PRINTED: 03/08/2016 FORM APPROVED OMB NO. 0938-0391

·		- WILDIONID OLIVIOLO			ONB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495185	B. WING	·	02/25/2016
	PROVIDER OR SUPPLIER  LY HEALTH AND REH	ABILITATION CENTER	456	REET ADDRESS, CITY, STATE, ZIP CO S E MAIN ST AVERLY, VA 23890	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 000	INITIAL COMMENT	rs	F 000	F314	4-8-16
	survey was conduct and 2/26/16. Corre compliance with 42 Term Care requirent survey/report will for investigated during. The census in this 1 106 at the time of the consisted of 19 cur (Residents #1 throus (Residents #1	120 certified bed facility was be survey. The survey sample rent Resident reviews gh #19) and 5 closed record #20 through #24). ENT/SVCS TO RESSURE SORES  Tehensive assessment of a must ensure that a resident ty without pressure sores essure sores unless the ondition demonstrates that ole; and a resident having ives necessary treatment and healing, prevent infection and	F 314  VDH/OLC	admission at determine the treatment of wound.  Obtaining treatments of the upon admission. The Unit Manager of monitor the assessment order for residents accorder for residents accorder to the fact wounds are identified are obtained, and treatmented as order will be referred to the	re reviewed on dentify the need insure that a place, and to ment is inpleted as ordered.  educated on:  of residents upon indireadmission to the need for inders to any eatment orders sion or readmission.  If designee will ent and treatment dimitted or illity to ensure that it, treatment orders atments are ed. Issues noted equality
	facility staff failed for of 24 residents in the obtain physician order	one resident (Resident #3) e survey sample, to assess, ers and treat a left heel ulcer.  the facility on 2/5/16, the	Ö 🕏	Assessment Committee recommendation.  Completion date: 4/8	

Any deficiency statement ending with an asterick (\*) deribtes 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.

LABORATORY DIRECTOR'S OF PROVIDER SUPPLIER DE

RESENTATIVE'S SIGNATURE

X6) DATE

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	STATEMENT OF OFFICIENCE	T WEDICAID SERVICES			OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
-		495185	B. WING	S		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/25/2016	
-	WAVERLY HEALTH AND REHA			456 E MAIN ST WAVERLY, VA 23890		
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	F 314 Continued From page	ne 1	_		1600 2	

#### Continued From page 1

facility staff did not assess Resident #3's left heel ulcer until 2/8/16 and failed to obtain and initiate treatment orders until 2/9/16.

The findings included:

Resident #3 was originally admitted to the facility on 8/26/15 with the diagnoses of, but not limited to, End Stage Renal Disease (ESRD) with hemodialysis, diabetes mellitus type 2, chronic stage III pressure ulcer, methicillin resistant staphylococcus aureus infection (MRSA), hypertension and congestive heart failure (CHF). Resident #3 had 5 hospitalizations due to changes in condition since admission; the most recent readmission was 2/20/16.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/21/15. A significant change MDS was in progress at the time of survey. The MDS coded Resident #3 with no cognitive impairment, required limited assistance from staff for bed mobility, transfers and toileting; required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3 was coded as independent with eating. The MDS coded Resident #3 with 1 stage 3 pressure ulcer and 1 unstageable pressure ulcer.

On 2/24/16 at 8:25 a.m., Resident #3 was observed lying across his bed with his eyes closed. His left leg was dangling off the bed. Resident #3 was wearing a thin white sock on his left foot with a visible dressing covering his heel. There was no drainage observed through the dressing or sock. Resident #3 had a right leg amputation.

F 314

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

Event ID: F8V611

Facility ID: VA0264

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTA. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 02/20/2010
WAVERL	Y HEALTH AND REH	ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	
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F 314	Continued From pa	ge 2	F 31	4	4.8.16

On 2/24/16 at 8:40 a.m., Resident #3's clinical record was reviewed. The review revealed a physician's order dated 2/9/16 which read: "Medihoney Wound/Burn Dressing Gel (Wound Dressings) Apply to Left heel topically in the evening...LEFT HEEL-CLEANSE WITH NS (normal saline), APPLY NO STING SKIN PREP TO PERI WOUND APPLY MEDIHONEY TO WOUND, COVER WITH GAUZE, AND WRAP IN KERILEX-Order date-02/09/2016..." Further review of the clinical record revealed Resident #3 was hospitalized on 1/15/16 due to fever, trembling, low blood pressure (90/60) and slow to respond. He had MRSA of bilateral heel wounds prior to discharge. Resident #3 was readmitted on 2/5/16 with a right leg below the knee amputation (BKA). There were no treatment or monitoring orders for his right stump (BKA). Prior to hospitalization on 1/15/16, the same treatment for his left heel wound care, as ordered above, was in effect and documented as being performed. Documentation revealed Resident #3 was originally admitted to the facility with a Stage III pressure ulcer on his left heel.

Review of the February 2016 Medication Administration Record (MAR) included the left heel treatment order and nurses initials which indicated the treatment was completed from 2/9/16 through 2/14/16 and 2/20/16 through 2/23/16 at 1800 (6:00 p.m.). There was no treatment order or documentation in the clinical record to reveal that wound care to the left heel was performed from readmission on 2/5/16 until 2/9/16.

Review of Nursing Progress Notes revealed the following documentation:

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	F 314 Continued From page	ge 3	F 3′	14		4-8-16

2/5/16 at 22:31 (10:31 p.m.) included:"...recent right BKA (below the knee amputation). Dressing to RBKA and left heel, unable to do complete skin assessment this shift...."

2/6/16 21:38 (9:38 p.m.) included: "...Dressing to rt. bka is dry and intact. Dressing to lt. foot dry and intact..."

2/7/16 04:54 (4:54 a.m.) included: "...dressing dry and intact to right BKA. dressing intact to left foot..."

2/7/16 16:26 (4:26 p.m.) included: "...staples intact to R bka, no drainage or s/s (signs/symptoms) of infection noted from area..." 2/7/16 17:25 (5:25 p.m.) "...Dressing to rt. bka is dry and intact. Dressing to lt. foot dry and intact..." 2/8/16 03:53 (3:53 a.m.) "...dressing dry and intact to right bka. and dressing dry and intact to left foot..."

A "Re-Admission History and Physical" performed by Resident #3's Medical Doctor dated 2/7/16 included "...Dressing; right BKA: Clean/dry. Has dry dressing, left heel..." The hospital discharge instructions did not include orders for wound care for either wound site.

The "Wound Record (Revised)" dated 2/8/16 listed the left heel wound was present on admission, and was a Stage III pressure ulcer. The current treatment plan read: "Cleanse with NS, apply medihoney, wrap with gauze daily."

Guidance given from the National Pressure Ulcer Advisory Panel (npaup.org) described a Stage III pressure ulcer as follows:

"Category/Stage III: Full thickness skin loss Full thickness tissue loss. Subcutaneous fat may

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	495185	B. WING			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/25/2016	
WAVERLY HEALTH AND REHA		4	156 E MAIN ST VAVERLY, VA 23890	-	
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exposed. Slough ma obscure the depth of undermining and tun Category/Stage III pranatomical location. occiput and malleolus subcutaneous tissue ulcers can be shallow significant adiposity of Category/Stage III prois not visible or direct On 2/26/16 at 1:40 p. (Admin-A) was informed delay to assess, obtain #3's left heel ulcer and monitor his right stum Review of Resident #3 following:  "Focus *Skin impairment stump Created on: 11/27/20 Revision on: 02/06/20  Goal *Resident will has skin impairment throug Created on: 11/27/20 Revision on: 02/06/16 Target Date: 04/06/20  Interventions/Tasks (up *Contact isolation as o	endon or muscle are not by be present but does not tissue loss. May include neling. The depth of a sessure ulcer varies by The bridge of the nose, ear, and Category/Stage III or contrast, areas of an develop extremely deep essure ulcers. Bone/tendon by palpable."  m., the Administrator and treat Resident dono orders to treat or princision site.  B's care plan included the ent: left heel and right  15  16  16  16  16  16  17  18  19  19  10  10  11  11  11  12  13  14  15  16  16  16  17  18  18  19  19  19  10  10  11  11  12  13  14  15  16  16  16  17  18  18  19  19  19  10  10  10  11  11  12  13  14  15  16  16  16  17  18  18  19  19  19  19  19  19  19  19	F 314		4-8-16	

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When the lack of treatment orders for Resident

Event ID: F8V611

Facility ID: VA0264

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION (DENTIFICATION NUMBER)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>i</b>	PLE CONSTRUCTION	(X3) DATE SURVEY
		DETTILIOATION NOWIDER.	A. BUILDING		COMPLETED
		495185	B. WING		02/25/2016
	F PROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 456 E MAIN ST WAVERLY, VA 23890	1 02/23/2010
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F 314	Admin-B stated she p.m., Admin-B state 2/9/16 like you did" to documented it wasn	/5/16-2/9/16 was discussed, would check into it. At 2:25 d "I didn't see an order until then stated "If it's not 't done." The Corporate as informed of the findings on	F 314		4-8-16
	Resident #3's left he Licensed Practical N removed the dressin which exposed a gar approximately 2 cent yellow red drainage. dark red/maroon in c cm x 0.5 cm of yellow the wound. The surro	o.m. an observation of sel ulcer was conducted with lurse-A (LPN-A). LPN-A g on Resident #3's heel uze-like dressing with timeters (cm) by 2 cm of The ulcer was clean and color with approximately 0.5 or slough in the 11:00 area of bunding skin was intact with There was no odor present. opain or discomfort.			
	No further information staff.	n was provided by the facility			
F 323 SS=D	Complaint Deficiency 483.25(h) FREE OF A HAZARDS/SUPERVI	ACCIDENT	F 323		
	as is possible; and ea	as free of accident hazards			
	This REQUIREMENT	is not met as evidenced			

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		495185	B. WING			
NAME OF PROVIDER	OR SUPPLIER		<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE	02/25/2016
		ABILITATION CENTER		456 E	E MAIN ST /ERLY, VA 23890	
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F 323 Continue by:			F 32	23	F323	4-8.16
documer the facilit	itation revie y staff faile	ion, staff interview, facility ew and clinical record review, d for 1 resident (Resident #4) of 24 residents to provide			Resident #4 has had no f November 4, 2015.	all since
adequate	supervisio	n.			Current residents were re ensure that those needin	g a two person
by one Ci Resident	ertified Nur #4 was car	of bed while being changed sing Assistant (CNA). The planned to need assistance activity of daily living care.			assist for bed mobility or identified and are receiving appropriate level of super	transfers are
	gs include				Certified Nursing Assistan staff will be educated on:	ts and licensed
facility on	4/19/06. H	ar old, was admitted to the ler diagnoses included depression and kidney			<ul> <li>Provision of two for bed mobility a for residents with</li> </ul>	and transfers i identified
(MDS) ass with an as 1/15/16. S Status sco	sessment was sessment rand a Each of 7 indi	ecent Minimum Data Set vas an annual assessment eference date (ARD) of Brief Interview of Mental cating severe cognitive uired extensive assistance			need of two pers Reporting change requiring increas assistance to Cha and/or Unit Mana	in condition ed need for rge Nurse
with her ac	tivities of d	aily living.			The Unit Manager or desig monitor provision of two p	nee will erson
observed ly mats were	ving in bed.	m., Resident #4 was The bed alarm and fall			assistance on a random we through observation and re documentation. Issues not	eekly basis eview of
Included wa 4/13/15 23: "Situation:	as a note ti 29 (11:29 p CNA (Certi	notes were reviewed. tle "Incident Note" dated o.m.). The note read fied Nursing Assistant) was			referred to the Quality Assi Committee for review and recommendation.	Jrance
cnanging re	sident. Re	esident's legs fell off the off the edge of bed on to			Completion date: 4/8/16	

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the floor. CNA stated "Resident landed on her knees." "Resident has a 0.2 x 0.2 skin tear on her

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NAME OF	PROVIDER OR SUPPLIER	495185	B WING			03/25/2040
WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 456 E MAIN ST WAVERLY, VA 23890	DE	02/25/2016	
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	Resident denies pair Bilateral legs contract No bruising noted at of motion within norreparty) in room on othe assisted back to bed of daily living) care x quietly in bed at this MD (doctor) aware. Nursing) aware. On Recommendations while in bed. Call for The facility staff was had been completed Facility staff provided dated 4/13/15 9:00 p. section of the form reresident attempting to CNA was changing reform read "4. Problem form read "4. Problem section 4, the following Unsteady gait/ poor bacerson assist?".  On 2/26/16 at 10:50 a. Nursing (ADM B) was care staff were expected sessistance. ADM B stagequired a two person.	o left little toe 0.1 x 0.1. In or discomfort noted. In or discomfort noted. It is time. ROM WNL (range mal limits). RP (responsible her side of curtain. Resident and completed adl (activity 3 staff. Resident resting time, call bell within reach. RP aware. DON (Director of call supervisor aware. In 2 person assist with adls assistance."  asked if a fall investigation for Resident #4's fall. In a "Post Fall Assessment" and "2. What was the loat the time of the fall? sident and resident slid out not Status" section of the las with Mobility". Under g were checked: "4a. In alance?" and "4c. Two  m., the Acting Director of asked during what types of led to provide 2 person.	F 3.	23		4-8-16

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On 2/26/16 at 11:00 a.m., Certified Nursing Assistant B (CNA B) was asked when working with a resident who needed a two person assist, which types of care would require a second person. CNA B stated that two staff should be

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Facility ID: VA0264

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STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Tana		<u>OMB NO. 0938-039</u>
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495185	B. WING		00/05/0040
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 456 E MAIN ST WAVERLY, VA 23890	02/25/2016
(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	LIDBE COMPLETION
F 32	CNA A was the staff Resident #4 during the statement dated 4/1 rounds of (resident resident resident frounds of (resident resident frounds of (resident resident frounds of (resident resident frounds of (resident frounds of (resident frounds frounds frounds of (resident frounds	all activities of daily living for a two person assist.  I that had been working with the incident. CNA A's 3/15 read, "I was doing name). Turned her over, she landed on her knee, y her arms."  I MDS with an ARD of 2/6/15 fon G (A) "Bed Mobility" was ependence on staff with at hysical assist).  Ilan was reviewed. A "focus" The resident has an ADL e deficit r/t (related to) of motion), Activity ure." The "Interventions" Routine: The resident "Transfer: The resident	F 32	23	4-8-16
F 332 SS=E	RATES OF 5% OR M		F 332		
		of five percent or greater.			
	by:	is not met as evidenced , staff interview, Resident			
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NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS. CITY, STATE, ZIP CODE	02/25/2016
WAVER	LY HEALTH AND REH.			456	SE MAIN ST AVERLY, VA 23890	-
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	complaint investigate ensure Three Resider #15,#16, & #3) were rate of less than 5% error rate was 17% opportunities, in a surfacility staff failed to Lactulose, and Aspir 2. For Resident #16, Medication pour and facility staff failed to Lactulose, and Aspir 2. For Resident #16, Medication pour and facility staff failed to a Timolol eye drops.  3. For Resident #3, oppour and pass obserfailed to administer a Hydrocortisone supportable to administer a H	cord review, facility ew, and in the course of a ion, the facility staff failed to ent's medications, (Residents administered with an error . The facility's medication with 5 errors out of 29 urvey sample of 24 residents.  on 2-24-16 during pass observations, the administer physician ordered in.  on 2-24-16 during pass observations, the administer physician ordered administer physician ordered balance of the facility staff physician ordered control of the general control control of the gener	F	332	Resident #15 is receiving Aspirin as ordered. Resireceiving Timolol eye dr. The Hydrocortisone supp Fluticosone nasal spray of discontinued for Resident February 26, 2016.  Current residents were resure that ordered medadministered as ordered.  Licensed staff will be edu  Medication administration  Medication administration  Medication administration  Offering of medication frequents or refusal  Physician notification is not ordered  The Unit Manager or design complete random weekly of medication administration. Issues no referred to the Quality Ass Committee for review and	ident #16 is ops as ordered. pository and were int #3 on  eviewed to dications are . cated on: inistration of medication  cation which itly refuses of medication  etion if it given as  gnee will observations ion and ited will be curance
 	Resident #15's most re MDS) was a quarterly	ecent Minimum Data Set assessment with an			recommendation.	

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Assessment Reference Date (ARD) of 12-16-15.

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Facility ID: VA0264

Completion date: 4/8/16

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STATEMENT (	OF DECICIENCIES				OMRIA	IO. 0938-039
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		IDENTIFICATION NOINBER:	A. BUILI	DING		OMPLETED
		495185	B. WING			
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS SITE OF THE	0	2/25/2016
				STREET ADDRESS, CITY, STATE, ZIP CODE		
WAVERLY HEALTH AND REHABILITATION CENTER				456 E MAIN ST		
				WAVERLY, VA 23890		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES				
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			17.0	CROSS-REFERENCED TO THE APPRI DEFICIENCY)	SPRIATE	DATE
F 332 C	Continued From no	ac 10				11 G W

### Continued From page 10

The MDS coded Resident #16 with no cognitive impairment. The Resident required extensive assistance from staff for bed mobility, transfers. toileting, dressing, hygiene and bathing. Resident #15 was also coded as independent with eating, and always incontinent of bowel and bladder.

On 2-24-16 at 9:00 a.m. Resident #15 was briefly interviewed during Medication administration, and was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident was fully interviewed on 2-26-16 at 9:30 a.m.

Resident #15 was observed on 2-24-16 at 9:00 a.m. during the medication pour and pass observation receiving medications. Licensed Practical Nurse (LPN) B, reviewed the MAR (medication administration record) for Resident #15. LPN B removed the 30 day, multiple dose blister packages, containing medications from the medication cart drawer. During the medication preparations one pill was dropped on the top of the medication cart. LPN B picked up the medication with a spoon, and placed it back into the cup with the other 10 pills and administered all of them to Resident #15. LPN B pushed the following 11 pill oral medications into the medication cup, and 1 liquid oral preparation, in water in a separate cup.

- 1 .Lisinopril 5 mg (milligrams) one tablet. To be given at 8:00 a.m.
- 2. Lasix 40 mg one tablet. To be given at 8:00
- 3. Glimeperide 1 mg one tablet. To be given at 8:00 a.m.
- 4. Metformin 850 mg one tablet. To be given at 8:00 a.m.

F 332

4-8-16

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

Event ID: F8V611

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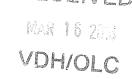
PRINTED: 03/08/2016 FORM APPROVED OMB NO 0938-0391

CENTERS FOR N	/IEDICARE	& MEDICAID SERVICES					RM APPROVE
STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) D	IO. 0938-039 PATE SURVEY OMPLETED
		495185	B. WING				10/05/0046
NAME OF PROVIDER O		ABILITATION CENTER	1	456	REET ADDRESS, CITY, STATE, ZIP CODE  E MAIN ST  VERLY, VA 23890	<u> </u>	2/25/2016
PREFIX (EACH	I DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE
8:00 a.m. 6. Topirar 8:00 a.m. 7. Escitale 8:00 a.m. 8. Gabape at 8:00 a.r. 9. Pramip at 8:00 a.r. 10. Choles at 8:00 a.m. 12. Potass one powde To be give 13. Multivit a.m.	nate 200 m opram 10 r opram 10 n opram 10 n on. exole 0.25 on. stipol 1 gra on. lifate 325 r sium Chlori or packet n on at 8:00 a camin one	ing one tablet. To be given at any one tablet. To be given at any one tablet. To be given at any one tablets. To be given at any one tablets. To be given at any one tablet. To be given at any one tablets. To be given at any one tablet. To be given at any one tablet. To be given at any one tablet any one tablet. To be given at any one tablet any one	F 3	32			4.8.16
taking the r	medication	s. Resident #15 accepted he medications without					
observation were reviev orders reve were ordere additional m	ns, Resider ved and re aled that a ed by the p nedications They are a						
1. Aspirin 3	25 mg one	tablet. To be given at 8:00					

ml. To be given at 8:00 a.m.

2. Lactulose 10 grams per (ml) milliliter, give 45

a.m.



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STATEMENT	OF DEFICIENCIES	THE SECTION OF THE SE			OMB NO. 0938-039
AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495185	B. WING		00/05/05 15
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/25/2016
WAVERLY	HEALTH AND REHA	ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	IDBE COMPLETION
F 332 (	Continued From pag	ge 12	F 33	32	4-8-16

On 2-24-16 at 10:00 a.m. a copy of Resident #15's Medication Administration Record (MAR) was requested, along with the MAR's for two other Residents involved in the medication pour and pass observation errors. At 12:00 noon all 3 MAR's were received from the Director of Nursing (DON). The documents revealed that the two medications omitted for Resident #15 during medication pour and pass observation were signed by the nurse as given.

LPN B was interviewed on 2-24-16 at 12:15 p.m., and told of the medication errors. She stated she was aware of the mistakes and had documented on the MAR in error for the omitted medications, and would fix the document. None of the omitted medications had been given at this hour.

On 2-24-16, Resident #15's care plan was reviewed. The Resident's care plan stated administer medications as ordered.

The facility policy was reviewed and stated all medications would be administered as ordered by the physician.

When the Director of Nursing (DON) was asked what specific source of text is used to model their medication administration and nursing practice by, she stated "We use Potter and Perry." Guidance was provided for appropriate documentation of physician's orders in 'Fundamentals of Nursing 7th Edition, Potter-Perry, p. 707, "A medication order is required for every medication you administer to a client...Regardless of how you receive an order, compare the prescriber's written orders with the medication administration record (MAR) when the medication is initially ordered. Once you

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Facility ID: VA0264

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MAR 16 2016

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CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPE	
STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
		495185	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	02/25/2016 E	
WAVER	LY HEALTH AND REHA	ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OUID BE COMPLETION	4
F 332	2 Continued From page 13 determine that information on the client's MAR is accurate, use the MAR to prepare and administer medications."  An interview was conducted with the Director of Nursing, (DON), and the administrator, at the end of day debrief on 2-24-16 at 3:30 p.m., and on 2-26-16 at 3:00 p.m All in attendance were made aware of the findings. The DON stated that LPN B had been re-educated by the Registered Nurse Staff Development Coordinator, and an inservice on Medication administration had been conducted on 2-25-16. The sign in sheet for the education and inservice information was provided as credible evidence by the Registered Nurse Staff Development Coordinator. No further		F 332		4-8.16	
! ? !	facility staff failed to a Timolol eye drops. Resident #16 was was 9-11-14 with diagnose Diabetes Mellitus, Hyp	cass observations, the dminister physician ordered				

and Below the Knee Amputation.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/2/15. Resident # 16 was coded with a brief interview for mental status

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CEIVI	ERS FOR MEDICARI	E & MEDICAID SERVICES			FORM APPROVI
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		495185	B. WING		
ŀ	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS. CITY. STATE ZIP CO 456 E MAIN ST WAVERLY, VA 23890	DE 02/25/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE CONSTRUCT
F 332	as independent in a always continent of	nt. Resident # 16 was coded ctivities of daily living; and bowel and bladder.	F 33	2	4-8-16
	was found to be talk oriented to person,	a.m. Resident #16 was briefly Medication administration, and cative, appropriate, and place, time, and situation.  July interviewed on 2-26-16 by			
	a.m. during the med observation receiving Practical Nurse (LPN (medication administration administration action) and the blister packages, cormedication cart draw	pserved on 2-24-16 at 9:15 ication pour and pass g medications. Licensed N) B, reviewed the MAR tration record) for Resident d the 30 day, multiple dose ntaining medications from the rer and pushed the following s into the medication cup.			
; ; ;	be given at 9:00 a.m. 2. Finasteride 5 mg of 9:00 a.m. 3. Metoprolol 50 mg of 9:00 a.m. 4. Gabapentin 300 mg of 9:00 a.m. 5. Lisinopril 20 mg on a.m. 6. Januvia 50 mg one a.m. 7. Hydrochlorothiazide given at 9:00 a.m.	(milligrams) one tablet. To one tablet. To be given at one tablet. To be given at g two tablets. To be given at e tablet. To be given at 9:00 tablet. To be given at 9:00 e 25 mg one tablet. To be given at one tablet. To be given at			

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

Event ID: F8V611

Facility ID: VA0264

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MAR 16 200

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CLIVIT	LNS FOR MEDICAR	E & MEDICAID SERVICES			FURM APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495185	B. WING		
WAVERLY HEALTH AND REHABILITATION CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS. CITY, STATE, ZIP COD 456 E MAIN ST WAVERLY, VA 23890	02/25/2016 DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	MILD DE COMPLETION
i i i i i i i i i i i i i i i i i i i	pill administration of LPN B. Resident #' the facility, and insis medications there a assisted the residen Resident #16 accep medications without Immediately followin observations, Reside were reviewed and rorders revealed that were ordered by the additional medication given. The medication Glaucoma. To be given to be given and pass observation MAR's were received (DON). The document of medication pour and passigned by the nurse as the PN B was interviewed and told of the medications aware of the mistales.	d to have 9 tablets total in the up, and this was verified with 16 was in the main hallway of sted on receiving his the medication cart. LPN B to twith taking the medications. The medication orders deficiently.  If the medication pass dent #16's medication orders deconciled. The physicians all of the medications given physician, however, one in was ordered and was not continued is as follows;  In the medication pass dent deconciled in the medication orders deconciled. The physicians all of the medications given physician, however, one in was ordered and was not continued in as follows;  In the medication one of times per day for dental 9:00 a.m.  In a.m. a copy of Resident dental medication pour derrors. At 12:00 noon all 3 from the Director of Nursing that revealed that the eye ded for Resident #16 during that the eye ded for Resident #16 durin	F 332		4-8-16

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

Event ID: F8V611

Facility ID. VA0264

If continuation sheet Page 16 of 40



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FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	495185	B. WING		00/07/02
	ABILITATION CENTER		STREET ADDRESS CITY, STATE, ZIP CO 456 E MAIN ST WAVERLY, VA 23890	02/25/2016 DE
(EACH DEFICIENCY	MUST BE PRECEDED BY EULI	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE COMPLETION
n 2-24-16, Reside viewed. The Resiminister medication efacility policy was edications would be physician. The Director of at specific source edication administration of physician administration of physician administration of physician entation of physician administration is initially ermine the prescrib dication administration is initially ermine that informurate, use the MA dications."  Interview was consing, (DON), and of day debrief on 2-26-16 at 3:00 p.r. de aware of the fin	ant #16's care plan was dent care plan stated ons as ordered.  The as reviewed and stated all be administered as ordered by a state of the state of text is used to model their ration and nursing practice use Potter and Perry."  The ded for appropriate ysician's orders in a sing 7th Edition, "A medication order is redication you administer to a flow you receive an order, per's written orders with the ation record (MAR) when the ordered. Once you retain on the client's MAR is a single to prepare and administer ducted with the Director of the administrator, at the 2-24-16 at 3:30 p.m., and m All in attendance were dings. The DON stated that	F 33		4-8-16
	SUMMARY STA  SUMMARY STA  (EACH DEFICIENCY REGULATORY OR LS  Dentinued From page of 2-24-16, Reside viewed. The Reside viewed.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Dentinued From page 16 In 2-24-16, Resident #16's care plan was viewed. The Resident care plan stated alminister medications as ordered.  The facility policy was reviewed and stated all edications would be administered as ordered by a physician.  Then the Director of Nursing (DON) was asked at specific source of text is used to model their edication administration and nursing practice, she stated "We use Potter and Perry."  Indiance was provided for appropriate cumentation of physician's orders in indiamentals of Nursing 7th Edition, tter-Perry, p. 707, "A medication order is quired for every medication you administer to a entRegardless of how you receive an order, inpare the prescriber's written orders with the dication administration record (MAR) when the dication is initially ordered. Once you ermine that information on the client's MAR is curate, use the MAR to prepare and administer	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI A BUILDI B WING  DVIDER OR SUPPLIER  HEALTH AND REHABILITATION CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  DID PREFIX TAG  TO Intinued From page 16 In 2-24-16, Resident #16's care plan was viewed. The Resident care plan stated alminister medications as ordered.  The facility policy was reviewed and stated all edications would be administered as ordered by a physician.  Then the Director of Nursing (DON) was asked the stated "We use Potter and Perry." Indiance was provided for appropriate cumentation of physician's orders in indamentals of Nursing 7th Edition, tter-Perry, p. 707, "A medication order is juiled for every medication you administer to a entRegardless of how you receive an order, mpare the prescriber's written orders with the dication administration record (MAR) when the dication is initially ordered. Once you ermine that information on the client's MAR is surate, use the MAR to prepare and administer dications."  Interview was conducted with the Director of sing, (DON), and the administrator, at the of day debrief on 2-24-16 at 3:30 p.m., and 2-26-16 at 3:00 p.m All in attendance were de aware of the findings. The DON stated that I B had been re-educated by the Registered se Staff Development Coordinator, and an	A95185   A95185   A95185   A95185   A BUILDING

conducted on 2-25-16. The sign in sheet for the education and inservice information was provided as credible evidence by the Registered Nurse Staff Development Coordinator. No further information was provided by the facility.

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CENTE	KS FOR MEDICAR	E & MEDICAID SERVICES			
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495185	B WING		
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP C	02/25/2016
WAVER		IABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETION
F 332	Continued From pa	age 17	F 33	2	4.8.16
	pour and pass obset failed to administer	on 2-24-16 during Medication ervations, the facility staff a physician ordered pository, and Fluticasone			
	Resident #3 was originally admitted to the facility on 8-26-15. Diagnoses included; End Stage Renal Disease (ESRD) with hemodialysis, diabetes mellitus type 2, chronic ulcer, methicillin resistant staphylococcus aureus infection, hypertension and congestive heart failure (CHF). Resident #3 had 5 hospitalizations since the original admission, with the most recent readmission being 2-20-16.				
   (   S   (   f   C   E	quarterly assessmer Reference Date (AR change MDS was in survey. The MDS coognitive impairment from staff for bed morequired extensive as dressing and hygiene	nimum Data Set (MDS) was a not with an Assessment D) of 12-21-15. A significant progress at the time of orded Resident #3 with no concern, required limited assistance obility, transfers and toileting; assistance from staff for B; was coded as independent			
C ir	On 2-24-16 at 9:25 a nterviewed during Me	.m. Resident #3 was briefly edication administration, and			

surveyor.

was found to be talkative, appropriate, and oriented to person, place, time, and situation. The Resident was fully interviewed by a second

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CENTERS	OR MEDICARI	& MEDICAID SERVICES			FORM APPROVE
STATEMENT OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495185	B. WING		
NAME OF PROVI	DER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	02/25/2016
WAVERLY HE		ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETE
F 332 Con	tinued From pa	ge 18	F 33	32	4.8.16
a.m. obse Prace (med #3. bliste medi 8 pill 1 An To be 2. Cle 9:00 3. Tai 9:00 a 4. Me 9:00 a 5. Cyc at 9:0 6. Col 9:00 a 7. Imo a.m. 8. Uloi a.m. LPN B pill adr LPN B spouse yellow assiste after of pulse. infectio	during the mederivation receiving tical Nurse (LPI dication administ LPN B removed are packages, contication cart draw oral medication aniodarone 200 regiven at 9:00 appidogrel 75 mg a.m.  Insulosin 0.4 mg a.m.  Itoprolol 50 mg a.m.  Itoprolol 50 mg a.m.  Clobenzaprine 50 a.m.  Clobenzaprine 50 a.m.  Chicine 0.6 mg a.m.	served on 2-24-16 at 9:25 lication pour and pass g medications. Licensed N) B, reviewed the MAR tration record) for Resident the 30 day, multiple dose ntaining medications from the ver and pushed the following s into the medication cup.  Ing (milligrams) one tablet.  I.m.  In one tablet. To be given at gone tablet. To be given at many one tablet. To be given at many one tablet. To be given at 9:00 liber. To be given at 9:00			

observation. That information is included in a FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: F

Event ID: F8V611

Facility ID: VA0264

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WAR 16 286

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CENT	ERS FOR MEDICAR	E & MEDICAID SERVICES				FOF	RM APPROVE
STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) C	O. 0938-039 DATE SURVEY COMPLETED
		495185	B. WING				
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	0	2/25/2016
WAVER		ABILITATION CENTER		45	6 E MAIN ST AVERLY, VA 23890		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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)	) RE	(X5) COMPLETION DATE
	(SOD 2567) report. swallowed all of the Immediately followin observations, Resid were reviewed and orders revealed that were ordered by the additional medication given. The medicat follows;  1. Hydrocortisone Adinsert one supposito 9:00 a.m. 2. Fluticasone Propione spray in each notal medication Administricture and signed by the nurse as medication pour and signed by the nurse as medication to the swall property of the same and signed by the nurse as medications of the swall property of the swall prop	e statement of deficiencies Resident #3 accepted and medications without difficulty.  In the medication pass Sent #3's medication orders reconciled. The physicians it all of the medications given it physician, however, two in were ordered and were not ions that were omitted are as  cetate Suppository 25 mg rry rectally. To be given at ionate 50 mcg (micrograms) iostril. To be given at 9:00  a.m. a copy of Resident #3's ration Record (MAR) was in the MAR's for two other in the medication pour and iors. At 12:00 noon all 3 If from the Director of Nursing ints revealed that both for Resident #3 during pass observation was is refused, however, neither and by the nurse during	F 3:	332			4-8-16
l á	LPN B was interviewe	ed on 2-24-16 at 12:15 p.m., ation errors. She stated that used these two medications,					

so she didn't offer them. The omitted medications had not been given at this hour.

PRINTED: 03/08/2016 FORM APPROVED OMB NO 0938-0391

STATEN	ENT OF DEFICIENCIES	WINDICAID SERVICES				10. 0938-039
AND PL	AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) [	DATE SURVEY COMPLETED
		495185	B. WING			
NAME OF PROVIDER OR SUPPLIER  WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 456 E MAIN ST WAVERLY, VA 23890	02/25/2016 DE		
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	-IOULD BE	(X5) COMPLETION DATE
F 431	The facility policy was medications would be the physician. When the Director of what specific source medication administre by, she stated "We An interview was con Nursing, (DON), and end of day debrief on on 2-26-16 at 3:00 p. made aware of the fir 2-26-16, that LPN B is Registered Nurse State day before (2-25-Medication administrate 2-25-16. The sign in sinservice information evidence by the Regist Development Coordin was provided by the fat 483.60(b), (d), (e) DRI	ant #3's care plan was dent care plan stated ons as ordered.  Its reviewed and stated all the administered as ordered by a final Nursing (DON) was asked of text is used to model their reation and nursing practice use Potter and Perry."  Inducted with the Director of the administrator, at the administrator, at the 2-24-16 at 3:30 p.m., and m All in attendance were addings. The DON stated on the provided and inservice on the administrator, and the provided and the provided on the steer of the education and was provided as credible stered Nurse Staff ator. No further information accility.  JG RECORDS	F 33			4-816
SS=D	of records of receipt ar controlled drugs in suff accurate reconciliation records are in order an	Dy or obtain the services of who establishes a system				

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Event ID: F8V611

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CENTI	ERS FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROVE
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495185	B. WING		
NAME OF	PROVIDER OR SUPPLIER		<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP COL	02/25/2016
		ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	JE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OUIDRE CONFIETURE
F 431	professional princip appropriate access	als used in the facility must be not with currently accepted ples, and include the ory and cautionary	F 43	F431  The expired Tubersol and Fremoved from the medicat	4-8-16 Prolixin were
	applicable.	e expiration date when		room on February 24, 2016  Medication storage rooms	i.
	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			were checked to ensure the no expired medications pre	at there were sent.
	permanently affixed controlled drugs listed Comprehensive Dru Control Act of 1976 abuse, except when package drug distrib quantity stored is mit be readily detected.	ovide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can		<ul> <li>Monitoring of expi of medication</li> <li>Removal and destr expired medication</li> <li>The Unit Manager or design monitor the medication stor on a random weekly basis to there are no expired medical present. Issues noted will be the Quality Assurance Comm</li> </ul>	ration dates  uction of  is  ee will rage rooms o ensure that itions e referred to
	by: Based on observatio document review,  fa	r is not met as evidenced in, staff interview, and facility cility staff failed to ensure were not available for use on		review and recommendation  Completion date: 4/8/16	1.
	The findings included	:			
r T	medication room on L The medication refrige	imately 10:00 AM, the Init One was inspected. erator contained a "Tubersol tion". Written on the open			

Facility ID: VA0264



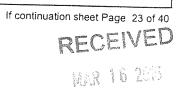
PRINTED: 03/08/2016 FORM APPROVED

STATEME	NT OF DEFICIENCIES	(X1) PROVIDED GUERIES IN	<u> </u>		<u> </u>
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
NAME OF	T DOOMBED OF STREET	495185	B. WING _		02/25/2016
1	F PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 456 E MAIN ST WAVERLY, VA 23890	) 02/25/2016 DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION
F 441 SS=D	refrigerator was a 5 milligrams per millili 1-1-15, which expire survey. The Director innoculation fluid, arkept one month after discarded.  On 2-24-16, the Admof nursing) were noted to further information 483.65 INFECTION SPREAD, LINENS  The facility must estall Infection Control Prosafe, sanitary and control prosafe, sanitary and control for the facility must estall Program under which (1) Investigates, control in the facility; (2) Decides what procase in the facility; (2) Decides what procase in the facility must estall Program under which (1) Investigates, control in the facility; (2) Decides what procase in the facility; (3) Maintains a record actions related to infection determines that a resign determines that a resign of solate the resident. (2) The facility must procase in the facility in the facility in the facility in the facility in	so in the medication milliliter vial of "Prolixin 25 ter" injectable, opened on ed 2-1-15, 12 months prior to or of Nursing stated the nd medication should only be r opening. Both were  ninistrator and DON (director fied of the above findings. on was provided. CONTROL, PREVENT  ablish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion.  Program blish an Infection Control it - rols, and prevents infections edures, such as isolation, in individual resident; and of incidents and corrective ections.  of Infection	F 431	F441  Residents #15 and #3  medications with use of infection control method infection of medications of medications appropriate infection of the control of	of appropriate rods. ications has been at residents are with the use of rontrol methods. ducated on: eplacement of g of precaution olies from orage area ole vital sign Residents al infection cions g items on wet

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

Event ID: F8V611

Facility ID: VA0264





PRINTED: 03/08/2016 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES	(X1) PROVIDED/GURDI IED/OU			NO. 0938-0391	
	AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	FIPLE CONSTRUCTION	(X3) DATE SURVEY	
		DENTI ICATION NOMBER.	A. BUILD	ING	COMPLETED	
			1			
I		495185	B. WING			
Ì	NAME OF PROVIDER OR SUPPLIER		13:11110		02/25/2016	
l	THE THE PARTY OF T			STREET ADDRESS, CITY, STATE, ZIP CODE	CODE	
ı	WAVERLY HEALTH AND REHABILITATION CENTER		1	456 E MAIN ST		
l	= = = = = = = = = = = = = = = = = = = =	ABILITATION CENTER	j	WAVERLY, VA 23890		
ľ	(X4) ID SUMMARY STA	TEMENT OF PETER		**AVERE!, VA 23890		
l	PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	VI	
	TAG REGULATORY OR IS	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD	PE COMPLETION	
		20 (DEITH THIS INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE	
-				DEFICIENCY)		

### F 441 Continued From page 23

from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to perform care and services in a manner to prevent the spread of infection for 2 Residents (Residents #15 and #3) of 24 residents in survey sample.

- 1. For Resident #15, the facility staff failed to maintain effective infection control practices during medication administration; Specifically, the facility staff dropped a pill on top of the medication cart, picked it up and administered it to the Resident.
- 2. For Resident #3, the facility staff failed to maintain effective infection control practices during medication administration; Specifically, the staff did not don isolation precaution garb properly, retrieved a box of gloves from another Resident's room to use in Resident #3's room, wrapped a contaminated stethoscope around her bare neck after use on Resident #3, laid a blood pressure cuff and stethoscope on a wet

F 441

4-8.16

The Unit Manager or designee will complete a random weekly observation of medication administration to ensure that proper infection control practices are followed. Issues noted will be referred to the Quality Assurance Committee for review and recommendation.

Completion date: 4/8/16

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

Event ID: F8V611

Facility ID: VA0264

If continuation sheet Page 24 of 40



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CENTE	ERS FOR MEDICAR	E & MEDICAID SERVICES				FOR	M APPROVEI
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		O. 0938-039 ATE SURVEY
			A. BUILDI	NG		CC	)MPLETED
NAME OF	PROVIDER OR SUPPLIER	495185	B. WING			02	2/25/2016
		ABILITATION CENTER		456 E	ET ADDRESS, CITY, STATE, ZIP CODE MAIN ST ERLY, VA 23890	1 02	-720720 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE)	000	(X5) COMPLETION DATE
F 441	contaminated sink t did not properly disi contaminated device cart, and contamina	ge 24 op while washing her hands, nfect resident equipment, took es to store in the medication ted trash items up the hallway medication cart trash can.	F 44	÷1			4.8.16
	The findings include	d;					i
·	the facility staff dropp medication cart, pick to the Resident.  Resident #15, was in on 8-5-15. Diagnose Diabetes type 2, Oste anxiety, congestive he cholesterol, anemia, p	eomyelitis, depression, eart failure, high polyneuropathy, flux disease (GERD), obesity, edema, and					
( // ir a to #	MDS) was a quarterly Assessment Reference in the MDS coded Residence in the Residence from staff fooleting, dressing, hyge its was also coded as	recent Minimum Data Set of assessment with an of Date (ARD) of 12-16-15. Ident #16 with no cognitive of and required extensive or bed mobility, transfers, iene and bathing. Resident of independent with eating, it of bowel and bladder.					
W	iterviewed during Med as found to be talkativ	n. Resident #15 was briefly dication administration, and we, appropriate, and ce, time, and situation.					

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Event ID: F8V611

Facility ID: VA0264

If continuation sheet Page 25 of 40

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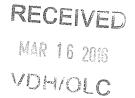
CENTERS FOR MEDICA	RE & MEDICAID SERVICES			FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A BUILDING	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	495185	B. WING		
NAME OF PROVIDER OR SUPPLIER  WAVERLY HEALTH AND REHABILITATION CENTER		45	REET ADDRESS. CITY. STATE. ZIP CODE 6 E MAIN ST AVERLY, VA 23890	02/25/2016
PREFIX (PACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I D DE
9.30 a.m.	page 25 s fully interviewed on 2-26-16 at observed on 2-24-16 at 9:00	F 441		4-8.16
a.m. during the moobservation received Practical Nurse (Langular (	edication pour and pass ving medications. Licensed PN) B, reviewed the MAR nistration record) for Resident ved the 30 day, multiple dose containing medications from the awer and pushed 11 oral pill ne medication cup, and 1 liquid water in a separate cup.			
picked up the medi placed it back into t and administered a	tion preparations one pill was of the medication cart. LPN B cation with a spoon, and the cup with the other 10 pills ll of them to Resident #15. oted and swallowed all of the t difficulty.			
Immediately followir observations, Resid were reviewed and i	ng the medication pass lent #15's medication orders reconciled.			
was requested, alon Resident, for whom were found to be def	a.m. a copy of Resident ministration Record (MAR) g with the MAR of a second infection control practices ficient. At 12:00 noon both d from the Director of Nursing			
She stated she was a would let the DON kn	ed on 2-24-16 at 12:15 p.m., fon control deficient practice. aware of the mistakes and now about the situations. she should not have picked			

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CENTERS FO	UR MEDICAR	E & MEDICAID SERVICES				FO	RM APPROVEI NO. 0938-039
AND PLAN OF COR	PRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			CONSTRUCTION	(X3) E	NO. 0938-039 DATE SURVEY COMPLETED
		495185	B. WING				
NAME OF PROVIDER OR SUPPLIER		1		EET ADDRESS, CITY, STATE, ZIP CODE	0	02/25/2016	
WAVERLY HEA	ALTH AND REH	ABILITATION CENTER		456	E MAIN ST /ERLY, VA 23890		
(X4) ID PREFIX ( TAG R	EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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)	וחפר	(X5) COMPLETION DATE
	inued From pa e pill and giver		F 44	11			4-8.16
for the RNSE our in asked admin result. retriev if all si and sh An inte Nursin end of on 2-2 made a 2-26-1 day be Staff D on Med had be sheet for was pro Registe	dinator (RNSD) of facility infection control of a pill is drop distration, what her answer was an even energied "yes of the fire (2-25-16) evelopment Codication adminiter conducted for the education vided as crediered Nurse State (RNSD).	Nurse Staff Development C), who was also responsible on control program. The follow the CDC guidelines for program." She was further oped during medication should the nurse do as a was to "discard the pill" and administer. She was asked educated on the standard, "" Inducted with the Director of the administrator, at the a 2-24-16 at 3:30 p.m., and m All in attendance were endings. The DON stated on had been re-educated the by the Registered Nurse coordinator, and an inservice istration and infection control on 2-25-16. The sign in on and inservice information ible evidence by the ff Development Coordinator. It was provided by the					
maintair during m	neffective infec nedication adm	e facility staff failed to ction control practices inistration; Specifically, the on precaution garb					

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CENTERS FOR MEDICAR				FURM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	495185	B. WING		
NAME OF PROVIDER OR SUPPLIER  WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 456 E MAIN ST WAVERLY, VA 23890	02/25/2016
I PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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 COMPLETION
wrapped a contaminate bare neck after use pressure cuff and so contaminated sink to did not properly disicontaminated device cart, and contaminate to throw away in the Resident #3 was origon 8-26-15. Diagnor Renal Disease (ESR diabetes mellitus typeresistant staphylocodinfection, Vancomyci (VRE), hypertension (CHF). Resident #3 the original admission readmission being 2-  The most recent Miniquarterly assessment Reference Date (ARE change MDS was in party and the property of the most recent Miniquarterly assessment Reference Date (ARE change MDS was in party and the property of the most recent Miniquarterly assessment Reference Date (ARE change MDS was in party of the most recent Miniquarterly impairment, the most recent management of the most re	use in Resident #3's room, nated stethoscope around her on Resident #3, laid a blood tethoscope on a wet op while washing her hands, nfect resident equipment, took es to store in the medication ted trash items up the hallway medication cart trash can.  ginally admitted to the facility ses included; End Stage (ED) with hemodialysis, e 2, chronic ulcer, methicillin occus aureus (MRSA) in Resistant Blood infection and congestive heart failure had 5 hospitalizations since in, with the most recent 20-16.  mum Data Set (MDS) was a twith an Assessment (D) of 12-21-15. A significant progress at the time of ded Resident #3 with no required limited assistance polity, transfers and toileting:	F 44		4.8.16
oressing and hygiene; bathing. Resident #3 with eating.  On 2-24-16 at 9:25 a.r interviewed during Mewas found to be talkatioriented to person, pla	dependent on staff for was coded as independent  n. Resident #3 was briefly dication administration, and			



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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495185	B. WING		
NAME OF PROVIDER OR SUPPLIER WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, 456 E MAIN ST WAVERLY, VA 23890	<b>02/25/2016</b> ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 441	Continued From pag surveyor.	ge 28	F 44	41	4.8.16
! ! ! ! ! ! ! ! ! ! ! ! ! ! ! ! ! ! !	a.m. during the med observation receiving Practical Nurse (LPN (medication administ #3. LPN B removed blister packages, cor medication cart draw medications into the asked why the isolatic Resident's door, and has VRE in the blood wound." methicillinaureus [MRSA], vancenterococcus [VRE]), LPN B was observed pill administration cup LPN B. LPN B left the proceeded to Resider was in his room with redside. The spouse was sitting at the beds was sitting at the beds accepted and swall without difficulty. Ther bserved in infection cegard to this Resident	she replied "this Resident, and MRSA in a foot resistant Staphylococcus omycin resistant  to have 8 tablets total in the and this was verified with emedication cart and at #3's room. The Resident his spouse sitting at wore no isolation garb and hide on a rollator walker.  W isolation precautions assisted the resident with			

On 2-24-16 at 9:25 a.m. LPN-B cleansed her

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CENTERS FO	R MEDICARE	E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEF AND PLAN OF CORR	ICIENCIES ECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER		495185	B. WING		03/35/3040
WAVERLY HEAL	TH AND REH	ABILITATION CENTER		STREET ADDRESS. CITY, STATE, ZIP ( 456 E MAIN ST WAVERLY, VA 23890	02/25/2016 CODE
(X4) ID PREFIX (E, TAG REG	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	SHOULD BE COMPLETION
medica and rei stethos the hal blood prisolation Reside stethos yellow prontoped devices  Upon fire Certified giving content of the door nei of gloves hands, a hands. If the draw gloves to the door the door nei of gloves the draw gloves to the draw gloves to the draw and then	moved a blace cope from the to Resident pressure cuffer cart which with a room, and who aper fiber is cope, and who aper fiber is cope, and who aper fiber is cope, and the room of the isolation. "Caphoor's room of the isolation of the part of the	ge 29 ich was at the nursing station, ick blood pressure cuff and ite cart, and proceeded down #3's room. She laid the black and stethoscope on top of the was located outside of She removed a yellow nite blood pressure cuff, and a plation gown, and laid them in cart, beside the two black es in the cart, she called to sistant (CNA) B, who was im next door to Resident #3. It to "(get me a box of gloves NA B came out of the next in with an open box, half full id it to LPN B with her bare excepted them in her bare placed the gloves in one of plation cart after removing 2 ir of the borrowed gloves, yellow gown, not covering in with the gloves, so as to	F 44	1	4.8.16

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administering medications.

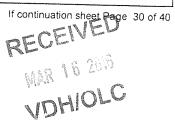
isolation cart.

blood pressure cuff and yellow stethoscope, leaving the black set outside of the room on the

LPN B did not tie the gown in back, and so it was flapping open in the front and her clothing was directly touching the Resident, and the Resident's bed. LPN B moved around Resident #3's bed while taking a blood pressure, and pulse, and

Event ID: F8V611

Facility ID: VA0264



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STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) AND TOLES					
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(EX)	O. 0938-039 DATE SURVEY COMPLETED
		495185	B. WING	3		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		)2/25/2016
		ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EVOLUCION SHE	III D RE	(X5) COMPLETION DATE
F 441	Continued From pag	ge 30	F∠	141		4-8-16

Immediately after touching the Resident's bare skin with the white blood pressure cuff and yellow stethoscope, while taking the blood pressure, and pulse, LPN B wrapped the stethoscope around her bare neck touching her skin. LPN B, then laid the blood pressure cuff on the Resident's overbed table, which had not been cleaned, and contained a water cup, and personal belongings, while she administered Resident #3's medications.

LPN (Licensed Practical Nurse) B then moved over to the sink after medications were administered, and with gloved hands, took the stethoscope off of her neck, and laid the stethoscope and blood pressure cuff on the sink counter top, which was soiled and wet.

LPN B removed her gloves and gown, and threw them away in the red biohazard trash container. She then washed her hands with soap and water for 10 seconds. LPN B dried her hands with 2 paper towels. She then picked up the stethoscope and blood pressure cuff in her bare left hand, together, in the middle of the devices, with the soiled wet paper towels she had dried her hands on. Both ends of the devices were uncovered, and she proceeded out of the Resident's room with them.

LPN B then laid the soiled stethoscope and blood pressure cuff on top of the isolation cart (beside the black stethoscope and blood pressure cuff from the medication cart). The 2 yellow and white devices were still partially wrapped in the middle where she had been holding them, in the wet, soiled paper towels, with her bare left hands.

She opened the drawer of the cart and removed

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		495185	B. WING		02/25/2010
NAME OF PROVIDER OR SUPPLIER  WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 456 E MAIN ST WAVERLY, VA 23890	02/25/2016 DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF 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)	RE COMPLETION
F 441 /	Continued From	04			11 6 11

#### Continued From page 31

one glove from the box of borrowed gloves, and gloved her right hand. With her left hand bare, she picked up the White and yellow stethoscope and blood pressure cuff still partially wrapped in the middle by the wet soiled paper towels, and with her right gloved hand opened the isolation cart drawer which held a plastic container of sanitizing wipes for equipment.

LPN B then pulled open the pop top with her thumb on the right hand (gloved) and removed one wipe and closed the container. LPN B proceeded to wipe both the yellow and white stethoscope and blood pressure cuff 3 times each with the sanitizing wipe. She only wiped each device in the areas that were sticking out of the paper towels, as she was unable to access the parts in the towels that she was holding in her ungloved left hand.

She then opened one of the 3 drawers in the cart with her gloved hand and dropped the stethoscope and blood pressure cuff into it holding onto the paper towel in her bare left hand. She removed her one glove, wrapping the paper towels in it as she pulled it off inside out, and held it in her left hand.

LPN B then picked up the black blood pressure cuff, and stethoscope in her right hand and proceeded back up the hall to the medication cart at the nursing station and threw away the glove which held the paper towels, and placed the black devices back in the medication cart.

On 2-24-16 at 10:00 a.m. a copy of Resident #15's Medication Administration Record (MAR) was requested, along with the MAR of a second Resident, for whom infection control practices

F 441

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CENTE	ERS FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROVE
ISTATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495185	B. WING_		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	02/25/2016 DE
		ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOUID RE COMPLETION
F 441	Timada i Tomi pa	ge 32	F 44	1	4-8-16
	were found to be de MAR's were receive (DON).	eficient. At 12:00 noon both ed from the Director of Nursing	,		•
	She stated she was	ved on 2-24-16 at 12:15 p.m., tion control deficient practice. aware of the mistakes and now about the situations.			
:	Nurse Staff Develop who was also respor control program. The document followed the RNSDC stated "We four infection control pall staff had been edushe replied "yes."  The following is the output of the staff had been edushe replied "yes."	a.m. the facility infection eviewed with the Registered ment Coordinator (RNSDC), asible for the facility infection e Isolation Precautions are CDC guidelines. The follow the CDC guidelines for program." She was asked if fucated on the standard, and guidance from the CDC; Prevention Website for illities			
f g a	debuted a new websit acilities. The site proguidance, tools, and it administrators, reside	ase Control and Prevention te for long-term care ovides infection prevention information for clinical staff, ints, and health department ong-term care settings.			
A s S e h in di	available resources ad urveillance (using the afety Network 's Lor nvironmental cleaning ygiene, antibiotic stev	ddress topics such as CDC National Healthcare DG-Term Care Module), g and disinfection, hand wardship, and prevention of loodborne pathogens. C			

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	E & MEDICAID SERVICES			OME	3 NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION		3) DATE SURVEY COMPLETED
	495185	B. WING			
NAME OF PROVIDER OR SUPPLIER  WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS. 456 E MAIN ST WAVERLY, VA 2	CITY, STATE, ZIP CODE	02/25/2016
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVID (EACH CO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE
barriers used alone combination to pro- and clothing from confectious agents. Frespirators, goggles shields, and gowns Multidrug-resistant general, bacteria the resistant to one or agents and usually to all but one or two antimicrobial agents VRE, extended spe [ESBL]-producing oresistant gram-negation of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a secont of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of the following readily transmissible proclivity toward caus associated with a second of	e equipment (PPE). A variety of e or in tect mucous membranes, skin, contact with PPE includes gloves, masks, s, face organisms (MDROs). In at are more classes of antimicrobial are resistant commercially available (e.g., MRSA, ctrum beta-lactamase r intrinsically ative bacilli) 176. at have one or g characteristics: 1) are ex; 2) have a using outbreaks; 3) may be evere ifficult to treat. Examples difficile, bacilli [ESBLs], Staphylococcus aureus in-resistant enterococci [VRE], asolation requires the use of sing and disinfection of the ment and equipment, and anning of Protective torso from neck to knees, and wrap around the back.	F 44	1		4.8.16

according to hand size. Extend to cover both

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CTATCHEN	TO F OR MEDICARE	* MEDICAID SERVICES				NO. 0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3)	DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	495185	B. WING	3		02/25/2016
	I NO VIDEN ON SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	<u> </u>	02/23/2016
WAVERI	Y HEALTH AND REHA	ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	<b>L.</b>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE IX (EACH CORRECTIVE ACTION SH	OHIDRE	(X5) COMPLETION DATE
F 441	Continued From pag wrists of isolation go		F 4	141		4-8-160
	I.B.3.a.ii. Indirect cor	ntact transmission In-direct	÷			

I.B.3.a.ii. Indirect contact transmission In-direct transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. In the absence of a point-source outbreak, it is difficult to determine how indirect transmission occurs. However, extensive evidence cited in the Guideline for Hand Hygiene in Health-Care Settings suggests that the contaminated hands of healthcare personnel are important contributors to indirect contact transmission 16. Examples of opportunities for indirect contact transmission include:

- Hands of healthcare personnel may transmit pathogens after touching an infected or colonized body site on one patient or a contaminated inanimate object, if hand hygiene is not performed before touching another patient.72, 73.
- Patient-care devices (e.g., electronic thermometers, glucose monitoring devices) may transmit pathogens if devices contaminated with blood or body fluids are shared between patients without cleaning and disinfecting between patients74 75-77.
- Instruments that are inadequately cleaned between patients before disinfection or sterilization (e.g., endoscopes or surgical instruments).
- Clothing, uniforms, laboratory coats, or isolation gowns used as personal protective equipment (PPE), may become contaminated with potential pathogens after care of a patient colonized or infected with an infectious agent, (e.g., MRSA 88, VRE 89, and C. difficile 90.

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		& MEDICAID SERVICES			OMP NO COSE COS
AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME OF	PROVIDED OF	495185	B. WING	B	03/35/3046
INAIVIE OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/25/2016
WAVER	LY HEALTH AND REHA	ABILITATION CENTER		456 E MAIN ST WAVERLY, VA 23890	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI IX (EACH CORRECTIVE ACTION SHOUL	D.P.E. CONSTRUCTION
F 441	implicated directly in	ge 35 ninated clothing has not been transmission, the potential nents to transfer infectious	F 4	141	4-8-16

I.C.1. b. Multidrug-Resistant Organisms (MDROs) In general, MDROs are defined as microorganisms - predominantly bacteria - that are resistant to one or more classes of antimicrobial agents176. Although the names of certain MDROs suggest resistance to only one agent (e.g., methicillin-resistant Staphylococcus aureus [MRSA], vancomycin resistant enterococcus [VRE]), these pathogens are usually resistant to all but a few commercially available antimicrobial agents. This latter feature defines MDROs that are considered to be epidemiologically important and deserve special attention in healthcare facilities177.

agents to successive patients.

MDROs are transmitted by the same routes as antimicrobial susceptible infectious agents. Patient-to-patient transmission in healthcare settings, usually via hands of Health Care Worker's, has been a major factor accounting for the increase in MDRO incidence and prevalence, especially for MRSA and VRE.

Facilities 199-201. Preventing the emergence and transmission of these pathogens requires a comprehensive approach that includes administrative involvement and measures (e.g., nurse staffing, communication systems, performance improvement processes to ensure adherence to recommended infection control measures), education and training of medical and other healthcare personnel, judicious antibiotic use, comprehensive surveillance for targeted MDROs, application of infection control

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	STATEM	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		1		OMB NO. 0938-039		
-	AND PLA	PLAN OF CORRECTION IDENTIFICATION NUMBER-		A. BUILD	TIPLE CONSTRUCTION NG	(X3)	DATE SURVEY COMPLETED	
-			495185	B. WING				
		NAME OF PROVIDER OR SUPPLIER WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 456 E MAIN ST WAVERLY, VA 23890		02/25/2016	
_	(X4) ID PREFIX TAG	X (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULDRE	(X5) COMPLETION DATE	
	F 44 F 514 SS=D	precautions during measures (e.g., cle patient care environdedicated single-patient care environdedicated single-patient care equipment), and deappropriate.  The prevention and national priority - one that all healthcare faresponsibility and patient programs 176. An interview was conversely programs 176. An interview was conversely (DON), and end of day debrief or on 2-26-16 at 3:00 pmade aware of the fit 2-26-16, that LPN B day before (2-25-16) Staff Development Conversely before the education admining the desired Nurse Standard Standar	patient care, environmental aning and disinfection of the ment and equipment, tient-use of non-critical colonization therapy when control of MDROs is a e that requires acilities and agencies assume articipate in community-wide 5, 177 " inducted with the Director of the administrator, at the in 2-24-16 at 3:30 p.m., and i.m All in attendance were indings. The DON stated on had been re-educated the by the Registered Nurse coordinator, and an inservice instration and infection control on 2-25-16. The sign in on and inservice information dible evidence by the aff Development Coordinator. In was provided by the	F 44			4.8.160	
		stanuards and practice	d; readily accessible; and					
		The clinical record mu information to identify	st contain sufficient the resident; a record of the					

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

Event ID: F8V611

Facility ID: VA0264

If continuation sheet Page 37 of 40



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CENTERS FOR MEDICA	RE & MEDICAID SERVICES			FORM APPROVE	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	495185	B WING			
NAME OF PROVIDER OR SUPPLIE WAVERLY HEALTH AND RE		STREET ADDRESS, CITY, STATE, ZIP CODE 456 E MAIN ST WAVERLY, VA 23890			
I PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	MIID DE COLUMN TO	
F 514 Continued From president's assess services provided	page 37 ments; the plan of care and ; the results of any	F 514	F514	4-8-16	
preadmission scre and progress note	ening conducted by the State		Resident #3's current med accurately documented.	dical record is	
by: Based on staff int review, the facility (Resident #3) of 2	ENT is not met as evidenced erview and clinical record staff failed for one resident 4 resident's in the survey an an accurate record.		Current residents with a not condition in the past more reviewed to ensure that the records were accurate.  Licensed staff will be educed.	onth were neir medical	
For Resident #3, the a change in condition hospitalization. The occurred and was a "late entry" of the condition of the condi	ne facility staff incorrectly dated on which required e actual change in condition documented on 11/16/15 but a ondition was documented and ed:  iginally admitted to the facility diagnoses of, but not limited I Disease (ESRD) with tes mellitus type 2, chronic istant staphylococcus aureus fon and congestive heart dent tions since admission; the		Accurate document in the medical recommendation accurate medical redocumentation on a randor basis. Issues noted will be reference the Quality Assurance Commendation and recommendation Completion date: 4/8/16	ta late entry ord nee will ecord m weekly referred to	
quarterly assessmer Reference Date (AR change MDS was in survey. The MDS co	nimum Data Set (MDS) was a not with an Assessment D) of 12/21/15. A significant progress at the time of oded Resident #3 with no progred limited assistance				



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MAME OF PROVIDER OR SUPPLIER   A SUDDING			Law SERVICES			OMB NO. 0938-039	
WAVERLY HEALTH AND REHABILITATION CENTER  WAVERLY HEALTH AND REHABILITATION CENTER  (ALL)  SUMMARY STATEMENT OF DEFICIENCIES (EACH DESIGNEY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR TAG  FINAL COntinued From page 38  required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3's clinical record was reviewed. The review revealed the following nursing Progress Notes:  "Late Entry 11/15/15 01:10 (1:10 a.m.) Type: Change in Condition SBAR (Situation-Background-Assessment-Recommend ation)Ahoromal vital signsAltered mental status Functional declineResident of condition Evaluation assessment for further information  The note was written by Licensed Practical Nurse-A (LPN-A).  The eINTERACT is electronic document within the facility electronic document within the facility electronic document system that is a comprehensive change in condition evaluation.  Nursing Progress Notes also included the following:  "11/15/15 at 20:56 (10:56 p.m.)States "I just do not feel good" Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest vary.	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY	
WAVERLY HEALTH AND REHABILITATION CENTER    MAYER   MAIN ST   WAVERLY, VA 23890			495185	B. WING			
SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514  Continued From page 38  required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3's clinical record was reviewed. The review revealed the following nursing Progress Notes:  "Late Entry 11/15/15 01:10 (1:10 a.m.) Type: Change in Condition SBAR (Situation-Background-Assessment-Recommend ation). Abnormal vital signsAltered mental status Functional declineRespiratory arrest Unresponsiveness This started on 11/15/15 during the MorningThe issues appears to be: dying. See eINTERACT Change of Condition Evaluation assessment for further information" The note was written by Licensed Practical Nurse-A (LPN-A).  The eINTERACT is electronic document within the facility electronic documentation system that is a comprehensive change in condition evaluation.  Nursing Progress Notes also included the following:  "11/15/15 at 20:56 (10:56 p.m.)States 'I just do not feel good' Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest yray.	NAME OF PROVIDER OR SUPPLIER				456 E MAIN ST	02/25/2016 CODE	
required extensive assistance from staff for dressing and hygiene; dependent on staff for bathing. Resident #3 was coded as independent with eating.  On 2/26/16 Resident #3's clinical record was reviewed. The review revealed the following nursing Progress Notes:  "Late Entry 11/15/15 01:10 (1:10 a.m.) Type: Change in Condition SBAR (Situation-Background-Assessment-Recommend ation)Abnormal vital signsAltered mental status Functional declineRespiratory arrest Unresponsiveness This started on 11/15/15 during the MorningThe issues appears to be: dying. See eINTERACT Change of Condition Evaluation assessment for further information" The note was written by Licensed Practical Nurse-A (LPN-A).  The eINTERACT is electronic document within the facility electronic documentation system that is a comprehensive change in condition evaluation.  Nursing Progress Notes also included the following:  "11/15/15 at 20:56 (10:56 p.m.)States 'I just do not feel good' Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest xray	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE COMPLETION	
reviewed. The review revealed the following nursing Progress Notes:  "Late Entry 11/15/15 01:10 (1:10 a.m.) Type: Change in Condition SBAR (Situation-Background-Assessment-Recommend ation)Abnormal vital signsAltered mental status Functional declineRespiratory arrest Unresponsiveness This started on 11/15/15 during the MorningThe issues appears to be: dying. See eINTERACT Change of Condition Evaluation assessment for further information" The note was written by Licensed Practical Nurse-A (LPN-A).  The eINTERACT is electronic document within the facility electronic documentation system that is a comprehensive change in condition evaluation.  Nursing Progress Notes also included the following:  "11/15/15 at 20:56 (10:56 p.m.)States 'I just do not feel good' Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest yray	F 514	required extensive a dressing and hygier bathing. Resident #	assistance from staff for ne; dependent on staff for	F 5	14	4-8.16	
Change in Condition SBAR (Situation-Background-Assessment-Recommend ation)Abnormal vital signsAltered mental status Functional declineRespiratory arrest Unresponsiveness This started on 11/15/15 during the MorningThe issues appears to be: dying. See elNTERACT Change of Condition Evaluation assessment for further information" The note was written by Licensed Practical Nurse-A (LPN-A).  The elNTERACT is electronic document within the facility electronic documentation system that is a comprehensive change in condition evaluation.  Nursing Progress Notes also included the following:  "11/15/15 at 20:56 (10:56 p.m.)States 'I just do not feel good' Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest xray		reviewed. The revie	w revealed the following				
the facility electronic documentation system that is a comprehensive change in condition evaluation.  Nursing Progress Notes also included the following:  "11/15/15 at 20:56 (10:56 p.m.)States 'I just do not feel good' Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest xray		Change in Condition (Situation-Backgrour ation)Abnormal vita status Functional del Unresponsiveness I during the Morning dying. See eINTER/Evaluation assessment The note was written	SBAR nd-Assessment-Recommend al signsAltered mental clineRespiratory arrest This started on 11/15/15 The issues appears to be: ACT Change of Condition ent for further information"				
following: "11/15/15 at 20:56 (10:56 p.m.)States 'I just do not feel good' Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest xray		the facility electronic is a comprehensive of	documentation system that				
not feel good' Wife at bedside and asking if the MD (medical doctor) need to him to hospital (sic), informed that I was waiting to get the chest xray		Nursing Progress Not following:	tes also included the				
results and then call the results to him. Xray results call to MD and no new orders received, resident is to go to hemo-dialysis in a.m. Xray shows mild chf (congestive heart failure)"  "11/16/15 01:19 (1:19 a.m.)resident found in		not feel good' Wife a MD (medical doctor) rinformed that I was waresults and then call the results call to MD and resident is to go to her shows mild chf (congestion).	at bedside and asking if the need to him to hospital (sic), aiting to get the chest xray ne results to him. Xray no new orders received, mo-dialysis in a.m. Xray estive heart failure)"				

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Event ID: F8V611

Facility ID: VA0264

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MAR 16 2016

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
NAME OF D	100//05500	495185	B. WING		02/25/2016
NAME OF PROVIDER OR SUPPLIER  WAVERLY HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 456 E MAIN ST WAVERLY, VA 23890		
(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 X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
F 514	Continued From pa	ge 39	F 5	14	4.8.16

#### Continued From page 39

resp. distress. 911 notified. resident transported to (hospital name) ER for evaluation and treatment...resp. (respirations) down to 4 (per minute). ventilation started via ambu bag. MD. RP (responsible party) and unit manager aware..."

On 2/26/16 at 2:45 p.m. an interview was conducted with the Unit Manager (Admin-B) and the Corporate Nurse (Admin-D). The concern that nursing documentation on 11/15/15 at 1:10 a.m. described Resident#3 as "appears to be dying, respiratory arrest and unresponsiveness" yet he wasn't sent to the hospital until 11/16/15 at 1:19 a.m. was discussed. Admin-B reviewed the documentation in the computer system and explained that LPN-A put the wrong date and time of the "late entry". She stated the actual change in condition started on 11/15/15 at 20:56 (10:56 p.m.), the MD (Medical Doctor) and RP were notified and a chest xray was ordered. She stated "Then at 1:19 a.m. on 11/16/15 he declined and went to the hospital." The decline in condition did not occur on 11/15/15 at 1:10 a.m. When asked if it was just a documentation error and not a delay in sending the resident to the hospital, Admin-B replied "Yes." Admin-D agreed it was an inaccurate record.

The facility staff did not present any further information regarding the findings.

