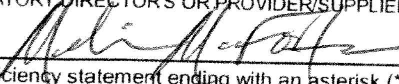
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING ______ B. WING ______	C 03/24/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/22/16 through 3/24/16. One complaint was investigated during the survey. 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 ten certified bed facility was eight at the time of the survey. The survey sample consisted of five current resident reviews (Residents #1 through #4 and #10) and five closed record reviews (Residents #5 through #9).	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review and facility policy document review, it was determined that the facility failed to implement policies to protect residents from abuse in one of five employee records reviewed, OSM (other staff member) #18, a therapy assistant. The facility staff failed to obtain a sworn statement from OSM #18, physical therapy assistant, prior to hire on 2/16/16. The findings include:	F 226	RECEIVED APR 08 2016 VDH/OLC **How corrective action will be accomplished for those residents found to have been affected by the deficient practice** Contracted Physical Therapist Assistant sworn statement was obtained immediately that day 3-24-16. **How facility will identify other residents having the potential to be affected by the same deficient practice** All contracted therapy team member sworn	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE ADMINISTRATOR (X6) DATE 4-7-16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING ______ B. WING ______	C 03/24/2016

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

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

F 226 Continued From page 1 — F 226

A review of the employee record for OSM #18 failed to reveal evidence that he signed and dated a sworn statement.

On 3/23/16 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of this concern.

On 3/24/16 at 8:35 a.m., OSM #15, corporate human resources director for the contract therapy provider, was interviewed regarding this concern. She stated that it was not the practice of the therapy company to obtain sworn statements from employees prior to hire because the company did not allow anyone to begin working until their criminal background checks from the state police were received. She stated: "Now we will know for the future that we have to have the sworn statement."

A review of the facility policy entitled "Abuse Recognition and Reporting" revealed, in part, the following: "All applicants being considered for employment...must be screened to determine that they do not have a history of abuse, neglect or mistreatment of residents. All potential employees will be subject to a Sworn Disclosure signed by the applicant."

No further information was provided prior to exit.

statements were obtained immediately that day 3-24-16.

Measure or system change to ensure the deficient practice will not recur
Flagship, our contracted therapy company, implemented a new process whereby all new hires will obtain the sworn statement upon hire and prior to their first day of work at Orchard Ridge.

How the facility plans to monitor its performance to make sure that solutions are sustained
Flagship Rehab Manager will ensure that Flagship, our contracted therapy company, will audit any files of newly appointed therapist to Orchard Ridge quarterly and report any negative compliance issue to Executive Director at the current quarterly operational meeting.

All corrective actions complete by 4-6-16.

F 371 SS=F 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY — F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local

RECEIVED
APR 08 2016
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING ______ B. WING ______	C 03/24/2016

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

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

F 371 Continued From page 2
authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

F 371

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, the facility failed to store and prepare food in a sanitary manner.

Three ovens and two hot boxes in the main facility kitchen were maintained in an unsanitary manner. The three ovens were observed with hard black debris on the inside top, bottom and sides of the oven.

The walk-in refrigerator contained two unlabeled and undated containers of thawed chicken breasts.

The findings include:

On 3/22/16 at 11:35 p.m., the facility's main kitchen was inspected. OSM (other staff member) #10, the registered dietician, and OSM #11, a dietary assistant, accompanied the surveyor on this inspection.

1. Three of three ovens in use by the facility staff contained hard black debris on the inside top, bottom and sides of the oven. Some of the black debris was baked on the oven surfaces; other pieces were lying loose on the oven floor. The inside of the glass doors of all three ovens were covered with hard brown debris.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice
A=All kitchen equipment/appliances cleaned immediately that day 3-22-16.
B=The unlabeled/undated chicken breasts were disposed of immediately that day 3-22-16.

How facility will identify other residents having the potential to be affected by the same deficient practice
A=New cleaning logs addressing the ovens and hot boxes were implemented 3-22-16 and 3-23-16.
B=Staff were re-educated on food labeling and dating starting on 3-22-16.

Measure or system change to ensure the deficient practice will not recur
A=All staff to be educated on new cleaning logs.
B=All staff to be re-educated on food labeling and dating.

RECEIVED
APR 18 2016
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING ______ B. WING ______	C 03/24/2016

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

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

F 371 Continued From page 3 F 371

2. Two of two hot boxes contained food debris on all inner surfaces.

3. The walk-in protein refrigerator contained a previously-opened bag of chicken breasts. The bag contained no label or date. This refrigerator also contained a stainless steel container with two thawed chicken breasts. Although covered, the container did not have a label or a date.

On 3/22/16 at 12:00 p.m., OSM #11 was interviewed about these observations. She stated: "I can't argue with you. Those ovens and hot boxes are not clean. They just are not."

On 3/22/16 at 12:05 p.m., OSM #12, a line cook, was interviewed regarding the chicken. He stated that the two breasts in the stainless steel container had been "pulled for last night." He stated that the bag of chicken breasts had been "pulled for today." He stated: "They both should have had a date."

On 3/23/16 at 2:00 p.m., OSM #14, the sous chef, was interviewed regarding these concerns. He stated: "We have cleaned all the equipment. It's my fault we don't have a log. I usually just give instructions verbally. And absolutely, the chicken in the cooler should have been dated and labeled."

On 3/23/16 at 4:45 p.m., ASM (administrative staff member) #1, the executive director, and ASM #2, the director of nursing, were informed of these concerns.

On 3/24/16 at 8:50 a.m., OSM #2, the executive chef, was interviewed. He stated that he

How the facility plans to monitor its performance to make sure that solutions are sustained.
Executive Chef or designee will audit 10% of cleaning logs monthly and walk-in refrigerators weekly to ensure compliance, and report any actionable trends to the monthly Quality Assurance Performance Improvement Committee.

All corrective actions complete by 4-8-16.

RECEIVED
APR 08 2016
VDH/OLC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495415	A. BUILDING ______ B. WING ______	C 03/24/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 4 implemented a new list of equipment cleaning approximately two weeks ago. He stated that the list had not yet been implemented by the sous chef at the time of the surveyor's initial tour of the kitchen on 3/22/16. He stated that the chicken should have had labels with dates on them. A review of the facility document entitled "Basics for Handling Food Safely" revealed, in part: "Cold Storage Chart: Product: Chicken or turkey, pieces, 1 to 2 days." No further information was provided prior to exit.	F 371		

RECEIVED
2016
VDH/OLC

VDH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0408	A. BUILDING ______ B. WING ______	03/24/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 3/22/16 through 3/24/16. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this ten certified bed facility was 8 at the time of the survey. The survey sample consisted of five current resident reviews (Residents #1 through #4 and #10) and five closed record reviews (Residents #5 and #9).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: Based on staff interview, employee record review and facility document review it was determined that the facility staff failed to implement policies for the prevention of abuse in three of 25 employee records reviewed. 1. For OSM (Other Staff Member) #10, the registered dietician, who was hired 1/7/14, the employee record did not contain any sworn disclosure statement, criminal background check, license verification or reference checks. 2. For OSM #19, a beautician who was hired 7/13/15, the employee record did not contain any sworn disclosure statement, criminal background check, license verification or reference checks. 3. For ASM (administrative staff member) #1, the executive director who was hired 7/2/15, the employee record did not contain a license verification at the time of hire.	F 001	RECEIVED APR 08 2016 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: ADMINISTRATOR
(X6) DATE: 4-7-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0408	A. BUILDING ______ B. WING ______	03/24/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 1	F 001		

The findings include:

12VAC5-371-110. Management and administration.
B. The nursing facility must comply with:
1. These regulations (12VAC5-371);
2. Other applicable federal, state or local laws and regulations; and
3. Its own policies and procedures.

12VAC5-371-140. Policies and procedures.
E. Personnel policies and procedures shall include, but are not limited to:
3. An accurate and complete personnel record for each employee including:
a. Verification of current professional license, registration, or certificate or completion of a required approved training course;
b. Criminal record check

On 3/23/16 at 4:45 p.m., ASM #1 and ASM #2, the director of nursing, were informed of these concerns.

On 3/24/16 at 9:35 a.m., OSM #5, the executive assistant, was interviewed regarding these concerns. She stated that she was not aware that the facility was responsible for obtaining these items on contracted staff (dietician and beautician). She stated that the facility did not have any of these records, but would be doing all the required screenings prior to hire for contracted staff from that point forward.

On 3/24/16 at 9:40 a.m., OSM #4, the coordinator of talent and culture, was interviewed regarding these concerns. She stated that the human resources file for ASM #1 was maintained at the corporate office. She stated that she had spoken

How corrective action will be accomplished for those residents found to have been affected by the deficient practice
Record information for contracted Registered Dietician and contracted Beautician that could be obtained post hire was completed i.e. sworn statement, current criminal record check, etc.

How facility will identify other residents having the potential to be affected by the same deficient practice
Obtained same named information on the other two contracted Beauticians.

Measure or system change to ensure the deficient practice will not recur
New process will be implemented of applying best practice of obtaining said measures (sworn disclosure statement, criminal background check, licensure verification or reference checks) for any new Registered Dietician or Beautician. Re-educated corporate office on not only obtaining verbal licensure verification on employees such as the Executive Director but on also obtaining the written licensure verification for the file too.

How the facility plans to monitor its performance to make sure that solutions are sustained
Executive Assistant will audit any record/file of

RECEIVED
APR 08 2016
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0408	A. BUILDING ______ B. WING ______	03/24/2016

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

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

F 001 Continued From Page 2 F 001

with the corporate staff earlier in the morning, and that the corporate staff stated they had done the license verification for ASM #1 at the time of hire, but that they did not have written evidence.

A review of the facility policy entitled "Abuse Recognition and Reporting" revealed, in part, the following: "All applicants being considered for employment...must be screened to determine that they do not have a history of abuse, neglect or mistreatment of residents. All potential employees will be subject to a Sworn Disclosure signed by the applicant, a criminal record check, verification of their past employment. Hired nursing personnel shall have their license checked with the State Board of Nursing to ensure that their licenses are current and that they are in good standing."

No further information was provided prior to exit.

Based on staff interview and facility document review, it was determined that the facility staff failed to conduct an annual policy review, with recommended changes submitted to the governing body for 2014-16.

The facility staff did not conduct an annual review of the policies specified in 12VAC5-371-140 for 2014-16.

The findings include:

12VAC5-371-140. Policies and procedures. (amended 9/2011)
A. The nursing facility shall implement written policies and procedures approved by the

newly contracted/hired Registered Dietician, Beautician, or Executive Director to Orchard Ridge and report any negative compliance issue to the Quality Assurance Performance Improvement Committee meeting.

All corrective actions complete by 4-29-16.

How corrective action will be accomplished for those residents found to have been affected by the deficient practice
Educated available department leaders immediately that day 3-23-16.

RECEIVED
APR 0 6 2016
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0408	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 03/24/2016
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) COMPLETE DATE

F 001 Continued From Page 3 F 001

governing body.
B. All policies and procedures shall be reviewed at least annually, with recommended changes submitted to the governing body for approval.
C. A written record of the annual policy review, including at least the review dates, participants, recommendations and action dates of the governing body, shall be maintained.
D. Administrative and operational policies and procedures shall include, but are not limited to:
1. Administrative records;
2. Admission, transfer and discharge;
3. Medical direction and physician services;
4. Nursing direction and nursing services;
5. Pharmaceutical services, including drugs purchased outside the nursing facility;
6. Dietary services;
7. Social services;
8. Activities services;
9. Restorative and rehabilitative resident services;
10. Contractual services;
11. Clinical records;
12. Resident rights and grievances;
13. Quality assurance and infection control;
14. Safety and emergency preparedness procedures; and
15. Professional and clinical ethics, including:
16. Facility security.

On 3/22/16 at the entrance conference, the surveyor requested written evidence that the facility had conducted an annual policy review for the last two years. ASM (administrative staff member) #2, the director of nursing, stated that she would communicate this information to ASM #1, the administrator.

On 3/23/16 at 4:45 p.m., the surveyor again requested written evidence that the facility had conducted an annual policy review for the last two years. ASM #1 stated that she was "working on

How facility will identify other residents having the potential to be affected by the same deficient practice
Educated all department leaders on policy standard 3-24-16.

Measure or system change to ensure the deficient practice will not recur
New process will be implemented this month to conduct an annual policy review by applicable departments for reporting to the Quality Assurance Performance Improvement Committee meeting. This will be noted on the Quality Assurance Performance Improvement Committee annual calendar for each February.

How the facility plans to monitor its performance to make sure that solutions are sustained
Executive Director or designee will verify the annual policy review at the designated Quality Assurance Performance Improvement Committee meeting (each February).

All corrective actions complete by 4-29-16.

RECEIVED
APR 08 2016
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0408	A. BUILDING ____ B. WING ____	03/24/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From Page 4	F 001		

this."

On 3/24/16 at 10:20 a.m., ASM #1 stated: "The policy review has been de-centralized. We are constantly reviewing policies. If we need to make changes, we do it through our quality committee. I doubt we are going to find organized reviews in some of the areas other than nursing." At this point, she provided the surveyor with a document signed by her and ASM #2. The document stated that the facility's nursing policies and procedures had been reviewed on 2/11/16.

On 3/24/16 at 10:50 a.m., ASM #1 stated: "I'm not finding anything else. I know of at least two departments that have not done the annual signature. Nursing has been our main focus."

No further information was provided prior to exit.

12VAC5-371-140 D6
Cross reference to F-371

RECEIVED
VDH/OLC