PRINTED: 04/04/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495415	B. WING			03/29/2017
NAME OF PROVIDER OR SUPPLIER  THE VILLAGE AT ORCHARD RIDGE			100 F	ET ADDRESS, CITY, STATE, ZIP CODE PROCESSION WAY CHESTER, VA 22603	00/20/2017	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENT	-s	FO	00		
	survey was conduct Corrections are req following 42 CFR P Care requirements. survey/report will for The census in this 2 nine at the time of the sample consisted of (Residents #1 throus reviews (Residents 483.20(g)-(j) ASSES ACCURACY/COOF (g) Accuracy of Assignation and Coordination A registered nurse registered nurse registered for the Corrections are required to the correction and the corrections are required to the corrections are required to the correction and the correction are required to the correction and the correction are required to the correction and the correction are required to the correction are required to the correction and the correction are required to the correction are required to the correction and the correction ar	20 certified bed facility was he survey. The survey f four current resident reviews gh #4) and four closed record # 5 through # 8). SSMENT RDINATION/CERTIFIED essments. The assessment ect the resident's status.	F 2	78		
	each assessment w participation of heal (i) Certification (1) A registered nurs the assessment is of	th professionals. se must sign and certify that				
	(2) Each individual v	who completes a portion of the ign and certify the accuracy of				
					ECEIVED	
	<ul><li>(j) Penalty for Falsification</li><li>(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</li><li>(i) Certifies a material and false statement in a</li></ul>				APR 12 2017	
					10H/OLC	

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

TITLE AUGUSTRATOR I ET

(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.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(	OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495415	B. WING	à		03/29/2017
NAME OF PROVIDER OR SUPPLIER  THE VILLAGE AT ORCHARD RIDGE			1	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 PREF TAG	ŀΧ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION
F 278	penalty of not more assessment; or  (ii) Causes another and false statement subject to a civil most \$5,000 for each asses (2) Clinical disagreematerial and false staterial stat	individual to certify a material tin a resident assessment is oney penalty or not more than sessment.  The individual to certify a material tin a resident assessment is oney penalty or not more than sessment.  The individual to certify a material tin a resident assessment assessment to a constitute a statement.  The individual to certify a material tin a resident as evidenced as evidenced as evidenced as evidenced as evidenced that a set) assessment for one of the survey sample, Resident #  The individual to certify a material tin a sessment for one of the survey sample, Resident #  The individual to certify a material tin a resident as evidenced	F	278		
	reference date) of 1 The findings include					
	with diagnoses that to Parkinson's disea cancer of the prostr constipation. Resid quarterly assessme coded Resident # 2 others and usually a Resident # 2 was co	dmitted to the facility on 8/4/16 included but were not limited ase, Dementia, hypertension, ate, muscle weakness, and lent # 2's most recent MDS, a nt with an ARD of 3/10/17 as usually understood by able to understand others. Dided as scoring an 8 out of a Brief Interview for Mental	ի r F	How residence prac Res	'8 CRITERIDN I v corrective action will be accomplished dents found to have been affected by ctice sident #2's MDS section K was corre I transmitted accurately on 3-29-17.	the deficient

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Status in Section C, Cognitive Patterns, indicating the resident was cognitively impaired. This MDS

Event ID:9M4K11

Facility ID: VA0408

If continuation sheet Page 2 of 9



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CENTERS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	495415	B. WING	<b>3</b>		03/29/2017	
NAME OF PROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE,	ZIP CODE		
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 PREF TAG		CTION SHOULD THE APPROPI	BE COMPLETION	
assessment, a sign with an ARD of 12/4 (significant change documentation at S Nutritional Status," the resident's weigh Weight (in pounds) measure in last 30 consistently, according practice (e.g., in all with shoes off, etc.  Review of the clinic documentation of w Resident # 2 that consignificant change 12/8/16. Resident and his weight was A physician order we every month on the discontinued on 12 this date is after the change MDS asses (assessment reference)  During an interview LPN (licensed practice to further stated that seconding that section (name of the regist LPN # 1 was asked)	ompared to the previous MDS officant change assessment 8/16. Review of this MDS of assessment revealed section K "Swallowing / in section K0200 B Weight, and the was coded as a dash. [B Base weight on most recent days; measure weight ding to standard facility m. after voiding, before meal, [b] cal record revealed weights being assessed for ould have been used on the assessment with the ARD of # 2 was weighed on 12/3/16	F	F278 CRITERION II How facility will ident potential to be affect same deficient pract An MDS audit of sec immediately (3-29-1' Any applicable revisi  F278 CRITERION III Measure or system of practice will not recu New process implem Manager will verify a section K of the MDS  F278 CRITERION IV How the facility plans make sure that solut Dietician will audit 10 ensure accuracy and the monthly Quality of Improvement (QAPI)  F278 CRITERION V All corrective actions	tify other resided by the cice ottoon K was of the cice of the cic	completed ats by the dietician. ddressed if needed.  nsure the deficient eby MDS QAPI completion of omission.  its performance to stained section K monthly to actionable trends to Performance	

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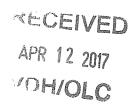
instrument) manual.

she used the RAI (resident assessment

Event ID: 9M4K11

Facility ID: VA0408

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	·		OMB	NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		495415	B. WING	TO Philadeless and the second		03/29/2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COL	DE .	00,20,20
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 CORRI K (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 3	F 2	78		
	OSM (other staff medietician, the coding Resident # 2's signi with the ARD of 12/3 stated that the residual 12/8/16 and as she anyone on hospice # 1 further stated the on 12/13/16 to disco OSM # 1 continued resident being admit and the physician of to go with the dash.  On 3/29/17 at 10:30 staff member) #1, the	on 3/29/17 at 10:20 a.m. with ember) # 1, the registered g of the dash for the weight on ificant change assessment 8/16 was discussed. OSM # 1 dent went on hospice on understood the hospice policy was not to be weighed. OSM at the physician gave an order ontinue the resident's weights. to say that because of the litted to hospice on 12/8/16 rder of 12/13/16 she decided of a.m., ASM (administrative ne administrator, and ASM # rses, were made aware of the				
	above concern.	for Medicare and Medicaid				
	ŕ	ual documented the following:				
	1. Base weight on the last 30 days. 2. Measure weight of accordance with fact which should reflect (shoes off, etc.). 3. For subsequent a medical record and 30 days of the ARD 4. If the last recorde than 30 days prior to	ent for K0200B, Weight the most recent measure in the consistently over time in consistently over the consistent in				

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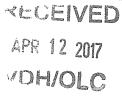
5. If the resident's weight was taken more than

resident again.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
495415			B. WING _		03/29/2017
	PROVIDER OR SUPPLIER	RIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION
F 278	Continued From pa	ge 4	F 27	78	
	once during the pre most recent weight.	ceding month, record the			
	* Use mathematica X.5 pounds [lbs] or the nearest whole p lbs, round down to the example, a weight of to 153 lbs and a we rounded to 152 lbs.  *If a resident cannibecause of extreme pathological fracture no-information code on the resident's me				
	No further information 483.35(b)(1)-(3) WADAYS/WK, FULL-TI		F 35	54	
	(f) of this section, the services of a register	ived under paragraph (e) or e facility must use the ered nurse for at least 8 day, 7 days a week.			
	<ul><li>(2) Except when waived under paragraph (e) or</li><li>(f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</li></ul>				
	(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:  Based on staff interview and facility document review, it was determined that the facility staff			F354 CRITERION I How corrective action will be those residents found to hav deficient practice An audit of the current day's completed immediately (3-2 deficient practice would occ	schedule was 9-17) to ensure no

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Event ID:9M4K11

Facility ID: VA0408-IVED

If continuation sheet Page 5 of 9

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
<b>495415</b> B. WING		POSITIVE	03/29/2017	
NAME OF PROVIDER OR SUPPLIER  THE VILLAGE AT ORCHARD RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	,
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	ILD BE COMPLETION
failed to maintain F for eight consecutive. The facility staff fail RN for eight consecutive. The findings included and the findings included and the facility administrator, and the facility and the facility was a facility with the facility without facility without facility shall have the facility shall have	RN (registered nurse) coverage we hours each day.  The ded to utilize the services of a cutive hours on Sunday  The estaff member) # 1, the asymptotic signment sheets were was signment sheet and ASM # 2, the director of signment sheet are coverage on Sunday 3/19/17. The for any documentation to san RN in the building for that and ASM # 2 stated that they here was no RN in the building both further stated that two switched their days without were doing so. The switch left RN coverage on that day. A policy was requested.  The eservices of a Registered consecutive hours a day, 7		potential to be affected by the practice An audit of the entire current was completed immediately other deficient practices were respective will not recur to the practice of the practice will not recur to the practice of the practice will not recur to the practice of the pra	month's schedule (3-29-17) to ensure no e scheduled.  c ensure the deficient d will continue for all abers regarding ity for RN coverage zed when staff make original schedule.  itor its performance to sustained ee will audit 10% of y to ensure ctionable trends to the erformance ttee.
(i) Medical records.			KECEIVED	
	PROVIDER OR SUPPLIER  LAGE AT ORCHARD  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR L  Continued From pa failed to maintain R for eight consecutiv  The facility staff fail RN for eight consecutiv  ASM (Administrativ administrator, and A nurses, the daily as reviewed. The daily documented no RN A request was mad show that there was day. Both ASM # 1 already knew that th on that day. They be staff members had reporting that they we the facility without R copy of the facility p  Review of the facility p	PROVIDER OR SUPPLIER  LAGE AT ORCHARD RIDGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5 failed to maintain RN (registered nurse) coverage for eight consecutive hours each day.  The facility staff failed to utilize the services of a RN for eight consecutive hours on Sunday 3/19/17.  The findings include:  During an interview on 3/29/17 at 10:30 a.m. with ASM (Administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, the daily assignment sheets were reviewed. The daily assignment sheet documented no RN coverage on Sunday 3/19/17. A request was made for any documentation to show that there was an RN in the building for that day. Both ASM # 1 and ASM # 2 stated that they already knew that there was no RN in the building on that day. They both further stated that two staff members had switched their days without reporting that they were doing so. The switch left the facility without RN coverage on that day. A copy of the facility policy: "Staffing and Scheduling Policy" documented in part "The facility shall have the services of a Registered Nurse available 8 consecutive hours a day, 7 days a week"  No further information was provided prior to exit. 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE	PROVIDER OR SUPPLIER  LAGE AT ORCHARD RIDGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 5  failed to maintain RN (registered nurse) coverage for eight consecutive hours each day.  The facility staff failed to utilize the services of a RN for eight consecutive hours on Sunday 3/19/17.  The findings include:  During an interview on 3/29/17 at 10:30 a.m. with ASM (Administrative staff member) # 1, the administrator, and ASM # 2, the director of nurses, the daily assignment sheets were reviewed. The daily assignment sheet were reviewed. The daily assignment sheet documented no RN coverage on Sunday 3/19/17. A request was made for any documentation to show that there was an RN in the building for that day. Both ASM # 1 and ASM # 2 stated that they already knew that there was no RN in the building on that day. They both further stated that two staff members had switched their days without reporting that they were doing so. The switch left the facility without RN coverage on that day. A copy of the facility policy was requested.  Review of the facility policy: "Staffing and Scheduling Policy" documented in part "The facility shall have the services of a Registered Nurse available 8 consecutive hours a day, 7 days a week"  No further information was provided prior to exit. 483.70(i)(1)(5) RES  RECORDS-COMPLETE/ACCURATE/ACCESSIB	PROVIDER OR SUPPLIER  495415  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603  SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION)  Continued From page 5 failed to maintain RN (registered nurse) coverage for eight consecutive hours each day.  The facility staff failed to utilize the services of a RN for eight consecutive hours on Sunday 3/19/17.  The findings include:  During an interview on 3/29/17 at 10:30 a.m. with ASM (Administrative staff member) # 1, the administrative staff member) # 1, the day administrative staff member) # 1, the day Both ASM # 1, and ASM # 2, the director of nurses, the daily assignment sheets were reviewed. The daily assignment sheets were reviewed. The daily assignment and for any documentation to show that there was an RN in the building on that day. They both further stated that two staff members had switched their days without reporting that they were doing so. The switch left the facility without RN coverage on that day. A copy of the facility policy." "Staffing and Scheduling Policy" documented in part "The facility shall have the services of a Registered Nurse available 8 consecutive hours a day, 7 days a week"  F 514  STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603  STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603  STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY INCHESTER, VA 22603  F 354  F 354  F 354  F 354  F 354  F 354 CRITERION II  Measure or system change to practice will not recur Education began 3-29-17 an applicable nursing team men regulation F354. The necess per 24-hours will be emphasi schedule revisions from the or such days to the facility plans to mon make sure that solutions are Director of Nursing or design 'as worked' schedule monthly compliance and report any monthly Quality Assurance P Improvement (QAPI) Commit  F 354 CRITERION II  Measure or system change to practice will not re

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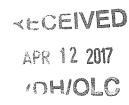
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		[ ' '	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
495415 B. WING			02/20/2047		
NAME OF PROVIDER OR SUPPLIER  THE VILLAGE AT ORCHARD RIDGE			STREET ADDRESS, CITY, STATE, ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603	03/29/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 514	standards and prac	ge 6 with accepted professional tices, the facility must cords on each resident that	F 5 <sup>-</sup>	14	
	(i) Complete;				
	(ii) Accurately docur	mented;			
	(iii) Readily accessit	ole; and			
	<ul><li>(iv) Systematically organized</li><li>(5) The medical record must contain-</li></ul>				
	(i) Sufficient informa	tion to identify the resident;			
	(ii) A record of the re	esident's assessments;			
	(iii) The comprehensive plan of care and services provided;				
	(iv) The results of ar and resident review determinations cond	* * *			
	(v) Physician's, nurs professional's progre	e's, and other licensed ess notes; and			
	services reports as r This REQUIREMEN by: Based on staff inter- and clinical record re the facility staff failed	ology and other diagnostic equired under §483.50.  T is not met as evidenced view, facility document review eview, it was determined that it to maintain a complete and one of eight residents in the dent #1.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
	495415	B. WING		03/29/2017
NAME OF PROVIDER OR SUPPL	IER		STREET ADDRESS, CITY, STATE, ZIP CODE	
THE VILLAGE AT ORCHARD RIDGE			100 PROCESSION WAY WINCHESTER, VA 22603	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
N. Oliver			F514 CRITERION I	

F 514

### F 514 Continued From page 7

The facility staff had filed another resident's psychiatric report in Resident #1's clinical record.

The findings include;

Resident #1 was admitted to the facility on 7/1/14 with a readmission on 9/8/15 with diagnoses that included, but were not limited to, atrial fibrillation (an irregular heart beat), dementia, depression and heart failure.

A review of Resident #1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/14/17 revealed, in part, that Resident #1 was coded as an eight out of a possible score of 15, indicating that Resident #1 was moderately cognitively impaired in daily decision making.

A review of Resident #1's clinical record revealed another resident's psychiatric consult report dated 3/20/17 filed in Resident #1's paper chart.

On 3/29/17 at 9:08 a.m. an interview was conducted with RN (registered nurse) #2, the floor nurse. RN #2 was asked whether or not the psychiatric consult dated 3/20/17 with another residents name belonged in Resident #1's clinical record. RN #2 stated that the psychiatric consult did not belong in Resident #1's record. RN #2 further stated, "We have one person that files so that misfiling does not occur, this was just an error."

On 3/29/17 at 9:30 a.m. ASM (administrative staff member) #2, the director of nursing, was made aware of the incorrect filing on another residents psychiatric consult in Resident #1's clinical record.

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

The named report was removed immediately (3-29-17) and placed in the correct medical record.

### F514 CRITERION II

How facility will identify other residents having the potential to be affected by the same deficient practice. An audit of all resident charts was completed immediately (3-29-17) to ensure no other documents were misfiled. Any applicable changes were addressed if needed.

#### F514 CRITERION III

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

a)Educate nursing team members that the Administrative Support Clerk is the person to file documents in resident medical records. b)Administrative Support Clerk implementing new process for filing.

### F514 CRITERION IV

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

Administrative Support Clerk will audit 10% of all medical records monthly to ensure compliance; Director of Nursing or designee will report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

### F514CRITERION V

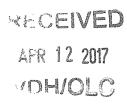
All corrective actions complete by 5-1-17.

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Event ID: 9M4K11

Facility ID: VA0408

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/04/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  A SULL DING  NAME OF PROVIDER OR SUPPLIER  THE VILLAGE AT ORCHARD RIDGE   SUMMO  SUMMO  SUMMO  STREET ADDRESS. CITY. STATE ZIP CODE 100 PROCESSION WAY WINCHESTER, VA 22603  [ZA4] ID PRETIX RESULATORY OR LSC SENTIFYING INFORMATION]  FREETY RESULATORY OR LSC SENTIFYING INFORMATION  FACTOR OR SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION SHOULD BE CREATED SHOULD SH	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
NAME OF PROVIDER OR SUPPLIER  THE VILLAGE AT ORCHARD RIDGE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514 Continued From page 8  A review of the facility policy titled "Medical Records Policy" revealed, in part, the following documentation; "(Name of facility) shall maintain an organized Medical Record on all residents according to recognized professional practices and federal and state regulations."  A meeting was conducted on 3/29/17 at 10:30 a.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. The administrative staff was made aware of the above concern.  No further information was provided prior to the				1			(X3) DA	ATE SURVEY
THE VILLAGE AT ORCHARD RIDGE  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY)  F 514 Continued From page 8  A review of the facility policy titled "Medical Records Policy" revealed, in part, the following documentation; "(Name of facility) shall maintain an organized Medical Record on all residents according to recognized professional practices and federal and state regulations."  A meeting was conducted on 3/29/17 at 10:30 a.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. The administrative staff was made aware of the above concern.  No further information was provided prior to the			495415	B. WING	∍		0:	3/29/2017
WINCHESTER, VA 22603  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514 Continued From page 8  A review of the facility policy titled "Medical Records Policy" revealed, in part, the following documentation; "(Name of facility) shall maintain an organized Medical Record on all residents according to recognized professional practices and federal and state regulations."  A meeting was conducted on 3/29/17 at 10:30 a.m. with ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing. The administrative staff was made aware of the above concern.  No further information was provided prior to the	NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE. ZIP CODE		0/20/20 : 1
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9M4K11

Facility ID: VA0408

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