DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING_ 495415 04/06/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE WINCHESTER, VA 22603 PROVIDER'S PLANOF CORRECTION SUMMARYSTATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION **PRÉFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

E 000

E 001

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 001 Establishment of the Emergency Program (EP) SS=C 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 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.

ABORATORY.	DIRECTO	R'S OR PROVIDER/	SUPPLIER RI	#PRESENTATIVE'S	SIGNATURE
	/		/ / /	,	

ADMINISTRATOR

(X6) DATE

Any deficiency statement ending with an asterisk (denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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.

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

Event ID:QT8M11

acility ID: VA0408

If continuation sheet Page 1 of 104

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

E035

E 035

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.

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 2 of 104



VDH/OLC

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4)1D (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION PRÉFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG

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 RNHCls 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

DEFICIENCY)

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

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.

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

Event ID: QT8M11

Facility ID: VA0408

E 039

If continuation sheet Page 4 of 104

		& MEDICAID SERVICES			FORM APPROVED OMB NO 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			ł	LTIPLE CONSTRUCTION JILDING	(X3) DATE SURVEY COMPLETED
		495415	B. WING	9	04/06/2018
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0 0 0
THE VII I	LAGE AT ORCHARD F	RIDGE		100 PROCESSION WAY	
				WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE COMPLETION
E 039	Continued From pa	ge 3	. F(039 E039	
	•	drills using the emergency		How corrective action will be acc	omplished for
	procedures. The LT	C facility must do all of the		those residents found to have be	•
	following:]			the deficient practice	en anected by
	community-based of exercise is not acceptacility-based. If the actual natural or marequires activation of [facility] is exempt from community-based of full-scale exercise for the actual event. (ii) Conduct an additional exercise for the actual event. (iii) Conduct an additional exercise for the actual event. (iii) Conduct an additional exercise for actual event. (iii) A second full-community-based of the actual event. (iii) A tabletop exercise for problem statement exercise for problem	r individual, facility-based or 1 year following the onset of tional exercise that may mited to the following: scale exercise that is r individual, facility-based. ercise that includes a group facilitator, using a narrated, mergency scenario, and a set of the following and interest of the facility's] response to and stion of all drills, tabletop regency events, and revise the ty plan, as needed.		Immediately conducted a review emergency preparedness plan to our program included all necessa that would not put resident at ris with current plans of a full-scale, facility-based exercise of a disaste 1, 2018. How facility will identify other rethe potential to be affected by the same deficient practice Immediately conducted a review emergency preparedness plan to our program included all necessar that would not put any residents a Continuing with current plans of a individual facility-based exercise odrill by 5-1-18.	assure that ry components k. Continuing individual er drill by May sidents having ee of our current assure that y components at risk. full-scale,
	must conduct exerci	sting. The [RNHCl and OPO] ses to test the emergency and OPO] must do the			

(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

following:

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING_ COMPLETED B. WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES (X4)1D ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 039 Continued From page 4 Measure or system change to ensure the E 039 of problem statements, directed messages, or deficient practice will not recur prepared questions designed to challenge an 1) New annual full-scale community-based emergency plan. (or individual based) exercise to be (ii) Analyze the [RNHCl's and OPO's] response

to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl'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.

- 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.

DEFAR LIVIEIN LOF HEALTH AND HUMAN SERVICES CENTERS EOR MEDICARE SMEDICARD CEDVICE

FORM APPROVED

OLIVILI	TO I ON WILDICARE	AMEDICAID SERVICES		ON	ИВ NO. 0938-039 [.]
	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495415	I⊟WING		04/06/2018
NAME OF P	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
THEVILL	THE VILLAGE AT ORCHARD RIDGE		1	00 PROCESSION WAY	
THE VILL	AGE AT URCHARD I		V	VINCHESTER, VA 22603	
(X4)1D PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENT	'S	F 000		

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 550 Resident Rights/Exercise of Rights SS=E CFR(s): 483.10(a)(1)(2)(b)(1)(2)

> §483.10(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.

§483.10(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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING-----B. WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES (X4)1D ID PROVIDER'S PLAN OF CORRECTION (X5) PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 550 Continued From page 6 F 550 Measure or system change to ensure the residents regardless of payment source. deficient practice will not recur Implement new practice whereby all residents §483.10(b) Exercise of Rights. who do not require assistance with drinking at The resident has the right to exercise his or her the breakfast table or whom it is their rights as a resident of the facility and as a citizen preference will be offered a drink at the table or resident of the United States. while waiting for their breakfast meal. §483.10(b)(1) The facility must ensure that the Residents who require assistance with a drink resident can exercise his or her rights without or whom is their preference will be assisted to interference, coercion, discrimination, or reprisal the living room until breakfast time. All nursing from the facility. to be educated on new practice and re-educate on dignity. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her How the facility plans to monitor its rights and to be supported by the facility in the performance to make sure that solutions are exercise of his or her rights as required under this sustained subpart. Audit to be completed 2 times per month by This REQUIREMENT is not met as evidenced bv: Director of Nursing or designee to ensure Based on observation, staff interview, facility compliance and report any actionable trends to document review and clinical record review, it the monthly Quality Assurance Performance was determined that the facility staff failed to Improvement (QAPI) Committee. 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

All corrective actions complete by 5-21-18.

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES					NO 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) I	DATE SURVEY COMPLETED
		495415	B. WING	;			04/06/2018
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		04/00/2010
THE VIL	LAGE AT ORCHARD	RIDGE		10	0 PROCESSION WAY		
			1	W	INCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BF	(X5) COMPLETION DATE
F 550	Continued From pa	ge 7	F 5	50			
	·	depressive disorder. Resident	F 3.	30			
	#1's most recent M	OS (minimum data set), a					
	quarterly assessme	ent with an ARD (assessment					
	reference date) of 3	3/28/18, coded the resident's					
	Resident #1 as requ	ly impaired. Section G coded uiring supervision with setup					
	help only with eating						
	·	_					
	Resident #2 was ad	lmitted to the facility on					
		#2's diagnoses included but nigh blood pressure, high					
	cholesterol and anx	iety disorder. Resident #2's					
	most recent MOS, a	n annual assessment with an					
	ARD of 12/29/17, co	oded the resident as					
	cognitively intact. Se	ection G coded Resident #2					
	eating.	sion with setup help only with					
	Resident #3 was ad	mitted to the facility on					
	7/15/17. Resident #3	3's diagnoses included but					
	were not limited to d	lifficulty swallowing, anxiety					
	disorder and high bl	ood pressure. Resident #3's					
	assessment with an	significant change in status ARD of 1/19/18, coded the					
		as moderately impaired.					
	Section G coded Re	sident #3 as requiring limited					
	assistance of one st	aff with eating.					
	Resident #4 was add	mitted to the facility on					
	2/26/16. Resident #4	1's diagnoses included but					
		nuscle weakness, high or depressive disorder.					
		recent MOS, a quarterly					
		ARD of 2/4/18, coded the					
	resident's cognition a	as severely impaired.					
	Section G coded Res	sident #4 as requiring					

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

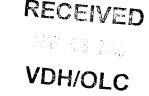
extensive assistance of one staff with eating.

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 9 of 104



CENTERS	S FOR MEDICARE	: & MEDICAID SERVICES		0	MB NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
THE VILLA	GE AT ORCHARD F	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION

F 550 Continued From page 8

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.

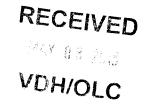
F 550

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 10 of 104



STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CUA	(X2) MUL	FIPLE CONSTRUCTION	OMB NO 0938-0
AND PLAN OF CORRECTION		ECTION IDENTIFICATION NUMBER:		NG	(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE 04/00/2018
THE VIL	LAGE AT ORCHARD F	RIDGE	j	100 PROCESSION WAY	
				WINCHESTER, VA 22603	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION (VE)
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCEDTO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 550	Continued From page	ge 9	F 55	50	
	Neither Resident #3	nor Resident #61 had food at			
		8 at 8:37 a.m., Resident #6			
	was wheeled to the	table. On 4/4/18 at 8:39 a.m			
	Resident #1 was wh	neeled to the table. On 4/4/18			
	at 9:00 a.m., Reside	ent #9 was wheeled to the			
	table. At this time, t	he only resident observed			
	with food was Resid	ent #2. Also at this time, an			
	member) #6 (the Ch	icted with OSM (other staff			
	talking with resident	aplain who was observed			
	table) OSM #6 was	s sitting at the dining room asked who was responsible			
	for serving food to re	esidents at the dining room			
	table. OSM #6 state	ed the cook usually makes			
	food and brings it ou	it to the unit. When asked			
	why residents were i	not yet being served, OSM#6			
	stated some residen	ts need assistance from care			
	staff so she thought	they were waiting to serve			
		when care staff was			
		em. OSM #6 stated the care			
	staff is typically getting	ng residents ready to come			
	out to the dining roor	m. On 4/4/18 at 9:03 a.m.,			
	resident #4 was who	eeled to the dining room			
	her husband were as	:05 a.m., Resident #61 and			
	0.16 a m. Posidonto	erved breakfast. On 4/4/18 at #3 and #1 were served			
	hreakfast then Resid	ents #4, #6 and #9 were			
	served and assisted	with breakfast.			
	During the above obs	servations, staff was not			
	observed offering foo	ed to the above residents			
	until the times docum	nented above.			
	On 4/5/18 at 2:16 p.n	n., an interview was			
	conducted with CNA	(certified nursing assistant)			
	#2 (a CNA working or	n the long-term care unit on			
	4/4/18). CNA #2 was	asked about the process			
	ior serving meals to re	esidents. CNA #2 stated			
	many of the	needed assistance with			

feeding so the CNAs try to get all the residents up

CENTERS FOR MEDICARE & MEDICAIDSERVICES OMB NO 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED ABUILDING-----R WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)1D (XS) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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.

a MEDICAID SERVICES			OMB NO 0938-039
(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
495415	B. WING_		04/06/2018
2		STREET ADDRESS, CITY, STATE, ZIP CODE	
BIDGE		100 PROCESSION WAY	
KIDGE		WINCHESTER, VA 22603	
ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (XS)
MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE DATE
		1	
	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 495415 RIDGE ATEMENT OF DEFICIENCIES WING MUST BE PRECEDED BY FULL (X2) MULTIL A. B. U.I. A. B. WING B. WING B. WING ATEMENT OF DEFICIENCIES WINGTHERMORE WINGTHERMORE ATEMENT OF DEFICIENCIES WINGTHERMORE W	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 495415 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP

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 beendangered;
- (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.

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	NO 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		495415	B. WING	S	(04/06/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE	
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 PREFI TAG	•	SHOULD BE	(X5) COMPLETION DATE
F 622	Continued From na	nge 12	E 6	322. How the facility plans to me	mitar its	

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

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 report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

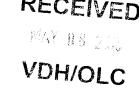
All corrective actions complete by 5-21-18.

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 13 of 104



CENTERS FOR MEDICARE & MEDICAID SERVICES I ONWI AFFRUVEL OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING_ COMPLETED 495415 B. WING 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) 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 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.

CENTERS FOR MEDICAR	RE & MEDICAID SERVICES		0	MB NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495415	⊫ WING _		04/06/2018
THE VILLAGE AT ORCHARE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	
PRÉFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION

F 622 Continued From page 14

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

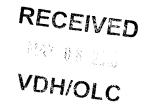
F 622

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 15 of 104



CENTER	S FOR MEDICAR	RE & MEDICAID SERVICES			MB NO 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
NAME OF PE	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0.000,2010
THE VILLA	GE AT ORCHARD	RIDGE		100 PROCESSION WAY	
				WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION

F 622 Continued From page 15

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

F 622

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 0938-0391
AND DI AN DE DOCUMENTO.		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0 1100.2010
THE VILI	LAGE AT ORCHARD	RIDGE		100 PROCESSION WAY	
				WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI ((EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 622	Continued From pa	ge 16	F 6:	22	
		note, advance directives,		-	
	advance care order	s. Send these documents if			
	available: Most rece	ent history and physical, recent			
		summary, recent MD/NP			
		PA (physician's assistant) and ow sheets, relevant lab			
		Relevant X-Rays and other			
	Diagnostic Test Res	sults, Nursing Home			
	Capabilities. Emerg	ency Department: Please			
	ensure that these do	ocuments are forwarded to			
	the hospital unit if th	ne patient is admitted. Thank			
	you. ASIVI #2 Could	not evidence what was sent Resident #3. ASM #2 stated			
	the care plan was a	Iso something that wasn't			
	typically sent with th	e 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 the above concerns.	ort clerk were made aware of			
		led, "Transfer or Discharge			
	notice," did not addr	ress the above concerns.			
	No further information	on was presented prior to exit.			
	2. For Resident #8, f	facility staff failed to evidence			
		rmation was provided to the or 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

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495415	B. WING_				04/06/2040
NAME OF F	PROVIDER OR SUPPLIER		·	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		04/06/2018
THE VILI	AGE AT ORCHARD I	RIDGE		100 P	PROCESSION WAY		
				WING	CHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(XS) COMPLETION DATE
F 622	Continued From pa	ge 17	F 62	22			
	•	assessment was a quarterly	. 02				
	assessment with ar	ARD (assessment reference					
	date) of 3/17/18. Re	esident #8 was coded as					
	decisions scoring 19	act in the ability to make daily 5 out of possible 15 on the					
	BIMS (Brief Intervie	w for Mental Status) exam.					
	Resident #8 was co	ded as requiring extensive					
	assistance with one most ADLS (activities	to two staff members with es of daily living).					
	he had been transfe The following was d "Around 0400 (4:00 assistants) alerted the to the touch. This withe tympanic temp (Multiple blankets we Blood sugar was tak was slow to responding wall. Guest was able juice. BS was check at 41. He then has a and BS was checked at 41. He then has a and BS was checked the following of Nursing) was also arrival were: blood s respirations 14, HR (and temp 95.0."	(heart rate) 58 and irregular					
† 	following: "POA (pow POA) updated on res	2/4/18 documented the ver of attorney), (Name of sident condition and being tal. In agreement with plan."					

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

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0MB NO 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	i	495415	B. WING	i.	04/06/2018
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	
TUE VII I	AGE AT ORCHARD F	PIDCE	ĺ	100 PROCESSION WAY	
THE VILL	AGE AT ORCHARD F	RIDGE		WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	•	LD BE COMPLETION
F 622	Continued From pa	ge 18	F 6		
	•	acidosis (1) and sepsis (2).	1 0.	22	
	information; Reside responsible party or Resident #B's care hospital for the facil #8 arrived back to the On 4/5/18 at 4:42 p. conducted with LPN #1, the only nurse of documentation was being transferred to that she would send medication list, and information for the high she would send the stated she had never care plan with the re #1 stated she was not responsible.	m., an interview was I (Licensed practical nurse) in the unit. When asked what sent with residents who were the hospital, LPN #1 stated I their advanced directives, a any other pertinent cospital staff. When asked if resident's care plan, LPN #1 or heard of nurses sending the esident to the hospital. LPN lew to the unit and had not yet the hospital. When asked if it			
	hospital, LPN #1 sta general statement the with the resident. LF wouldn't specify whithe resident. LPN #2	sent with the resident to the sted that she would write a nat all paperwork was sent out PN #1 stated she probably ch paperwork was sent with I stated there was no way work was sent out with			

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

CENTE	KO FUK WIEDICAKE	& MEDICAID SERVICES			OMP NO 0029 0204
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495415	B. WING		0410010045
	AME OF PROVIDER OR SUPPLIER HE VILLAGE AT ORCHARD RIDGE (X4)1D SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	04/06/2018
(X4)1D PREFIX TAG	{EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE COMPLETION
	with the patient (che transfer form, perso Patient Transfer For Current Medication (medication adminis (situation, backgrour recommendation) ar condition progress in advance care orders available: Most rece hospital discharge si (nurse practitioner)/F Specialist orders, flo (laboratory) results, Diagnostic Test Res Capabilities. Emerge ensure that these do the hospital unit if the you." ASM #2 could to the hospital with F the care plan was als typically sent with the ASM #2 stated she was transfer checklist to in On 4/5/18 at 5:10 p.r administrator, ASM # administrative support the above concerns. Facility policy titled, "notice," did not address.	ck all that apply): Patient and belongings identified on are enclosed, Face sheet, List or Current MAR atration record), SBAR and, assessment, and or other change in a tote, advance directives, as Send these documents if ant history and physical, recent ummary, recent MD/NP PA (physician's assistant) and as sheets, relevant lab Relevant X-Rays and other alls, Nursing Home ency Department: Please accuments are forwarded to be patient is admitted. Thank and evidence what was sent are so something that wasn't are resident to the hospital. It was going to update her anclude the care plan. The ASM #1, the Patand ASM #3, the art clerk were made aware of the above concerns. Transfer or Discharge assist the above concerns. The was presented prior to exit.	F 62	22	
1	 Lactic acidosis is a blood. This informatio 	a buildup of lactic acid in the on was obtained from The			

FORM APPROVED OMB NO 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A BUILDING-B. WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLANOF CORRECTION ID (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRFFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 622 Continued From page 20 F 622 National Institutes of Health. https://search.nih.gov/search?utf8= %E2%9C%93&affiliate=nih&query=lactic+acidosi (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 623 Notice Requirements Before Transfer/Discharge F 623 F623 SS=D CFR(s): 483.15(c)(3)-(6)(8) How corrective action will be accomplished for those residents found to have been affected by §483.15(c)(3) Notice before transfer. the deficient practice

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;
- (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.

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.

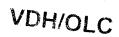
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 21 of 104





CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO 0938-0391

		<u> </u>			MID 140 0930-039
	MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495415	B. WING	3	04/06/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	T #7 00/ 20 10
				100 PROCESSION WAY	
IHE	VILLAGE AT ORCHARD F	RIDGE		WINCHESTER, VA 22603	
()(4)	CLIMANACIVOTA	TELEVITORIO		WHOTESTER, VA 22003	
(X4) PRE TA	FIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	(= 1011 GOLLATE MOLION SHOOLD	BE COMPLETION

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 thefacility 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.

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB I	NO 0938-0391
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		DATE SURVEY COMPLETED
		495415	B. WING				04/06/2018
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE	I	
THE VILL	AGE AT ORCHARD	RIDGE			PROCESSION WAY NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLANOF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE
F 623	Continued From pa	-	F 6	23			
		advocacy of individuals with					
		abilities established under Part ental Disabilities Assistance					
		act of 2000 (Pub. L. 106-402,					
	codified at 42 U.S.0	C. 15001 et seq.); and					
		cility residents with a mental					
		disabilities, the mailing and telephone number of the					
		e for the protection and					
	advocacy of individ	uals with a mental disorder					
	established under t for Mentally III Indiv	he Protection and Advocacy riduals Act.					
	effecting the transfe must update the re	the notice changes prior to er or discharge, the facility cipients of the notice as soon e the updated information					
	In the case of facilit	ce in advance of facility closure ty closure, the individual who is					
		f the facility must provide					
		prior to the impending closure Agency, the Office of the					
		care Ombudsman, residents of					
		resident representatives, as					
		the transfer and adequate					
	483.70(1).	sidents, as required at §					
		NT is not met as evidenced					
	by: Based on staff inte	erview, facility document					
		record review, it was					
	determined that the	e facility staff failed to provide					
	written notification t	to the resident representative					

and the long term care ombudsman for a

the survey sample, Resident #3 and #8.

facility-initiated transfer for two of 14 residents in

		& MEDICAID SERVICES				0938-039
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		495415	B. WING			10010010
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	DE (U4)	/06/2018
THE VII	LAGE AT ORCHARD R	IDGE	1	100 PROCESSION WAY		
				WINCHESTER, VA 22603		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE	RECTION	
PREFIX TAG	REGULATORY OR LS	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	Continued From page	ge 23	F 62	23		
	notification to the recombudsman when F to the hospital on 1/8 2. The facility staff far notification to the recombudsman when F to the hospital on 2/4 The findings include: 1. Resident #3 was a 10/16/14 and readmindiagnoses that included the state of the pressive disorder, Resident #3's most reset) was a significant ARD (assessment reresident #3 was codimpaired in cognitive	ailed to provide written sident representative and Resident #8 was transferred 1/18.				
	Mental Status) exam. requiring extensive a members with most A	Resident #3 was coded as ssistance of one to two staff ADLS (activities of daily				
	living). Review of Resident # that she went out to the following nursing note fell this AM (morning) bathroom witnessed to assistant). Hit head of	3's clinical record revealed the hospital on 1/5/18. The was documented, "Guest 0745 (7:45 a.m.) in by CNA (certified nursing the toilet and implemented thecks. 0940 (9:40 a.m.)				

request for breakfast and stated her vision was

	CENTERS FOR MEDICARE	CENTERS FOR MEDICARE & MEDICAID SERVICES 01				
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			E SURVEY IPLETED
		495415	B. WING		04/	06/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	THE VILLAGE AT ORCHARD F	PINGE		100 PROCESSION WAY		
	THE VILLAGE AT ORGHAND I	ND OL		WINCHESTER, VA 22603		
	PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE

F 623 Continued From page 24

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

F 623

CENTERS FOR MEDICARE & MEDICAID SERVICES OUM ALERONED OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495415 B. WING 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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.

to the hospital on 2/4/18.

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

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

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	i	495415	B. WING		04/06/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
THE VILL	AGE AT ORCHARD F	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 623	Continued From pa	ge 26	F 6:	23		
	high blood pressure pneumonia. Reside (minimum data set) assessment with an date) of 3/17/18. Rebeing cognitively int decisions scoring 18 BIMS (Brief Intervie Resident #8 was coassistance with one most ADLS (activitie Review of Resident he had been transfer The following was downward of the touch. This was the tympanic temp (Multiple blankets we Blood sugar was take was slow to responsible. BS was check at 41. He then has a and BS was checket.	oidism, muscle weakness, e, Parkinson's disease and nt #S's most recent MDS assessment was a quarterly ARD (assessment reference esident #8 was coded as act in the ability to make daily 5 out of possible 15 on the w for Mental Status) exam. Indeed as requiring extensive to two staff members with es of daily living). #S's clinical record revealed erred to the hospital on 2/4/18. Indeed to the hospital on 2/4/18. Indeed the error of the example of the guest and the example over top of him. In the example of the				

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

and temp 95.0."

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,

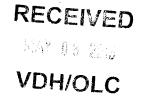
respirations 14, HR (heart rate) 58 and irregular

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."

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 27 of 104



CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES				0	MB NO 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION		(X3) DATE SURVEY COMPLETED
		495415	B. WING				04/06/2049
NAME OF	PROVIDER OR SUPPLIEF	8	<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIF	P CODE	04/06/2018
THE VIII	LAGE AT ORCHARD	Dino-			OCESSION WAY		
TITE VIE	LAGE AT ORCHARD	RIDGE			HESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD HEAPPROPE	BE COMPLETION
F 623	Continued From pa	age 27	F 6	23			
	Resident #8 was addiagnoses of lactic Resident #8 arrived Further review of R failed to evidence to notified in writing of transfer to the hosp received a copy of the conducted with LPN #1, regarding the notified first assess to determine to sent out. LPN #1 staphysician to obtain out to the hospital. It call the administrate attorney) and then to thow she would notified in susually verbally of she would provide wexplaining the reason #1 stated, "I haven't	de clinical record revealed dmitted to the hospital with acidosis (1) and sepsis (2). If back to the facility on 2/6/18. If back to the facility on a condition of the facility of the family, LPN #1 stated she can be conditionable of the family of the family, LPN #1 stated it for the phone. When asked if written notification to the family on for resident transfer, LPN sent anyone to the hospital stated she usually works in					
	sending written notif ombudsman regardi	n asked if nurses should be ication to the long term care ng a resident's transfer to the					

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

CENTE	13 FOR MEDICARE	E & MEDICAID SERVICES				UNB	MO 0938-039
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		DATE SURVEY COMPLETED
		495415	B. WING				04/06/2018
NAME OF F	PROVIDER OR SUPPLIER		<u>' </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
THE VILL	AGE AT ORCHARD	RIDGE	ŀ		PROCESSION WAY		
				WIN	ICHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	〈	PROVIDER'S PLAN OF CORREC {EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	Continued From pa	·	F 6	23			
	member) #1, the act DON (Director of N the above concerns they were not awar was to be notified in transfer. ASM #1 as aware the long term provided written not facility-initiated transfer. The facility policy transfer," did not add No further information	tled, "Transfer or Discharge lress the above concerns. ion was presented prior to exit.					
	blood. This informa National Institutes of https://search.nih.g						
	your body has an o response to a bactereleased into the blurigger widespread information was obtainstitutes of Health. https://medlineplus.	tained from The National gov/sepsis.html					
	Preparation for Safe CFR(s): 483.15(c)(7	e/Orderly Transfer/Dschrg 7)	F 6	24			

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

CENTER		& MEDICAIDSERVICES			FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF D	OVER OF CURRENTS	495415	B. WING_		04/06/2018
	ROVIDER OR SUPPLIER	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	
(X4)1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTIONSHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION

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.

LI ANTINILIA I OF HEALTH AND HUMAN SEKVICES

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.

(X3) DATE SURVEY

COMPLETED

04/06/2018

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A BUILDING-----B. WING 495415 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE

WINCHESTER, VA 22603

(X4) ID PRÉFIX 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)

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

How the facility plans to monitor its F 624 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.

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 31 of 104

RECEIVED

VDH/OLC

<u> </u>	NO FOR MEDICAL	AL & MEDICAID SERVICES	_		0MB NO 0038 030
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	_	495415	B. WING		04/06/2040
	PROVIDER OR SUPPLIER LAGE AT ORCHARD			STREET ADDRESS, CITY, STATE, ZIP CO 100 PROCESSION WAY WINCHESTER, VA 22603	04/06/2018 DDE
(X4)1D PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE	SHOULD BE COMPLETION
F 624	Continued From p could not recall the the hospital on 1/5	e day she was transferred to	F 62	24	
	conducted with LP #1, regarding the ransferred out to the would first assess vital signs to determ to be sent out. LPN the physician to obtain the physician to obtain the physician to obtain the mould also call the and then the ambut documentation for stated that should nurse's note such a change in condition. When asked if nurse the resident was on transfer, LPN #1 staked why this shot stated, the resident transfer so they know gives the resident and the condition of the condition. On 4/5/18 at 5:10 padministrator, ASM Nursing) and ASM clerk were made as the condition of the facility policy time.	p.m., an interview was 'N (Licensed practical nurse) nurses' role when a resident is the hospital. LPN #1 stated she the resident, and then obtain mine the need for the resident with #1 stated she would then call obtain an order to send the hospital. LPN #1 stated she administrator, family or POA plance. When asked about the a hospital transfer, LPN #1 document everything in a last he resident's vital signs, the last he additionally be documenting if the steel and prepared for the lated, "I believe so." When build be documented, LPN #1 to should be oriented to the last he what is going on and it a chance to refuse the transfer. In last he last he was a last he was a last he resident was a chance to refuse the transfer. In last he last he was a last he wa			
	Resident #8 was pr	failed to document that operly oriented and prepared er that occurred on 2/4/18.			

CENTERS FOR	MEDICARE	& MEDICAID SERVICES			OMB NO 0938-0391	
STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495415	B. WING		04/06/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILLAGE AT	ORCHARD I	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603		
	CH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	DBE COMPLETION	
		<u> </u>				

F 624

F 624 Continued From page 32

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) MUL A. BUILD	TIPLE CONSTRUCTION DING	OMB NO 0938-039 (X3) DATE SURVEY COMPLETED
		495415	B. WING	3	04/06/0040
NAME OF PROVIDER OR SUPPLIER THE VILLAGE AT ORCHARD RIDGE				STREET ADDRESS, CITY, STATE, ZIP COD 100 PROCESSION WAY WINCHESTER, VA 22603	04/06/2018 E
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH	OULD BE COMPLETION
	following: "POA (po POA) updated on resent out to the hosp." Further review of the Resident #8 was acting diagnoses of lactic Resident #8 arrived. There was no docume videncing the resident grepared for 2/4/18 hospital. On 4/5/18 at 12:56 perconducted with Resident with Resident hought the staff to the hospital prior. On 4/5/18 at 1:25 perconducted with LPN #1, regarding the nutransferred out to the would first assess the vital signs to determ to be sent out. LPN is the physician to obtain the physician to obtain the staff to the hospital prior. The physician to obtain the physician to obtain the physician to obtain the ambulated or and then the ambulated or and then the ambulated or and the stated that should do nurse's note such as change in condition, When asked if nurse	d 2/4/18 documented the ower of attorney), (Name of esident condition and being pital. In agreement with plan." the clinical record revealed that standard to the hospital with acidosis (1) and sepsis (2). back to the facility on 2/6/18. The mentation in the clinical record dent was oriented and facility-initiated transfer to the so.m., an interview was ident #8. Resident #8 stated did tell him why he was going to his transfer on 2/4/18.	F 6	24	

transfer, LPN #1 stated, "I believe so." When asked why this should be documented, LPN #1

CENTE	KS FUK MEDICAKE	& MEDICAID SERVICES				UN	/IB NO 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495415	B. WING	i			04/06/2018
	PROVIDER OR SUPPLIER	RIDGE		100 P	ET ADDRESS, CITY, STATE, ZIP PROCESSION WAY CHESTER, VA 22603	CODE	0410012010
(X4J'JD PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD B E APPROPRIA	
F 624	transfer so they knd gives the resident at On 4/5/18 at 5:10 padministrator, ASM Nursing) and ASM clerk were made as The facility policy tinotice," did not add (1) Lactic acidosis i blood. This informa National Institutes of https://search.nih.g	should be oriented to the ow what is going on and it a chance to refuse the transfer. o.m., ASM #1, the #2, the DON (Director of #3, the administrative support ware of the above concerns. tled, "Transfer or Discharge ress the above concerns. s a buildup of lactic acid in the tion was obtained from The of Health.	F6:	24			
	your body has an oresponse to a bactereleased into the blutrigger widespread information was obtinstitutes of Health. https://medlineplus. Notice of Bed Hold I CFR(s): 483.15(d)(1) S483.15(d) (1) Notice of S483.15(d)(1) No	ained from The National gov/sepsis.html Policy Before/Upon Trnsfr	F6	25			

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 35 of 104





FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING-----495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** CROSS-REFERENCED TO THE APPROPRIATE DATE

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;

DEPARTMENT OF HEALTH AND HUMAN SERVICES

- (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

DEFICIENCY)

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 ligison on the

workers, community outreach liaison on the new "Notice of Bed Hold Policy" form and associated process.

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

FORM APPROVED

OMB NO 0938-0391

CENTERS FOR MEDICARE &MEDICARD SERVICES							0930-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1`'	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495415	B. WING	;		04/	/06/2018	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE VILLAGE AT ORCHARD RIDGE				1	00 PROCESSION WAY VINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(XS) COMPLETION DATE	
F 625	Continued From pa	ge 36	Fθ	325	How the facility plans to manife a			

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.

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 37 of 104



VDH/OLC

CENTE	KO FUK MEDICAK	E &MEDICAID SERVICES				MA	B NO 0938-039
STATEMEN AND PLAN (TOF DEFICIENCIES DF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE DING	CONSTRUCTION		(3) DATE SURVEY COMPLETED
		495415	B. WING	3			04/06/2018
	PROVIDER OR SUPPLIER			100	EET ADDRESS, CITY, STATE, ZIP CO PROCESSION WAY NCHESTER, VA 22603	DE	04/06/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLANOF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION FE DATE
F 625	Continued From pa	ge 37	Fé	325			
	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.						
	failed to evidence the discussed with the r	ary 2018 social worker notes at the bed hold policy was resident or representative for itiated transfer to the hospital.					
	interview was condu	imately 12:15 p.m., an acted with Resident #3. She day she was transferred to 8.					
: : : : : :	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.						
	with OSM (other stat	an interview was conducted f member) #7, the social ed that when a resident is					

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES							
1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED		
		495415	B. WING_	·	04/	06/2018		
NAME OF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
THE VILLAGE AT ORCHARD RIDGE			İ	100 PROCESSION WAY				
I DE VILL	AGE AT ORCHARD F	RIDGE		WINCHESTER, VA 22603				
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(XS)		
PREFIX TAG	•	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS REFERENCES TO THE ARREST		COMPLETION DATE		
17.0	NEGODITORI ON EC	SO IDENTIFY THE INTOMINATION	170	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE		
F 625	Centinued From no	20						
F 020	Continued From page	ge so	F 62	!5				

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

Event ID:QT8M11

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		0MB NO 0938-0 (X3) DATE SURVEY COMPLETED			
		495415	B. WING		04/06/2018			
NAME OF PROVIDER OR SUPPLIER THE VILLAGE AT ORCHARD RIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION			
F 625	Continued From page	ge 39	F 6	25				

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 mostADLS (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

CENTE	RS FOR MEDICARI	E &MEDICAID SERVICES			OMB NO	O 0938-039 ⁻
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILDING	(X3) DA1	TE SURVEY MPLETED
		495415	B. WING_		04	/06/2018
	PROVIDER OR SUPPLIER		<u></u>	STREET ADDRESS, CITY, STATE, ZIP 100 PROCESSION WAY WINCHESTER, VA 22603		10012010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	IONSHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 625	and BS was checker result 33. This write physician) around 4 send him out to the of Nursing) was also arrival were: blood serespirations 14, HR and temp 95.0." The next note dated following: "POA (por POA) updated on resent out to the hosp. Further review of the Resident #8 was addiagnoses of lactic as Resident #8 arrived. A bed holed policy significant and for the facility initiated to evidence a copy of the facility initiated to evidence the discussed with the reconducted with Resin ot recall being offer transfer. On 4/5/18 at 1:256 p. 10 on 4/5/18 at 1:25 p. 10 on 4/5/18 at 1:25 p. 11 on 4/5/18 at 1:25 p. 11 on 4/5/18 at 1:25 p. 12 on 4/5/18 at 1:25 p. 13 on 4/5/18 at 1:25 p. 13 on 4/5/18 at 1:25 p. 13 on 4/5/18 at 1:25 p. 15 on 4/5/	another cup of orange juice ed another 15 minutes later to er then called (Name of 4:30 a.m., who gave orders to a hospital. The DON (Director to called. Vitals upon EMS	F 62	5		

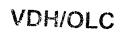
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 41 of 104





1994 J. J. J.

OLIVIENO FOR WEDICARI	= &IVIEDICAID SERVICES			OMB NO	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
	495415	B. WING	<u> </u>	04/	06/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00.2010
THE VILLAGE AT ORCHARD RIDGE			100 PROCESSION WAY WINCHESTER, VA 22603		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(= 10.1.0014 (E.M.) 1014 (II)	OULD BE	(X5) COMPLETION DATE
transferred out to th	nge 41 urses' role when a resident is ne hospital. When asked who r offering the bed hold policy at	F 6	325		

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 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 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON

the resident." OSM #7 confirmed residents do not receive written bed hold notification, at the time of

transfer to the hospital.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

FORM APPROVED 91

CENTE	RS FOR MEDICARE	&MEDICAID SERVICES			0MB NO 0938-03
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495415	B. WING_	<u> </u>	04/06/2018
	PROVIDER OR SUPPLIER	RIDGE		STREET ADDRESS, CITY, STATE, ZIP 100 PROCESSION WAY WINCHESTER, VA 22603	
(X4)1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 657	the above concerns provided prior to exprovided prior to exprovided prior to exprovided prior to exprovided prior to exprove the concerns blood. This informal National Institutes that the children of the children of the children of the concerns of the children of the comprehensive (ii) Prepared by an includes but is not I (A) The attending prior (B) A registered nurresident. (C) A nurse aide wiresident. (D) A member of for (E) To the extent prior children of the concerns	a) and ASM #3, the port clerk were made aware of s. No further information was sit. is a buildup of lactic acid in the tion was obtained from The of Health. ov/search?utf8= liate=nih&query=lactic+acidosi ous illness. It happens when verwhelming immune erial infection. The chemicals ood to fight the infection inflammation. This tained from The National gov/sepsis.html nd Revision 2)(i)-(iii) chensive Care Plans mprehensive care plan must n 7 days after completion of assessment. interdisciplinary team, that imited to	F 65		y revised on 4-4-18 to not the compression other residents having ed by the completed I Manager. All

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

FORM APPROVED 0MB NO 0938-0391

<u> </u>	ON THE PROPERTY OF THE PROPERT					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495415	B. WING_		04/06/2	018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILLAGE AT ORCHARD RIDGE				100 PROCESSION WAY WINCHESTER, VA 22603		
(X4}1D SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIAD DEFICIENCY)			LD BE COM	(X5) IPLETION DATE		
F 657	Continued From pa	ige 43	F 65	7 Measure or system change to e	nsura tha	

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

F 657 Measure or system change to ensure the deficient practice will not recur

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.

CENTE	RS FOR MEDICARE	E &MEDICAID SERVICES				ON	MB NO 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		495415	B. WING_	:			04/06/2018
NAME OF I	PROVIDER OR SUPPLIER	{		: 8	STREET ADDRESS, CITY, STATE, Z	ZIP CODE	04/00/2010
THE VILL	LAGE AT ORCHARD F	PINCE	1		100 PROCESSION WAY		
		KIDGL			WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BI THE APPROPRIA	
F 657	Continued From pa	age 44	F 65	- 357	7		
	set) was a significal	ant change assessment with an	•	•			
	ARD (assessment r	reference date) of 1/19/18.					
		oded as being moderately ve function, scoring 10 out of					
		BIMS (Brief Interview for					
	Mental Status) exar	m. Resident #3 was coded as					
		e assistance of one to two staff					
	members with most living).	et ADLS (activities of daily					
	livirig <i>).</i>						
	that she went out to following nursing no fell this AM (morning bathroom witnessed assistant). Hit head neuro (neurological) resident sitting in Direquest for breakfast blurry. BP (blood pre 67, T (temperature) (sweaty) and clammassist and BP reched doctor) made aware resident to ER (emerevaluation), S/P (stinjury. Left facility at 3 EMS (emergency voice and speech clanswer all questions	•					
	revealed she was addiagnoses of dehydr	esident #3's clinical record admitted to the hospital with dration and a UTI (urinary tract #3 arrived back to the facility					

Review of Resident #3's fall care plan dated

on 1/7/18.

_ CENTERS I OR MEDICARE WINE	DICAID SERVICES					NO 0938-0391
	OVIDER/SUPPLIER/CUA ENTIFICATION NUMBER:	1		CONSTRUCTION		DATE SURVEY COMPLETED
	495415	B. WING	3 <u></u>			04/06/2018
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	E	04/00/2018
THE VILLAGE AT ORCHARD RIDGE				0 PROCESSION WAY INCHESTER, VA 22603		
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST I TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657 Continued From page 45 6/20/17 and revised 10/24 the care plan was reviewed her 1/5/18 fall. Review of dated 1/5/18 failed to evic intervention was put into palls. On 4/5/18 at 9:52 a.m., at conducted with ASM (admember) #2, the DON (diregarding the process staresident has a fall. ASM #resident falls, a nurse wor at the time of the fall to pr #2 stated therapy will also When asked if the interver place should be on the cathat it should. When asked of a fall intervention being ASM #2 stated that it was plan to reflect the fall or an When asked who had access to the care plan. An urses and the MOS nurs plan. ASM #2 stated that all tea access to the care plan. An urses and the MOS nurs plan. ASM #2 confirmed sthe care plan was reviewed Resident #3's 1/5/18 fall. the incident report and consee an intervention put intervention put intervention put intervention put intervention put intervention #1, the administrant ASM #3, the administrant were made aware of the access to the care plan was reviewed and ASM #3, the administrant ASM #3, the administrant ASM #3, the administrant were made aware of the access to the administrant were made aware of the access to the administrant ASM #3, the administrant ASM #3, the administrant were made aware of the access to the administrant were made aware of the access to the administrant ASM #3, the administrant were made aware of the access to the administrant were made aware of the access to the administrant were made aware of the access to the administrant were made aware of the access to the	ed or updated following Resident #3's fall report lence that an place to prevent future in interview was ministrative staff rector of nursing), ff follows when a 2 stated, when a uld add an intervention event future falls. ASM of evaluate a resident, intion that is put into re plan, ASM #2 stated diabout the importance added to the care plan, important for the care everyone was in the loop by change in condition, where so the care plan, immembers have SM #2 stated the floor expected or updated after ASM #2 also viewed infirmed that she did not on place after the 1/5/18 and (administrative staff frator, ASM #2, the DON trative support clerk	F6	657			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	!	495415	B. WING		04/06/2018
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP C	
THE VII I	LAGE AT ORCHARD R	3:5AE	i	0 PROCESSION WAY	
INE VIC.	AGE AT UNUTAIND IN	RIDGE	Wi	INCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 657	Continued From page	ige 46	F 657		
		g: "An comprehensive,			
	person-centered car	are plan that included			
	measurable objectiv	ves and timetables to meet the	a		
	resident's physical,	psychosocial and functional			
		and implemented for each			
		Planning/Interdisciplinary			
		e for the review and updating name there has been a significant			
		ent's condition. b. When the			
		met. c. When the resident has	2		
		the facility from a hospital	'		
	stay; and d. At least	t quarterly, in conjunction with			
	the required quarter	rly MDS assessment."			
		amentals of Nursing Lippincott			
	Williams and Wilkins	s 2007 pages 65-77 itten care plan serves as a			
		tten care plan serves as a a among health care team			
		s ensure continuity of			
		care plan is a vital source of			
	information about the	ne patient's problems, needs,			
	and goals. It contain	ns detailed instructions for			
		established for the patient			
		t careexpect to review,			
		he care plan regularly, when n condition, treatments, and			
	with new orders"	1 CONDITION, treatments, and			
	No further information	on was provided prior to exit.			
		failed to revise Resident #3's			
		e plan when an L2 (lumbar			
		fracture was found on			
	1/15/18.				

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

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 47 of 104





CENTE	ERS FOR MEDICARE	E & MEDICAID SERVICES			(NO. 0938-039
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495415	B. WING	Э			4/06/2018
NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 0-	4/06/2010
THE VII	LLAGE AT ORCHARD F	BIUCE	1	1	PROCESSION WAY		
11.	LAOL AT ONTINUE.	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	İ	WIN	NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLANOF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 657	Continued From pa	age 47	F (657			
	·	ote was documented, "Guest	• -	,,,			
	fell this AM (morning	ng) 0745 (7:45 a.m.) in					
	bathroom witnessed	ed by CNA (certified nursing					
		d on toilet and implemented l) checks. 0940 (9:40 a.m.)					
	resident sitting in D	PR (dining room) per her					
	request for breakfas	st and stated her vision was					
	blurry. BP (blood pre	ressure) 72/42, HR (heart rate)					
	6/, I (temperature)) 97.4. Resident diaphoretic my. Assisted back to bed x 2					
	assist and BP reche	ecked 88/52. MD (medical					
	doctor) made aware	e and given orders to send					
	resident to ER (eme	ergency room) for eval					
	(evaluation), S/P (st	status/post) fall with head it 1030 (10:30 a.m.) am with x					
	3 EMS (emergency	r services) personnel. Alert to					
	voice and speech cl	clear at the time. Able to					
	answer all questions						
	Further review of Re	esident #3's clinical record					
	revealed she was ac	idmitted to the hospital with					
	diagnoses of dehydr	Iration and a UTI (urinary tract					
	infection). Resident on 1/7/18.	#3 arrived back to the facility					
		esident #3's clinical record					
		ent #3 started to complain of					
		n following her fall. An x-ray 5/18. The x-ray dated					
	1/15/18, documented						
	"Age-indeterminate r	mild to moderate L2					
	compression fracture tomography) is recor	re. CT (computed					
		d 1/17/18 documented that					i
	Resident #3's respor	nsible party had declined the					

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 (X1) PROVIDER/SUPPLIER/CUA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSCIDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 F684 further information was provided prior to exit. How corrective action will be accomplished for F 684

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

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.

FRINTED. U4/11/2010 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING E-MG 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603**

ID

PREFIX

TAG

F 684 Continued From page 49

bν

(X4) ID

PRÉFIX

TAG

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.

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

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

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION

DATE

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.

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MIH	TIDI E	CONSTRUCTION		O. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:			DING		TE SURVEY
		495415	B. WING			0.	1/06/2018
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 0-	100/2016
T: ::= \		ND OF	}	100	PROCESSION WAY		
I HE VIL	FHE VILLAGE AT ORCHARD RIDGE			WI	NCHESTER, VA 22603		
(X4)1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(XS) COMPLETION DATE
F 684	Continued From pa	ge 50	F6	84			
	•	ours as needed for pain." This	. •	•			
	order was initiated	•					
	3) "Tramadol (2) H0	CL (hydrochloride) Tablet 50					
	MG Give 1 tablet by	mouth every 6 hours as					
	needed for pain." To 1/16/18.	his order was initiated on					
	(Medication Administration Resident #3 received	#3's March 2018 MARS stration Record) revealed ed Tramadol 50 MG on I Extra Strength 500 mg on					
	There were no para above orders on wh	meters or instructions on the nen to give each pain					
	medication.						
	conducted with LPN When asked how st medication to give it	m., an interview was I (licensed practical nurse) #1. ne would know which f a resident had three different ication, LPN #1 stated she					
	orders. LPN #1 state	cal director and clarify the ed the pain medication orders					
	determine when to g nurses were able to	cales attached to them to give each one. When asked if determine which medication					
	"No. Nurses are no	discretion, LPN #1 stated, t allowed to determine which vhen." LPN #1 stated she					
		ork on the skilled nursing unit					
		ot a nurse who administered					
	the above pain med						
		m., ASM (administrative staff					
	member) #1, the ad (Director of Nursing	ministrator, ASM #2, the DON and ASM #3, the					
	(Silvoto) of Harsing	, and row #0, are					

administrative support clerk were made aware of

CENTERS FOR MEDICARE & MEDICAID SERVICES				0MB NO 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495415	B. WING		04	/06/2018
	PROVIDER OR SUPPLIER LAGE AT ORCHARD R	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603		
(X4)1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	JLD BE	(X5) COMPLETION DATE
F 684	Continued From page	ge 51	F 6	84		
	the above concerns		, ,			
	No further information	on was provided prior to exit.				
	The facility policy tit Clarification" did not	led, "Orders and Order t address the above concerns.				
	Nursing, 7th edition, following statements competent nursing particle and members when you carry out intervention, it is as	and Perry's, Fundamentals of page 268 documents the s: "Clarifying an order is practice, and it protects the of the health care team. an incorrect or inappropriate much your error as the r transcribed the original				
	and reduces fever. obtained from The N	o treat minor aches and pains This information was lational Institutes of Health. n.nih.gov/pubmedhealth/PMH letails.				
	moderate to severe obtained from Davis' 11th edition p. 1197.	nalgesic used to treat pain. This information was s Drug Guide for Nurses, revent/Heal Pressure Ulcer b(i)(ii)	F 68	36		
	resident, the facility r (i) A resident receive professional standard pressure ulcers and	ure ulcers. ehensive assessment of a				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/17/2018 **FORMAPPROVED**

CENTERS FOR MEDICAL	RE & MEDICAID SERVICES			0MB NO 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495415	B. WING_		04/06/2018		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
THE VILLAGE AT ORCHARD RIDGE			100 PROCESSION WAY			
THE VICEAGE AT OROHANE	- NIDGE		WINCHESTER, VA 22603			
PRÉFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORI (EACH CORRECTIVE ACTION: CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION		
F 686 Continued From p	age 52	F 0.0	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).

F 686

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 reeducation 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'.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 495415 B. WING 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)

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.

FINITIED. 04/17/2010

All corrective actions complete by 5-15-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495415

B. WING

04/06/2018

NAME OF PROVIDER OR SUPPLIER

THE VILLAGE AT ORCHARD RIDGE

STREET ADDRESS, CITY, STATE, ZIP CODE

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

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

F 686

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 55 of 104

RECEIVED

VDH/OLC

PRINTED: 04/17/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING----495415 B. WING 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE WINCHESTER, VA 22603 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLANOF CORRECTION (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 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 Free of Accident Hazards/Supervision/Devices F 689 F689 SS=D CFR(s): 483.25(d)(1)(2) How corrective action will be accomplished for those residents found to have been affected by §483.25(d) Accidents. the deficient practice The facility must ensure that a) Immediately educated caregiver §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and involved on resident needs and resource for updated resident needs. §483.25(d)(2)Each resident receives adequate Resident fall prevention interventions supervision and assistance devices to prevent were reviewed; no new interventions accidents. needed. This REQUIREMENT is not met as evidenced How facility will identify other residents having Based on staff interview, clinical record review, and facility document review, it was determined the potential to be affected by the that facility staff failed to ensure residents were free from accidents or hazards for one of 14

same deficient practice

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

sustained fall on 1/5/18.

The findings include:

residents in the survey sample, Resident #3.

The facility staff failed to develop and implement fall preventive interventions after Resident #3

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

		WEDIO/ ND OFKAIOFO			CIVID	NO 0938-0391
STATEMENT OF DEFICIENC AND PLAN OF CORRECTION		1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	1, ,	NATE SURVEY OMPLETED
		495415	B. WING		0	04/06/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VILLAGE AT OR	CHARD RIE	OGE		100 PROCESSION WAY WINCHESTER, VA 22603		
PRÉFIX (EACH D	EFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFI TAG	(= 1011 0011112 110110110110	OULD BE	(X5) COMPLETION DATE
F 000 0 11	_					

F 689 Continued From page 56

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."

F 689 Measure or system change to ensure the deficient practice will not recur

 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.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED 91

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				0MB NO 0938-03	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUNG	JCTION	(X3) DATE SURVEY COMPLETED	
		495415	B. WING_	******		04/06/2018	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLANOF CORRE ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 689	Resident #3's 1/5/1 the incident report a see an intervention fall. On 4/5/18 at 5:10 p member) #1, the ac #3, the administrati aware of the above	eviewed or updated after 8 fall. ASM #2 also viewed and confirmed that she did not put into place after the 1/5/18 .m., ASM (administrative staff Iministrator, ASM #2 and ASM we support clerk were made	F 68	39 F695			
F 695 SS=D	CFR(s): 483.25(i) § 483.25(i) Respiratracheostomy care The facility must enneeds respiratory care and tracheal scare, consistent wit practice, the compressed and 483.65 of this second	and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences,	F 69	How control the deal (a) (b)	residents found to have residents found to have ficient practice Resident's oxygen or reflect the amount of parameters on 4-5-18 Resident's stated oxy immediately discarde obtained and placed a appropriate dating.	der was clarified to foxygen 3. gen tubing was ed; new tubing was in a bag with	
	Based on observat document review as was determined that respiratory care and residents in the sun 1a. The facility staff physicians order for	ion, staff interview, facility and clinical record review, it t facility staff failed to provide a services to one of 14 yey sample, Resident #8. failed to clarify Resident #S's oxygen. failed to maintain Resident		the po same o a)	tential to be affected to deficient practice An audit of all resident completed immediated the Director of Nursin oxygen orders had the All residents on oxyge to ensure oxygen tubicanaryon; and ice	oy the ots on oxygen was ely on 4-5-18 by g to ensure e amount of liters. n were assessed ng was stored	

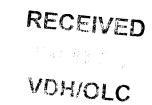
FORM CMS-2567(02-99) Previous Versions Obsolete

#B's oxygen equipment in a sanitary manner.

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 59 of 104



appropriately; any issues identified

were corrected.

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

OTATEMENT OF DESIGNATION		- 		OMB NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X3) DATE SURVEY COMPLETED	
	495415	B. WING_		04/06/2018
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	
THE VILLAGE AT ORCHARD	RIDGE		100 PROCESSION WAY	
			WINCHESTER, VA 22603	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION

F 695 Continued From page 59

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 tomake 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

F 695

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.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 0938-039
	OF DEFICIENCIES OF CORRECTION			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495415	B. WING_		04/06/2018
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/00/2010
THE VILI	AGE AT ORCHARD F	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 695	levels. There was reliters of oxygen Respulse ox (1) was taken On 4/5/18 at 1:25 p. conducted with LPN When asked what the meant, LPN #1 states had the liters of 02 to stated she would can order. When asked medication, LPN #1 how nursing staff are saturation, LPN #1 staking the pulse ox. should be taken with or off, LPN #1 states on when the pulse ox when the pulse ox ox if there is no way of oxygen the reside pulse ox check. LPN accurate way. When many liters of oxygen	g Resident #S's oxygen no indication of how many sident #8 was on while his sen. .m., an interview was I (licensed practical nurse) #1. ne above oxygen order ed that oxygen orders usually so start the oxygen. LPN #1 ill the physician and clarify the if oxygen was considered a stated it was. When asked	F 69	95	

liters minute.

#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

	IT OF DEFICIENCIES OF CORRECTION	RRECTION IDENTIFICATION NUMBER:		LTIPLE	(X3) D/	NO 0938-039	
			A.BUILD	JING		i CC	OMPLETED
		495415	B.WING	ı			110010040
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	U	4/06/2018
TUE VII	LACE AT OBOUADD			ı	PROCESSION WAY		
I HE VIL	LAGE AT ORCHARD F	RIDGE			NCHESTER, VA 22603		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION}	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETION DATE
F 695	Continued From pa	ge 61	F 6	395			
	documents in part the facility) shall have a includes the oxygen and the flow rated (sthe resident."	cled, "Oxygen Therapy Policy" the following: "The (Name of a valid physician's order that a source, the delivery source, sic) deemed therapeutic for the source of the sou					
	edition, Elkin, Perry "Oxygen is a drug a	and Potter 2000, page 936, and is administered and same care as any other					
	member) #1, the adi (Director of Nursing)	ort clerk were made aware of					
	No further information	on was provided prior to exit.					
	probe attached to the measures the percel saturated with oxyge information was obtainstitutes of Health	etry) - The pulse oximeter is a ne patient's finger that entage of hemoglobin en in the blood. This ained from The National n.nih.gov/pmc/articles/PMC30					
	1b. The facility staff f #S's oxygen equipm	failed to maintain Resident ent in a sanitary manner.					
	On 4/5/18 at 10:30 a observation was mar	a.m. and 12:56 p.m., an de of Resident #8. He had					



If continuation sheet Page 62 of 104

his oxygen in place via nasal cannula. Resident

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/17/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE 0MB NO 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
	PROVIDER OR SUPPLIER LAGE AT ORCHARD F	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	DBE COMPLÉTION
F 695	#B's oxygen tubing concentrator while sees Resident #8 also has secured on the back oxygen tubing for the behind his wheelch. On 4/5/18 at 1:25 p. conducted with LPN When asked how or maintained when no oxygen tubing shou When asked why oxin a plastic bag when "To keep dust particulation control." Lewriter to Resident #8	was hooked up to his oxygen sitting up in his wheelchair. ad an oxygen tank that was k of his wheelchair. The se oxygen tank was rolled up air, not stored in a bag. .m., an interview was I (licensed practical nurse) #1. kygen tubing should be of in use, LPN #1 stated that Id be stored in a plastic bag. kygen tubing should be stored in not in use, LPN #1 stated, eles or anything else out of it. PN #1 accompanied this 8's room. LPN #1 confirmed en tubing attached to his	F 6	95	

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 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.

F697 F 697

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

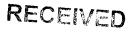
Resident # 3 and #10's pain medication order was clarified to reflect assessment, location and intensity of pain.

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 63 of 104





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

PKINTED: 04/17/2018 FORM APPROVED OMB NO 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		0	MB NO. 0938-0391	
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495415	B. WING		04/06/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS. CITY, STATE, ZIP CODE	<u> </u>	
THE VILLAGE AT ORCHARD RIDGE				100 PROCESSION WAY WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	

F 697 Continued From page 63

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).

F 697

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.

CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES				_	KM APPKUVEL
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		ILDING	(X3) D/	NO 0938-0391 ATE SURVEY OMPLETED
		495415	B. WING	з <u>_</u>		0	4/06/2018
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY		4/00/2010
I ME VILL	AGE AT UNUNAND I	RIDGE		ſ	WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(XS) COMPLETION OATE
F 697	Continued From pa	аge 64	F6	97	7		
		at #3's most recent POS ummary) revealed the following ders:					
		ra Strength 500 MG (milligram) outh every 6 hours as needed					
		CL (hydrochloride) Tablet 50 y mouth every 6 hours as					
	(Medication Adminis Resident #3 receive 3/12/18. The followi	t #3's March 2018 MAR istration Record) revealed ed Tramadol 50 MG on ring was documented: "Pain e)." The location of pain was clinical record.					
	revealed she receive mg on 3/16/18, 3/20 and intensity of pain clinical record for 3/3 following nursing no 3/16/18: "given (sic)	desident #3's March 2018 MAR yed Tylenol Extra Strength 500 0/18 and 3/22/18. A location in was not identified in the 1/20/18 and 3/22/18. The sote was documented on 1/20/18 (as needed) Tylenol for seessed intensity of pain was the 3/16/18 note.					
		, an interview was attempted the could not answer questions 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

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 65 of 104



CENTE	RS FOR MEDICAR	RE & MEDICAID SERVICES					KIVI APPKUVEL NO 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) D	DATE SURVEY COMPLETED
		495415	B. WING	3		,	04/06/2018
	PROVIDER OR SUPPLIER			100	REET ADDRESS, CITY, STATE, ZIP CODE PROCESSION WAY		MINGLESIC
	AGE AT UNUTAND	RIDGE		WIN	NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTIONSHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 697	Continued From pa	age 65	F6	397			
		ne location of pain and the		-			
		stated if the resident were not pain level, she would then use					
		pain level, she would then use e. When asked if the pain					
	assessment was do	locumented in the clinical					
		ated that it should be. LPN #1 ually be documented in a					
		n asked how she would know					
	what the resident's	pain location or intensity was					
		8., 3/20/18, and 3/22/18, and if there was no documentation in					
		LPN #1 stated that she					
		p.m., ASM (administrative staff					
	member) #1, the ad	dministrator, ASM #2, the DON					
	(Director of Nursing administrative supp	g) and ASM #3, the port clerk were made aware of					
	the above concerns						
		itled, "Pain Management"					
		the following: "Nursing will					
		and severity of pain including ation, intensity, frequency,					
	duration etc.) using	a standardized pain					
	assessment instrum resident's cognitive	ment appropriate to the elevel."					
		to treat minor aches and pains					
		This information was National Institutes of Health.					
		m.nih.gov/pubmedhealth/PMH					
	T0008785/?report=c						

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

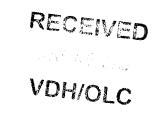
11th edition p. 1197.

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 66 of 104



CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			FORM APPROVE
		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION	OMB NO 0938-039 (X3) DATE SURVEY COMPLETED
	l	495415	B. WING	3	04/06/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 100 PROCESSION WAY WINCHESTER, VA 22603	P CODE
(X4)1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTIVE	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 697	Continued From page	ge 66	F6	397	
	to the administration several occasions in Resident #10 was a 12/21/17 with diagnor not limited to Hemip following intracrania weakness, type two cancer. Resident #1 (minimum data set): assessment with an date) of 3/21/18. Resident gognitively into decisions scoring 12 Interview for Mental was coded as requir for most AOL (activition Review of Resident: (physician order sumpain medication order "Tylenol liquid 500 M (milliliters) (acetamin G-Tube (gastronomy needed for pain." Review of Resident: MARS (medication arevealed Resident #1 on 3/1/18, 3/12/18, 3 4/3/18. The location of the clinical record for	ion and intensity of pain prior n of pain medication on n March and April of 2018. admitted to the facility on oses that included but were olegia (one sided paralysis) at hemorrhage, muscle diabetes, and prostate IO's most recent MOS assessment was a quarterly ARD (assessment reference esident #10 was coded as fact in the ability to make daily 2 out of 15 on the BIMS (Brief Status) exam. Resident #10 ring total dependence on staff ties of daily living). #10's most recent POS mmary) revealed the following er: MG (milligrams)/15 ML nophen) Give 20 ml via y tube) every 6 hours as #10's March and April 2018 administration record) 10 received Tylenol 500 mg 8/27/18, 3/29/18, 3/30/18 and of pain was not identified in r the above dates. In I or intensity of pain was not			

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

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES					M APPROVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO 0938-039 ² (X3) DATE SURVEY COMPLETED	
		495415	B. WING	i		0.	1/06/2 018	
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COL		+/00/2010	
THE VIL	LAGE AT ORCHARD I	RIDGE			PROCESSION WAY ICHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLANOF CORRE (EACH CORRECTIVE ACTIONSH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDBE	(X5) COMPLETION DATE	
F 697	Continued From page	ge 67	F6	97				
1 037		ident #10. Resident #10		0,				
	stated that he occas	sionally has pain and						
		Tylenol for pain. Resident #10						
	could not recall if the nursing staff assess his pain prior to administering pain medication.							
	conducted with LPN When asked about to administering pail she would first conducted ask the resident the intensity. LPN #1 states to tell her the pathe face pain scale. assessment was do record, LPN #1 states tated it would usual nursing note. LPN # know what the resid was on the above dathere was no docume LPN #1 stated that stated that stated that stated that stated that stated it would usual nursing note. LPN # know what the resid was on the above dathere was no docume LPN #1 stated that stated it would usual nursing note.							
	member) #1, the add (Director of Nursing)	ort clerk were made aware of						
F 700	and reduces fever. obtained from The N https://www.ncbi.nlm T0008785/?report=d							
	Posted Nurse Staffin CFR(s): 483.35(9)(1)		F 7	32				

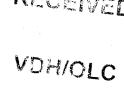
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 68 of 104





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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING-----B. WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4)1D (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

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.

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			FURIN APPRUVE 0MB NO 0938-039		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495415	B. WING		04/06/2048		
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	04/06/2018 CODE		
THE VILI	LAGE AT ORCHARD I	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE COMPLETION DATE		
F 732	Continued From pa	ge 69	F 7	32			
	document review, it	t was determined that the post required nurse staffing	. ,				
	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:						
	observation of the r titled, "LONG TERM REHAB STAFF ON form was posted in documented inform to the facility name, nursing staff on duty document the total	ation including but not limited date, census, names of y and shift. The form failed to number and actual hours nursing staff directly					
	conducted with ASM member) #2 (the dir stated the long-term on duty form had ex but she and the sup form to include an a When asked what in documented on the should include the r assignments staff sl RN (registered nurs	m., an interview was (administrative staff rector of nursing). ASM #2 in care and skilled rehab staff kisted since the facility opened aport clerk had revised the assignment key at the bottom. Information should be form, ASM #2 stated the form the ineighborhood, census, the anould have and titles such as see) and LPN (licensed practical sted 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

PRINTED: 04/1/12018

DEPAR	IMENI OF HEALIF	TAND HUMAN SERVICES			FO!	RM APPROVEI	
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			0MB	NO 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495415	B. WING_		,	04/06/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,			
THE VIL	LAGE AT ORCHARD	RIDGE	l l	100 PROCESSION WAY WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 732	staff member) #3 (t	age 70 port clerk) and OSM (other the director of environmental de aware of the above	F 732	2			
	long-term care and form documented to example, 7:00 a.m. if a nurse's schedul that variation is docexample, 7:00 a.m. 7:48 a.m., ASM #2 and skilled rehab so that documented (r. 7:00 a.m. to 1:00 p. nurse) on duty from 4/6/18 at 9:11 a.m., staff posting remain total number and acceptance of the composition of the com	a.m., ASM #2 stated the skilled rehab staff on duty he shift hours worked (for to 7:00 p.m.) ASM #2 stated le varies from that shift, then cumented on the form (for to 2:00 p.m.) On 4/6/18 at presented a long-term care taff on duty form dated 3/18/18 name of nurse) on duty from .m., and (name of another in 1:00 p.m. to 7:00 p.m. On , ASM #2 was made aware the ned a concern because the ctual hours worked by licensed y responsible for resident care ested.					
	recorded on the Da shift. The information includef. The actu	tled, "Staff Posting" staffing information shall be illy Assignment form for each on recorded on the form shall ual time worked during that ory and type of nursing staff"					
F 757		on was presented prior to exit.	F 757	, F757			

SS=D 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-

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.

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

PRINTED: 04/17/2018 FORM APPROVED

OLIVICIV.	OT OR MEDIO/ARE	- G MEDIONID OF LANGER			OIMB M	IO 0938-039
	OF DEFICIENCIES CORRECTION	[\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			ATE SURVEY OMPLETED	
		495415	B. WING		0.	4/06/2018
	OVIDER OR SUPPLIER	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 757	Continued From na	nge 71		C-7		

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

This REQUIREMENT is not met as evidenced

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.

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 nonpharmacological interventions were attempted prior pain medication, and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) committee.

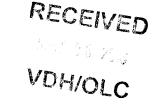
All corrective actions complete by 5-21-18.

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 72 of 104



CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				M APPROVEI O 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY
		495415	B. WING			1/06/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 100 PROCESSION WAY WINCHESTER, VA 22603	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLANOF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE
F 757	The findings include	9 :	F 7	57		
	10/16/14 and readn	admitted to the facility on nitted on 1/7/18 with uded 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.

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 73 of 104

VDH/OLC

FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0MB	NO 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OATE SURVEY COMPLETED
		495415	B. WINC	3		04/06/2018
NAME OF F	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
THE VILL	THE VILLAGE AT ORCHARD RIDGE			100 PROCESSION WAY		
				WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	(= 1011 00111120111121101	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 757	Continued From page	ge 73	F 7	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

		I AND HUMAN SEIVICES				FOF	RM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					NO 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		OATE SURVEY COMPLETED
		495415	B. WING	i			0.4/0.0/0.4.0
NAME OF	PROVIDER OR SUPPLIER	l		STR	EET ADDRESS, CITY, STATE, ZIP COD		04/06/2018
					PROCESSION WAY	, L	
THE VILI	LAGE AT ORCHARD	RIDGE			NCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 757	(Director of Nursing administrative supp the above concerns The facility policy tit not address the above (1) Tylenol is used the and reduces fever. Obtained from The Mittps://www.ncbi.nlr.T0008785/?report=(2) Tramadol is an amoderate to severe	dministrator, ASM #2, the DON and ASM #3, the cort clerk were made aware of s. tled, "Pain management" did ove concerns. to treat minor aches and pains This information was National Institutes of Health. m.nih.gov/pubmedhealth/PMH details. analgesic used to treat pain. This information was b's Drug Guide for Nurses,	F 7	57			
	prior to the administ Resident #10 on set April of 2018. Resident #10 was a 12/21/17 with diagn not limited to Hemip following intracrania weakness, type two cancer. Resident #1 (minimum data set) assessment with an date) of 3/21/18. Re being cognitively int decisions scoring 12	failed to attempt all pain relief interventions tration of pain medication to veral occasions in March and admitted to the facility on oses that included but were olegia (one sided paralysis) all hemorrhage, muscle diabetes, and prostate O's most recent MOS assessment was a quarterly ARD (assessment reference esident #10 was coded as act in the ability to make daily 2 out of 15 on the BIMS (Brief Status) exam. Resident #10					

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

was coded as requiring total dependence on staff

for most AOL (activities of daily living).

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 75 of 104



MAN WEST



					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY
7412124401	OOTTICOTION	IDENTIFICATION NUMBER:	ABU	ILDING	COMPLETED
					•
		495415	B. WING		04/06/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
THE VILLA	GE AT ORCHARD F	PIDGE		100 PROCESSION WAY	
				WINCHESTER, VA 22603	
(X4) ID	SUMMARYSTA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(= 1011 COLUMN SHOULD SHOULD	BE COMPLETION
.,.0		SO IDEITIN THIS INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	NATE DATE

F 757 Continued From page 75

Review of Resident #10's most recent POS (physician order summary) revealed the following pain medication order:
"Tylenol (1) liquid 500 MG (milligrams)/15 ML

"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 #10'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 #10'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

F 757

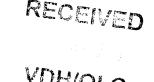
DEFICIENCY)

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 76 of 104



DEDARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/17/2018

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MAPPROVE 0 0938-039
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU AND PLAN OF CORRECTION IDENTIFICATION			PLE CONSTRUCTION		TE SURVEY MPLETED
		495415	B.WING_		04	1/06/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
THE VIL	LAGE AT ORCHARD	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 757	Continued From pa	age 76	F 757	7		
	the face pain scale non-pharmacologic attempted prior to t medication, LPN #' When asked where non-pharmacologic prior to administerin stated that it would note. LPN #1 stated interventions attem	pain level, she would then use. When asked if cal interventions should be the administration of pain 1 stated that they should. It is staff documented the cal interventions attempted the grain medications, LPN #1 be documented in a nurses' diff non-pharmacological pted were not documented in then she would not know if				

(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/PMH T0008785/?report=details.

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

administrative support clerk were made aware of the above concerns. No further information was

(Director of Nursing) and ASM #3, the

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

presented prior to exit.

§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.

F761

How corrective action will be accomplished for F 761 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.

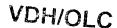
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 77 of 104





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

PRINTED: 04/17/2018 FORM APPROVED 0MB_NO. 0938-0391

CENTERS FOR MEDICARE	<u>- & MEDICAID SERVICES</u>		0	MB_ NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	495415	B. WING		04/06/2018
NAME OF PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	
THE VILLAGE AT ORCHARD I	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
PREFIX (EACH DEFICIENCY	ATEMENTOF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION

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

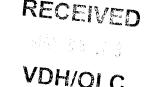
- a) Conduct re-education for all nurses regarding securing medication cart.
- b) Conduct re-education for all nurses regarding compliance with storage of medicines in the medication room; New consistent process now implemented of compliant emergency kit boxes to be replaced once monthly by the pharmacy.

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

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 78 of 104



PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING-----495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 761 Continued From page 78

- 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

F 761 How the facility plans to monitor its performance to make sure that solutions are sustained

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.

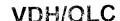
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QT8M11

Facility ID: VA0408

If continuation sheet Page 79 of 104





F 761 Continued From page 79
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

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.

access the unlocked cart, LPN #1 stated that she

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

F761

didn't think about that.

rtonic-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/PMH TOO10059/?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

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

Event JD:QT8M11

Facility ID: VA0408

If continuation sheet Page 81 of 104

RECEIVED



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

FORM APPROVED OMB NO 0938-0391

CENTER	S FUR WEDICARE	& MEDICAID SERVICES			MB NO 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
THE VILLA	AGE AT ORCHARD F	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION

F 761 Continued From page 81 T0011186/?report=details.

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

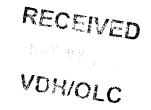
F 761

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 82 of 104



		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495415	B. WING	;	04/06/2018
	PROVIDER OR SUPPLIER LAGE AT ORCHARD F	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	
(X4)1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	(JLD BE COMPLETION
F 761	the written open dat was 1/22. ASM #2 v solution expired after stated she would che aware of the expired the rehabilitation me. On 4/5/18 at 7:55 a. solution was good for ASM #2 stated she PPD solution and he vancomycin and help to a solution with a single properties. ASI is responsible for chemergency box. ASI pharmacist is support month when she controlled the box en asked who is responsed to replace the box en asked who is responsed to refrigeration.	rector of nursing) confirmed the on the vial of PPD solution was asked when the PPD or being opened. ASM #2 the eck. ASM #2 was made divancomycin and heparin in redication refrigerator. The matter of the period of the eck. ASM #2 stated the PPD or 30 days after being opened. Was going to dispose of the eck and already disposed of the	F7	'61	

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."

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

> §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.

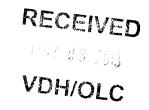
F 804

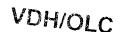
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 84 of 104





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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1''		[` '	(X3) DATE SURVEY COMPLETED	
	495415	B. WING_		04/06/2018		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
GE AT ORCHAR	D RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603			
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE COME	(X5) PLETION DATE	
	SUMMARY S	CORRECTION LEADER: 495415	A. BU 495415 B. WING COVIDER OR SUPPLIER GE AT ORCHARD RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOVER OF THE PRECEDED BY FULL A. BU B. WING A. BUILDING 495415 B. WING COVIDER OR SUPPLIER GE AT ORCHARD RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) A. BUILDING B. WING 100 PROCESSION WAY WINCHESTER, VA 22603 PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIR	CORRECTION IDENTIFICATION NUMBER: A. BUILDING — 04/06/20 COVIDER OR SUPPLIER COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETE 04/06/20 04/06/20		

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.

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO. 0938-0391

CENTER	3 I OIL MEDICAILE	- WINDUCAID SERVICES		UI UI	VID NO. 0930-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		1`'	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495415	BWING_		04/06/2018
NAME OF PR	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				100 PROCESSION WAY	
THE VILLA	AGE AT ORCHARD I	RIDGE		WINCHESTER, VA 22603	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(XS)
PREFIX	•	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE DATE

F 804 Continued From page 85 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

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.

lete

Event ID:QT8M11

Facility ID: VA0408

If optimuation sheet Page 86 of 104



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

Facility ID:VA0408

If continuation sheet Page 87 of 104

RECEIVED

		& MEDICAID SERVICES					RM APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTI		DNSTRUCTION	(X3)	NO 0938-039 DATE SURVEY COMPLETED
		495415	B.WING_				04/06/2018
	PROVIDER OR SUPPLIER	RIDGE		100 PF	ET ADDRESS, CITY, STATE, ZIP C ROCESSION WAY CHESTER, VA 22603		0.100.2010
(X4) ID PREFIX TAG	{EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 804	other food, OSM #4 plates and the porte the unit. When aske the silver lids are us OSM #4 stated the pwarmer until the foo On 4/5/18 at 5:11 p. administrator), ASM ASM #3 (the admini OSM (other staff me environmental service above concern. A powas requested.	s a lid over it. In regards to stated she puts lids over the er takes the food right out to ed if any devices other than led to keep the food warm, plates are kept on a plate d is plated.	F 80)4			
	Food Procurement. SCFR(s): 483.60(i)(1) §483.60(i) Food safe The facility must - §483.60(i)(1) - Procure approved or consider state or local authoric (i) This may include from local producers and local laws or reg (ii) This provision do facilities from using a gardens, subject to a safe growing and food (iii) This provision do from consuming food §483.60(i)(2) - Store	Store/Prepare/Serve-Sanitary (2) ety requirements. ure food from sources ered satisfactory by federal, ities. food items obtained directly s, subject to applicable State	F 81	2			

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

			The state of the s	****
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495415	B. WING		04/06/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	! <u></u>
THE VILLAGE AT ORCHARD F	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION

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

- 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

- 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

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

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 89 of 104



VDH/OLC

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO. 0938-0391

CENTER	S FOR MEDICARE	A MEDICAID SERVICES			UNID NO. 0930-0391
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
THE VILLA	GE AT ORCHARD I	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLETION
					· · · · · · · · · · · · · · · · · · ·

F 812 Continued From page 89

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

F 812 How the facility plans to monitor its performance to make sure that solutions are sustained

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.

		AND TUIVIAN SERVICES & MEDICAID SERVICES			FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495415	B. WING		04/06/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/00/2010
THE VIL	LAGE AT ORCHARD F	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
F 812	the refrigerator and OSM #5 stated if the resident then the ite open date. OSM #5 surveyor's observation freezer. OSM #5 stated with the residence overed. OSM #5 wobservation of the fra.m., OSM #5 returns tated the item in the family member stuckstated the family meremove the item durnit. When asked if family it. When asked if family refrigerators and "Yes." When asked if properly stored in the freezers, OSM #5 stated a sign that instructs the OSM #5 stated a sign long-term care unit refrigerator), ASM	DSM #5 was asked if items in freezer should be labeled. The item is for a particular of should be labeled with an an away was made aware of this item item should be dent's name and date, and as asked to make an eezer. On 4/4/18 at 9:14 and to this surveyor. OSM #5 are freezer was ice cream a at in the freezer. OSM #5 and the previous night but left only members had access to diffeezers, OSM #5 stated, how staff ensures food is a unit refrigerators and ated, "We need to have a em what to do on that fridge." In was already posted on the efrigerator.	F8	12	
	OSM (other staff me	mber) #3 (the director of ses) 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

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					MB NO 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT			CTION	(X3) DATE SURVEY COMPLETED
		495415	B. WING_				04/06/2018
NAME OF F	PROVIDER OR SUPPLIER		<u>' </u>	STREE	TADDR	ESS, CITY, STATE, ZIP CODE	1 0470072010
THE VILI	_AGE AT ORCHARD I	RIDGE				SION WAY ER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 812	use, storage and hat follows: a. All foods resident's name, and placed in a closed of the country kitchen	ge 91 mmunity, safe and sanitary andling shall be maintained as shall be labeled with the id dated. b. All foods shall be container and may be stored in in the appropriate location" on was presented prior to exit.	F 8 ⁻		F880		
F 880 Infection Prevention SS=E CFR(s): 483.80(a)(1		•	F 88	80 I	How c	orrective action will be ac	complished for
		1)(2)(4)(e)(f)				residents found to have b	een affected by
	§483.80 Infection C	ontrol		1		ficient practice	
	The facility must es infection prevention designed to provide comfortable enviror development and tr diseases and infect §483.80(a) Infection program. The facility must es and control progran a minimum, the following services to arrangement based conducted according	tablish and maintain an and control program a safe, sanitary and ament and to help prevent the ansmission of communicable ions. In prevention and control tablish an infection prevention in (IPCP) that must include, at owing elements: Item for preventing, identifying, sing, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment g to §483.?0(e) and following			b) c)	Policy complete; On-site planned; Remainder of pcompletion underway. It assessment, no resident Director of nursing immediated LPN #1 regards hygiene and proper producessing change on 4-5-2 had no negative effect realleged deficient practice Resident's oxygen tubing immediately discarded; sobtained and placed in a appropriate dating. LPN #1 was educated iminfection control practice medication administration	orogram n addition, after s at risk. ediately ing proper hand cedure for 18. Resident # 3 elated to the e. g on was new tubing was n bag with
	accepted national s					acility will identify other r	=
		en standards, policies, and program, which must include,			•	tential to be affected by t deficient practice	.ne
	but are not limited to			•		Policy complete; On-site	testing already

(i) A system of surveillance designed to identify

scheduled; Remainder of program

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED
		495415	B. WINC	<u> </u>	d	4/06/2018
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
THE VILLA	GE AT ORCHARD F	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(= 10.1.00111.1201112710111	ONSHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880 C	Continued From pa	ao 92		220		

Continued From page 92

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

F 880

- 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.

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

PRINTED: 04/17/2018 FORM APPROVED 0MB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	I.	B) DATE SURVEY COMPLETED
	495415	B. WING_		04/06/2018
NAME OF PROVIDER OR SUPPLI			STREET ADDRESS, CITY. STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(XS) COMPLETION E DATE

F 880 Continued From page 93

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.

F 880 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.

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE 0MB NO 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495415	SWING		04/06/0040
NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STATE, ZIP	04/06/2018 CODE
THE VIL	LAGE AT ORCHARD I	RIDGE		100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X {EACH CORRECTIVE ACTION	N SHOULD BE COMPLETION
	member) #1, the ad (Director of Nursing administrative supp the above concerns provided prior to exi The facility policy "V to Prevent Legionna part the following: "Testablishing and mamanagement progra occurrence of Legio bacterium Legionella pneumonia called L riskoutbreaks have maintained water sy complex water systelong-term care facilit Legionella by inhalin containing the bacte	m., ASM (administrative staff ministrator, ASM #2, the DON) and ASM #3, the ort clerk were made aware of No further information was it. Vater Management Program aire's Disease" documented in The facility is committed to intaining an effective water am system to minimize the nnaire's Disease. The a can cause serious type of O in persons at the been linked to poorly stems in building with large or tems including hospitals and	F 8	80	
	control practices dur #3. Resident #3 was adr 10/16/14 and readmi diagnoses that includosteoporosis, muscledementia without beldepressive disorder, Resident #3's most reset) was a significant ARD (assessment re	miled to maintain infection ing wound care for Resident mitted to the facility on tted on 1/7/18 with ded but were not limited to exweakness, unspecified navioral disturbance, major and high blood pressure. Execut MOS (minimum data change assessment with an ference date) of 1/19/18.			

impaired in cognitive function, scoring 10 out of

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES 0MB NO 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CUA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING----B. WING 495415 04/06/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY THE VILLAGE AT ORCHARD RIDGE **WINCHESTER, VA 22603** SUMMARY STATEMENT OF DEFICIENCIES (X4)1D ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTIONSHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 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

hands.

new gloves, and put a new brief on the resident. LPN #1 then removed her gloves and washed her

On 4/5/18 at 4:45 p.m., an interview was conducted with LPN #1. When asked how to

					OMB NO 0838
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURV COMPLETED
		495415	B. WING		04/06/20
	ROVIDER OR SUPPLI		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 PROCESSION WAY VINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPI

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

F 880

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MU A. BUILD		E CONSTRUCTION		ATE SURVEY OMPLETED
		495415	B. WING	: _	·	0	4/06/2018
	PROVIDER OR SUPPLIER LAGE AT ORCHARD F	RIDGE		10	REET ADDRESS. CITY. STATE. ZIP CODE 0 PROCESSION WAY INCHESTER, VA 22603	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 880	ulcer without slough should not be used burns, perinea! derrexcoriation. *Bruising indicates: This information wa Pressure Ulcer Adv http://www.npuap.or (2) Stage III pressure Full thickness tissue be visible but bone, exposed. Slough may obscure the depth of undermining and turn the depth of a stage anatomical location. occiput and malleolitissue and stage III is contrast, areas of sindevelop extremely of Bone/tendon is not a This information was Pressure Ulcer Advinttp://www.npuap.or (3) SANTYL® Ointmactive enzymatic the removes necrotic tis microscopic level. The bed of microscopic of the contrast of the removes necrotic tis microscopic level. The contrast of the removes necrotic tis microscopic of the contrast of the removes necrotic tis microscopic level. The contrast of the removes necrotic tis microscopic level. The contrast of the removes necrotic tis microscopic of the contrast of the removes necrotic tis microscopic level. The contrast of the removes necrotic tis microscopic development of the removes necrotic tis microscopic dev	ts as a shiny or dry shallow or bruising.* This stage to describe skin tears, tape matitis, maceration or suspected deep tissue injury is obtained from National isory Panel website at rg/pr2.htm. The sore of loss. Subcutaneous fat may tendon or muscle are not at the present but does not off tissue loss. May include the ling. Further description: of the bridge of the nose, ear, us do not have subcutaneous ulcers can be shallow. In gnificant adiposity can leep stage III pressure ulcers. It is obtained from National sory Panel website at rg/pr2.htm. The provided of the mose of the pressure ulcers of the sory Panel website at rg/pr2.htm. The provided of the wound obtained from wounds at the his works to free the wound cellular debris, allowing ed and epithelialization to	F	380			

Resident #8.

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

		& MEDICAID SERVICES			FORM APPROVE
1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495415	B. WING	S	04/06/2018
	PROVIDER OR SUPPLIER _AGE AT ORCHARD F	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	(=: 1011 001 11 12 A0110110110	OULD BE COMPLETION
F 880	Continued From pa	ge 98	F8	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

		E & MEDICAID SERVICES					RM APPROVED NO 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495415	В.	WING_			4/06/2018
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP C		
THE VILI	AGE AT ORCHARD I	RIDGE		ì	PROCESSION WAY CHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLANOF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 99	F	880			
	"To keep dust partic Infection control." L Resident #S's room	en not in use, LPN #1 stated, cles or anything else out of it. PN #1 followed this writer to a. LPN #1 confirmed that the en tubing attached to his ot stored in a bag.					
	member) #1, the ac (Director of Nursing	ort clerk were made aware of					
	Facility policy titled, address the above	"Oxygen Therapy" did not concerns.					
	No further information	on was provided prior to exit.					
	failed to maintain in	and Resident #6, facility staff fection control practices administration observation.					
	7/15/15 and readmithat included but we dementia without be weakness, and high #4's most recent M0 assessment was a CARD (assessment r Resident #4 was co	dmitted to the facility on ted on 9/7/16 with diagnoses are not limited to unspecified chavioral disturbance, muscle in blood pressure. Resident OS (minimum data set) quarterly assessment with an reference date) of 2/4/18. Indeed as being severely the 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

	TOF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Town MILE		OMB_NO_0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION UILDING	(X3) DATE SURVEY COMPLETED
=		495415	B. WING	3	04/06/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	04/06/2018 P CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(TON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 880	Continued From pa	ige 100	F8	380	
	with diagnoses that to dementia, muscle pressure and major Resident #6's most set) assessment with an date) of 3/12/18. Rebeing severely impascoring 99 out of pointerview for Mental was coded as being most ADLs (activities On 4/4/18 at 8:31 a. was observed of LP #1. At 8:40 a.m., LP	n.m., medication administration PN (licensed practical nurse) PN #1 was preparing sident #4. The following prepared:			
		O IU (international unit)- 1 tablet vitamin- 10 ml			
	pressure cuff and he Resident #4's blood blood pressure was cuff and stethoscope This writer did not se	42 a.m., LPN #1 used a blood er stethoscope to take pressure. Resident #4's 148/72. LPN #1 placed the e on the medication cart. ee LPN #1 sanitize the blood thoscope after use. LPN #1 bllowing 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	B. WING	04/06/2018
	 ,		, ,

NAME OF PROVIDER OR SUPPLIER

THE VILLAGE AT ORCHARD RIDGE

STREET ADDRESS, CITY, STATE, ZIP CODE

100 PROCESSION WAY **WINCHESTER, VA 22603**

(X4)1D PRFFIX 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.

FOR WEDICARE	& MEDICAIDSERVICES		(0MB NO 0938-0391	
DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	495415	B. WIN	۱G	04/06/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GE AT ORCHARD I	RIDGE				
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
	DEFICIENCIES CORRECTION DVIDER OR SUPPLIER GE AT ORCHARD I SUMMARY STA (EACH DEFICIENCY	CORRECTION IDENTIFICATION NUMBER:	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. B. U. 495415 B. WIN OVIDER OR SUPPLIER GE AT ORCHARD RIDGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X2) MULTIPLE A. B. U. PREFIX	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X2) MULTIPLE CONSTRUCTION A. BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	

F 880 Continued From page 102

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

F 880

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 103 of 104

RECEIVED

MAY 08 2010

		E & MEDICAIDSERVICES					ORM APPROVED NO 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
	'	495415	B. WING	G	and the second s		04/06/2018
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		1410012010
THE VILL	LAGE AT ORCHARD R	RIDGE		1	IOO PROCESSION WAY WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ΊX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	Continued From page	age 103	F !	880			
	control procedures	(e.g. handwashing, antispetic					
		isolation precautions. etc.) for of medications as applicable."					
	(1) Aspirin is used t	to decrease mild to moderate					
	pain associated with	th inflammatory disorders. This					
		tained from Davis's Drug					
	Guide, 11th edition, (2) Vitamin D Table	, p. 1087. et- "Vitamin D is a fat-soluble					
		rally present in very few foods,					
	added to others, and	nd available as a dietary					
	supplement." This in	information was obtained from					
	The National Institut						
		ov/factsheets/VitaminD-Health					
	Professional/. 3) Rumex is a diure	etic used to treat fluid retention.					
	•	as obtained from The National					
	Institutes of Health.						
	https://www.ncbi.nln T0009343/?report=c	m.nih.gov/pubmedhealth/PMH details					
	•	nultivitamin used to treat					
	vitamin deficiency.	This information was obtained					
	··· ·· ···	.com/drugs/2/drug-13950/elde					
	rtonic-oral/details.	501 a. a.g.a. a. a.g.a.					
		d to treat depression and					
	_	nation was obtained from The					
	National Institutes o						
	nttps://www.ncbi.nin	m.nih.gov/pubmedhealth/PMH details					
		d to treat high blood pressure,					
	angina, and heart fa	ailure. This information was					
	obtained from The N	National Institutes of Health.					
	https://www.ncbi.nln T0011186/?report=c	m.nih.gov/pubmedhealth/PMH details.					

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

Event ID:QT8M11

Facility ID: VA0408

If continuation sheet Page 104 of 104

RECEIVED

MAY 08 2018

Y² € + 5

State of Virginia				TORWALLOVE
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A BUILE	DING:	COMPLETED
	VA0408	B. WING		04/06/2018
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST.	ATE, ZIP CODE	
	100 PRO	CESSION WAY	•	
THE VILLAGE AT ORCHARD	RIDGE WINCHE	STER, VA 226	03	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLANOF CORRECTIV (EACHCORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETE
F 000 Initial Comments		F 000		
Inspection was co Corrections are re following with the for the Licensure of The census in this	biennial State Licensure nducted 4/4/18 through 4/6/18. quired for compliance with the Virginia Rules and Regulations of Nursing Facilities. s 20 certified bed facility was 15 survey. The survey sample		12VAC5-371-180 Cross Re Plan of Correction (POC) fo Infection Prevention & Con 12VAC5-371-300 Cross Re POC for F761 Label/Store	or F880 trol. eference to
consisted of 12 cu (Residents#9, 61 and 115) and two (Residents# 12 a	rrent resident reviews , 10, 4,112, 1, 6, 8, 3,111, 2 closed record reviews		Biologicals. 12VAC5-371-340 Cross Re POC for F812 Food Procur Sotre/Prepare/Serve-Sanita	eference to ement,
F 001 Non Compliance		F 001		
following state lice			12VAC5-371-140 Cross Re POC for F622 Transfer and Discharge Requirements; F Notice Requirements Befor Transfer/Discharge; F624 Preparation for Safe/Orderl Transfer/Dschrg; and F625	7623 e
	Di de la completa de la completa de la completa de la completa de la completa de la completa de la completa de		Bed Hold Policy Before/Upo	
cross reference to 12VAC5-371-340 program cross reference to	Dietary and food service		12VAC5-371-250 Cross Reference to POC for F657 Plan Timing and Revision, I Drug Regimen is free from Unnecessary Drugs, F686 Treatment/Svcs to prevent/ pressure ulcer, F695	F757
references to F62 12VAC5-371-250. Care Planning cro	Policies and Procedures cross 2, F623, F624, F625 Resident assessment and oss references to F657, F757,		Respiratory/tracheostomy c and suctioning, and F697 P management.	
F686, F695, F697 12VAC5-371-200 references to F68	Director of Nursing cross		Reference to POC for F684 Quality of Care.	

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

STATE FORM

6899

TITLE NSTRAZ

(X6) DATE

PRINTED: 04/17/2018 FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLI	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		
			ABUIL			
		VA0408	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	TATE, ZIP CODE	04/06/2018	
THE VILI	LAGE AT ORCHARD I	RIDGE	DCESSION WAY ESTER, VA 226			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETE	
F 001	Continued From pag	ge 1	F 001			
	12VAC5-371-220. I references to F757	Nursing Services cross		12VAC5-371-220 Cross Reference to POC for F Regimen is free from Unnecessary Drugs.	757 Drug	

STATE FORM

6899

NLLC11

If continuation sheet 2 of 2