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 _____	03/29/2017

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	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 3/28/17 through 3/29/17. 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 nine at the time of the survey. The survey sample consisted of four current resident reviews (Residents #1 through #4) and four closed record reviews (Residents # 5 through # 8).

F 278 SS=D 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED — F 278

(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.

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

(i) Certification
(1) A registered nurse must sign and certify that the assessment is completed.

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

(j) Penalty for Falsification
(1) Under Medicare and Medicaid, an individual who willfully and knowingly-

(i) Certifies a material and false statement in a

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR/ED — (X6) DATE: 4-11-17

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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F 278	Continued From page 1	F 278		

resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
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 maintain an accurate MDS (minimum data set) assessment for one of eight residents in the survey sample, Resident # 2.

The facility staff failed to accurately code Resident # 2's weight on a significant change MDS assessment with an ARD (assessment reference date) of 12/8/16.

The findings include:

Resident # 2 was admitted to the facility on 8/4/16 with diagnoses that included but were not limited to Parkinson's disease, Dementia, hypertension, cancer of the prostrate, muscle weakness, and constipation. Resident # 2's most recent MDS, a quarterly assessment with an ARD of 3/10/17 coded Resident # 2 as usually understood by others and usually able to understand others. Resident # 2 was coded as scoring an 8 out of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was cognitively impaired. This MDS

F278 CRITERIDN I
How corrective action will be accomplished for those residents found to have been affected by the deficient practice
Resident #2's MDS section K was corrected immediately and transmitted accurately on 3-29-17.

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F 278	Continued From page 2	F 278		

assessment was compared to the previous MDS assessment, a significant change assessment with an ARD of 12/8/16. Review of this MDS (significant change) assessment revealed documentation at Section K "Swallowing / Nutritional Status," in section K0200 B Weight, the resident's weight was coded as a dash. [B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)]

Review of the clinical record revealed documentation of weights being assessed for Resident # 2 that could have been used on the significant change assessment with the ARD of 12/8/16. Resident # 2 was weighed on 12/3/16 and his weight was 135.6 pounds.

A physician order was written on 10/1/16 "Weigh every month on the 1st" this order was discontinued on 12/13/16 by the physician (*note this date is after the ARD of the significant change MDS assessment with an ARD (assessment reference date) of 12/8/16).

During an interview on 3/29/17 at 10:00 a.m., with LPN (licensed practical nurse) # 1, the MDS coordinator, regarding the dash that was entered for Resident # 2's weight, LPN # 1 stated that it was her practice to never code a dash. LPN # 1 further stated that she was not responsible for coding that section and referred the question to (name of the registered dietician). At this time LPN # 1 was asked what reference she used to complete the MDS assessments. LPN #1 stated she used the RAI (resident assessment instrument) manual.

F278 CRITERION II
How facility will identify other residents having the potential to be affected by the same deficient practice
An MDS audit of section K was completed immediately (3-29-17) of residents by the dietician. Any applicable revisions were addressed if needed.

F278 CRITERION III
Measure or system change to ensure the deficient practice will not recur
New process implemented whereby MDS QAPI Manager will verify and ensure completion of section K of the MDS prior to submission.

F278 CRITERION IV
How the facility plans to monitor its performance to make sure that solutions are sustained
Dietician will audit 10% of MDS section K monthly to ensure accuracy and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee.

F278 CRITERION V
All corrective actions complete by 4-28-17.

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F 278	Continued From page 3	F 278		

During an interview on 3/29/17 at 10:20 a.m. with OSM (other staff member) # 1, the registered dietician, the coding of the dash for the weight on Resident # 2's significant change assessment with the ARD of 12/8/16 was discussed. OSM # 1 stated that the resident went on hospice on 12/8/16 and as she understood the hospice policy anyone on hospice was not to be weighed. OSM # 1 further stated that the physician gave an order on 12/13/16 to discontinue the resident's weights. OSM # 1 continued to say that because of the resident being admitted to hospice on 12/8/16 and the physician order of 12/13/16 she decided to go with the dash.

On 3/29/17 at 10:30 a.m., ASM (administrative staff member) #1, the administrator, and ASM # 2, the director of nurses, were made aware of the above concern.

The CMS (Centers for Medicare and Medicaid Services) RAI manual documented the following:

Steps for Assessment for K0200B, Weight
1. Base weight on the most recent measure in the last 30 days.
2. Measure weight consistently over time in accordance with facility policy and procedure, which should reflect current standards of practice (shoes off, etc.).
3. For subsequent assessments, check the medical record and enter the weight taken within 30 days of the ARD of this assessment.
4. If the last recorded weight was taken more than 30 days prior to the ARD of this assessment or previous weight is not available, weigh the resident again.
5. If the resident's weight was taken more than

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F 278	Continued From page 4 once during the preceding month, record the most recent weight. Coding Instructions for K0200B, Weight * Use mathematical rounding (i.e., If weight is X.5 pounds [lbs] or more, round weight upward to the nearest whole pound. If weight is X.1 to X.4 lbs, round down to the nearest whole pound). For example, a weight of 152.5 lbs would be rounded to 153 lbs and a weight of 152.4 lbs would be rounded to 152 lbs. *If a resident cannot be weighed, for example because of extreme pain, immobility, or risk of pathological fractures, use the standard no-information code (-) and document rationale on the resident's medical record. No further information was presented prior to exit.	F 278		
F 354 SS=D	483.35(b)(1)-(3) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON (1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. (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	F 354	**F354 CRITERION I** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice** An audit of the current day's schedule was completed immediately (3-29-17) to ensure no deficient practice would occur.	

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F 354	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 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.	F 354	**F354 CRITERION II** **How facility will identify other residents having the potential to be affected by the same deficient practice** An audit of the entire current month's schedule was completed immediately (3-29-17) to ensure no other deficient practices were scheduled. **F354 CRITERION III** **Measure or system change to ensure the deficient practice will not recur** Education began 3-29-17 and will continue for all applicable nursing team members regarding regulation F354. The necessity for RN coverage per 24-hours will be emphasized when staff make schedule revisions from the original schedule. **F354 CRITERION IV** **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' schedule monthly to ensure compliance and report any actionable trends to the monthly Quality Assurance Performance Improvement (QAPI) Committee. **F354 CRITERION V** All corrective actions complete by 5-1-17.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records.	F 514		

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F 514	Continued From page 6	F 514		

(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-

(i) Complete;

(ii) Accurately documented;

(iii) Readily accessible; and

(iv) Systematically organized

(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
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 maintain a complete and accurate record for one of eight residents in the survey sample, Resident #1.

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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.	F 514	**F514 CRITERION I** **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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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 end of the survey process.