old dressing. Resident #3 had a stage three pressure wound with minimal drainage. LPN #1 then removed her gloves and placed on new gloves. LPN #1 did not wash her hands before applying new gloves. LPN #1 washed the wound with soap and water. LPN #1 then cleaned the wound with normal saline and applied Santyl to a Q-tip. LPN #1 applied the Santyl into the wound bed using the Q-tip, and then covered the wound with a meplix border. LPN #1 removed her gloves, placed on new gloves, and put a new brief on the resident. LPN #1 then removed her gloves and washed her hands.

On 4/5/18 at 4:45 p.m., an interview was conducted with LPN #1. When asked how to maintain infection control during wound care, LPN #1 stated that she should have washed her hands before putting on her new gloves. LPN #1 stated, "I know that is what I missed."

F 686 **How the facility plans to monitor its performance to make sure that solutions are sustained**

Director of Nursing or designee will audit 10% wound dressing changes monthly, and 10% of Braden Scale assessments and look for corresponding interventions to ensure compliance and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-15-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 54	F 686		

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing) and **ASM #3,** the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Treatment of Pressure Ulcers," documents in part the following: "Infection Control Protocol and Safety: 1. Wash your hands thoroughly with soap and water at the following intervals:...d. when changing/removing gloves or any personal protective equipment."

No further information was presented prior to exit.

*A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron's Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

(1) Stage III pressure sore
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage 111 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 686	Continued From page 55	F 686		

contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(2) SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

F 689 SS=D Free ofAccident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined that facility staff failed to ensure residents were free from accidents or hazards for one of 14 residents in the survey sample, Resident #3.

The facility staff failed to develop and implement fall preventive interventions after Resident #3 sustained fall on 1/5/18.

The findings include:

F 689 **F689**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

a) Immediately educated caregiver involved on resident needs and resource for updated resident needs.
b) Resident fall prevention interventions were reviewed; no new interventions needed.

How facility will identify other residents having the potential to be affected by the same deficient practice

Remaining residents at-risk for falls were reviewed for proper fall preventive interventions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 56	F 689	**Measure or system change to ensure the deficient practice will not recur** a) Re-educate applicable team members on resource for updated resident needs and fall preventive intervention measures. **How the facility plans to monitor its performance to make sure that solutions are sustained** MDS/QAPI Manager or designee will audit 10% of all care plans monthly to ensure compliance and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee. All corrective actions complete by 5-15-18.	

Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent **MOS** (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's clinical record revealed that she went out to the hospital on 1/5/18. The following nursing note was documented, "Guest fell this AM (morning) 0745 (7:45 a.m.) in bathroom witnessed by CNA (certified nursing assistant). Hit head on toilet and implemented neuro (neurological) checks. 0940 (9:40 a.m.) resident sitting in DR {dining room) per her request for breakfast and stated her vision was blurry. BP {blood pressure) 72/42, HR (heart rate) 67, T (temperature) 97.4. Resident diaphoretic (sweaty) and clammy. Assisted back to bed x 2 assist and BP rechecked 88/52. MD (medical doctor) made aware and given orders to send resident to ER (emergency room) for eval (evaluation), S/P (status/post) fall with head injury. Left facility at 1030 (10:30 a.m.) am with x 3 EMS (emergency services) personnel. Alert to voice and speech clear at the time. Able to answer all questions appropriately."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 57	F 689		

Further review of Resident #3's clinical record revealed she was admitted to the hospital with diagnoses of dehydration and a UTI (urinary tract infection). Resident #3 arrived back to the facility on 1/7/18.

Review of Resident #3's fall care plan dated 6/20/17 and revised 10/24/17 failed to evidence the care plan was reviewed or updated following her 1/5/18 fall.

Review of Resident #3's fall report dated 1/5/18 failed to evidence that an intervention was put into place to prevent future falls.

Further review of Resident #3's clinical record revealed that she had not had any further falls since 1/5/18.

On 4/5/18 at 9:52 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (director of nursing), regarding the process staff follows when a resident has a fall. ASM #2 stated, when a resident falls, a nurse would add an intervention at the time of the fall to prevent future falls. ASM #2 stated therapy will also evaluate a resident. When asked if the intervention that is put into place should be on the care plan, ASM #2 stated that it should. When asked about the importance of a fall intervention being added to the care plan, **ASM #2** stated that it was important for the care plan to reflect the fall so everyone was in the loop and aware of the fall or any change in condition. When asked who had access to the care plan, **ASM #2** stated that all team members have access to the care plan. ASM #2 stated the floor nurses and the MOS nurse could update the care plan. ASM #2 confirmed she did not see where

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 58 the care plan was reviewed or updated after Resident #3's 1/5/18 fall. ASM #2 also viewed the incident report and confirmed that she did not see an intervention put into place after the 1/5/18 fall. On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2 and ASM #3, the administrative support clerk were made aware of the above concerns. A policy could not be provided regarding the above concerns.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to provide respiratory care and services to one of 14 residents in the survey sample, Resident #8. 1a. The facility staff failed to clarify Resident #S's physicians order for oxygen. 1b. The facility staff failed to maintain Resident #B's oxygen equipment in a sanitary manner.	F 695	**F695** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice** a) Resident's oxygen order was clarified to reflect the amount of oxygen parameters on 4-5-18. b) Resident's stated oxygen tubing was immediately discarded; new tubing was obtained and placed in a bag with appropriate dating. **How facility will identify other residents having the potential to be affected by the same deficient practice** a) An audit of all residents on oxygen was completed immediately on 4-5-18 by the Director of Nursing to ensure oxygen orders had the amount of liters. b) All residents on oxygen were assessed to ensure oxygen tubing was stored appropriately; any issues identified were corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 695	Continued From page 59	F 695		

The findings include:

1a. Resident #8 was admitted to the facility on 10/9/17 and readmitted on 2/6/18 with diagnoses that included but were not limited to atrial fibrillation, hypothyroidism, muscle weakness, high blood pressure, Parkinson's disease and pneumonia. Resident #S's most recent MOS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/17/18. Resident #8 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #S's most recent POS (physician order summary) revealed the following order: "02 (oxygen) via NC (nasal cannula). May titrate to maintain 02 greater or equal to 92 percent every shift."

Review of Resident #S's respiratory care plan dated 12/9/17 and revised on 1/13/18 documented the following intervention: "02 via nasal cannula per physician's orders."

On 4/4/18 at 1:30 p.m., 4/4/18 at 4:00 p.m., and 4/5/18 at 9:05 a.m., observations of Resident #8 were conducted. During each observation Resident #8 was receiving oxygen and his oxygen concentrator was observed with the flow meter set at 2.5 LPM (liter per minute).

Review of Resident #S's April 2018 TAR (treatment administration record) revealed that

Measure or system change to ensure the deficient practice will not recur

a) New process implemented whereby MDS/QAPI Manager and/or designee will review all oxygen orders from last twenty four hours to ensure order entry accuracy.
b) Re-educate nursing team members on proper oxygen tubing storage.

How the facility plans to monitor its performance to make sure that solutions are sustained

MDS/QAPI Manager or Director of Nursing will audit 10% of all oxygen orders and compliance with oxygen tubing storage monthly to ensure accuracy, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-15-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 695	Continued From page 60	F 695		

staff were monitoring Resident #S's oxygen levels. There was no indication of how many liters of oxygen Resident #8 was on while his pulse ox (1) was taken.

On 4/5/18 at 1:25 p.m., an interview was conducted with.LPN (licensed practical nurse) #1. When asked what the above oxygen order meant, LPN #1 stated that oxygen orders usually had the liters of 02 to start the oxygen. LPN #1 stated she would call the physician and clarify the order. When asked if oxygen was considered a medication, LPN #1 stated it was. When asked how nursing staff are monitoring oxygen saturation, LPN #1 stated every shift nursing is taking the pulse ox. When asked if the pulse ox should be taken with the supplemental oxygen on or off, LPN #1 stated that the oxygen should be on when the pulse ox is taken. LPN #1 was asked how nursing staff are accurately monitoring Resident #S's oxygen saturations with the pulse ox if there is no way of knowing how many liters of oxygen the resident is on at the time of the pulse ox check. LPN #1 confirmed it was not an accurate way. When asked if she knew how many liters of oxygen Resident #8 was on at that moment, LPN #1 stated she was not sure. LPN #1 was asked how many liters of oxygen Resident #8 was receiving when she checked his pulse ox and entered 98 percent on the April 2018 MAR that morning. LPN #1 stated that she could not remember. When asked the purpose of monitoring oxygen saturation, LPN #1 stated the purpose was to ensure residents were breathing properly and that monitoring could be used to try to titrate oxygen back. LPN #1 accompanied this writer to Resident #S's room, and confirmed Resident #S's oxygen flow rate was set to 2.5 liters minute.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 61	F 695		

The facility policy titled, "Oxygen Therapy Policy" documents in part the following: "The (Name of facility) shall have a valid physician's order that includes the oxygen source, the delivery source, and the flow rated (sic) deemed therapeutic for the resident."

Nursing Interventions and Clinical Skills, 2nd edition, Elkin, Perry and Potter 2000, page 936, "Oxygen is a drug and is administered and monitored with the same care as any other medication."

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

No further information was provided prior to exit.

(1) Pulse Ox (oximetry) - The pulse oximeter is a probe attached to the patient's finger that measures the percentage of hemoglobin saturated with oxygen in the blood. This information was obtained from The National Institutes of Health https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3080222/.

1b. The facility staff failed to maintain Resident #S's oxygen equipment in a sanitary manner.

On 4/5/18 at 10:30 a.m. and 12:56 p.m., an observation was made of Resident #8. He had his oxygen in place via nasal cannula. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 695 Continued From page 62

#B's oxygen tubing was hooked up to his oxygen concentrator while sitting up in his wheelchair. Resident #8 also had an oxygen tank that was secured on the back of his wheelchair. The oxygen tubing for the oxygen tank was rolled up behind his wheelchair, not stored in a bag.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked how oxygen tubing should be maintained when not in use, LPN #1 stated that oxygen tubing should be stored in a plastic bag. When asked why oxygen tubing should be stored in a plastic bag when not in use, LPN #1 stated, "To keep dust particles or anything else out of it. Infection control." LPN #1 accompanied this writer to Resident #8's room. LPN #1 confirmed Resident #8's oxygen tubing attached to his oxygen tank was not stored in a bag.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Oxygen Therapy" did not address the above concerns.

No further information was provided prior to exit.

F 695

F 697 Pain Management
SS=D CFR(s): 483.25(k)

§483.25(k) Pain Management.
The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,

F 697 **F697**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

Resident # 3 and #10's pain medication order was clarified to reflect assessment, location and intensity of pain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 697	Continued From page 63	F 697		

the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to have a complete pain assessment prior to the administration of pain medication for two of 14 residents in the survey sample, Resident #3 and 10.

1. The facility staff failed to assess and document the location and intensity of pain prior to the administration of pain medication on several occasions in March of 2018.

2. The facility staff failed to assess and document the location and intensity of pain prior to the administration of pain medication on several occasions in March and April of 2018.

The findings include:

1. Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with mostADLS (activities of daily living).

How facility will identify other residents having the potential to be affected by the same deficient practice
Audit of all residents with pain medication orders was completed immediately by the Director of Nursing and MDS/QAPI Manager to ensure that an assessment, location and intensity of pain in place. All applicable revisions were made.

Measure or system change to ensure the deficient practice will not recur
Re-education began on 4-6-18 and will continue for nurses regarding pain medication order entry to ensure it includes assessment, location and intensity of pain prior to the administration of pain medication.

How the facility plans to monitor its performance to make sure that solutions are sustained
MDS/QAPI Manager or Director of Nursing will audit 10% of all pain medication orders monthly to ensure accuracy, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-15-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION OATE
F 697	Continued From page 64	F697		

Review of Resident #3's most recent POS (physician order summary) revealed the following pain medication orders:

1) "Tylenol (1) Extra Strength 500 **MG** (milligram) Give 1 tablet by mouth every 6 hours as needed for pain."

2) "Tramadol (2) HCL (hydrochloride) Tablet 50 **MG** Give 1 tablet by mouth every 6 hours as needed for pain."

Review of Resident #3's March 2018 MAR (Medication Administration Record) revealed Resident #3 received Tramadol 50 MG on 3/12/18. The following was documented: "Pain level: 8, E (effective)." The location of pain was not identified in the clinical record.

Further review of Resident #3's March 2018 MAR revealed she received Tylenol Extra Strength 500 mg on 3/16/18, 3/20/18 and 3/22/18. A location and intensity of pain was not identified in the clinical record for 3/20/18 and 3/22/18. The following nursing note was documented on 3/16/18: "given (sic) **PRN** (as needed) Tylenol for back pain..." The assessed intensity of pain was not documented in the 3/16/18 note.

On 4/4/18 at 1 p.m., an interview was attempted with Resident #3. She could not answer questions regarding her pain medication.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows prior to administering pain medication, LPN #1 stated she would first conduct a pain assessment and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 65	F 697		

ask the resident the location of pain and the intensity. LPN #1 stated if the resident were not able to tell her the pain level, she would then use the face pain scale. When asked if the pain assessment was documented in the clinical record, LPN #1 stated that it should be. LPN #1 stated it would usually be documented in a nursing note. When asked how she would know what the resident's pain location or intensity was on 3/12/18, 3/16/18., 3/20/18, and 3/22/18, and if it was assessed, if there was no documentation in the clinical record, LPN #1 stated that she wouldn't know.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Pain Management" documents in part, the following: "Nursing will assess the nature and severity of pain including characteristics (location, intensity, frequency, duration etc.) using a standardized pain assessment instrument appropriate to the resident's cognitive level."

(1) Tylenol is used to treat minor aches and pains and reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

(2) Tramadol is an analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 66	F 697		

2. The facility staff failed to assess and document the location and intensity of pain prior to the administration of pain medication on several occasions in March and April of 2018.

Resident #10 was admitted to the facility on 12/21/17 with diagnoses that included but were not limited to Hemiplegia (one sided paralysis) following intracranial hemorrhage, muscle weakness, type two diabetes, and prostate cancer. Resident #1O's most recent **MOS** (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/21/18. Resident #10 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #10 was coded as requiring total dependence on staff for most AOL (activities of daily living).

Review of Resident #1O's most recent POS (physician order summary) revealed the following pain medication order:
"Tylenol liquid 500 MG (milligrams)/15 ML (milliliters) (acetaminophen) Give 20 ml via G-Tube (gastronomy tube) every 6 hours as needed for pain."

Review of Resident #1O's March and April 2018 MARS (medication administration record) revealed Resident #10 received Tylenol 500 mg on 3/1/18, 3/12/18, 3/27/18, 3/29/18, 3/30/18 and 4/3/18. The location of pain was not identified in the clinical record for the above dates. In addition, a pain level or intensity of pain was not documented on 3/12/18.

On 4/4/18 at 10:36 a.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 67	F 697		

conducted with Resident #10. Resident #10 stated that he occasionally has pain and sometime receives Tylenol for pain. Resident #10 could not recall if the nursing staff assess his pain prior to administering pain medication.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows prior to administering pain medication, LPN #1 stated she would first conduct a pain assessment and ask the resident the location of pain and the intensity. LPN #1 stated if the resident were not able to tell her the pain level, she would then use the face pain scale. When asked if the pain assessment was documented in the clinical record, LPN #1 stated that it should be. LPN #1 stated it would usually be documented in a nursing note. LPN #1 was asked how she would know what the resident's pain location or intensity was on the above dates, and if it was assessed, if there was no documentation in the clinical record. LPN #1 stated that she wouldn't know.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

(1) Tylenol is used to treat minor aches and pains and reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

F 732 Posted Nurse Staffing Information F 732
SS=C CFR(s): 483.35(9)(1)-(4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 732 Continued From page 68

§483.35(9) Nurse Staffing Information.
§483.35(9)(1) Data requirements. The facility must post the following information on a daily basis:
(i) Facility name.
(ii) The current date.
(iii) 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:
(A) Registered nurses.
(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
(C) Certified nurse aides.
(iv) Resident census.

§483.35(9)(2) Posting requirements.
(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.
(ii) Data must be posted as follows:
(A) Clear and readable format.
(B) In a prominent place readily accessible to residents and visitors.

§483.35(9)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(9)(4) Facility data retention requirements. 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

F 732 **F732**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice
The staff posting was corrected immediately on 4-6-18 to meet the regulatory language and show the mathematics.

How facility will identify other residents having the potential to be affected by the same deficient practice
The staff posting sheet was revised immediately to satisfy the regulatory language and ensure no other deficient practice occurred.

Measure or system change to ensure the deficient practice will not recur
Education began on 4-6-18 and will continue for all applicable team members responsible for completing the document regarding regulation F732.

How the facility plans to monitor its performance to make sure that solutions are sustained
Director of Nursing or designee will audit 10% of as worked staff posting to ensure compliance and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 4-6-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 732	Continued From page 69	F 732		

document review, it was determined that the facility staff failed to post required nurse staffing information.

The facility staff failed to post the total number and actual hours worked by licensed nursing staff directly responsible for resident care per shift.

The findings include:

On 4/4/18 at 7:15 a.m. and 4/5/18 at 8:00 a.m., observation of the nurse staffing information titled, "LONG TERM CARE AND SKILLED REHAB STAFF ON DUTY" was conducted. The form was posted in the lobby. The form documented information including but not limited to the facility name, date, census, names of nursing staff on duty and shift. The form failed to document the total number and actual hours worked by licensed nursing staff directly responsible for resident care per shift.

On 4/5/18 at 3:16 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the long-term care and skilled rehab staff on duty form had existed since the facility opened but she and the support clerk had revised the form to include an assignment key at the bottom. When asked what information should be documented on the form, ASM #2 stated the form should include the neighborhood, census, the assignments staff should have and titles such as RN (registered nurse) and LPN (licensed practical nurse). ASM #2 stated the shift is documented on the form too.

On 4/5/18 at 5:11 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 732 Continued From page 70

administrative support clerk) and OSM (other staff member) #3 (the director of environmental services) were made aware of the above concern.

On 4/6/18 at 7:20 a.m., ASM #2 stated the long-term care and skilled rehab staff on duty form documented the shift hours worked (for example, 7:00 a.m. to 7:00 p.m.) ASM #2 stated if a nurse's schedule varies from that shift, then that variation is documented on the form (for example, 7:00 a.m. to 2:00 p.m.) On 4/6/18 at 7:48 a.m., ASM #2 presented a long-term care and skilled rehab staff on duty form dated 3/18/18 that documented (name of nurse) on duty from 7:00 a.m. to 1:00 p.m., and (name of another nurse) on duty from 1:00 p.m. to 7:00 p.m. On 4/6/18 at 9:11 a.m., ASM #2 was made aware the staff posting remained a concern because the total number and actual hours worked by licensed nursing staff directly responsible for resident care per shift was not posted.

The facility policy titled, "Staff Posting" documented, "Shift staffing information shall be recorded on the Daily Assignment form for each shift. The information recorded on the form shall include...f. The actual time worked during that shift for each category and type of nursing staff..."

No further information was presented prior to exit.

F 732

F 757 SS=D Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)

§483.45(d) Unnecessary Drugs-General.
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-

F 757

F757

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

Assessment occurred to identify if non pharmacological interventions were more appropriate for residents #3 & # 10.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 757 Continued From page 71

§483.45(d)(1) In excessive dose (including duplicate drug therapy); or

§483.45(d)(2) For excessive duration; or

§483.45(d)(3) Without adequate monitoring; or

§483.45(d)(4) Without adequate indications for its use; or

§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to ensure residents were free from unnecessary medications for two of 14 residents in the survey sample, Resident #3 and #10.

1. The facility staff failed to attempt non-pharmacological pain relief interventions prior to the administration of pain medication to Resident #3 on several occasions in March of **2018.**

2. The facility staff failed to attempt non-pharmacological pain relief interventions prior to the administration of pain medication to Resident #10 on several occasions in March and April of 2018.

F 757

How facility will identify other residents having the potential to be affected by the same deficient practice
Audit of all residents who had pain medication orders was completed immediately by the Director of Nursing and MDS/QAPI Manager to identify if non pharmacological interventions were more appropriate. All applicable revisions were made.

Measure or system change to ensure the deficient practice will not recur
Education began on 4-6-18 and will continue for all applicable team members regarding attempts of non pharmacological interventions prior to the administration of pain medication.

How the facility plans to monitor its performance to make sure that solutions are sustained
Director of Nursing or designee will audit 10% of orders monthly to ensure that non-pharmacological interventions were attempted prior pain medication, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 72	F 757		

The findings include:

1. Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance of one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's most recent POS (physician order summary) revealed the following pain medication orders:

1) "Tylenol (1) Extra Strength 500 MG (milligram) Give 1 tablet by mouth every 6 hours as needed for pain."

2) "Tramadol (2) HCL (hydrochloride) Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for pain."

Review of Resident #3's March 2018 MAR (Medication Administration Record) revealed Resident #3 received Tramadol 50 MG on 3/12/18. There was no documentation in the clinical record evidencing non-pharmacological pain relief interventions were attempted prior to the administration of the Tramadol.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 73	F 757		

Further review of Resident #3's March 2018 MAR revealed that she received Tylenol Extra Strength 500 mg on 3/16/18, 3/20/18 and 3/22/18. There was no documentation in the clinical record evidencing non-pharmacological pain relief interventions were attempted prior to the administration of the Tylenol.

Resident #3's pain care plan dated 6/20/17 and revised 4/5/18, did not address attempting non-pharmacological interventions prior to the administration of pain medications.

On 4/4/18 at 1 p.m., an interview was attempted with Resident #3. She could not answer questions regarding her pain medication.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows prior to administering pain medication, LPN #1 stated she would first conduct a pain assessment and ask the resident the location of pain and the intensity. LPN #1 stated if the resident were not able to tell her the pain level, she would then use the face pain scale. When asked if non-pharmacological interventions should be attempted prior to the administration of pain medication, LPN #1 stated that they should. When asked where staff documented the non-pharmacological interventions attempted prior to administering pain medications, LPN #1 stated that it would be documented in a nurses' note. LPN #1 stated if non-pharmacological interventions attempted were not documented in the clinical record, then she would not know if they were offered.

On 4/5/18 at 5:10 p.m., ASM (administrative staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 74	F 757		

member) #1, the administrator, ASM #2, the DON (Director of Nursing) and **ASM #3,** the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Pain management" did not address the above concerns.

(1) Tylenol is used to treat minor aches and pains and reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.
(2) Tramadol is an analgesic used to treat moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.

2. The facility staff failed to attempt non-pharmacological pain relief interventions prior to the administration of pain medication to Resident #10 on several occasions in March and April of 2018.

Resident #10 was admitted to the facility on 12/21/17 with diagnoses that included but were not limited to Hemiplegia (one sided paralysis) following intracranial hemorrhage, muscle weakness, type two diabetes, and prostate cancer. Resident #1O's most recent **MOS** (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/21/18. Resident #10 was coded as being cognitively intact in the ability to make daily decisions scoring 12 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #10 was coded as requiring total dependence on staff for most AOL (activities of daily living).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 75	F 757		

Review of Resident #1O's most recent POS (physician order summary) revealed the following pain medication order:
"Tylenol (1) liquid 500 MG (milligrams)/15 ML (milliliters) (acetaminophen) Give 20 ml via G-Tube (gastronomy) every 6 hours as needed for pain."

Review of Resident #1O's March and April 2018 MARS (medication administration record) revealed that Resident #10 received Tylenol 500 mg on 3/1/18, 3/12/18, 3/27/18, 3/29/18, 3/30/18 and 4/3/18.

There was no documentation in the clinical record evidencing non-pharmacological pain relief interventions were attempted prior to the administration of the Tylenol.

Resident #1O's pain care plan dated 12/22/17 and revised 3/21/18, did not address attempting non-pharmacological interventions prior to the administration of pain medications.

On 4/4/18 at 10:36 a.m., an interview was conducted with Resident #10. Resident #10 stated that he occasionally has pain and sometime receives Tylenol for pain. Resident #10 could not recall if the nursing staff do other things before giving medication.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process staff follows prior to administering pain medication, LPN #1 stated she would first conduct a pain assessment and ask the resident the location of pain and the intensity. LPN #1 stated if the resident were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 76	F 757		

able to tell her the pain level, she would then use the face pain scale. When asked if non-pharmacological interventions should be attempted prior to the administration of pain medication, LPN #1 stated that they should. When asked where staff documented the non-pharmacological interventions attempted prior to administering pain medications, LPN #1 stated that it would be documented in a nurses' note. LPN #1 stated if non-pharmacological interventions attempted were not documented in the clinical record, then she would not know if they were offered.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns. No further information was presented prior to exit.

(1) Tylenol is used to treat minor aches and pains and reduces fever. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008785/?report=details.

F 761 SS=E Label/Store Drugs and Biologicals
CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

F 761

F761

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

a) LPN#1 was re-educated same day and immediately secured the cart thereafter.
b) Expired medications were immediately removed from medication room refrigerator; and the emergency kit box (skilled medication room) was replaced on 4-5-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 761 Continued From page 77

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store medications in a safe manner for one of two medication carts (medication cart on the long term care unit); and one of two medication rooms (the skilled rehabilitation [rehab.] medication room).

1. The medication cart on the long term care unit was left unsecured during medication administration observation.

2. One expired vial of Aplisol PPD (purified protein derivative) solution, three expired bottles of vancomycin hydrochloride sterile powder and five expired heparin lock flush syringes was observed in the skilled rehab medication room.

The findings include:

F 761

How facility will identify other residents having the potential to be affected by the same deficient practice

a) Nurse on duty rounded to ensure the other medication cart was secured.
b) An audit of all medications in the medication room refrigerator and the emergency kit box (skilled medication room) was completed by the Director of Nursing on 4-5-18 to ensure there were no other expired medications in emergency kit box.

Measure or system change to ensure the deficient practice will not recur

a) Conduct re-education for all nurses regarding securing medication cart.
b) Conduct re-education for all nurses regarding compliance with storage of medicines in the medication room; New consistent process now implemented of compliant emergency kit boxes to be replaced once monthly by the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 761	Continued From page 78	F 761	**How the facility plans to monitor its performance to make sure that solutions are sustained**	

1. On 4/4/18 at 8:31 a.m., medication administration was observed on the long term care unit with LPN (licensed practical nurse) #1. At 8:40 a.m., LPN #1 was preparing medications for Resident #4. The following medications were prepared:

1) Aspirin 81 mg (milligrams) - 1 tablet
2) Vitamin D3 1000 IU (international unit) - 1 tablet
3) Bumex 2 mg - 1 tablet
4) Edler tonic multivitamin- 10 ml
5) Cymbalta capsule 30 mg - 1 capsule
6) Lopressor 25 mg- 1 tablet

At 8:56 a.m., LPN #1 stated that she had to open up the Cymbalta. LPN #1 grabbed the Cymbalta with her bare hands from the medication cup that contained all the other medications, and placed it into an empty medication cup. LPN #1 stated that she shouldn't have touched the medication with her bare hands but she didn't have gloves on her cart. At 8:56 a.m., LPN #1 left the medication cart with all of Resident #4's medications on top of the cart. The cart was also left unlocked. Resident #4 remained in front of the medication cart. LPN #1 went to the back of Resident #4's room to grab gloves. LPN #1 was not in view of the medication cart. On 4/4/18 at 8:58 a.m., LPN #1 came back with a handful of gloves. She then placed gloves on and opened up the Cymbalta capsule.

Resident #4's most recent MOS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/5/18. Resident #4 was coded as being severely impaired in cognitive function scoring 2 out of possible 15 on the BIMS (Brief Interview for

Facility and pharmacy will work together to ensure that emergency kit boxes are exchanged monthly and contents in kit are not expired. Random audits of emergency kit box, medication room refrigerator and medication cart will be completed monthly by the Director of Nursing or designee with a report of any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-15-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 79	F 761		

Mental Status) exam.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN #1. When asked how the medication cart should be kept when she is not near the cart, LPN #1 stated the cart should be locked. LPN #1 stated she always locks the cart when she is not near the cart. When asked if she had left the cart during medication administration, LPN #1 stated she did, to get gloves. When asked if Resident #4 was in front of the cart when she left the cart, LPN #1 stated that she was. LPN #1 stated if Resident #4 got a hold of the medications on top of the cart, nothing would happen because they were her medications. LPN #1 stated narcotics were in a locked box in the medication cart. LPN #1 stated, "The only thing that might have happened was Resident #4 could have choked on the medications if she were to reach for it on the cart." When asked if it was possible for other residents to walk by and access the unlocked cart, LPN #1 stated that she didn't think about that.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Medication Administration" documents in part, the following: "During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse. It may be kept in the doorway of the resident's room with open drawers facing inward and all other sides closed. No medications are kept on top of the cart. The cart must be clearly visible to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 80	F 761		

personnel administering medications and all outward sides must be inaccessible to residents or others passing by."

(1) Aspirin is used to decrease mild to moderate pain associated with inflammatory disorders. This information was obtained from Davis's Drug Guide, 11th edition, p. 1087.

(2) Vitamin D Tablet- "Vitamin D is a fat-soluble vitamin that is naturally present in very few foods, added to others, and available as a dietary supplement." This information was obtained from The National Institutes of Health. https://ods.od.nih.gov/factsheets/VitaminD-HealthProfessional/.

3) Bumex is a diuretic used to treat fluid retention. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009343/?report=details

4) Edler tonic is a multivitamin used to treat vitamin deficiency. This information was obtained from https://www.webmd.com/drugs/2/drug-13950/elderrtonic-oral/details.

5) Cymbalta is used to treat depression and anxiety. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHTOO10059/?report=details.

6) Lopressor is used to treat high blood pressure, angina, and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 81 T0011186/?report=details.	F 761		

2. One expired vial of Aplisol PPD (purified protein derivative) solution (1), three expired bottles of vancomycin hydrochloride sterile powder (2) and five expired heparin lock flush syringes (3) was observed in the skilled rehab medication room.

On 4/5/18 at 7:35 a.m., observation of the skilled rehabilitation medication room was conducted with LPN (licensed practical nurse) #1. The following was observed:

- One open vial of Aplisol PPD solution with a written open date of 1/22 was observed in the medication refrigerator.

- An IV (intravenous) starter emergency box with a label that documented, "THIS BOX EXPIRES ON JAN 30 2018." Observation of the contents in the box revealed three bottles of vancomycin hydrochloride sterile powder with a manufacturer's expiration date of 2/1/18 and five heparin lock flush syringes with a manufacturer's expiration date of 1/1/18.

Immediately after the above observations, an interview was conducted with LPN #1. LPN #1 was asked how long the PPD solution was good for after being opened. LPN #1 stated, "I want to say 30 days." LPN #1 also confirmed the manufacturer's expiration dates on the vancomycin and heparin. When asked who was responsible for checking the medication refrigerator and the IV starter emergency box, LPN #1 stated she did not know.

On 4/5/18 at 7:43 a.m., ASM (administrative staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 82	F 761		

member) #2 (the director of nursing) confirmed the written open date on the vial of PPD solution was 1/22. ASM #2 was asked when the PPD solution expired after being opened. ASM #2 stated she would check. ASM #2 was made aware of the expired vancomycin and heparin in the rehabilitation medication refrigerator.

On 4/5/18 at 7:55 a.m., ASM #2 stated the PPD solution was good for 30 days after being opened. ASM #2 stated she was going to dispose of the PPD solution and had already disposed of the vancomycin and heparin.

On 4/5/18 at 3:16 p.m., another interview was conducted with ASM #2. ASM #2 was asked who is responsible for checking the IV starter emergency box. ASM #2 stated the consulting pharmacist is supposed to check the box each month when she completes her medication regimen reviews and the pharmacy is supposed to replace the box each month. ASM #2 was asked who is responsible for checking the medication refrigerators. ASM #2 stated the night nurse is supposed to check the refrigerators once a week.

On 4/5/18 at 5:11 p.m., ASM #1 (the administrator), ASM #2, ASM #3 (the administrative support clerk) and OSM (other staff member) #3 (the director of environmental services) were made aware of the above concern.

The facility policy titled, "Medication Storage" documented, "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 83	F 761		

No further information was presented prior to exit.

(1) Aplisol PPD solution is used in the diagnosis of tuberculosis (a lung disease). This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=1e91a67c-1694-4523-9548-58f7a8871134
The solution manufacturer's instructions documented, "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..."

(2) Vancomycin hydrochloride sterile powder is used to prevent or treat infections. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=0713a847-a334-4b73-af22-343aa06621b9&type=display

(3) Heparin lock flush syringes are used to maintain patency of an indwelling venipuncture device. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=cbc26e3c-aee9-4c0d-bdb1-bf350308fbce

F 804 SS=B — Nutritive Value/Appear, Palatable/Prefer Temp
CFR(s): 483.60(d)(1)(2) — F 804

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 804 Continued From page 84

attractive, and at a safe and appetizing temperature.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, resident representative interview, staff interview and clinical record review, it was determined that the facility staff failed to provide food at a palatable temperature.

The facility staff failed to provide food at a palatable temperature during dinner on 4/4/18.

The findings include:

Resident #1 was admitted to the facility on 6/26/17. Resident #1's diagnoses included but were not limited to diabetes, chronic kidney disease and major depressive disorder. Resident #1's most recent MOS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/28/18, coded the resident's cognition as severely impaired. On 4/4/18 at 11:02 a.m., a telephone interview was conducted with Resident #1's representative. The representative stated the facility food was not always warm enough.

Resident #115 was admitted to the facility on 3/30/18. Resident #115's diagnoses included but were not limited to chest pain, chronic kidney disease and vitamin deficiency. Resident #115's admission MOS was not complete. A BIMS (brief interview for mental status) dated 4/5/18 coded Resident #115 as cognitively intact. On 4/4/18 at 11:04 a.m., an interview was conducted with Resident #115. Resident #115 stated she sends food back every day because it is cold and she cannot eat hot food cold. Resident #115 stated

F 804 **F804**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

Followed up with named residents to review the procedure and options when a meal is not at a palatable or preferable temperature.

How facility will identify other residents having the potential to be affected by the same deficient practice

Following up with all residents to review the procedure and options when a meal is not at a palatable or preferable temperature.

Measure or system change to ensure the deficient practice will not recur

a) Conducting an in-service for dining on how to hot hold the food for service and how to properly cover and serve the food in a timely manner in collaboration with nursing to ensure that food is delivered to the residents for a palatable temperature.

b) Conducting an in-service with nursing to ensure collaboration with dining to see that food is delivered to the residents for a palatable temperature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B.WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 804	Continued From page 85	F 804	**How the facility plans to monitor its performance to make sure that solutions are sustained** Chef Supervisor or designee will conduct weekly audits of tableside food temperatures randomly to ensure food is delivered to the residents at a palatable temperature, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee. All corrective actions complete by 5-21-18.	

staff zaps the food in the microwave when she asks.

Resident #111 was admitted to the facility on 3/23/18. Resident #111's diagnoses included but were not limited to pain, vitamin deficiency and aftercare following joint replacement surgery. Resident #111's most recent MDS, an admission assessment with an ARD of 3/30/18, coded the resident as cognitively intact. On 4/4/18 at 11:05 a.m., an interview was conducted with Resident #111. The resident stated the facility food was not warm at times.

Resident #112 was admitted to the facility on 3/21/18. Resident #112's diagnoses included but were not limited to right leg fracture, blindness and high cholesterol. Resident #112's most recent MDS, an admission assessment with an ARD of 3/28/18, coded the resident's cognition as severely impaired. On 4/4/18 at 11:15 a.m., an interview was conducted with Resident #112. The resident stated the facility food was bland and cold.

On 4/4/18 at 4:20 p.m., the holding temperatures of dinner were obtained by OSM (other staff member) #4 (the cook) and included but were not limited to the following:
Stuffed peppers- 153 degrees Fahrenheit
Meatloaf- 176 degrees Fahrenheit
Corn- 153 degrees Fahrenheit

After the holding temperatures were taken, plates were prepared (a couple of plates at a time), covered with a silver lid and taken to the skilled rehab unit (a couple of plates at a time) on an open cart. After the plates arrived on the unit, one **CNA** (certified nursing assistant) was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 804	Continued From page 86	F 804		

observed taking the plates to the residents. Two surveyors conducted a test tray after the final resident on the skilled rehab unit was served. OSM #4 was asked to obtain temperatures of the food and the temperatures were as followed:
Stuffed peppers- 125 degrees Fahrenheit
Meatloaf- 129 degrees Fahrenheit
Corn- 91 degrees Fahrenheit
Both surveyors sampled the food and both surveyors agreed the food was not warm enough to be palatable. OSM #4 was asked to sample the food. OSM #4 stated she was vegetarian. OSM #4 sampled the corn. When asked if the corn was warm enough to be palatable, OSM #4 stated the corn was warm but could be warmer.

On 4/5/18 at 2:16 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked about the process for serving meals and was asked what is done to ensure the food is kept warm. CNA #2 stated the kitchen staff brings five to six plates on a plastic cart to the unit. **CNA #2** stated usually everyone is served and there is only two plates left to be served which is brought out on the cart immediately after all other trays are served. **CNA** #2 stated the plates are covered with metal lids to keep the food warm.

On 4/5/18 at 2:20 p.m., an interview was conducted with **OSM** #4 regarding her role for serving meal trays. **OSM** #4 stated she puts the food plates on a cart with a lid and if the nursing staff is not waiting at the kitchen door then she takes the cart to the unit where nursing staff serves residents. **OSM** #4 stated if she does not see nursing staff on the unit then she takes the cart back to the kitchen. When asked what is done to keep food warm, **OSM** #4 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A BUILDING _____ B.WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES {EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 804	Continued From page 87 wraps soup and puts a lid over it. In regards to other food, OSM #4 stated she puts lids over the plates and the porter takes the food right out to the unit. When asked if any devices other than the silver lids are used to keep the food warm, OSM #4 stated the plates are kept on a plate warmer until the food is plated. On 4/5/18 at 5:11 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), **ASM** #3 (the administrative support clerk) and **OSM** (other staff member) #3 (the director of environmental services) were made aware of the above concern. A policy regarding palatable food was requested. No further information was presented prior to exit.	F 804		
F 812 SS=E	Food Procurement.Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 812 Continued From page 88

standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to prepare and store food in a sanitary manner.

1. The facility staff failed to change gloves and wash her hands in between answering the telephone and frying scrambled eggs.

2. One cup of ice cream was observed open to air and not labeled in the skilled rehab unit freezer.

The findings include:

1. The facility staff failed to change gloves and wash her hands in between answering the telephone and frying scrambled eggs.

On 4/4/18 at 7:31 a.m., observation of the kitchen was conducted. OSM (other staff member) #4 was observed wearing gloves and frying scrambled eggs with a spatula on the stove. The telephone rang and OSM #4 answered the telephone with the gloves remaining on her hands. After hanging up the phone, OSM #4 continued frying the eggs with a spatula on the stove. OSM #4 did not change gloves or wash her hands.

On 4/5/18 at 2:20 p.m., an interview was conducted with OSM #4. OSM #4 was asked what should be done if she is cooking food with gloves on and answers the phone with the same gloves on her hands. OSM #4 stated, "Take the gloves off and wash your hands." When asked if

F 812 **F812**

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

a) Named cook was re-educated immediately on proper glove wearing procedure.
b) As documented, named ice cream was discarded 4-4-18.

How facility will identify other residents having the potential to be affected by the same deficient practice

a) Began addressing all dining team members on proper glove wearing procedure.
b) The remainder of the refrigerator/freezer was assessed for any other food items out of compliance.

Measure or system change to ensure the deficient practice will not recur

a) All dining team members will be in-serviced on the proper procedure of glove wearing in the kitchen and on the updated policy of Food Preparation and Handling.
b) Applicable Dining, Nursing and ConnectedLiving team members will be re-issued the policy of Use and Storage of Resident Obtained Foods.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 89	F 812	**How the facility plans to monitor its performance to make sure that solutions are sustained**	

she removed her gloves and washed her hands after answering the phone on the previous day, OSM #4 stated, "Probably not because I was rushing."

On 4/5/18 at 5:11 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the administrative support clerk) and OSM (other staff member) #3 (the director of environmental services) were made aware of the above concern.

The facility policy titled, "Food Preparation and Handling" failed to document information regarding the above findings.

No further information was presented prior to exit.

2. One cup of ice cream was observed open to air and not labeled in the skilled rehab unit freezer.

On 4/4/18 at approximately 8:00 a.m., observation of the skilled rehab unit freezer was conducted. One Styrofoam cup containing a brown substance resembling ice cream was observed in the freezer. A clear dome lid with a hole in the top was on the cup and a spoon was stuck in the hole down into the substance resembling ice cream. The substance was exposed to air and the cup was not labeled.

On 4/4/18 at 9:08 a.m., OSM (other staff member) #5 (the social worker) was observed looking at and removing items from the long-term care refrigerator. After OSM #5 left the refrigerator, this surveyor asked OSM #5 what she was doing in the refrigerator. OSM #5 stated, "Periodically we just do checks so I was checking

Chef Supervisor or designee will conduct weekly audits to ensure proper glove wearing procedures and to ensure proper food labeling and storage in the skilled rehab refrigerator/freezer, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-21-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 90	F 812		

expiration dates." **OSM** #5 was asked if items in the refrigerator and freezer should be labeled. **OSM** #5 stated if the item is for a particular resident then the item should be labeled with an open date. **OSM** #5 was made aware of this surveyor's observation of the skilled rehab unit freezer. OSM #5 stated the item should be labeled with the resident's name and date, and covered. **OSM** #5 was asked to make an observation of the freezer. On 4/4/18 at 9:14 a.m., **OSM** #5 returned to this surveyor. OSM #5 stated the item in the freezer was ice cream a family member stuck in the freezer. OSM #5 stated the family member was supposed to remove the item during the previous night but left it. When asked if family members had access to unit refrigerators and freezers, OSM #5 stated, "Yes." When asked how staff ensures food is properly stored in the unit refrigerators and freezers, OSM #5 stated, "We need to have a sign that instructs them what to do on that fridge." **OSM** #5 stated a sign was already posted on the long-term care unit refrigerator.

On 4/5/18 at 5:11 p.m., ASM #1 (the administrator), ASM #2 (the director of nursing), **ASM** #3 (the administrative support clerk) and OSM (other staff member) #3 (the director of environmental services) were made aware of the above concern.

The facility policy titled, "Use and Storage of Resident Obtained Foods" documented, "Purpose: To assure that foods obtained by residents through personal purchase, family member or visitor, is used in a safe and sanitary manner related to storage, handling and consumption...?. Should a resident choose to consume food at the Community that was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 91	F 812		

obtained by the Community, safe and sanitary use, storage and handling shall be maintained as follows: a. All foods shall be labeled with the resident's name, and dated. b. All foods shall be placed in a closed container and may be stored in the country kitchen in the appropriate location..."

No further information was presented prior to exit.

F 880 Infection Prevention & Control
SS=E CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) Asystem for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.?0(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify

F 880

F880

How corrective action will be accomplished for those residents found to have been affected by the deficient practice

a) Policy complete; On-site testing already planned; Remainder of program completion underway. In addition, after assessment, no residents at risk.
b) Director of nursing immediately educated LPN #1 regarding proper hand hygiene and proper procedure for dressing change on 4-5-18. Resident # 3 had no negative effect related to the alleged deficient practice.
c) Resident's oxygen tubing on was immediately discarded; new tubing was obtained and placed in a bag with appropriate dating.
d) LPN #1 was educated immediately on infection control practices regarding medication administration

How facility will identify other residents having the potential to be affected by the same deficient practice

a) Policy complete; On-site testing already scheduled; Remainder of program

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 92	F 880		

possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility

completion underway. In addition, after assessment, no residents at risk.

b) Licensed nurses will have proper hand hygiene re-education session.

c) All residents on oxygen were assessed to ensure their oxygen tubing were stored appropriately, any issues identified were corrected.

d) LPN#1 was educated immediately; LPN #1 was coverage for facility; no other intervention needed at this time.

Measure or system change to ensure the deficient practice will not recur

a) Associated testing scheduled. Remediation plans will occur if/where needed. On-going surveillance schedule to be implemented. Policy revisions will occur if needed.

b-d) Re-educate nursing on proper hand hygiene, proper oxygen tubing storage, and proper cleaning of equipment between residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY. STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 880	Continued From page 93	F 880		

document review, and clinical record review, it was determined that facility staff failed to have a complete Legionella program, and failed to follow infection control practices for four of 14 residents in the survey sample, Resident #3, #8, #4 and #6.

1. The facility staff failed to have a complete Legionella program.

2. The facility staff failed to maintain infection control practices during wound care for Resident #3.

3. The facility staff failed to store respiratory equipment in a manner to prevent infections for Resident #8.

4. For Resident #4 and #6, facility staff failed to maintain infection control practices during medication administration observation.

The findings include:

1. On 4/5/18 at 2:17 p.m., review of the Legionella Program was conducted with OSM (other staff member) #3, the Director of Environmental Services. OSM #3 handed this writer a Legionella policy that the facility was going to use a guide to develop their program. A blank form titled, "Water Management Program"- Site Monitoring log was also handed to this writer. When OSM #3 was asked if the Legion program was completed, OSM #3 stated, "We are planning on doing testing but we haven't done it yet. When asked if the program was incomplete, OSM #3 stated, "Well, we developed our policy." OSM #3 was not aware the Legionella program had to be completed at this time.

How the facility plans to monitor its performance to make sure that solutions are sustained

Director of nursing or designee will audit 10% of random rounding to ensure infection control and medication pass compliance and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

Director of Environment Services or designee will report out Legionella program compliance to the Quality Assurance Performance Improvement (QAPI) committee.

All corrective actions complete by 5-15-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 880	Continued From page 94	F 880		

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and **ASM #3,** the administrative support clerk were made aware of the above concerns. No further information was provided prior to exit.

The facility policy "Water Management Program to Prevent Legionnaire's Disease" documented in part the following: "The facility is committed to establishing and maintaining an effective water management program system to minimize the occurrence of Legionnaire's Disease. The bacterium Legionella can cause serious type of pneumonia called LO in persons at risk...outbreaks have been linked to poorly maintained water systems in building with large or complex water systems including hospitals and long-term care facilities. People contact Legionella by inhaling aerosolized water droplets containing the bacteria, or less commonly, aspiration of contaminated drinking water."

2. The facility staff failed to maintain infection control practices during wound care for Resident #3.

Resident #3 was admitted to the facility on 10/16/14 and readmitted on 1/7/18 with diagnoses that included but were not limited to osteoporosis, muscle weakness, unspecified dementia without behavioral disturbance, major depressive disorder, and high blood pressure. Resident #3's most recent MOS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 1/19/18. Resident #3 was coded as being moderately impaired in cognitive function, scoring 10 out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 95	F 880		

possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #3 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #3's clinical record revealed she had a stage three pressure sore (2) on her left buttock.

Review of Resident #3's most recent POS (physician order summary) revealed the following order: "Cleanse left buttock with soap and water, then cleanse with **NS** (normal saline) if wound has a dry bed. Apply Santy! (3) cover with Meplix border dressing daily." This order was initiated on 3/23/18.

On 4/5/18 at 3:39 p.m., wound care observation was conducted with LPN (licensed practical nurse) #1. LPN #1 had set up her supplies before calling this writer in for observation. LPN #1 with her gloves on removed Resident #3's old dressing. Resident #3 had a stage three pressure wound with minimal drainage. LPN #1 then removed her gloves and placed on new gloves. LPN #1 did not wash her hands before applying new gloves. LPN #1 washed the wound with soap and water. LPN #1 then cleaned the wound with normal saline and applied Santy! to a Q-tip. LPN #1 applied the Santy! into the wound bed and then covered the wound with a meplix border. LPN #1 removed her gloves, placed on new gloves, and put a new brief on the resident. LPN #1 then removed her gloves and washed her hands.

On 4/5/18 at 4:45 p.m., an interview was conducted with LPN #1. When asked how to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 96	F 880		

maintain infection control during wound care, LPN #1 stated that she should have washed her hands before putting on her new gloves. LPN #1 stated, "I know that is what I missed."

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

Facility policy titled, "Treatment of Pressure Ulcers," documents in part the following: "Infection Control Protocol and Safety: 1. Wash your hands thoroughly with soap and water at the following intervals:...d. when changing/removing gloves or any personal protective equipment."

No further information was presented prior to exit.

*A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of skin lubricants and a water or air mattress. Also called bedsores. Pressure sores. Barron ' s Dictionary of Medical Terms for the Non Medical Reader 2006; Mikel A. Rothenberg, M.D. and Charles F. Chapman. Page 155.

(1) Stage II pressure sore
Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 97	F 880		

description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perinea! dermatitis, maceration or excoriation.
*Bruising indicates suspected deep tissue injury. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(2) Stage III pressure sore
Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep stage III pressure ulcers. Bone/tendon is not visible or directly palpable. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.

(3) SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

3. The facility staff failed to store respiratory equipment in a manner to prevent infections for Resident #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 880	Continued From page 98	F 880		

Resident #8 was admitted to the facility on 10/9/17 and readmitted on 2/6/18 with diagnoses that included but were not limited to atrial fibrillation, hypothyroidism, muscle weakness, high blood pressure, Parkinson's disease and pneumonia. Resident #8's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 3/17/18. Resident #8 was coded as being cognitively intact in the ability to make daily decisions scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #8 was coded as requiring extensive assistance with one to two staff members with most ADLS (activities of daily living).

Review of Resident #8's most recent POS (physician order summary) revealed the following order: "02 (oxygen) via NC (nasal cannula). May titrate to maintain 02 greater or equal to 92 percent every shift."

On 4/5/18 at 10:30 a.m. and 12:56 p.m., an observation was made of Resident #8. He had his oxygen in place via nasal cannula. Resident #8's oxygen tubing was hooked up to his oxygen concentrator while sitting up in his wheelchair. Resident #8 also had an oxygen tank that was secured on the back of his wheelchair. The oxygen tubing for the oxygen tank was rolled up behind his wheelchair, not stored in a bag.

On 4/5/18 at 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked how oxygen tubing should be maintained when not in use, LPN #1 stated that oxygen tubing should be stored in a plastic bag. When asked why oxygen tubing should be stored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 99	F 880		

in a plastic bag when not in use, LPN #1 stated, "To keep dust particles or anything else out of it. Infection control." LPN #1 followed this writer to Resident #S's room. LPN #1 confirmed that the Resident #S's oxygen tubing attached to his oxygen tank was not stored in a bag.

On 4/5/18 at 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

Facility policy titled, "Oxygen Therapy" did not address the above concerns.

No further information was provided prior to exit.

4. For Resident #4 and Resident #6, facility staff failed to maintain infection control practices during medication administration observation.

Resident #4 was admitted to the facility on 7/15/15 and readmitted on 9/7/16 with diagnoses that included but were not limited to unspecified dementia without behavioral disturbance, muscle weakness, and high blood pressure. Resident #4's most recent MOS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 2/4/18. Resident #4 was coded as being severely impaired in cognitive function scoring 2 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #4 was coded as requiring extensive assistance from one to two staff members with most ADLs (activities of daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 880	Continued From page 100	F 880		

'living).

Resident #6 was admitted to the facility on 9/9/14 with diagnoses that included but were not limited to dementia, muscle weakness, high blood pressure and major depressive disorder. Resident #6's most recent MOS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 3/12/18. Resident #6 was coded as being severely impaired in cognitive function scoring 99 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #6 was coded as being totally dependent of staff with most ADLs (activities of daily living).

On 4/4/18 at 8:31 a.m., medication administration was observed of LPN (licensed practical nurse) #1. At 8:40 a.m., LPN #1 was preparing medications for Resident #4. The following medications were prepared:

1) Aspirin 81 mg (milligrams)- 1 tablet
2) Vitamin D 3 1000 IU (international unit)- 1 tablet
3) Bumex 2 mg - 1 tablet
4) Edler tonic multivitamin- 10 ml
5) Cymbalta capsule 30 mg - 1 capsule

At approximately 8:42 a.m., LPN #1 used a blood pressure cuff and her stethoscope to take Resident #4's blood pressure. Resident #4's blood pressure was 148/72. LPN #1 placed the cuff and stethoscope on the medication cart. This writer did not see LPN #1 sanitize the blood pressure cuff or stethoscope after use. LPN #1 then prepared the following medication:

6) Lopressor 25 mg- 1 tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4)1D PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 101	F 880		

At 8:56 a.m., LPN #1 administered the Edler tonic to Resident #4. LPN #1 placed her bare fingers on the rim of the medication cup and administered the medication to Resident #4. Resident #4 had her lips directly on the rim of the medication cup, where LPN #1 had touched with her bare fingers.

At 8:56 a.m., LPN #1 stated that she had to open up the Cymbalta. LPN #1 grabbed the Cymbalta with her bare hands from the medication cup that contained all the other medications, and placed it into an empty medication cup. LPN #1 stated that she shouldn't have touched the medication with her bare hands but she didn't have gloves on her cart. At 8:56 a.m., LPN #1 left the medication cart with all of Resident #4's medications on top of the cart. The cart was also left unlocked. Resident #4 remained in front of the medication cart. LPN #1 went to the back of Resident #4's room to grab gloves. On 4/4/18 at 8:58 a.m. LPN #1 came back with a handful of gloves. She then placed gloves on and opened up the cymbalta capsule. LPN #1 then crushed all other medications and mixed the contents of the Cymbalta into the medication cup with the crushed medications. LPN #1 then removed her gloves. LPN #1 added chocolate pudding to medications and administered the crushed medications to Resident #4. LPN #1 then poured a glass of water and grabbed the rim of the cup with her bare hands and *gave* the cup of water to Resident #4. Resident #4 had her lips directly on the rim of the water cup, where LPN #1 had touched with her bare fingers.
LPN #1 then sanitized her hands. This writer did not observe LPN #1 sanitize the blood pressure cuff or her stethoscope.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING_____ B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 102	F 880		

On 4/4/18 at 9:15 a.m., LPN #1 was observed walking up the hallway with the same blood pressure cuff and stethoscope that was used on Resident #4. LPN #1 took Resident #6's blood pressure using the same equipment. On 4/4/18 at 9:18 a.m., an interview was conducted with LPN #1. When asked what she uses to sanitize a blood pressure cuff, LPN #1 stated that she uses sani wipes but that she did not have them on her cart at the moment. When asked if she had sanitized the blood pressure cuff in between using it on Resident #4 and Resident #6, LPN #1 stated that she did. LPN #1 stated, "I am not even going to lie, I forgot to wipe my stethoscope in between the two residents."

On 4/5/18 at 1:25 p.m., further interview was conducted with LPN #1. When asked how to maintain infection control practices during medication pass, LPN #1 stated that she should wash or sanitize hands before and after each resident, wipe off equipment before using on another person, and she shouldn't touch the pills with her bare hands/fingers. When asked if bare fingers should be touching the rim of the medication or water cup, LPN #1 stated that it shouldn't. LPN #1 stated that her hands could spread germs.

On 4/5/18 at 5:10 p.m., ASM {administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #3, the administrative support clerk were made aware of the above concerns.

The facility policy titled, "Medication Administration" documents in part, the following: "Staff shall follow established facility infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING _____ B. WING _____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 103	F 880		

control procedures (e.g. handwashing, antispetic technique, gloves, isolation precautions. etc.) for the administration of medications as applicable."

(1) Aspirin is used to decrease mild to moderate pain associated with inflammatory disorders. This information was obtained from Davis's Drug Guide, 11th edition, p. 1087.
(2) Vitamin D Tablet- "Vitamin D is a fat-soluble vitamin that is naturally present in very few foods, added to others, and available as a dietary supplement." This information was obtained from The National Institutes of Health. https://ods.od.nih.gov/factsheets/VitaminD-HealthProfessional/.
3) Bumex is a diuretic used to treat fluid retention. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009343/?report=details
4) Edler tonic is a multivitamin used to treat vitamin deficiency. This information was obtained from https://www.webmd.com/drugs/2/drug-13950/eldertonic-oral/details.
5) Cymbalta is used to treat depression and anxiety. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010059/?report=details.
6) Lopressor is used to treat high blood pressure, angina, and heart failure. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0011186/?report=details.

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0408	A. BUILDING:---------- B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 4/4/18 through 4/6/18. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 20 certified bed facility was 15 at the time of the survey. The survey sample consisted of 12 current resident reviews (Residents#9, 61, 10, 4,112, 1, 6, 8, 3,111, 2 and 115) and two closed record reviews (Residents# 12 and 11).	F 000	12VAC5-371-180 Cross Reference to Plan of Correction (POC) for F880 Infection Prevention & Control. 12VAC5-371-300 Cross Reference to POC for F761 Label/Store Drugs and Biologicals. 12VAC5-371-340 Cross Reference to POC for F812 Food Procurement, Sotre/Prepare/Serve-Sanitary.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-180. Infection control cross reference to F880 12VAC5-371-300. Pharmaceutical services cross reference to F761 12VAC5-371-340. Dietary and food service program cross reference to F812 12VAC5-371-140. Policies and Procedures cross references to F622, F623, F624, F625 12VAC5-371-250. Resident assessment and Care Planning cross references to F657, F757, F686, F695, F697, 12VAC5-371-200. Director of Nursing cross references to F684.	F 001	12VAC5-371-140 Cross Reference to POC for F622 Transfer and Discharge Requirements; F623 Notice Requirements Before Transfer/Discharge; F624 Preparation for Safe/Orderly Transfer/Dschrg; and F625 Notice of Bed Hold Policy Before/Upon Trnsfr. 12VAC5-371-250 Cross Reference to POC for F657 Care Plan Timing and Revision, F757 Drug Regimen is free from Unnecessary Drugs, F686 Treatment/Svcs to prevent/heal pressure ulcer, F695 Respiratory/tracheostomy care and suctioning, and F697 Pain management. 12VAC5-371-200 Cross Reference to POC for F684 Quality of Care.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 5-4-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0408	A. BUILDING:---------- B. WING_____	04/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT ORCHARD RIDGE	100 PROCESSION WAY WINCHESTER, VA 22603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 1 12VAC5-371-220. Nursing Services cross references to F757	F 001	12VAC5-371-220 Cross Reference to POC for F757 Drug Regimen is free from Unnecessary Drugs.	