## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED		
		495246	B. WING	B. WING		C <b>12/08/2016</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	FO	000			
	conducted on 12/6/ Complaints were in Corrections are red following 42 CFR P Care requirements. survey/report will for The census in this 113 at the time of the consisted of 20 cur (Residents #1 throut reviews (Residents 483.12(a)(3)(4)(c)(1) ALLEGATIONS/INI  (a) The facility mus  (3) Not employ or of who-  (i) Have been found exploitation, misapp mistreatment by a continuous cii) Have had a find nurse aide registry exploitation, mistre misappropriation of ciii) Have a disciplir or her professional body as a result of exploitation, mistre misappropriation of continuous continu	ne survey. The survey sample rent resident reviews agh #20) and six closed record #21 through # 26).  1)-(4) INVESTIGATE/REPORT DIVIDUALS  t- therwise engage individuals  diguilty of abuse, neglect, propriation of property, or court of law;  ing entered into the State concerning abuse, neglect, atment of residents or their property; or eary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or	F2	1. Residents #4 & #5 coreside at the facility in condition. Both reside assessed and records No evidence of abuse other injuries of unknowere identified.  2. Records of current reserviewed by the Center Executive (CNE)/desidetermine any other in unknown source. Not identified during this  3. Facility staff in all degrand on all shifts will be educated by the Center Director (CED)/desige current regulations, reand policies specific tabuse, neglect, misap	n stable ents were reviewed. , neglect or own source sidents were er Nurse egnee to njuries of ne were review.\ partments per Executive nee on the equirements o resident		
	( DUDEOTODIO OD DDOL 45	NED/CLIDDLIED DEDDESENTATIVE'S SIG	==	TITI É		(X6) DATE	

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

---

VO) DHIE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT	OF HEALTH	AND HUM	SERVICES SERVICES
CENTERS FOR	MEDICARE	& MEDIC	SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING			120	) 08/2016
NAME OF F	PROVIDER OR SUPPLIER		L		STREET ADDRESS, CITY, STATE, ZIP CODE	12/(	JO/2V 10
WOODM	ONT CENTED			1	1 DAIRY LANE		
VVCCDIVI	ONT CENTER			ı	FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	actions by a court of which would indicate nurse aide or other (c) In response to a exploitation, or mis:  (1) Ensure that all a abuse, neglect, exploitation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that cau abuse and do not rethe administrator of officials (including the adult protective serfor jurisdiction in local accordance with St procedures.  (2) Have evidence thoroughly investigation, or mis investigation is in performance of the result administrator or his representative and with State law, including the procedure of the result administrator or his representative and with State law, including the procedure, within 5 were resulted.	s any knowledge it has of of law against an employee, the unfitness for service as a facility staff.  Allegations of abuse, neglect, treatment, the facility must:  Alleged violations involving poloitation or mistreatment, funknown source and fresident property, are ely, but not later than 2 hours is made, if the events that in involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to fithe facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established that all alleged violations are ated.  Potential abuse, neglect, treatment while the rogress.	F 2	225	and injuries of unknown sor All new employees will recthis information as part of the initial orientation.  4. CNE/designee will conduct of resident records, as well review documentation during standing clinical meetings, determine compliance with reporting requirements. Rethe audits and reviews will shared at the monthly QA Committee meetings x3 mo	eive heir audits as as to all sults of	1/21/17

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495246	B. WING				08/2016
	PROVIDER OR SUPPLIER  ONT CENTER		11 DAIRY LA		STREET ADDRESS, CITY, STATE, ZIP CODE . 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	by: Based on staff into and clinical record the facility staff fail injury of unknown the survey sample  1. The facility staff Resident #4's 5/4/injury to the require  2. The facility staff unknown origin (rigrequired state age Resident #5.  The findings includ  1. Resident #4 wa 11/15/10 and read that included but we depression and are The most recent A quarterly assessm reference date) of being severely impression severely impression severely impression and severely impression se	nust be taken.  INT is not met as evidenced erview, facility document review review, it was determined that ed to investigate and report an origin for two of 26 residents in , Resident #4 and Resident #5.  failed to investigate and report 16 fractured ankle of unknown ed state agency.  failed to report a fracture of ght femoral neck) to the ncy in a timely manner for  de:  as admitted to the facility on mitted on 1/3/11 with diagnoses were not limited to: dementia, nemia.  IDS (minimum data set), a ent, with an ARD (assessment 11/28/16 coded the resident as paired cognitively. The resident uiring assistance from staff for	F2	225			
·	a.m. documented, (Name of resident ankle/grimacing a inner ankle noted warm to touch, sw	se's notes dated 5/4/16 at 11:00 "Type: Change in Condition. ) is experiencing pain. L (left) nd yelling when touched. L to be discolored, L ankle is ollen and painful to touch." umentation regarding how this					

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

<i></i>	n.
£	.3
W	Ĵ

VIDER OR SUPPLIEF	495246	B. WING		ŀ	С
	2			12	2/08/2016
CENTER	`		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	•	,
(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
eview of the physicumented, "x rapecture." Further of 5/4/16 documented) ER (emergial) ER (emergial) ER (emergial) + TREA eview of the emergial p.m. documented in x ray done todal bula) fracture."	sician's orders dated 5/4/16 by L ankle r/o (rule out) review of the physician's orders ented, "SEND TO (name of rgency room) TO EVAL AT."  ergency room note dated 5/4/16 mented, "(Name of facility) is jury happened. Pt (patient) had ay showing a tib (tibia) fib				
SM (administration country) for a country, for a country or an acture of unknown ought all the FR esident #4. A receive the injury was not interview was own, with ASM #2. Illows for an injury atted, "When we at shift complete ext day we come sked to review the bast of the country of untry of the country o	ve staff member) #2, the nurse by of the facility reported Resident #4's 5/4/16 leg vn origin. ASM #2 stated, "I Is in." There was no FRI for quest to review the investigation hade at that time.  conducted on 12/8/16 at 2:25. When asked the process staff ry of unknown injury, ASM #2 have an incident, the nurse on es it (the incident report)." When even the in and investigate it." When the investigation for Resident isknown origin, ASM #2 stated,				
THE POOR TEST OF THE TOTAL OF THE TOTAL AND THE TOTAL OF	view of the phycumented, "x racture." Further of 5/4/16 documes pital) ER (emeraluate) + TREA view of the emeraluate) + TREA view of the emeraluate of the injury was made to the injury was made in the injur	view of the physician's orders dated 5/4/16 cumented, "x ray L ankle r/o (rule out) cture." Further review of the physician's orders 5/4/16 documented, "SEND TO (name of spital) ER (emergency room) TO EVAL aluate) + TREAT."  view of the emergency room note dated 5/4/16 2:03 p.m. documented, "(Name of facility) is sure how the injury happened. Pt (patient) had x ray done today showing a tib (tibia) fib rula) fracture."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of distal tibia."  equest was made on 12/8/16 at 9:30 a.m. to M (administrative staff member) #2, the nurse ecutive, for a copy of the facility reported ident (FRI) for Resident #4's 5/4/16 leg cture of unknown origin. ASM #2 stated, "I bught all the FRIs in." There was no FRI for sident #4. A request to review the investigation the injury was made at that time.  interview was conducted on 12/8/16 at 2:25 n. with ASM #2. When asked the process staff ows for an injury of unknown injury, ASM #2 ted, "When we have an incident, the nurse on at shift completes it (the incident report)." When	view of the physician's orders dated 5/4/16 cumented, "x ray L ankle r/o (rule out) cture." Further review of the physician's orders 5/4/16 documented, "SEND TO (name of spital) ER (emergency room) TO EVAL aluate) + TREAT."  view of the emergency room note dated 5/4/16 20:03 p.m. documented, "(Name of facility) is sure how the injury happened. Pt (patient) had x ray done today showing a tib (tibia) fib rula) fracture."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of distaltibia."  equest was made on 12/8/16 at 9:30 a.m. to M (administrative staff member) #2, the nurse ecutive, for a copy of the facility reported ident (FRI) for Resident #4's 5/4/16 leg cture of unknown origin. ASM #2 stated, "I rule that FRIs in." There was no FRI for sident #4. A request to review the investigation the injury was made at that time.  interview was conducted on 12/8/16 at 2:25 n. with ASM #2. When asked the process staff ows for an injury of unknown injury, ASM #2 ted, "When we have an incident, the nurse on it shift completes it (the incident report)." When ked what happened next, ASM #2 stated, "The kit day we come in and investigate it." When ked to review the investigation for Resident is fracture of unknown origin, ASM #2 stated, ecause we had a diagnosis of osteopenia (1) I	intinued From page 3 Iry occurred.  View of the physician's orders dated 5/4/16 cumented, "x ray L ankle — r/o (rule out) cture." Further review of the physician's orders 5/4/16 documented, "SEND TO (name of spital) ER (emergency room) TO EVAL aluate) + TREAT."  View of the emergency room note dated 5/4/16 2:03 p.m. documented, "(Name of facility) is sure how the injury happened. Pt (patient) had x ray done today showing a tib (tibia) fib ula) fracture."  View of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of distal tibia."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of distal tibia."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of distal tibia."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of distal tibia."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of of stal tibia."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of of stal tibia."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of interview as made on 12/8/16 at 9:47 n. documented, "Impression: Fracture of unknown origin, ASM #2 ted, "When we have an incident, the nurse on the injury was made at that time.  interview was conducted on 12/8/16 at 2:25 n. with ASM #2. When asked the process staff ows for an injury of unknown injury. ASM #2 ted, "When we have an incident, the nurse on the first completes it (the incident report)." When wed was the process to stated, "The kt day we come in and investigate it." When wed to review the investigation for Resident s fracture of unknown origin, ASM #2 stated, because we had a diagnosis of osteopenia (1) I	intinued From page 3 Iry occurred.  view of the physician's orders dated 5/4/16 sumented, "x ray L ankle — r/o (rule out) cture." Further review of the physician's orders 5/4/16 documented, "SEND TO (name of spital) ER (emergency room) TO EVAL alluate) + TREAT."  view of the emergency room note dated 5/4/16 9:03 p.m. documented, "(Name of facility) is sure how the injury happened. Pt (patient) had x ray done today showing a tib (tibia) fib ula) fracture."  view of the x-ray report dated 5/4/16 at 9:47 n. documented, "Impression: Fracture of distal tibia."  equest was made on 12/8/16 at 9:30 a.m. to M (administrative staff member) #2, the nurse soutive, for a copy of the facility reported ident (FRI) for Resident #4's 5/4/16 leg cture of unknown origin. ASM #2 stated, "I sught all the FRIs in." There was no FRI for sident #4. A request to review the investigation the injury was made at that time.  interview was conducted on 12/8/16 at 2:25 n. with ASM #2. When asked the process staff ows for an injury of unknown injury, ASM #2 ted, "When we have an incident, the nurse on t shift completes it (the incident report)." When ked what happened next, ASM #2 stated, "The kt day we come in and investigate it." When ked to review the investigation for Resident s fracture of unknown origin, ASM #2 stated, pecause we had a diagnosis of osteopenia (1) I

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	B. WING				C
NAME OF I	PROVIDER OR SUPPLIER	1	D. Wilde	••••••••••	REET ADDRESS, CITY, STATE, ZIP CODE	1 1	2/08/2016
	ONT CENTER			11	DAIRY LANE LEDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	Prohibition" docum company) shall proexploitation, involumisappropriation of the following:Invallegations 5. State as suspicions bruis occurrences, patter constitute abuse, at the investigation. 6 concerning a report executive director) an immediate and shall focus on: 6.1. and to what extent thoroughly docume form, and on the Invalled the Investigation on the Investigation on the Invalled the Investigation on the Invalled the Investigation on the Invalled the	ty's policy titled, "Abuse ented, "POLICY (Name of obibit abuse, neglect, ntary seclusion, and f property for resident through vestigation of incidents and aff shall identify events such sing of residents rns, and trends that may and determine the direction of a Upon receiving information of abuse, the CED (chief or designee shall: 6.1 Conduct thorough investigation which a lf abuse or neglect occurred and any state required acident/Accident Investigation."  It ion was provided prior to exit.  Desteopenia is a term to define a not normal but also not as as. By definition from the World of the observation of the world of the observation of the world of the second of the second of the world of	F	225			
	required state ager Resident #5.	ncy in a timely manner for					

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
-		495246	B. WING _			C <b>12/08/2016</b>	
NAME OF	PROVIDER OR SUPPLIER	<del></del>		STREET ADDRESS, CITY, STATE, ZIP	CODE		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 2240	5		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD I SE APPROPR	BE	(X5) COMPLETION DATE
F 225	that included but we diabetes, unspecific behavioral disturbated difficulty in walking breast cancer, hear Resident #5's mosset) was a significated ARD (assessment Resident # 5 was compaired in the abilist scoring 07 out of 1 for mental status) as requiring extensistaff members with toileting, bathing, at Review of the physical following note docupractitioner on 11/8 (complaint) pain in present illness: 83 female, a LTC (Lor (name of facility), following note docupractitioner on 11/8 (complaint) pain in present illness: 83 female, a LTC (Lor (name of facility), following note docupractition with sepsitions of facility), and the sepsition of facility is apparent that is as she is more quitanswer questions as seen today for new	mitted on 9/9/16 with diagnoses are not limited to type two sed dementia without ance, muscle weakness, hypertension, osteoporosis, art failure, and hypothyroidism.  It recent MDS (minimum data ant change assessment with an reference date) of 11/22/16. Coded as being cognitively lity to make daily decisions 5 on the BIMS (brief interview exam. Resident #5 was coded sive assistance from two plus and transfers, bed mobility, and locomotion off the unit.  Sician's notes revealed the amented by the nurse 18/16: "Chief complaint: C/O B/L (bilateral) legs. History of y.o. (year old) Caucasian and Term Care) resident at nospitalized 9/5 to 9/9 with AMS atus) due to UTI (Urinary Tract asis, and worsening CHF aillure). Since her readmission the has had a mental decline et in nature and was not able to as she has in the past. She is a reports of pain and	F 22				
	hypothyroidism E Res (resident) w/p: and knees upon m her lungs, will orde asking for pain me	M (diabetes mellitus) and Diagnoses and Assessment: ain (with pain) in hips, pelvis ovement. Yells at the top of er x-rays. Res (Resident) is not d (medication) prn (as needed) rex (1) 100 mg (milligrams) po					

DEPARTMENT OF HEALTH	AND HUM SERVICES			FORM APPROVED
CENTERS FOR MEDICARE	& MEDICATO SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	COMPLETED
				С
	495246	B. WING	<u> </u>	12/08/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 225 Continued From page 6 F 225 (by mouth) BID (twice a day) w/meals (with

meals) and will start low dose fentanyl patch (2) of 12 mcg (micrograms)...Spoke with RP (responsible party) about above concerns, RP verbalized understanding and agrees with POC (Plan of Care)."

Review of Resident #5's physician verbal orders

Review of Resident #5's physician verbal orders revealed the following order dated 11/8/16: "...3 Celebrex 100 mg 1 cap (capsule) po BID 8 AM and 5 PM with food...4. Fentanyl patch 12 mcg apply patch q72 hours (every 72 hours) for pain...5. X-ray of B/L hips and pelvis for pain...6. X-ray of bilateral knees."

Review of Resident #5's X-ray results revealed that the X-ray did not arrive to the facility until 11/9/16 (the following day). The radiology report documented the following: "Hips bilat (bilateral) W (with) pelvis 2 view...Results: Nondisplaced age-indeterminate fracture of the right femoral neck. No fracture of the left hip. Bilateral degenerative changes involving the hips..."

Review of the FRI (Facility Reported Incident) revealed that the fracture of unknown origin was not reported to the OLC (Office of Licensure and Certification) until 11/16/16 (6 (six) working days) after the fracture was discovered.

Review of the follow up report dated 11/21/16; revealed that the fracture was determined to be pathological in nature after the investigation was completed. The investigation was initiated on 11/18/16.

Review of the investigation revealed the following note dated 11/18/16 by a nurse who worked on 11/10/16 and 11/11/16 on the 3-11 shift: "I worked

PRINTED: 12/15/2016

		AND HUM SERVICES				FORM	0: 12/15/2016 MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495246	B. WING			12	C 2 <b>/08/2016</b>
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		· · · · · · · · · · · · · · · · · · ·
WOODM	ONT CENTER				1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 225	Continued From pa	age 7	F2	225			
		Thur/Fri). Was told in report					
	that XR (X-ray) was negative and that MRI						
	(Magnetic Resonance Imaging) may be considered. No unusual indication c/o						
		(complaints of) of pain verbalized or reported.					1
		anyl patch were ordered 11/8			:		
	and were in effect when I worked Nov 10 and 11."				:		
		ne investigation revealed a					
		6 from the Nurse Practitioner. following: "She was assessed	1				
		pain as reported by nursing.			•		:
		ral) hips and pelvis were					
		cal assessment along with					:
		and pain meds (medications).					•
	•	ere done and not received until					•
	p.m.	t in the building					
	11/10/16= I was no	d up X-ray results (+) (positive)			·		•
		ral neck fracture. Continued			:		
	pain med.						
		ontact RP (responsible party)					
		ults of X-ray and POC (Plan of					
	Care) which include				:		
		ortho (orthopedic) consult. She alth Bearing) at this time. Will			:		
		ations of ortho consultation,	!				
	appt (appointment)	•					
	On 12/7/16 at 2:57	p.m., an interview was	:				
		N (licensed practical nurse) #5,					

the nurse who worked on 11/10/16 and 11/11/16, on the 3-11 shift. When asked what she could recall about Resident #5's fracture, LPN #5 stated that she was not quite sure how her fracture occurred. When asked about the process staff follows if a resident's X-rays come back positive for a fracture, LPN #5 stated that she would call the NP for notification and to receive new orders,

		AND HUM SERVICES			FORM	: 12/15/2016 APPROVED : 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING			C <b>08/2016</b>	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 224	)5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 225	received. LPN #5 s staff to see if they k resident could have administration imm she was told in rep were negative on 1	age 8 and then chart orders that were stated that she would talk to know anything about how the e obtained a fracture and notify rediately. LPN #5 stated that ort that Resident #5's X-rays 1/10/16. LPN #5 stated that ally look at the X-ray results	F 2	225	,		

On 12/7/16 at 3:11 p.m., an interview was conducted with LPN #6, the nurse who faxed the orders for the X-rays. LPN #6 stated that she was called in to work part of 7-3 and 3-11 shifts on 11/8/16. LPN #5 stated she saw the orders flagged for the X-ray and pain medication, and she took the orders off and faxed them to pharmacy. LPN #6 also stated that she called for the X-ray and notified the family. LPN #6 stated that the X-ray was not ordered STAT (Immediate) and X-ray did not arrive on her shift. LPN #6 stated that if the situation is not an emergency. X-rays will not be ordered STAT. LPN #6 stated that if X-rays are not ordered STAT, they usually arrive to the facility the next day. LPN #6 worked until 11 p.m. that night. When asked the reason for the X-ray, LPN #6 stated that she was told the resident was complaining of increased pain and the NP assessed the resident before writing the order. When asked if Resident #5's positive X-ray results should have been reported to administration immediately, LPN #5 stated that Administration should be notified right away so they can start an investigation on how the fracture

because she was told in report that they were

negative.

On 12/8/16 at approximately 11:30 a.m., an interview was conducted with ASM (administrative

occurred.

		AND HUM SERVICES & MEDICAID SERVICES			FORM	): 12/15/2016 /I APPROVED ): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495246	B. WING _		12	C /08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	(administrative staf (Director of Nursing injury of unknown of #2 stated, "Right Av 24 hours." ASM #2 FRI (facility reporte happened was the (resident) for an unresident was in a loordered X-rays of the and bilateral knees looked at the X-ray negative and though She left them for N to facility (11/11/16) administration was fracture until 11/16/ reported this fracture that they concluded given her medical of the exact time that on 11/11/16 she positive for fracture facility and then she in the exact time that on 11/11/16 she positive for fracture facility and then she in the exact time facility and then she exact time facility and the exact time facilit	he administrator and ASM f member) #2, the DON g). When asked when an origin should be reported, ASM way." ASM 1 stated, "Within 2 stated, "This was the delayed d incident). I think what NP went to check on her related situation and the tof pain at that time. She he bilateral hips and pelvis, whoever the nurse was who is, saw that one X-ray was ht all X-rays were negative. P to view when the NP arrived her asked that not made aware of the 16 and they immediately re to the state. ASM #2 stated I the fracture was pathological	F 22	5		

results.

stated that she wrote an order that day for an ortho consult. ASM #5 stated that the ortho consult did not really address the fracture of the right femoral neck because they were treating it like an old fracture. ASM #5 stated that the consult only addressed the bilateral pain to Resident #5's knees. ASM #5 could not recall if she made administration aware of the X-ray

		AND HUM SERVICES			FORM	D: 12/15/2016 MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	). 0938-0391 TE SURVEY MPLETED
		495246	B. WING _		12	C 2 <b>/08/2016</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 10	F 22	5		And the form of th
		oximately 1130 a.m., made aware of the above				Administration refrontier to the control of the con
	documents in part, cases of suspected exploitation require	mandatory reporting within the Department of Health and				
	drug used to treat r relieve symptoms of stiffness, and joint p obtained from The	steroidal anti-inflammatory nild to moderate pain and help of arthritis such as swelling, pain." This information was National Institutes of Health. m.nih.gov/pubmedhealth/PMH details.				
	synthetic opioid and morphine but is 50 a schedule II prescused to treat patien manage pain after used to treat patien physically tolerant trinformation was ob-	"Fentanyl is a powerful algesic that is similar to to 100 times more potent. It is ription drug, and it is typically ts with severe pain or to surgery. It is also sometimes ts with chronic pain who are o other opioids." This tained from The National				
	483.12(b)(1)-(3), 48	use.gov/drugs-abuse/fentanyl. 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC	F 22	6 1. Residents #4 & #5 confreside at the facility in		

**POLICIES** 

483.12

reside at the facility in stable condition. Both residents were

assessed and records reviewed.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/15/2016 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED С 495246 B. WING 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 226 Continued From page 11 F 226 No evidence of abuse, neglect or (b) The facility must develop and implement other injuries of unknown source written policies and procedures that: were identified. 2. Records of current residents were (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of reviewed by the Center Nurse resident property. Executive (CNE)/designee to determine any other injuries of (2) Establish policies and procedures to investigate any such allegations, and unknown source. None were identified during this review. (3) Include training as required at paragraph 3. Facility staff in all departments §483.95. and on all shifts will be reeducated by the Center Executive 483.95 Director (CED)/designee on the (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation current regulations, requirements requirements in § 483.12, facilities must also and policies specific to resident provide training to their staff that at a minimum abuse, neglect, misappropriation educates staff on-

(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.

- (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property
- (c)(3) Dementia management and resident abuse prevention.

This REQUIREMENT is not met as evidenced

Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement abuse policies for two of 26 residents in the survey sample. Resident #4 and Resident #5.

1. The facility staff failed to implement the

- and injuries of unknown source. All new employees will receive this information as part of their initial orientation.
- 4. CNE/designee will conduct audits of resident records, as well as review documentation during standing clinical meetings, to determine compliance with all reporting requirements. Results of the audits and reviews will be reported to the Quality Assurance Committee x3 months for their review.

1/21/17

	V2.17			
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES			PRINTED: 12/15/2016 FORM APPROVED
				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495246	B. WING	<u> </u>	C
NAME OF PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP COE	12/08/2016
WOODMONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405	,
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH	MILD BE COMPLETION
unknown origin (fractequired state agency Resident #4. In addity complete an investing fracture of unknown and the policies and report and (right femoral neck) the in a timely manner food to the findings include:  1. Resident #4 was and 11/15/10 and readmity that included but were depression and anem.  The most recent MDS quarterly assessment, reference date of 11/2 being severely impaired was coded as requiring all activities of daily lived. Review of the nurse's documented, "Type: Conformity of the finding and you inner ankle noted to be warm to touch, swoller there was no docume injury occurred.  Review of the physician documented, "x ray Lage was simple for the physician documented, "x ray Lage was no documented, "x ray Lage was not d	y and report a fracture of ture tibia on 5/4/16) to the ty in a timely manner for tion the facility failed to ation for Resident #4's origin to rule out abuse.  illed to implement abuse fracture of unknown origin o the required state agency r Resident #5.  admitted to the facility on ted on 1/3/11 with diagnoses e limited to: dementia, nia.  6 (minimum data set), a, with an ARD (assessment 28/16 coded the resident as ed cognitively. The resident ag assistance from staff for ing.  notes dated 5/4/16 at 11:00 change in Condition. (Name noting pain. L (left) elling when touched. L ed discolored, L ankle is a and painful to touch." Intation regarding how this orders dated 5/4/16 at 18:00 change in Condition.	F 2	226	

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



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495246	B. WING			12	C / <b>08/2016</b>
	PROVIDER OR SUPPLIER		3	11 [	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 226	Review of the eme at 9:03 p.m. docur unsure how the inj an x ray done toda (fibula) fracture."  Review of the x-ra p.m. documented,	rgency room) TO EVAL	F 2	226			
	ASM (administrative executive, for a consideration (FRI) for a fracture of unknown brought all the FR	de on 12/8/16 at 9:30 a.m. to ve staff member) #2, the nurse ppy of the facility reported Resident #4's 5/4/16 leg vn origin. ASM #2 stated, "I Is in." There was no FRI for quest to review the investigation hade at that time.	to the state of th				
	p.m. with ASM #2. follows for an injur stated, "When we that shift complete asked what happe next day we come asked to review th #4's fracture of un "Because we had think it got me off FRI) into the state	conducted on 12/8/16 at 2:25 When asked the process staff ry of unknown injury, ASM #2 have an incident, the nurse on es it (the incident report)." When ened next, ASM #2 stated, "The in and investigate it." When he investigation for Resident known origin, ASM #2 stated, a diagnosis of osteopenia (1) I the track and I didn't send it (a ." When asked if an heen completed ASM #2 stated han investigation.					
		lity's policy titled, "Abuse nented, "POLICY (Name of	· ·				

PRINTED: 12/15/2016 DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING \_ 495246 B. WING 12/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 14 F 226 company) shall prohibit abuse, neglect,

exploitation, involuntary seclusion, and misappropriation of property for resident through the following: ....Investigation of incidents and allegations... 5. Staff shall identify events -- such as suspicions bruising of residents -occurrences, patterns, and trends that may constitute abuse, and determine the direction of the investigation. 5.1.3 All cases of suspected abuse, neglect, or exploitation require mandatory reporting within one working day to the Department of Health and Human Services...5.1.4 The report must include, but is not limited to, name of resident, date and time incident occurred, circumstances surrounding the incident, where the incident took place, extent of the injury or reaction and necessary treatment, names of any witnesses's, name of person (s) charged with committing the act. recommendations for corrective action, and other information as appropriated. 6. Upon receiving information concerning a report of abuse, the

CED (chief executive director) or designee shall:

investigation which shall focus on: 6.1.1 If abuse or neglect occurred and to what extent...6.2 The investigation shall be thoroughly documented on

Resident/Patient Incident Report shall be placed in the resident's medical record. 7.1 Investigation

6.1 Conduct an immediate and thorough

any state required form, and on the Incident/Accident Investigation, 7. The

separately in the CED's office."

No further information was provided prior to exit.

forms, logs and statement shall be stored

(1) Osteopenia — Osteopenia is a term to define bone density that is not normal but also not as low as osteoporosis. By definition from the World

Facility ID: VA0279

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	<b>*</b>		RINTED: 12/15/2016 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	405046	R WING	С

(3) DATE SURVEY COMPLETED C 12/08/2016 495246 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 226 | Continued From page 15 F 226 Health Organization osteopenia is defined by bone densitometry as a T score -1 to -2.5. There are many causes for osteopenia including calcium and vitamin D deficiency and inactivity. This information was obtained from: https://www.ncbi.nlm.nih.gov/pubmed/21234807/ 2. The facility staff failed to implement abuse policies and report a fracture of unknown origin (right femoral neck) to the required state agency in a timely manner for Resident #5. Resident #5 was admitted to the facility on 3/2/2011 and readmitted on 9/9/16 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, muscle weakness, difficulty in walking, hypertension, osteoporosis, breast cancer, heart failure, and hypothyroidism. Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/22/16. Resident # 5 was coded as being cognitively impaired in the ability to make daily decisions scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #5 was coded as requiring extensive assistance from two plus staff members with transfers, bed mobility. toileting, bathing, and locomotion off the unit. Review of the physician's notes revealed the following note documented by the nurse practitioner on 11/8/16: "Chief complaint: C/O (complaint) pain in B/L (bilateral) legs. History of present illness: 83 y.o. (year old) Caucasian

female, a LTC (Long Term Care) resident at (name of facility), hospitalized 9/5 to 9/9 with AMS (altered mental status) due to UTI (Urinary Tract infection) with sepsis, and worsening CHF

DEPARTMENT OF HEALTH AND HUM	ERVICES
CENTERS FOR MEDICARE & MEDICARD S	ERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION MUNDED.		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
			A. DOILE			(		
		495246	B. WING	·		12/0	08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			11	REET ADDRESS, CITY, STATE, ZIP CODE  DAIRY LANE REDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΙX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 226	it is apparent that sas she is more quidanswer questions a seen today for new management of DN hypothyroidism DRes (resident) w/pa and knees upon mher lungs, will order asking for pain meso will order celebr (by mouth) BID (tw meals) and will state of 12 mcg (microgram (responsible party)	age 16 ailure). Since her readmission the has had a mental decline et in nature and was not able to as she has in the past. She is reports of pain and M (diabetes mellitus) and biagnoses and Assessment: ain (with pain) in hips, pelvis ovement. Yells at the top of r x-rays. Res (Resident) is not d (medication) prn (as needed) ex (1) 100 mg (milligrams) po ice a day) w/meals (with rt low dose fentanyl patch (2) rams)Spoke with RP about above concerns, RP anding and agrees with POC	F	226				
	revealed the follow Celebrex 100 mg 1 and 5 PM with food apply patch q72 hd pain5. X-ray of B pain6. X-ray of be Review of Resident that X-ray did not a (the following day) documented the following day) documented the following celebrates age-indeterminate neck. No fracture degenerative chan	t #5's physician verbal orders ing order dated 11/8/16: "3 cap (capsule) po BID 8 AM d4. Fentanyl patch 12 mcg ours (every 72 hours) for /L (bilateral) hips and pelvis for illateral knees."  It #5's X-ray results revealed arrive to the facility until 11/9/16. The radiology report dilowing: "Hips bilat (bilateral) W dResults: Nondisplaced fracture of the right femoral of the left hip. Bilateral ges involving the hips"						
	revealed that the fi	acture of unknown origin was OLC (Office of Licensure and						

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES	
CENTERS FOR MEDICARE & MEDICARD SERVICES	



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1`'	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495246	B. WING		1 1:	2/08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 2240	CODE	.705/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 226	Review of the followarevealed that the from pathological in nature completed. The in 11/18/16.  Review of the inversion of th	In/16/16 (6 (six) working days) ras discovered.  W up report dated 11/21/16; acture was determined to be use after the investigation was vestigation was initiated on  Stigation revealed the following 6 by a nurse who worked on /16, on the 3-11 shift: "I 0 + 11 (Thur/Fri). Was told in ay) was negative and that MRI nce Imaging) may be usual indication / c/o of pain ted. Celebrex and Fentanyl d 11/8 and were in effect when	F 22	26			
	note dated 11/18/1 It documented the on 11/8/16 for c/o p X-ray of B/L (Bilate ordered with physicantiinflammatories 11/9/16= X-rays we p.m. 11/10/16= I was not 11/11/16- I follower for (R) (right) femore pain med. 11/14/16- Able to cand discussed res Care) which include management and is NWB (Non Weigel Control of the	d up X-ray results (+) (positive) ral neck fracture. Continued contact RP (responsible party) ults of X-ray and POC (Plan of					

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



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495246	B. WING			08/2016
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 226	conducted with LPI the nurse who work shift. When asked Resident #5's fractives was not quite sure When asked about resident's X-rays of fracture, LPN #5 st NP for notification anotify the family, ar received. LPN #5 staff to see if they be resident could have administration immishe was told in repwere negative on 1 she did not personal	<del>-</del>				
	conducted with LPI orders for the X-ray was called in to wo on 11/8/16. LPN #5 flagged for the X-ray she took the orders pharmacy. LPN #6 X-ray and notified the X-ray was not of X-ray did not arrive that if the situation will not be ordered X-rays are not order to the facility the new that if the situation will not be ordered X-rays are not ordered to the facility the new that if the situation will not be ordered X-rays are not ordered to the facility the new that if the situation will not be ordered X-rays are not ordered to the facility the new that if the x-ray was not ordered X-rays are not ordered to the facility the new that if the x-ray was not ordered X-rays are not ordered X-rays are not ordered to the facility the new that x-ray was called in to wo on 11/8/16. LPN #5	p.m., an interview was N #6, the nurse who faxed the vs. LPN #6 stated that she rk part of 7-3 and 3-11 shifts is stated she saw the orders ay and pain medication, and soff and faxed them to also stated that she called for the family. LPN #6 stated that ordered STAT (Immediate) and on her shift. LPN #6 stated is not an emergency, X-rays STAT. LPN #6 stated that if ered STAT, they usually arrive ext day. LPN #6 worked until When asked the reason for				

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES



NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER  XTREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION ING	(X3	OMPLETED
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  (X5) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  (X6) ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)			495246	B. WING			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY		WOODMONT CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			11 DAIRY LANE		
F 226 Continued From page 19 F 226	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO THE	ION SHOULD BE HE APPROPRIAT	
the X-ray, LPN #6 stated that she was told the resident was complaining of increased pain and the NP assessed the resident before writing the order. When asked if Resident #5's positive X-ray results should have been reported to administration immediately, LPN #5 stated that Administration should be notified right away so they can start an investigation on how the fracture occurred.  On 12/8/16 at approximately 11:30 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM (administrative staff member) #1, the pool of the pool of the profit of Nursing). When asked when an injury of unknown origin should be reported, ASM #2 stated, "Right Away." ASM 1 stated, "Within 24 hours." ASM #2 stated, "This was the delayed FRI (facility reported incident). I think what happened was the NP went to check on her (resident) for an unrelated situation and the resident was in a lot of pain at that time. She ordered X-rays of the bilateral hips and pelvis, and bilateral knees. Whoever the nurse was who looked at the X-rays, saw that one X-ray was negative and thought all X-rays were negative. She left them for NP to view when the NP arrived to facility (11/11/16)." ASM #2 stated that administration was not made aware of the fracture until 11/16/16 and they immediately reported this fracture to the state. ASM #2 stated that administration was not made aware of the fracture until 11/16/16 and they immediately reported this fracture to the state. ASM #2 stated that administration was not made aware of the fracture was pathological given her medical condition.  On 12/8/16 at approximately 1 p.m., an interview was conducted with ASM #5, the Nurse Practitioner. ASM #5 stated that the exact timeline of events but she stated that that on 11/11/16 he saw that the X-ray was	F 226	the X-ray, LPN #6 resident was compthe NP assessed to order. When asked X-ray results shou administration imm. Administration should they can start an information occurred.  On 12/8/16 at appointerview was constaff member) #1, (administrative start (Director of Nursin injury of unknown #2 stated, "Right A24 hours." ASM #FRI (facility reported happened was the (resident) for an unresident was in a lordered X-rays of and bilateral kneed looked at the X-ray negative and though She left them for the facility (11/11/16) administration was fracture until 11/16 reported this fractithat they conclude given her medical.  On 12/8/16 at app was conducted with Practitioner. ASM recall the exact times and the practitioner.	stated that she was told the plaining of increased pain and the resident before writing the ed if Resident #5's positive Id have been reported to nediately, LPN #5 stated that build be notified right away so nivestigation on how the fracture roximately 11:30 a.m., an educted with ASM (administrative the administrator and ASM (ff member) #2, the DON (ag). When asked when an origin should be reported, ASM (away." ASM 1 stated, "Within (2 stated, "This was the delayed of incident). I think what a NP went to check on her niclated situation and the ot of pain at that time. She the bilateral hips and pelvis, so thoever the nurse was who as yes, saw that one X-ray was ght all X-rays were negative. NP to view when the NP arrived (as not made aware of the condition). The stated that she could not neeline of events but she stated that she could not neeline of events but she stated	9			

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

(X2) MULTIPLE CONSTRUCTION

PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING				COMPLETED		
	405046		n wine			1	C		
NAME OF	PROVIDER OR SUPPLIER	495246	B. WING		ET ADDRESS, CITY, STATE, ZIP CODE	12	/08/2016		
WOODM	ONT CENTER				IRY LANE DERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 226	positive for fracture facility and then she they wanted aggres stated that she wro ortho consult. ASM consult did not real right femoral neck like an old fracture. consult only addres Resident #5's knee she made administ results.  On 12/8/16 at approadministration was concerns.  Facility policy titled documents in part, cases of suspected exploitation require	when she arrived to the e called the family to see if sive treatment. ASM #5 te an order that day for an #5 stated that the ortho ly address the fracture of the because they were treating it ASM #5 stated that the seed the bilateral pain to s. ASM #5 could not recall if ration aware of the X-ray oximately 11:30 p.m., made aware of the above	F 2	26					
	drug used to treat relieve symptoms of stiffness, and joint obtained from The https://www.ncbi.nl								
	synthetic opioid and	"Fentanyl is a powerful algesic that is similar to to 100 times more potent. It is	: : S						

DEPARTMENT OF HEAL	TH AND HUM SERVICES
CENTERS FOR MEDICA	RE & MEDICATO SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
	495246		B. WING		C <b>12/08/2016</b>	
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOUL  CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 250	used to treat patier manage pain after used to treat patier physically tolerant to information was oblinitiates of Health https://www.drugate. 483.40(d) PROVIS RELATED SOCIAL (d) The facility mussocial services to a practicable physical well-being of each This REQUIREMED by:  Based on resident facility document reand in the course of was determined the provide medically rof 26 residents in the facility staff fair interventions to decrelated to her room.  The findings include Resident #3 was as with diagnoses that to: arthritis, high ble anxiety and obesity.  The most recent Medically and the most recent Medical patients.	ription drug, and it is typically hts with severe pain or to surgery. It is also sometimes hts with chronic pain who are to other opioids." This tained from The National suse.gov/drugs-abuse/fentanyl. ION OF MEDICALLY. SERVICE  It provide medically-related ditain or maintain the highest all, mental and psychosocial resident.  NT is not met as evidenced interview, staff interview, eview, clinical record review of a complaint investigation, it at the facility staff failed to elated social services for one the survey sample, Resident led to develop and implement crease the resident's anxiety imate's behavior.  e:  dmitted to the facility on 6/6/16 tincluded but were not limited bod pressure, kidney disease,	F 2	1. Consistent with a care-plan meeting on 11/22/16, with Resident Representative (R CED & CNE present, Residents are assessed and no further issuidentified.  2. Resident or RR requests for changes will be honored by availability of an appropria.  3. New residents are assigned based on the information refrom the transferring facility Considerations for placemes semi-private living arrange for all residents are based on number of factors including gender, behavior issues, mestatus, presence or absence infections, and transfer status/requirements. Residents for a room change made to Social Services and	R), lent #3 on present vas tes room sed on te bed. rooms ceived y, nt in ments n a dical of ent are	

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



	D PLAN OF CORRECTION  (X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER:		l ` ′	NG	COMPLETED		
		495246	B. WING _		C 12/08/2016		
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 250	having scored a 1 interview for ment was cognitively in The resident was from staff for all a eating once the tr.  A complaint receive 11/1/16 alleged, "The roommate, (all night keeping repositive to babysits her and general facility on 3/24/16 diagnoses that incheart failure, stroke the facility on 3/24/16 diagnoses that incheart failure, stroke the facility on 3/24/16 diagnoses that incheart failure, stroke the facility of t	f 10/31/16 coded the resident as 5 out of 15 on the BIMS (brief tal status, indicating the resident tact to make daily decisions. coded as requiring assistance ctivities of daily living except for	F 2	discussed at daily clinical meetings where feasibility request are discussed with interdisciplinary team. Do are then shared with the re RP and possible new room.  4. Social Services department log all requests for room of and the decision made with accompanying rationale, be integrated into practice reported to the Quality As Committee x 3 months.	of the the ecisions esident, omate. of this will changes the This will and		

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



STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i .	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			7 501.25			С		
		495246	B. WING		12	/08/2016		
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE	CODE			
WOODM	ONT CENTER			FREDERICKSBURG, VA 22405	5			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	Continued From patated, "If you coryou move and I want to move. I decreased to Market and to move and their roommate."  Review of the cardocumentation reby staff to decreased to her room and their roommate. Was mind is that they'dere are no behave their roommate. Resident #3 was OSM #6 stated, "compatible roommate and discussed so Resident #3's conwould be document."	page 23 Implain (about your roommate) Ivas here first so that's why I don't Ivas here first so notes dated Ivas p.m. documented, "Usually she Ivas plan did not evidence Ivas plan did not eviden	F 2					
	been developed, no." When asked developed, OSM the nursing staff potential adjust is can make strateg what strategies h	n asked if the care plan had OSM #6 stated "Not currently why a care plan would be #6 stated, "Certainly we want to be aware and that there are usues with a new roommate. We ples to help them." When asked ad been developed, OSM #6 roommate comfortable at night						

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	495246		B. WING			C <b>12/08/2016</b>		
NAME OF I	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP 0	<u>l</u> CODE	12/	J8/2016	
	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERE			BE	(X5) COMPLETION DATE			
F 250	was responsible fo OSM #6 stated it was common p.m. with LPN (lice nurse caring for Resident #3 got ald #5 stated, "(Name should care for her about it and I told had be care of her."  On 12/8/16 at 12:1 staff member) #1, the nurse executive clinical quality specifindings.  An interview was common p.m. with OSM #5, how the concerns roommate were common oos M #5 stated, "When the care proommates were not we try to match refer to match refer to wasn't interact when a bed come	s improved." When asked who in developing the interventions, was her responsibility.  conducted on 12/7/16 at 1:10 ensed practical nurse) #5, the esident #3. When asked how ong with her roommate, LPN of resident) feels like she resident) feels like she resident. We've talked her it's not her place to take  5 p.m. ASM (administrative the executive director, ASM #2, e and ASM #3, the regional cialist were made aware of the conducted on 12/8/16 at 4:30 a social worker. When asked Resident #3 had about her formunicated to front line staff, we would develop a plan and plan or verbally share it." When rocess staff follows if not compatible, OSM #5 stated, esidents up. (Name of Resident ting too much with a roommate, s open we'll try to		250				
	When asked who	t. She feels it's her atch her (the roommate)." would be moved, OSM #5 er both of them a room	:				:	
	p.m. with CNA (clir	conducted on 12/8/16 at 4:42 nical nursing assistant) #4, the Resident #3. When asked how	:	i i				

DEPARTMENT OF HEALTH AND HUM	SERVICES
<b>CENTERS FOR MEDICARE &amp; MEDICAR</b>	SERVICES



AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	1 ' '	ING		COMPLETED		
		495246	B. WING		12	C /08/2016		
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE		
F 250	#4 stated, "(Name (name of Resident (Resident #3) feels for her. I tell her that She doesn't want a don't want her to fat nervous when she alarm)." When aske information about it use to decrease Restated, "No."  Review of the facilit "Social Services" d SUMMARY: The Sworks with patients members/significant through use of the identifying their stremental health need developing, and/or services to meet the Services Special Is with the highest pra and psychosocial want Advocacy. 3. Responding the patients/residents as satisfaction with sein the development plan of care for each identifies the psychosocial want of care for each identifies the	ong with her roommate, CNA of Resident #3) looks out for #18 the roommate). She like she needs to watch out at's good but you don't have to. nything to happen to her and I II. She (Resident #3) gets hears the beep (from the bed ed if she had received any interventions that staff should esident #3's concerns, CNA #4 ty's job description titled, ocumented, "POSITION ocial Services Specialist I /residents and their family int others within the facility psychosocial perspective engths, social, emotional, and is along with providing, aiding in the access of ose needs. The Social shall provide patient/resident actical level of physical, mental well-being and quality of life. Onds to issues identified by and families to determine rvices. Clinical. 3. Participates of a written, interdisciplinary chipatient/resident that osocial needs/issues of the egoals to be accomplished for and the appropriate Social		250				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE S COMPL	
	495246		B. WING			C <b>12/08/2016</b>	
	PROVIDER OR SUPPLIER  ONT CENTER			11 DAIRY LA	RESS, CITY, STATE, ZIP CODE ANE :KSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
	Complaint deficience 483.20(d);483.21(b) COMPREHENSIVE 483.20 (d) Use. A facility reassessments comprehensive the resident results of the assess and revise the resident.  483.21 (b) Comprehensive (1) The facility must comprehensive pereach resident, consist forth at §483.10 includes measurable to meet a resident's and psychosocial recomprehensive assessments comprehensive assessments of the formal for the facility must comprehensive pereach resident's and psychosocial recomprehensive assessments comprehensive assessments comprehensive pereach resident's and psychosocial recomprehensive assessments comprehensive pereach resident's and psychosocial recomprehensive assessments comprehensive pereach resident's and psychosocial recomprehensive assessments comprehensive pereach resident (i) The services that or maintain the responsibility of the facility o	ion was provided prior to exit.  by  )(1) DEVELOP  CARE PLANS  nust maintain all resident bleted within the previous 15 ent's active record and use the esments to develop, review dent's comprehensive care  Care Plans  t develop and implement a reson-centered care plan for esistent with the resident rights 0(c)(2) and §483.10(c)(3), that le objectives and timeframes as medical, nursing, and mental reeds that are identified in the resement. The comprehensive riche the following -  at are to be furnished to attain rident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required as 3.25 or §483.40 but are not a resident's exercise of rights luding the right to refuse	F 2	1. T & in C U R R 2. T ot id tri cc re 3. N in Pe by nu th in 4. W by de re: int au Qu	The care plans for Resident & Resident #13 were revised. As that were triggered: Urinary Incontinence for Resident #11 and Nutrition Resident #13. The MDS Coordinator revises ther residents' records to dentify care plans not reflecting to the resident #13 and the residents of the resident of the resident of the resident of the resident care plans reflecting the CNE/designee to be retermine compliance with resident care plans reflecting the resident care plans reflecting th	sed to or the n for iewed ecting as, with ded. will be y's policy new eive heir hucted ag all deep eer new eiement hucted en eer new eer new eiement hucted en eer new eer	1/21/17

		I AND HUN SERVICES				FOR	D: 12/15/2016 MAPPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495246	B. WING		<del>.</del>	12	C 2/08/2016
NAME OF	PROVIDER OR SUPPLIER	***************************************	·		EET ADDRESS, CITY, STATE, ZIP COI		
WOODM	ONT CENTER				AIRY LANE DERICKSBURG, VA 22405		
(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 AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 27	F 27	79			
	rehabilitative service provide as a result recommendations. findings of the PAS	I services or specialized ces the nursing facility will of PASARR If a facility disagrees with the SARR, it must indicate its ident's medical record.					
	<ul><li>(iv)In consultation with the resident and the resident's representative (s)-</li><li>(A) The resident's goals for admission and desired outcomes.</li></ul>						
	future discharge. F whether the reside community was as	preference and potential for acilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate rpose.					TARLES AND
	plan, as appropriat	is in the comprehensive care e, in accordance with the orth in paragraph (c) of this					
	by: Based on staff into review, and clinical determined that faccomprehensive car	NT is not met as evidenced erview, facility document I record review, it was cility staff failed to develop a re plan for two of 26 residents ble, Resident #11 and #13.					

1. The facility staff failed to develop a comprehensive care plan from the triggered CAA (Care Area Assessment Summary) in Section V for "Urinary Incontinence" on Resident #11's admission MDS (minimum data set) assessment

with an ARD (assessment reference date) of

DEPARTMENT OF HEALTH AND	HUM SERVICES
<b>CENTERS FOR MEDICARE &amp; M</b>	IEDICAID SERVICES



AND PLAN OF CORRECTION  (A1) PROVIDENSUPPLIENCEM  IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495246	B. WING			ì	C <b>08/2016</b>
	PROVIDER OR SUPPLIEF	3		11	REET ADDRESS, CITY, STATE, ZIP CODE  DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 279	a comprehensive CAA area in Sectic #13's admission in date of 11/23/16.  The findings include 1. Resident #11 with 11/7/16 with diagnostic limited to cellulitis pressure, atrial fib dementia with Levidisease.  Resident #11's moset) was an admis (assessment refer Resident #11 was impaired in the abscoring 06 out of for mental status) coded as requiring walking, locomotic hygiene, and bath from staff with train Resident #11's addated 11/24/16 dotriggered CAA area Assessment Sum	It is, facility staff failed to develop care plan from the triggered on V for "Nutrition" on Resident MDS assessment with and ARD de:  Was admitted to the facility on loses that included but were not of the left lower leg, high blood willation, high cholesterol, wey bodies (1) and heart  Dest recent MDS (minimum data assion assessment with an ARD rence date) of 11/24/16.  Coded as being cognitively willity to make daily decisions 15 on the BIMS (brief interview exam. Resident #11 was gextensive assistance with on, dressing, toileting, personal ing; and extensive assistance mission MDS assessment becomented the following as under Section V (Care Area	F 2	79			
							- - -

	MENT OF HEALTH	AND HUM SERVICES			FORM	D: 12/15/2016 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495246	B. WING _		12	C 2 <b>/08/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 224	105	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	11/21/16, failed to rinterventions.  On 12/7/16 at 2:07 conducted with LPI the MDS nurse. W staff follows for deveriggered CAA area area triggers on the care planned, then completed by that of that she completed such as ADLs (activincontinence, and of stated that incontin sometimes bunched When asked if she incontinent care plastated, "It is not held somebody else did the RAI (Resident Amanual as a refere MDS.	ge 29 If #11's care plan dated eveal any urinary incontinence  p.m., an interview was N (licensed practical nurse) #2, hen asked about the process reloping a care plan from the s, LPN #2 stated that if an e CAAs and it is marked to be a care plan should be department. LPN #2 stated all nursing related sections vities of daily living), urinary communication etc. LPN #2 ent care interventions are d into the skin care plan. could find a urinary an for Resident #11, LPN #2 re. Either I missed it or " LPN #2 stated that she uses Assessment Instrument) nce when completing the  p.m., ASM (administrative	F 27			
:	staff member) #1, t (The Director of Nu	he administrator and ASM #2, irsing) were made aware of the further information was				
	Review of the PAI	3.0 manual documents in part				•

the following: Review a triggered CAA by doing an in-depth, resident-specific assessment of the triggered condition in terms of the potential need

for care plan interventions. While reviewing the CAA, consider what MDS items caused the CAA to be triggered. This is also an opportunity to consider any issues and/or conditions that may

		AND HUM SERVICES			FORM	: 12/15/2016 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		495246	B. WING			C <b>08/2016</b>
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(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 SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	necessarily captured CAAs helps staff to intervention is necessarily captured intervention may be results of the assessinterdisciplinary teat and/or resident's resoft concern that:  Warrant interved Affect the resident implement intervention maintain current possible, based up	ggered condition, but are not ed in MDS data. Review of decide if care plan essary, and what types of a appropriate. Using the esment can help the em (IDT) and the resident epresentative to identify areas	F 2	279		

artery.

CAA area "Nutrition."

 Can help to minimize the onset or progression of impairments and disabilities; and
 Can help to address the need and desire for other specialized services (e.g. palliative care, including symptom relief and pain management).

2. For Resident #13, facility staff failed to develop a comprehensive care plan from the triggered

Resident #13's most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 11/23/16.
Resident #13 was coded as being cognitively intact in the ability to make daily decisions scoring

Resident #13 was admitted to the facility on 11/16/16 with diagnoses that included but were not limited to acute spondylosis, high blood pressure, Alzheimer's disease, type two diabetes mellitus, a burn to the right leg that occurred at home and occlusion of unspecified vertebral

DEPARTMENT	OF HEALTH AND	HUN SERVICES
CENTERS FOR	MEDICARE & MI	EDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495246		1 ' '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED				
		495246	B. WING		12	C <b>12/08/2016</b>			
	NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405					
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULI			(X5) COMPLETION DATE			
F 279	mental status) exa as requiring extens	age 31 BIMS (brief interview for m. Resident #13 was coded sive assistance from staff with on, dressing, toileting, personal	F 2	<b>79</b>					
	hygiene, and bathing Resident #13's address 11/23/16 doctriggered CAA area Assessment Sumn	ng. mission MDS assessment cumented the following a under Section V (Care Area							
	Review of Residen 11/29/16, failed to interventions.	t #13's care plan dated reveal any nutrition	:						
	conducted with OS Dietary Manager. staff follows for der triggered CAAs, Ocare plan with anyon utritional issues a often; monthly instassessment." OSI CAA worksheet for on Resident #13's 11/23/16. OSM #4 that particular one care plan there wo sure who complete me." OSM #4 state nutritional care pla 12/7/16, at 2:45 p.1	p.m., an interview was iM (other staff member) #4, the When asked about the process veloping a care plan from the SM #4 stated, "You would do a one deemed at risk for nd I would also visit more ead of quarterly for an M #4 was asked if she did the the area "Nutritional Status" admission MDS dated stated, "I don't believe I did but if I said I was going to do a uld be a care plan. I am not es these sections other than ed that she could not find a in for Resident #13. On m., OSM #4 stated, "Because aggered for a burn when she							
	was admitted here								

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



AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495246	B. WING		12	C / <b>08/2016</b>	
	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405		700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 279	MDS should have decision."  On 12/7/16 at 6:45 the administrator at of Nursing) were refindings.  Facility policy titled documents in part interdisciplinary tempatient and/or residappropriate, will estoutcomes of care, and duration of carelated to the effect Documentation will Patient's goals and in triggered Care AD Development of care planning for a	age 32 hal care plan at that time. The said NO to care planning  p.m., administration (ASM) #1, and ASM #2, the DON (Director hade aware of the above  I, "Person-Centered Care Plan", the following: "The am, in conjunction with the dent representative, as stablish the expected goals and the type, amount, frequency, re, and any other factors ctiveness of the plan of care. If show evidence of: d preferences; Patient's status area Assessments (CAAs); are planning interventions for all the MDS; and Rationale for not a specific triggered CAA."		279			
	is one of the most dementia. People experience a varie changes in alertne hallucinations; proposture; muscle simemory loss. Alth body dementia is are thought to rescalled alpha-synuc	Dementia-"Lewy body demential common forms of progressive affected by this condition may bety of symptoms such as less and attention; blems with movement and tiffness; confusion; and/or ough the exact cause of Lewy boorly understood, symptoms all when clumps of a protein clein ("Lewy bodies")					

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

		LI INCLUSIONATIONALISMOCO.		PLE CONSTRUCTION  IG	СОМ	(X3) DATE SURVEY COMPLETED	
		495246	B. WING _		1	C 08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP O 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 280	https://raredisease wy-body-dementia 483.10(c)(2)(i-ii,iv, PARTICIPATE PL. 483.10 (c)(2) The right to and implementation plan of care, inclu- (i) The right to particulating the right be included in the request meetings revisions to the per (ii) The right to particulate to sign after of care.  (c)(3) The facility right to participate shall support the inplanning process	National Institutes of Health es.info.nih.gov/diseases/3243/le a. v)(3),483.21(b)(2) RIGHT TO ANNING CARE-REVISE CP participate in the development on of his or her person-centered ding but not limited to: ticipate in the planning process, to identify individuals or roles to planning process, the right to and the right to request erson-centered plan of care. rticipate in establishing the and outcomes of care, the type, y, and duration of care, and any ed to the effectiveness of the receive the services and/or items an of care.  The treatment and resident in this or her treatment and resident in this right. The must—reclusion of the resident and/or items and of the resident and/or items and the resident and/or items and resident in this right. The must—reclusion of the resident and/or	F 28	1 77	esidents were survey.  Itor reviewed ntify resident updates, with as needed. Shifts will be company's are Plan policy be. All new will receive far as their Morning II include ans that are nour or risk-te. De conducted to the committee x3	1/21/17	

PRINTED: 12/15/2016 DEPARTMENT OF HEALTH AND HUM! SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING C 495246 B. WING 12/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 280 Continued From page 34 F 280 (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-(i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-(A) The attending physician. (B) A registered nurse with responsibility for the resident.

Event ID: UKHU11

(C) A nurse aide with responsibility for the

(D) A member of food and nutrition services staff.

(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs

or as requested by the resident.

resident's care plan.

resident.

		AND HUM SERVICES & MEDICAID SERVICES				FORM /	12/15/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	-	COM	SURVEY PLETED
		495246	B. WING _			12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 35	F 28	0			
	team after each as comprehensive and assessments. This REQUIREMEI by: Based on observation document review a was determined that review and revise the for five of 26 reside Residents #10, #7,  1. The facility staff comprehensive car clam shell brace or 2. The facility staff comprehensive car discontinuation of a (discontinued on 10 and	tion, staff interview, facility and clinical record review, it at the facility staff failed to the comprehensive care plantents in the survey sample, #3, #4 and #5.  failed to revise Resident #10's be plan to include a right ankled dered on 8/4/16.  failed to revise Resident #7's be plan to include the a Foley urinary catheter 0/4/16).  failed to review and revise prehensive care plan to the the plan to the the prehensive care plan to the prehensive care plan to the					

Event ID: UKHU11

4. The facility staff failed to develop a comprehensive care plan for the care of Resident #4's left leg splint.

5. The facility staff failed to review or revise the comprehensive care plan after a stage two pressure ulcer was found on Resident #5's left

heel.

#### PRINTED: 12/15/2016 DEPARTMENT OF HEALTH AND HUM SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 495246 12/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 Continued From page 36 F 280 The findings include: 1. The facility staff failed to revise Resident #10's comprehensive care plan to include a right ankle clam shell brace ordered on 8/4/16. Resident #10 was admitted to the facility on 6/25/16. Resident #10's diagnoses included but were not limited to: displaced ankle fracture of the right lower extremity, chronic kidney disease and heart failure. Resident #10's most recent MDS (minimum data set), a significant change in status assessment with an ARD (assessment reference date) of 9/19/16, coded the resident's cognition as being severely impaired. Section G coded the resident as requiring extensive assistance of one staff with bed mobility, transfers, locomotion, dressing, toilet use, personal hygiene and bathing. An orthopedist consult note dated 8/4/16 documented, "S/P (Status post) ORIF (open reduction internal fixation [surgical procedure]) Right ankle fx (fracture). Skin intact, incisions

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

protect skin..."

as tolerated with walker and

well-healed...Recommendations: Weight bearing

assistance/observation at all times. Fall Risk. 2. Wear ankle clam shell/ (illegible word) brace at all times. Wear thick sock underneath at all times to

A physician's order dated 8/4/16 documented, "Weight bearing as tolerated with walker & (and) assistance /observation at all times. Wear ankle clam shell brace at all times, wear thick sock underneath-protect skin. F/U (follow up) in 4 wks (weeks)." The brace was discontinued on

PRINTED: 12/15/2016 DEPARTMENT OF HEALTH AND HUM SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING \_ 495246 B. WING 12/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 Continued From page 37 F 280 Resident #10's comprehensive care plan initiated on 7/5/16 and active during the time period of 8/4/16 through 8/16/16 documented, "Resident is at risk for skin breakdown as evidenced by limited mobility, incontinence...Weekly skin assessment by license nurse..." The care plan failed to document any information regarding the resident's clam shell brace. On 12/8/16 at 11:16 a.m., an interview was conducted with RN (registered nurse) #1 (unit manager). RN #1 confirmed residents' care plans should be updated when a resident receives a new order for a brace. RN #1 was asked how staff would know how to care for a brace if it was not documented on the care plan. RN #1 stated, "That's why it should be care planned." At this time, RN #1 was asked to look at Resident #10's care plan and verify that it was not revised to include the ankle clam shell brace ordered on 8/4/16. RN #1 stated she would get back to this surveyor. On 12/8/16 at 12:00 p.m., ASM (administrative staff member) #1 (the executive director) and

ASM #2 (the nurse executive) were made aware of the above findings.

On 12/8/16 at 4:10 p.m., LPN (licensed practical nurse) #2 (MDS coordinator) confirmed Resident #10's care plan had not been revised to include the brace ordered on 8/4/16.

The facility policy titled, "Person-Centered Care Plan" documented, "Care plans will be: 5.2 Reviewed and revised a minimum of quarterly and as needed to reflect the response to care and changing needs and goals..."

	MENT OF HEALTH	AND HUM SERVICES & MEDICALD SERVICES			FORM	: 12/15/2016 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION IG	CON	E SURVEY MPLETED
		495246	B. WING _		l l	C /08/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA	22405	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 38	F 28	<b>30</b>		
	No further informat	ion was presented prior to exit.				
	comprehensive car	failed to revise Resident #7's re plan to include the resident Foley urinary catheter (1) 0/4/16).	Animampuna mara ara ara ara ara ara ara ara ara a			
	1/28/11. Resident:	dmitted to the facility on #7's diagnoses included but heart failure, shortness of god pressure.	1			
	set), a quarterly as (assessment reference the resident's cognimpaired. Section	t recent MDS (minimum data sessment with an ARD ence date) of 11/7/16 coded ition as being severely H coded Resident #7 as of bladder and as not having eter.				
	physician's order d resident's Foley ca #7's comprehensiv documented, "Res catheter related to Catheter care as in	t #7's clinical record revealed a ated 10/4/16 to discontinue the theter. Review of Resident re care plan created on 4/4/16 ident requires indwelling foley wound(s)Interventions: ndicated. Keep catheter off en appropriate. Provide privacy				

observed.

was observed.

On 12/6/16 at 3:08 p.m., Resident #7 was observed sitting up in bed. No Foley catheter

On 12/7/16 at 7:46 a.m., Resident #7 was observed lying in bed. No Foley catheter was

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING		12	C / <b>08/2016</b>	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE	.00,2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 280	conducted with RN manager). RN #1 scoordinators update could update a care care plan should be catheter is discontil who received the dhave been able to unit manager has trupdate is done.  On 12/7/16 at 6:45 staff member) #1 (ASM #2 (the nurse of the above finding On 12/8/16 at 7:47 nurse) #2 (the MDS removed the Foley Resident #7's care  No further informate (1) A Foley urinary body to drain and of This information was https://medlineplus	p.m., an interview was (registered nurse) #1 (unit stated she and the MDS e care plans but any nurse e plan. RN #1 confirmed a e updated when a Foley nued. RN #1 stated the nurse iscontinuation order should update the care plan and the o follow up to make sure the  p.m., ASM (administrative the executive director) and executive) were made aware gs.  a.m., LPN (licensed practical coordinator) stated she had catheter documentation from plan.  ion was presented prior to exit. catheter is a tube placed in the collect urine from the bladder. as obtained from the website: .gov/ency/article/003981.htm	F 2	280			
		failed to review and revise prehensive care plan to				:	

#### DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			TE SURVEY MPLETED	
		495246	B. WING			12	C 2/08/2016
	PROVIDER OR SUPPLIER  ONT CENTER	<u> </u>		11 D	EET ADDRESS, CITY, STATE, ZIP C AIRY LANE EDERICKSBURG, VA 22405	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 280	roommate and to it to decrease the recrommate's behave Resident #3 was a	#3's anxiety related to her nclude interventions to be used sident's anxiety related to her ior.  dmitted to the facility on 6/6/16	F	280			
		It included but were not limited ood pressure, kidney disease, y.					
	quarterly assessm reference date) of having scored a 15 interview for menta was cognitively into The resident was	MDS (minimum data set), a ent, with an ARD (assessment 10/31/16 coded the resident as 5 out of 15 on the BIMS (brief al status, indicating the resident act to make daily decisions. coded as requiring assistance ctivities of daily living except for ay was set up.					
	11/1/16 alleged, "The roommate, (i all night keeping n	red to the state agency on The complainant states that, name of roommate), stays up mother up; my mother gets stressed out"					
	facility on 3/24/16 diagnoses that inc	roommate, was admitted to the and readmitted on 8/16/16 with cluded but were not limited to: e and high blood pressure.					A Appendix of the Control of the Con
	with an ARD of 9/2 being severely im	nt MDS, a quarter assessment, 26/16 coded the resident as paired cognitively. The resident uiring assistance from staff for ly living.					
		conducted with Resident #3 on a.m. When asked how she got	:				

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

_	,,,,,	a.,		
1			NO.	
ŧ.	ė.		j	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED	
		495246	B. WING				08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405	DE	12/00/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE	
F 280	didn't sleep at first going to fall. She was bed." When asked decrease her condition Resident #3 stated about her but if I through them." Resident were going to give Does she look condition. Review of Resident 10/31/16 at 10:38 is up in W/C (whee watching TV, keep roommate"  Review of the care documentation regions staff to decreas related to her room.	mmate, Resident #3 stated, "I because I was afraid she was as always trying to get out of what staff had done to ern for her roommate, I, "They tell me not to worry link she's going to get hurt to the #4 stated, "They told me they me a compatible roommate. In the modern mate in the modern mate in the modern mate in the modern mate. In the modern mate in the modern mate. In the modern mate in the modern mate in the modern mate in the modern mate in the modern mate.		280				
	worker. When ask selected, OSM #6 mind is that they're there are no behave their roommate." We sident #3 was cosm #6 stated, "I compatible roomm #3)." OSM #6 stated team had discussed and Resident #18 had discussed sor Resident #3's conwould be document.	taff member) #6, the social ed how roommates were stated, "Compatibility in my e able to communicate. That vioral issues that would impact When asked if she thought compatible with her roommate, think there are more nates for (name of Resident ed that the interdisciplinary ed the residents (Resident #3 the roommate) and that they me interventions to decrease cerns. When asked if that nated, OSM #6 stated, "I would asked if the care plan had						

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1`'	NG		MPLETED
		495246	B. WING		40	C
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 280	no." When asked developed, OSM the nursing staff to potential adjustm roommate. We cathem." When ask developed, OSM comfortable at nigimproved."  An interview was p.m. with LPN (lic nurse caring for Resident #3 got a #5 stated, "(Nam should care for habout it and I told care of her."	page 42 OSM #6 stated "Not currently I why a care plan would be #6 stated, "Certainly we want to be aware and that there are ent issues with a new an make strategies to help ted what strategies had been #6 stated, "Keep her roommate ght and I know that has  conducted on 12/7/16 at 1:10 censed practical nurse) #5, the Resident #3. When asked how along with her roommate, LPN e of resident) feels like she er (roommate). We're talked I her it's not her place to take	F 2	80		
	staff member) #1 the nurse execut	I, the executive director, ASM #2, ive and ASM #3, the regional ecialist were made aware of the				
	p.m. with OSM # how the concerns roommate were o OSM #5 stated, '	conducted on 12/8/16 at 4:30 5, a social worker. When asked s Resident #e had about her communicated to front line staff, "We would develop a plan and plan or verbally share it."				
	p.m. with CNA (c aide who cares for Resident #3 got a #4 stated, "(Nam	conducted on 12/8/16 at 4:42 dinical nursing assistant) #4, the or Resident #3. When asked how along with her roommate, CNA be of Resident #3) looks out for ont #18, roommate). She feels				

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495246	B. WING	B. WING			08/2016
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODI 11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	good but you don't anything to happer fall. She (Resident hears the beep (fro asked if she had reinterventions that she Resident #3's cond.  No further information of the facility staff comprehensive cate #4's left leg splint.  Resident #4 was a 11/15/10 and read that included but with depression and and the most recent of the facility assessment of the facility assessment of the facility assessment of the facility of resident, "Typof resident) is experienced at the facility of resident, is experienced and inner ankle noted that included warm to touch, switch the facility of the faci	vatch out for her. I tell her that's have to. She doesn't want in to her and I don't want her to #3) gets nervous when she om the bed alarm)." When exceived any information about staff should use to decrease terns, CNA #4 stated, "No." tion was provided prior to exit.  failed to develop a re plan for the care of Resident admitted to the facility on mitted on 1/3/11 with diagnoses were limited to: dementia, iemia.  #IDS (minimum data set), a ent, with an ARD (assessment 1/1/28/16 coded the resident as paired cognitively. The resident uiring assistance from staff for y living.  se's notes dated 5/4/16 at 11:00 e: Change in Condition. (Name eriencing pain. L (left) and yelling when touched. L to be discolored, L ankle is ollen and painful to touch."		280			
	instructions dated Application: Poste	ergency room discharge 5/4/16 documented, "Splint rior short leg fiberglass splint er leg. Wear splint until					

		I AND HUM SERVICES			FORM	): 12/15/2016 MAPPROVED ): 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION  NG	(X3) DA	TE SURVEY MPLETED
		495246	B. WING_		12	C 2 <b>/08/2016</b>
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP C		,
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(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 COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 280	Continued From pa	age 44	F 28	80		
	released. Follow-up Follow up tomorrow	p with: (Name of doctor). v."				
	Review of the phys documentation reg	ician's orders did not evidence arding the splint.				
	p.m. documented, LLE (left lower extr	e's notes dated 5/5/16 at 1:11 "Area remains painful to touch remity) remains in soft cast." splint is not soft but rigid.]				
	p.m. with LPN (lice wound nurse. Whe plan when a reside	onducted on 12/7/16 at 2:45 nsed practical nurse) #1, the en asked who updated the care ent had a splint, LPN #1 stated ow but it was not her.				
	a.m. with RN (regis manager. RN #1 w were updated. RN conditions, falls, sk have to update the was important to u	onducted on 12/8/16 at 11:07 stered nurse) #1, the unit as asked when care plans #1 stated, "Any change in cin tears, all new changes, we care plan." When asked why it pdate the care plan, RN #1				
	of care." When ask plan when a reside "The wound nurse, update the care pla Resident #4's care	ure we are current in our plan ked who would update the care ent had a splint, RN #1 stated, the nurse. Everyone should an." When asked to review plan for documentation of the lied on 5/4/16, RN #1 could not	deminates taked the state of th			

findings.

locate documentation regarding the splint.

On 12/8/16 at 12:15 p.m. ASM (administrative staff member) #1, the executive director, ASM #2, the nurse executive and ASM #3, the regional clinical quality specialist were made aware of the

DEPARTMENT OF HEALTH AND	HUM/ SERVICES
CENTERS FOR MEDICARE & ME	DICAL SERVICES



PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
•		495246	B. WING_		12	C /08/2016
,	PROVIDER OR SUPPLIER  ONT CENTER	1		STREET ADDRESS, CITY, STATE, ZIF 11 DAIRY LANE FREDERICKSBURG, VA 2240	CODE	
(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 C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	p.m. with LPN #2, asked who updated #2 stated, "The AD nursing) or the nursif a care plan would a splint applied, LF No further information."  5. The facility staff comprehensive capressure ulcer was heel.  Resident #5 was a	onducted on 12/9/16 at 1:45 the MDS coordinator. When d the resident's care plan, LPN ON (assistant director of ses on the floor." When asked d be updated if a resident had N #2 stated, "Yes." tion was provided prior to exit.  failed to review or revise the re plan after a stage two a found on Resident #5's left dmitted to the facility on	· F·2	80		
	3/2/2011 and readithat included but will diabetes, unspecific behavioral disturbation difficulty in walking breast cancer, head reading with the series of t	dmitted to the facility on mitted on 9/9/16 with diagnoses were not limited to type two lied dementia without ance, muscle weakness, in hypertension, osteoporosis, art failure, and hypothyroidism.  It recent MDS (minimum data ant change assessment with an reference date) of 11/22/16. Coded as being cognitively lity to make daily decisions 5 on the BIMS (brief interview exam. Resident #5 was coded sive assistance from two plus in transfers, bed mobility, and locomotion off the unit.				

PRINTED: 12/15/2016 DEPARTMENT OF HEALTH AND HUMA **SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAL SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 495246 B. WING 12/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 280 F 280 Continued From page 46 Wound Date: 11/22/16, Initial Stage: two...anatomical location: L (left) heel." Review of Resident #5's care plan dated 11/11/16 revealed that pressure prevention interventions were put into place prior to the development of the stage two heel ulcer. Review of Resident #5's care plan failed to show that the care plan was reviewed or revised after the discovery of a stage two pressure ulcer on Resident #5's left heel. Review of Resident #5's physician telephone orders revealed that different treatments were put into place to treat Resident #5's left heel ulcer. On 12/7/16 at 2:57 p.m., an interview was conducted with LPN (licensed practical nurse) #5, the nurse who found the open area. When asked who was responsible for updating the care plan for each resident, LPN #5 stated that she was not sure. LPN #5 stated, "I think it's MDS but I am not guite sure." When asked when a care plan would be updated, LPN #5 stated for any change in condition such as a resident refusing showers, eating habits. When asked if skin alterations or pressure areas would be documented on the care plan, LPN #5 stated, "I don't know about

On 12/7/16 at approximately 2:10 p.m., an interview was conducted with RN (Registered Nurse) #3. RN #3 stated that nurses on the unit were responsible for updating the care plan for issues such as falls, infections, catheters etc. RN #3 stated the nurse who recognizes the change in condition is responsible for updating the care plan. When asked if skin conditions should be

pressure." When asked if she updated the care plan after she discovered the open area to Resident #5's heel, LPN #5 stated, "I did not."

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495246	B. WING			12/0	)8/2016
	PROVIDER OR SUPPLIER			11 C	EET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	Should be on Care On 12/7/16 at 3:11 conducted with LPI purpose of the care let you know about or a change in con- care plan is update plan is updated wit wounds or any maj is responsible for us stated that unit masometimes the floor On 12/7/16 at appr (Administrative Sta Administrator and a were made aware	plan, RN #3 stated, "Yes it Plan."  p.m., an interview was N #6. When asked what the e plan was, LPN #6 stated, "To the patient's welfare, condition dition." When asked when the ed, LPN #6 stated that the care thany issues with pain, falls, for change. When asked who updating the care plan, LPN #6 nagers, supervisors, and or nurses update the care plan.  Toximately 6:45 p.m., ASM off Member) #1, the ASM #2, (Director of Nursing) of the above concerns.		280			
F 281 SS=D	Facility policy titled did not address up 483.21(b)(3)(i) SEI PROFESSIONAL: (b)(3) Comprehens The services provi as outlined by the must- (i) Meet profession This REQUIREME by: Based on staff into			281	<ol> <li>The code status of Resident Code status was corrected, consistent with the corresponding physician order and advance directive on the chart.</li> <li>Current residents' records we reviewed to determine accurregarding current and desire status. No other issues were identified.</li> <li>A chart review will be conducted by the CNE/designee during</li> </ol>	onding e were racy ed code e	

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

September 1
£
£
<b>1</b>
"West of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		ATE SURVEY MPLETED
		495246	B. WING		4.	C 2/08/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZI		2/06/2010
				11 DAIRY LANE	. 0002	
WOODM	ONT CENTER			FREDERICKSBURG, VA 224	05	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		/VE)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 48	F 2	81 month and shangs	orion and	
	the facility staff faile	ed to follow professional		month-end change-	•	
		ce for one of 26 residents in		newly-admitted res		
	the survey sample,			have their advance	directives	
				reviewed and appro	priately coded	*
		ed to transcribe a Durable Do		Nursing staff will b	e re-educated	
		der to Resident #1's		by the CNE/design		
	physician's order fo	rm.		accurate transcripti		1
	The findings include			orders. All new ord		•
	The findings include	<b>∀.</b>		reviewed at the mo		
	Resident #1 was an	dmitted to the facility on 3/4/15.			ining chinear	
		noses included but were not		meetings.		
		besity and chronic kidney		4. A facility-wide rev		
		#1's most recent MDS		orders for accuracy		
	(minimum data set)	, an annual assessment with		conducted by the C	NE/designee.	A Administra
	an ARD (assessme	ent reference date) of 10/17/16,		New orders/change	s that involve	
	coded the resident	as being cognitively intact.		advance directives	will be reporte	d l
				to the monthly QA		
		#1's clinical record revealed a		months.	COMMITTEE NO	1/21/17
		esuscitate Order" signed by		monus.		1/21/1/
		sident's physician and dated		•		
		documented, "I, the that I have a bona fide		•		
		lationship with the patient				
		ve certified in the patient's				
		he/she or a person authorized		:		
		atient's behalf has directed				
	that life-prolonging	procedures be withheld or		•		
		ent of cardiac or respiratory	:			
		tify (must check 1 or 2): (a				1 :
		) 1. The patent is CAPABLE of	:			; :
		d decision about providing,	:	•		:
		drawing a specific medical e of medical treatment.		•		:
		of medical treatment.  It is required)I hereby direct				
	` • .	d health care personnel,	:	:		
		e effective date noted above,		• •		
		ulmonary resuscitation		•		:
		on, endotracheal intubation				

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

	e de	-	·-	
r	×		1100	
۶.			. 3	
			. \$	
ŭ.			3	
8				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
							С
		495246	B. WING				2/08/2016
NAME OF	PROVIDER OR SUPPLIE	R			REET ADDRESS, CITY, STATE, ZIP CO	DE	
WOODN	ONT CENTER				DAIRY LANE		
AACCDIA	IONI CENTER			FR	EDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 281	Continued From	page 40	. E	281			
F 201		· -		201			
		ced airway management, artificial					
		rillation, and related procedures)		:			
		in the event of the patient's					
		atory arrest. I further direct such vide the patient other medical					
		ch as intravenous fluids, oxygen,					
		s deemed necessary to provide					1
	comfort care or a						
	Consider Care of a	meviate pairi.		:			
	Further review of	Resident #1's clinical record					
		cian's order form signed by the		Y .			
		6/16 that documented, "CODE					
		ATTEMPT CPR-FULL CODE"					
							:
	Resident #1's co	mprehensive care plan revised					
	on 10/25/16 faile	d to document information		1			
	regarding the res	sident's code status.	:				
				:			
		25 p.m., an interview was	İ	:			
		RN (registered nurse) #1 (unit	:				
		1 was asked if residents' DNR		1			
		tate) forms were ever compared					
		order forms. RN #1 stated the		•			
		compared with the physician a change in condition, when					:
		admitted from the hospital and	:	:	•		
_		meetings. RN #1 was asked					1
		documented on the physician's	i	:	•		
		a resident had a DNR. RN #1		:			:
		cian order form should document					:
		vas asked what documentation					
		ok at to determine if CPR					
		y resuscitation) should be					
		dent coded (the resident's heart					
	stopped beating	). RN #1 stated nurses would					
		and the DNR form. RN #1 was	:				:
		ld happen if Resident #1 coded	i				
		a DNR form and an order					
	documented as	"full code" on his physician's					

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED		
	495246	B. WING				8/2016
	3		11	DAIRY LANE		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL		3	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
order form. RN # check."  On 12/7/16 at 6:4 staff member) #1 ASM #2 (the nurs of the above finding requested the fact of practice regard facility standard of the end of the substitution of the end of the e	1 stated, "I'm going to double  5 p.m., ASM (administrative (the executive director) and e executive) were made aware ngs. At this time, this surveyor dity policy and facility standard ing the above matter. The fractice was not provided prior survey. The facility policy titled, Orders" documented, "POLICY: athorized licensed independent anscribed by a licensed nurse. By be transcribed by a Health HUC) with appropriate training. The must verify accuracy and sign scribed by a HUC. PURPOSE: all practitioner orders to ing patient's care and services provided to facility resident must receive and the de the necessary care and or maintain the highest cal, mental, and psychosocial stent with the resident's ssessment and plan of care.			facility.  2. CNE/designee reviewed resi records to determine timely management of pain. No oth residents were affected by th deficient practice.  3. The Admissions Department identify whether pain managis required for any re-admiss or new admissions, that these	dent ner is will ement ions	
				pani		
	PROVIDER OR SUPPLIEF ONT CENTER  SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From p order form. RN # check."  On 12/7/16 at 6:4! staff member) #1 ASM #2 (the nurse of the above findir requested the faci of practice regard facility standard or to the end of the s "Transcription of C Orders from an au practitioner are tra Written orders ma Unit Coordinator ( A licensed nurse r off on orders trans To communicate a caregivers regard treatment"  No further informa 483.24, 483.25(k) FOR HIGHEST W 483.24 Quality of Quality of life is a applies to all care residents. Each r facility must provi services to attain practicable physic well-being, consis comprehensive as 483.25	A95246  PROVIDER OR SUPPLIER  ONT CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 50 order form. RN #1 stated, "I'm going to double check."  On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the nurse executive) were made aware of the above findings. At this time, this surveyor requested the facility policy and facility standard of practice regarding the above matter. The facility standard of practice was not provided prior to the end of the survey. The facility policy titled, "Transcription of Orders" documented, "POLICY: Orders from an authorized licensed independent practitioner are transcribed by a licensed nurse. Written orders may be transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a HUC. PURPOSE: To communicate all practitioner orders to caregivers regarding patient's care and treatment"  No further information was presented prior to exit. 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	A BUILD  A95246  B. WING  PROVIDER OR SUPPLIER  ONT CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 50 order form. RN #1 stated, "I'm going to double check."  On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the nurse executive) were made aware of the above findings. At this time, this surveyor requested the facility policy and facility standard of practice regarding the above matter. The facility standard of practice was not provided prior to the end of the survey. The facility policy titled, "Transcription of Orders" documented, "POLICY: Orders from an authorized licensed independent practitioner are transcribed by a licensed nurse. Written orders may be transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a HUC. PURPOSE: To communicate all practitioner orders to caregivers regarding patient's care and treatment"  No further information was presented prior to exit. 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.	FORRECTION    A95246   B. WING	PROVIDER OR SUPPLIER  ONT CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY)  Continued From page 50 order form. RN #1 stated, "I'm going to double check."  On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the nurse executive) were made aware of the above findings. At this time, this surveyor requested the facility policy and facility standard of practice regarding the above matter. The facility standard of practice was not provided prior to the end of the survey. The facility policy of Independent practitioner are transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must very accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must very accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must very accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed	A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION)  Continued From page 50 order form. RN #1 stated, "I'm going to double check."  On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the nurse executive) were made aware of the above findings. At this time, this surveyor requested the facility policy and facility standard of practice regarding the above matter. The facility policy titled, "Transcription of Orders" documented, "POLICY: Orders from an authorized licensed independent practitioner are transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a Health Unit Coordinator (HUC) with appropriate training. A licensed nurse must verify accuracy and sign off on orders transcribed by a HUC. PURPOSE: To communicate all practitioner orders to caregivers regarding patient's care and treatment"  No further information was presented prior to exit. 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE S						
_						C	
		495246	B. WING			12/0	8/2016
	PROVIDER OR SUPPLIEI  ONT CENTER	₹		1	TREET ADDRESS, CITY, STATE, ZIP CODE  1 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	provided to reside consistent with property the comprehensive and the residents.  (I) Dialysis. The foresidents who receives, consisted of practice, the concare plan, and the preferences. This REQUIREM by:  Based on staff in and facility documentated facility staff for survey sample, Resident #26 was 3/11/16 with diagolimited to aftercate surgery, presence osteoarthritis, high cholesterol, anend anxiety disorder #26 modern #2	ensure that pain management is ents who require such services, ofessional standards of practice, re person-centered care plan, goals and preferences.  acility must ensure that quire dialysis receive such ent with professional standards omprehensive person-centered e residents' goals and  ENT is not met as evidenced eterview, clinical record review, nent review it was determined alled to maintain the highest for one of 26 residents in the desident #26.  alled to assess pain levels the administration of pain alled to administer pain ly to treat Resident #26's pain.  ade:  s admitted to the facility on moses that included but were not re following joint replacement e of right artificial hip joint, the blood pressure, high mia, major depressive disorder,	F	309	medication prior to transfer facility, and that the individual arrives at the facility with a corresponding physician or that the medication can be requested immediately by the admitting nurse from the pharmacy.  All new admissions will be assessed for pain behaviors pain assessment and their pain managed appropriately. The pharmacy will be immedication is not available stated by the admitting numbers whenever the prescribed medication is not available stated box.  Nursing staff on all shifts we re-educated by the CNE/designee will regular review the stated box with the pharmacy representative, a review all admissions and pain timely procurement of medications so that the residual and an easy transition monthly audits will be comby the CNE/designee specitimely pain management, we pro-active measures to minimal pain will be addressed daily	der so he using ain ediately arse in the fill be signee ly e nd provide dent ducted fic to vith imize	
	assessment with	an assessment reference date	:		pain will be addressed daily	у.	

#### DEPARTMENT OF HEALTH AND HUMASERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING			1	C 08/2016	
NAME OF	PROVIDER OR SUPPLIER	1-302-70			TREET ADDRESS, CITY, STATE, ZIP CODE	12/	08/2010	
	ONT CENTER			11	1 DAIRY LANE REDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 309	cognitively intact in decisions scoring 1 interview for mental was coded as requiransferring, walkin hygiene, and bathin meals and locomorphysician order shorder: "Hydrocodormg/325 mg (milligr mouth) every four location or the coder was classed following: "Give 1 hyprn mild to moderate."	the #26 was coded as being the ability to make daily 15 out of 15 on the BIMS (brief al status exam). Resident #26 diring supervision with 15 or 16 or 17 or 18 or	F	309	Results of these audits will reviewed at the monthly Qa Committee meetings x3 mo	<b>A</b> `	1/21/17	
	documented the for exhibits or is at risl mobility related to Resident will be sure of independence and adaptations in 90 cas ordered and obmonitor for side effindicated Monitor medicate as order indicated.  Review of the nurse following note date (patient) became visited in the sure of the	at #26's care plan dated 3/12/16 ollowing: "Focus: Resident of for alterations in functional hip replacementGoal: apported to return to prior level and mobility with necessary daysInterventions: Medicate serve for effectiveness and fects, report to physician as for pain and stiffness, ed and report to physician as sing notes revealed the ed 3/16/16 at 1:06 a.m.: "Ptwery upset about pain	THE DESIGNATION OF THE PROPERTY OF THE PROPERT					
		nacy contacted, and pain -ordered and reported to be			:		:	

PRINTED: 12/15/2016 DEPARTMENT OF HEALTH AND HUM! SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICARD SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C 495246 B. WING 12/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 F 309 Continued From page 53 delivered stat. This nurse went to patient and offered non-pharmacological pain interventions until Norco arrived from pharmacy. Pt (patient) requested an ice pack and to lie in bed. Ice pack provided to patient and pt assisted into reclining position in bed. This nurse offered to contact to contact the physician and request either Tylenol or ibuprophen on her behalf. Pt denied offer stating, "If I take that now, I won't be able to take the Norco when it gets here. I will just wait." Pt placed her c-pap mask on and stated "I'll just try to relax. Please bring me my medicine when it gets here." Review of the narcotic log revealed that Resident #26's last dose of Norco was on 3/15/16 at 5 p.m. A pain score was not documented. A note documenting pain medication effectiveness was not found. Further review of the narcotic log for Norco 7.5/325 mg revealed that Resident #26 did not receive her Norco until 3:40 a.m. on 3/16/16. A pain score was not documented when she received her medication. A note could not be found documenting pain medication effectiveness. Review of the facility's emergency stat box

revealed that Norco 7.5 /325 mg was not

On 12/8/16 at 9:04 a.m., an interview was

conducted with LPN (licensed practical nurse) #9, a nurse who worked with Resident #26. When asked about the process staff follows when refilling resident pain medications, LPN #9 stated that nursing staff should refill pain medications before it runs out. LPN #9 stated that she waits

available in the stat box.

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495246	B. WING		12	C 2/08/2016	
, , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 11 DAIRY LANE FREDERICKSBURG, VA 2240	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	before she will refistated that it is new medication especi #9 stated that issufurther delaying the pharmacy needing that if a resident description of the physician musual ternative medical on 12/8/16 at 9:37 conducted with AS member) #2, the EASM #2 stated that available because script. ASM #2 stated that she refise before it runs out. Tuns out of pain medication. Supharmacy and have the medication. Supharmacy to obtain out of the STAT be staff follows if the box, RN #4 stated doctor) for a different on 12/8/16 at 10:30 conducted with LF a nurse who was formed that it is not staff to the staff of the staff o	ets are left in the package Il the medication. LPN #9 ver ok to run out of pain ally if they are narcotics. LPN es can arise with narcotics e refill process such as g a hard script. LPN #9 stated oes run out of pain medication, t be notified to get an ation.  7 a.m., an interview was SM (administrative staff DON (Director of Nursing). At Resident #26's Norco was not the facility did not have a hard ated that the resident had a eking behavior.  96 a.m., an interview was N (registered nurse) #4. RN #4 ills medications three days RN #4 stated that if a resident edication she would call ve them STAT (Immediate) out he stated that she will also call n a code to get the medication ox. When asked the process medication is not in the STAT , "I would call the MD (medical	F	09			
	about 6 pills are le that sometimes ph	off in the package. He stated narmacy will require a hard cotics so it is important to refill					

DEPARTMENT	OF HEALTH ANI	D HUN SERVICES
CENTERS FOR	R MEDICARE & N	/IEDICAN SERVICES

	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		495246	B. WING _		12	C 2/08/2016
	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	Continued From p	page 55	F 30	09		
	these medications	s right away.		·		
	conducted with RI shift when Reside out. RN #6 stated pain medication the medication runnin (3/16/16) pharmachave the original process of the doctor for alter could not explain the medication was #6 could not recall score when the resident with pharmacy, but the medication was the medication was the medication was #6 could not recall score when the resident when the resident was the medication was process of the doctor for the medication was the medication was process of the doctor for the medication was the medication was process of the doctor for the medication was the medication was process of the doctor for th	11 a.m., an interview was N #6, the nurse who worked the ent #26's pain medication ran I that she will usually re-order nree days prior to the 19 out. RN #6 stated that night between the reserving that they did not corescription for Resident #26's not refill the medication. If explaining to pharmacy that has refilled before, so they must be rescription. RN #6 stated that hent #26 alternative pain he she could work out the issue at the resident declined. Hent declined, RN #6 did not call remaive pain medication. RN #6 why the facility staff waited until has out before it was refilled. RN I if she had documented a pain resident finally did receive her recumented pain level at least 30 Norco was received.				
	(administrator) an	proximately 12:02 p.m., ASM #1 d ASM #2 (director of nursing) of the above findings.				
	were made aware	or the above infulfigs.	•			:
	documents in part medications are g the MAR (Medical on the PRN Pain Center staff will re	d, "Pain Management" t, the following: "5. If PRN given document on the back of tion Administration Record) or Management flow sheet. 6. eport any observation or				***************************************
		f pain to the nurse responsible . Patients receiving		· :		

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

1	99%	44	
1		4	
ž.,		. 3	
₹.		7	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	ING	CONSTRUCTION	0	PLETED :
	ROVIDER OR SUPPLIER	495246	B. Wilke	STF 11 I	DAIRY LANE EDERICKSBURG, VA 22405	1 12/0	)8/2016 
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 309	effectiveness and relief. Document: 8.1 Effectiveness 8.2 Ineffectiveness including intervent physician/APN/PA 8.3 Side effects, if physician/APN/PA 8.4 Non-pharmace effectiveness."	ain will be monitored for the side effects in providing pain of pain medications. s of routine or PRN medications ions, follow-up, and notification; present and notification of	F3	809			
F 314 SS=D	PREVENT/HEAL  (b) Skin Integrity -  (1) Pressure ulcer comprehensive as facility must ensure (i) A resident receprofessional standard pressure ulcers an ulcers unless the demonstrates that (ii) A resident with necessary treatment professional standard pressional standard prevent in from developing.	ATMENT/SVCS TO PRESSURE SORES  rs. Based on the seessment of a resident, the		314	<ol> <li>During the survey, Resider #10 were addressed, physic orders obtained, and Treath Administration Records (Tinitiated to establish completed to esta</li></ol>	cian ment (ARs) (iance. was three tify and to might the gimens sary ending ender. will be esignee tolicy on, and	

PRINTED: 12/15/2016 RVICES DEPARTMENT OF HEALTH AND HUMA FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495246 B. WING 12/08/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLÉTION EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 314 F 314 Continued From page 57 reporting tool reviewed with staff Based on observation, staff interview, facility in all departments by the policy review and clinical record review, it was CED/designee to optimize early determined that the facility staff failed to provide detection of any skin issues. care and services for pressure ulcer prevention for two of 26 residents in the survey sample, Bi-Weekly skin assessments on Resident #4 and Resident #10. resident shower days will be enforced by the Nurse Unit 1. On 5/4/16 emergency room discharge Managers. instructions documented that the resident had a The Nurse Unit Managers will left leg splint. The facility staff failed to seek clarification from the physician regarding the complete weekly wound rounds removal of the splint and skin assessments on their respective residents to underneath the splint. A skin assessment dated ensure treatment protocols are 5/13/16 documented a deep tissue injury (DTI) [1] initiated and followed. A dietitian on Resident #4's left heel. will be included on these rounds as indicated, as well as notified of 2. On 8/4/16 Resident #10's orthopedist wrote an any new IHA pressure sores. order for an ankle clam shell brace. The facility 4. All skin assessments will be staff failed to seek clarification regarding removal of the brace and skin assessments for the area reviewed by the CNE/designee underneath the brace. A skin assessment dated and reviewed at the monthly QA 8/16/16 documented a deep tissue injury (1) on Committee meetings x6 months. the resident's right inner ankle and a stage two Monthly audits of IHA pressure ulcer (1) on the resident's right outer notification to the dietician will be ankle.

The findings include:

1. Resident #4 was admitted to the facility on 11/15/10 and readmitted on 1/3/11 with diagnoses that included but were limited to: dementia, depression and anemia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 11/28/16 coded the resident as being severely impaired cognitively. The resident

1/21/17

completed by the CNE/designee, with the results of these audits

reviewed at the monthly QA Committee meetings x6 months.

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I CONTINUE ON A DIMENTION IN INCIDENT.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING				08/2016	
NAME OF	PROVIDER OR SUPPLIER	<u>.l</u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	121	00/2010	
WOODM	ONT CENTER				1 DAIRY LANE REDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 314	all activities of daily Review of the nurse documented, "Typo of resident) is experienced and inner ankle noted awarm to touch, sworthere was no evide to if the staff were occurred.  Review of the nurse 5/4/16 at 1:29 p.m of L (left) ankle d/t fx (fracture). Staff trauma.  Review of the physigned on 5/4/16 at "SEND TO (name room) to EVAL (even Review of the eministructions dated nondisplaced fractileft tibia. Splint Ap fiberglass splint ap splint until release doctor). Follow up	uiring assistance from staff for y living.  se's notes dated 5/4/16 at 11:00 e: Change in Condition. (Name eriencing pain. L (left) and yelling when touched. L to be discolored, L ankle is collen and painful to touch." ence of documentation related aware of how the injury  se practitioner's note dated aware of how the injury  se practitioner's note dated documented, "Will order x-ray (due to) possible pathological reports no falls or recent  sician's orders dated and at 4:15 p.m. documented, of hospital) ER (emergency	F.	314				
	"Fracture of distal Review of the phy signed on 5/5/16 a "POSTERIOR BR extremity) KEEP B							

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

Later of the later
2
<b>4</b>
<b>2</b>
"Chining of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING		1	C 2/08/2016	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP ( 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE	.700/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	Continued From p sensation) CHECI FU (follow up) WI'doctor)."  Review of the nurs 5/5/16 documenteresponsible party to have follow up a she did not want to procedures done of the phy further orders related following the RP's seen by the orthogonal to the splint was to be Review of the May record documented CMS checks to LL at all times." There documented on ea 5/5/16 to 5/31/16 in the sensation of the splint was to be compared to the splint was to be compare	age 59 KS TO LLE Q (every) SHIFT. TH (name of orthopedic  se practitioner's (NP) note dated d that the resident's (RP) did not want the resident with the orthopedic doctor as he resident to have any further to the fracture.  sician's orders did not evidence ted to the care of the splint refusal for the resident to be bedic doctor that day (the day	F 3	DEFICIENCY)			
	evidence docume splint.  Review of the nurs 5/9/16 documente 5/5/16 at 1:11 p.m (left lower extremi a fiberglass splint 5/5/16 6:29 p.m. F	remains painful to touch LLE ty) remains in soft cast." [Note: is not soft but rigid.] Posterior brace/cast to LLE;					
	movement and se	ry at all times; CMS (circulation, nsation) checks to LLE Q ollow up) with (name of"					

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY IPLETED
		495246	B. WING			1	C / <b>08/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	(left) ankle s/p (stawarm and dry." 5/7/16 at 1:42 a.m ankle. CMS check 5/7/16 at 8:00 p.m are warm and pink secondsMonitor for any acute chan and symptoms) of 5/8/16 at 11:00 a.m CMS checks composite for any acute chan and symptoms of 5/8/16 at 11:15 a.m CMS checks composite for any acute chan and symptoms of 5/9/16 at 11:15 a.m CMS checks composite for any acute chan and symptoms of for the splint had been assessed during the splint had been assessed d	Soft cast remains in place to Latus post) fx (fracture). Skin is  "Soft cast in place to left at patient baseline."  "Soft cast intact left leg, toes with CRF (capillary refill) < 3 circulation status of left foot & ges or increased S/S (signs pain in left leg.  "Soft cast to LLE still intact, pleted per orders."  "Soft cast to LLE still intact, pleted per orders." There were notes related to the splint until as no evidence documented that a removed or that the skin had ring that time.  Se's notes dated 5/13/16 at 3:04 sident) has a new onset/change evidenced by ulcer-pressure. Se is notes dated 5/13/16 at 4:02 "N.O. (new order)."  Se's notes dated 5/13/16 at 4:02 "N.O. (new order) remove cast sel (with) NS (normal d cleanser) apply granulex, gauze dressing) then reapply of the wrap, fiber glass splint and (every day). ortho (orthopedic)) fx of L tibia please assess vice secondary to pressure on plint."		314			
	6/6/16 at 12:37 p.i	se practitioner's noted dated m. documented, "Will DC tt d/t worsening of wound will					

DEPARTMENT (	OF HEALTH AND	HUM SERV	ICES
CENTERS FOR	MEDICARE & ME	FDICA SFRV	ICES



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  ING	(X3) DATE SURVEY COMPLETED
		495246	B. WING		C 12/08/2016
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, Z 11 DAIRY LANE FREDERICKSBURG, VA 224	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 314	Continued From pa	age 61	F 3	314	
	Medical Director w	nulex. Discussed this with the ho agrees with this PoC (plan cushion to be ordered."		:	
		opedic doctor's note on 6/16/16 ocumentation regarding using	no morale architectur on oversions		
	p.m. documented, completed today re	e's note dated 5/13/16 at 3:05 "A Braden Scale was esulting (sic) in a score of 12." 10-12 is considered high risk n.	en e		
,	reports from 5/13/2 the wound had gor wound to 100 perc staged until 11/4/14 documented to have tissue (3) and slou	ity's skin integrity weekly 16 to 11/29/16 documented that ne from an intact deep purple tent eschar (2) and could not be 6 when the wound was ve 75 percent granulation gh (4). On 11/4/16 the wound as being a Stage III (5).	***		
		sician's note dated 7/8/16 heel pressure wound being irse practitioner)."			
	made on 12/7/16 a practical nurse) #1 ASM (administrative practitioner who can wound was cleans measured 0.3 cm a drainage. A dry drawound care observe practitioner, stated	Resident #4's wound care was at 7:55 a.m. with LPN (licensed, the wound care nurse and we staff member) # 5, the nurse ared for the resident. The heel ed as ordered. The wound x 0.5 cm and was pink without essing was applied. During the vation ASM #5, the nurse I, "The hospital didn't really Resident #4's left leg splint) off.			

#### DEPARTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495246	B. WING		12	C /08/2016
	PROVIDER OR SUPPLIER	:	•	STREET ADDRESS, CITY, STATE, ZIF 11 DAIRY LANE FREDERICKSBURG, VA 2240	CODE	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	instructions about stated he had not. was as big as the p stated that there w  An interview was op.m. with RN (regis manager. When as follows when a res stated, "Make sure they can wiggle the were reviewed with was documentation removed and the s no. When asked if cast, RN #1 stated	octor had been called for the care of the splint, ASM #5 ASM #5 stated, "It (the wound) balm of my hand." LPN #1 also as no padding in the splint. conducted on 12/7/15 at 1:45 stered nurse) #1, the unit sked about the process staff ident had a splint, RN #1 e it's not too tight, make sure eir toes." The nurse's notes in RN #1. When asked if there in that the splint had been skin assessed, RN #1 stated a fiberglass cast was a soft I, "No." When asked if the staff ed Resident #4's splint order,	F3	14		
	with LPN #6. Whe resident with a leg sure the resident is and check for circu When asked if the stated, "It depends keep the splint in p check for a bruise device because it cause friction. A bl nurse I would have asked if she remer #4's when she had "I remember she had remember exactly	conducted 12/7/16 at 2:15 p.m. in asked how staff cares for a splint, LPN #6 stated, "Make is aware of the splint, secure it, ulation and for any bruises." splints were removed, LPN #6 is on the order. If the order is to place I would still unwrap it and and the skin integrity. It is a goes against the skin and it can ister could come off. As a set to check the skin." When imbered caring for Resident if the leg splint, LPN #6 stated, and a splint but I don't what it was like."				
		the nurse executive and LPN				

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	RIPLE CONSTRUCTION  NG		TE SURVEY MPLETED C
		495246	B. WING		12	/08/2016
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 314	process staff follor splint, ASM #2 star comes in with order splint. We have to (the order) says to circulation, the color that area." LPN #1 Resident #4) skin what the splint loo a hard cast on the (a thin white gauz. When asked if the resident's RP did involved in the resyes. When asked care of the resider "We are." When a splint to be left on was inspected, AS	age 63 e nurse. When asked about the ws for a resident with a leg sted, "Anyone with a splint ers regarding the care of the be able to check the skin. If it leave it on we check the or and the range of motion of stated, "We know (name of was very fragile." When asked ked like, LPN #1 stated, "It was bottom, then there was webrolle) and an ace wrap I think." be were aware that the not want the orthopedic doctor sident's care ASM #2 stated, who was responsible for the not's splint care, ASM #2 stated, asked if it was reasonable for a for nine days before the skin SM #2 stated, "I've seen it both smove splint and orders to keep	F 3			
-	An interview was p.m. with RN (reg cared for Residen cared for a reside "First I check to se they can remove i living)." When ask were no orders, R circulation and ch splint (to make su asked to review h p.m. When asked resident's splint to "I honestly don't re the risk of a splint	conducted on 12/7/16 at 5:55 istered nurse) #7, a nurse who t #4. When asked how staff nt with a splint, RN #7 stated, see what the orders are and if t for ADLs, (activities of daily sed what staff would do if there IN #7 stated, "We check the eck around the edge of the re it's not too tight." RN #7 was er nurse's note of 5/7/16 at 8:00 if she had removed the assess the skin, RN #7 stated, emember." When asked what is to a resident, RN #7 stated, he pressure becomes extensive				

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495246	B. WING		12	C /08/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	<del></del>	
WOODM	ONT CENTED			11 DAIRY LANE		
AACCDM	ONT CENTER			FREDERICKSBURG, VA 2240	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From page	age 64	F3	14		
	it can become an u would do with the s physician the follow	ulcer." When asked what she splint if resident did not see the wing day as ordered, RN #7 t a clarification order."				
	staff member) #1,	p.m. ASM (administrative the executive director, ASM #2, e and ASM #3, the regional		:		
:		cialist were made aware of the		:		
	a.m. with ASM #2, the nurse practition care nurse. ASM # first came back with the daughter and so be seen by the ort	conducted on 12/8/16 at 8:00 the nurse executive, ASM #5, her and LPN #1, the wound #5 stated that when the resident the splint she had talked with she did not want the resident to hopedic doctor. When asked ble for the care of the resident				
	and the fracture, A ASM #5 stated, "K history, we had to	SM #5 stated that she was. nowing her (Resident #4's) skin do a skin check. When we saw a problem." When asked why		· :		
	they had waited ni resident with an ur that she had check	ne days to check the skin on a npadded splint, ASM #5 stated ked the x-ray again before they t. When asked if she had				Annual term management a service de la companya de
	the splint, ASM #5 asked if she had re physician she said	opedic doctor about the care of stated that she had not. When eviewed the care with the she had. When asked if it was				· :
	history to go nine of staff did not respo	s resident who had a skin days without a skin check the nd. When asked what had in place to prevent the		· .		
	pressure ulcer, LP circulation. There through the splint.	What in place to prevent the What is place to prevent the What is stated, "We checked her was no drainage coming "When asked if circulation cate skin integrity, LPN #1		: :		

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		MPLETED
		495246	B. WING		1:	C 2/08/2016
WOODMONT CENTER  SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405	Y, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 314	Continued From p	page 65	F3	14		
	to come through a	n asked if waiting for drainage a splint before checking a egrity was routine nursing stated it was not.	A company of the second control of the secon			
	a.m. with RN #5. follows when a re stated, "You're go	conducted on 12/8/16 at 8:25 When asked the process staff sident had a leg splint, RN #5 ing to assess the extremity.				
·	circulation, check any discomfort. B and check the ski	t with care; check the to see if the resident is having athe the area, dry it thoroughly n." When asked what process if as no doctor's order for the				
	care of the splint, the medical direct orders). Send it (t	RN #5 stated, "Go directly to for or NP (nurse practitioner) (for he order) to rehab treat." When asked if she had				
		at #4 when she had the leg splint				
	a.m. with OSM (o occupational there	conducted on 12/8/16 at 8:40 ther staff member) #8, the apist. When asked about				
	with a splint, OSM the order says. If	apy's role in caring for a resident If #8 stated, "It depends on what it says remove every shift that's				:
		nt #4's splint order was reviewed M #8 stated, "I would contact further orders."	:	•		
	a.m. with LPN #5	conducted on 12/8/16 at 9:55 . When asked the process staff resident had a splint, LPN #5				
	stated, "We chec sensation." Wher	k circulation, movement and asked if the splint would ved, LPN #5 stated, "It depends				
	I would get a clar	fication on that." LPN #5 ergency room discharge	1			

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES



	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		495246	B. WING_		12	C /08/2016
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	when the resident doctor. When ask resident did not set day as ordered, LI get a clarification cared for Resident LPN #5 stated she LPN #5 stated she An interview was a.m. with ASM #4, asked what he recifracture, ASM #4 from an unwitness When asked who and splint care if the resident to be see ASM #4 stated, "If (orthopedic) surge have extensive or how a resident's singury nursing staff, ASM the splint at least of (deep tissue injury nursing." When as order to remove the that's not a normal pressure device; a you develop a prewas reasonable to before inspecting would not be good asked if the nurse resident's care with reviews resident's care with reviews resident's practitioners and the brought to my atterior was reasonable to be seed asked if the nurse resident's care with reviews resident's care with reviews resident's practitioners and the brought to my atterior was resident's practitioners and the properties of the resident's care with reviews resident's practitioners and the properties are the resident to my atterior was resident to my atterior	sident #4 documenting that the in place until the following day was seen by the orthopedic ed what she would do if the et the physician the following PN #5 stated, "I would call and order." When asked if she had the splint, et had not.  conducted on 12/8/16 at 10:10 the resident's physician. When called about Resident #4's legistated, "I know it was either sed fall or osteo (osteoporosis)." cared for the resident's fracture the resident's family refused the notes that the orthopedic doctor, if they don't go to an ortho eon, I would take care of it. I tho experience." When asked plint should be managed by the 1 #4 stated, they should remove once a day. You can get a DTI or with a splint. Its good sked if there would be a specific the splint, ASM #4 stated, "No, I thing. A splint is a potential anytime you develop pressure soure wound." When asked if it a leave a splint on for nine days the skin, ASM #4 stated, "That it. I was not aware of it." When practitioner had reviewed the him, ASM #4 stated that he care with his nurse hat "anyone with a splint is				

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495246	B. WING		12	C /08/2016
	PROVIDER OR SUPPLIE	₹		STREET ADDRESS, CITY, STATE, ZI 11 DAIRY LANE FREDERICKSBURG, VA 224	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From p	page 67	F3	314		
,	with two nurses w	30 a.m. voice mails were left tho cared for Resident #4. The urn the call prior to exit.				
	Management" do implementation or integrity manager delivery process. monitors patients revisions to the please of the Center's 24-H Develop compress as indicated. 4.1	cumented, "Skin Integrity cumented, "POLICY. The fan individual patient's skin ment occurs within the care Staff continually observes and for changes and implements an of care as needed. ovide safe and effective care to rence of pressure ulcers, at, and promote healing of all by patient's skin integrity status rention intervention treatment on iour Summary Report. 4. It is integrity interdisciplinary plan of evention and wound treatments, implement pressure ulcer ntified risk factors."				
	Heel Protectors, a Devices" docume assisted as neces application and resuch as splints, hother supportive/gon the service plaprovided in accorresident's physici appropriate assis promote health a or debilitation8. preventative/protewith soap and was	titled, "13.2 Splints, Hand Rolls, and Other Supportive/Protective ented, "POLICY: Residents are sarry by trained staff with the emoval of preventative devices and rolls, heel protectors, or protective devices as specified an. The measures/devices are dance with an order from the an. PURPOSE: To provide tance to resident in order to not well being and prevent injury Splints, braces, and other ective devices: 8.1 Wash area ster; dry with towel. 8.1.1 Ensure overed is dry. 8.2 Apply device				

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

<i>€</i>	
¥ 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED C		
		495246	B. WING		12	12/08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 314	Continued From page 68		F 3	14			
	available) or reside directions. 8.3 Ob placement of device Remove and replaservice plan. 8.5 Cand removing deviskin abnormalities applied, time remoproblems in logboom						
	No further information was provided prior to exit.  (1) Deep Tissue Injury Deep Tissue Pressure			:			
	Injury: Persistent in maroon or purple of non-intact skin with non-blanchable dediscoloration or ep dark wound bed or temperature changes. Discoloradarkly pigmented sintense and/or proforces at the bone-may evolve rapidly tissue injury, or manecrotic tissue, sultissue, fascia, mustructures are visit thickness pressure or Stage 4). This in http://www.npuap.onts/	con-blanchable deep red, discoloration. Intact or in localized area of persistent ep red, maroon, purple idermal separation revealing a blood filled blister. Pain and ge often precede skin color ation may appear differently in skin. This injury results from longed pressure and shear muscle interface. The wound to reveal the actual extent of ay resolve without tissue loss. If boutaneous tissue, granulation scle or other underlying ole, this indicates a full a injury (Unstageable, Stage 3 information was obtained from: org/resources/position-stateme sue If necrotic tissue,					
	subcutaneous tiss muscle or other ur this indicates a full	ue, granulation tissue, fascia, derlying structures are visible, thickness pressure injury ge 3 or Stage 4). This					

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED C	
		495246	B. WING_		12	/08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		<u> </u>		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 314	Continued From pa	age 69	F 3	14			
	information was obhttp://www.npuap.conts/ (3) Eschar If nectissue, granulation underlying structure full thickness press 3 or Stage 4). This from: http://www.npuap.conts/ (4) Slough The pa chronic wound preffective wound he healing and reduce microorganisms careffectively reducing debridement is a new wounds that have enon-viable tissue wounds that have enon-viable tissue wounds the attachmoiofilms. Biofilms a implications in raising delaying wound he contain only slough methods are not coremoval. This infor https://www.ncbi.nl	protection of the process of the pro					
	The depth of tissue location; areas of s develop deep would tunneling may occur	e damage varies by anatomical significant adiposity can					

DEPARTMENT (	OF HEALTH AND	HUM SERVICES EDICAL SERVICES
CENTERS FOR	<b>MEDICARE &amp; M</b>	EDICA SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		MPLETED  C	
		495246	B. WING			12	2/08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				11 D	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 314	Continued From	page 70	F:	314			***************************************	
,	loss this is an Un information was of	ar obscures the extent of tissue stageable Pressure Injury. This obtained from: o.org/resources/position-stateme	A A A A A A A A A A A A A A A A A A A				The second secon	
	order for an ankle staff failed to see of the brace and underneath the b 8/16/16 documer the resident's right	ident #10's orthopedist wrote an e clam shell brace. The facility k clarification regarding removal skin assessments for the area race. A skin assessment dated ated a deep tissue injury (1) on at inner ankle and a stage two) on the resident's right outer						
	6/25/16. Resider were not limited to right lower extreme heart failure. Resident management with date of 9/19/16, as being severely documented the assistance of one transfers, locomorpersonal hygiene documented Resident management	s admitted to the facility on at #10's diagnoses included but to: displaced ankle fracture of the nity, chronic kidney disease and sident #10's most recent MDS et), a significant change in status an ARD (assessment reference coded the resident's cognition y impaired. Section G resident required extensive e staff with bed mobility, otion, dressing, toilet use, and bathing. Section M sident #10 presented with two secure ulcers (1) due to ressing/device.						
	dated 7/16/16 do mild risk for pres form documented perception was s	or predicting pressure sore risk cumented Resident #10 was at sure ulcer development. The d the resident's sensory lightly limited, the resident's skin moist, the resident was chair		÷				

#### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES



PRINTED: 12/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING				c
		495246	B. WING			1	08/2016
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			11	REET ADDRESS, CITY, STATE, ZIP CODE  DAIRY LANE REDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		:	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO T DEFICIENCY		) BE	(X5) COMPLETION DATE
F 314	Continued From page 71 fast, the resident's mobility was slightly limited, the resident's nutrition was adequate and the resident presented with a potential problem regarding friction and shear.  An orthopedist consult note dated 8/4/16 documented, "S/P (Status post) ORIF (open reduction internal fixation [surgical procedure]) Right ankle fx (fracture). Skin intact, incisions well-healedRecommendations: Weight bearing as tolerated with walker and assistance/observation at all times. Fall Risk. 2. Wear ankle clam shell/ (illegible word) brace at all times. Wear thick sock underneath at all times to protect skin" The brace was discontinued on 8/24/16.			314			
	"Weight bearing as assistance /observ clam shell brace a	dated 8/4/16 documented, stolerated with walker & (and) ration at all times. Wear ankle t all times, wear thick sock t skin. F/U (follow up) in 4 wks					
	bearing as tolerate observation at all t (follow up [with the		A CONTROL CONT				
	"Action/nursing into assist with all ADL patient (sic) is inco bladder). No c/o (	ed 8/6/16 documented, erventions: patient is a total s (activities of daily living). ontinent of B&B (bowel and complaint of) pain or distress at ) brace to the right RLE (right					

lower extremity) remains intact..."

### DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES



	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE (COMPLETED IN COMPLETED I		E SURVEY PLETED				
		405040				1	
		495246	B. WING			12/0	08/2016
	PROVIDER OR SUPPLIER  ONT CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE I1 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE	(X5) COMPLETION DATE
F 314		age 72 ed 8/9/16 documented, "A skin ed. No skin injury/wound(s)	F3	314			
	A "skin check" form	•					
	8/16/16 failed to re	notes from 8/4/16 through veal any further documentation t #10's brace, removal of the kin checks.					
	administration reco Check CMS (circul on right lower extre further documented shell brace at all tir underneath- protect	gust 2016 TAR (treatment ord) documented, "6/30/16-ation, motion and sensation) emity every shift." The TAR d, "8/4/16- Wear ankle clammes, wear thick sock ot skin." The TAR failed to a sock was being removed.					
	of service from 8/5 signed on 8/19/16 "Precautions/Contr bearing as tolerate The report failed to information regard	raindications: WBAT (weight d), R ankle brace, Fall risk" o document any further ing Resident #10's brace or garding the resident's skin				•	
	8/16/16 documente "Precautions/Contr lower extremity), to	apy notes dated 8/5/16 through ed, raindications: WBAT RLE (right wear clam shell with heavy t all times" The notes further	The state of the s				

DEPARTMENT OF HEALTH AN	ND HUM BERVICES
CENTERS FOR MEDICARE &	MEDICAID SERVICES



	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495246	B. WING			C 12/08/201	6
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	12/00/20 :	<u> </u>
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, V	A 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION IVE ACTION SHOULD I ED TO THE APPROPR FICIENCY)	BE COMPLE	ETION
F 314	manage the right a notes did not specir required. A note da resident was able to body bathing and d 8/12/16 documente socks, bathe down The notes dated 8/document informat assessments for the and clam shell brace 8/16/16 failed to do regarding removal.  Resident #10's condon 7/5/16 and active 8/4/16 through 8/16 at risk for skin bread mobility, incontinent by license nurse"	sident required assistance to nkle clam shell brace. The fy the type of assistance ated 8/10/16 documented the o doff socks, complete lower on socks. A note dated at the resident was able to doff to the feet and don socks. 5/16 through 8/16/16 failed to ion regarding skin e skin underneath the sock ate. The notes from 8/12/16 to ocument any information of socks.  In prehensive care plan initiated to during the time period of 6/16 documented, "Resident is akdown as evidenced by limited accWeekly skin assessment. The care plan failed to remation regarding the	F3	314			
	"Skin Check Perfor Identified- Yes. 2. Identified- Yes. 3. Injury/Wound(s) Redevices (cast/prost External Device(s) device removed an area beneath devic (deep tissue injury)	n dated 8/16/16 documented, med. 1. Skin Injury/Wound(s) New Skin Injury/Wound(s) Previously Noted Skin ecorded- No. 4. External hetic, brace) present- Yes. 4a removable. 5a. External d site inspected. 5b. Describe ee- R (Right) foot with DTI to outer and inner ankle. ear D/C (discharge) noted. R caly"					
		ed 8/16/16 documented, "A skin led. The following New skin					

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

A
A
S
\$
V

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED		
		495246	B. WING				C <b>08/2016</b>
NAME OF	PROVIDER OR SUPPLIE		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	CODE	121	00/2010
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD I	BE	(X5) COMPLETION DATE
F 314	Description: Fung device removed a with DTI to outer a of clear D/C noted removable."  A skin integrity redocumented: "Circle Primary Tydocumented arou Anatomical Locati Wound Date: 8/16 Appearance: IP-I [centimeters]) 1.0 physician's order order to cleanse t dry and apply a diaccording to the sremained a DTI ochanged to includ the area declined	rere identified: Rash(s): real rash to Groin. External and site inspected: R foot noted and inner ankle, scant amount d, R foot also dry and scaly,  port initiated on 8/16/16  repe of Wound- (a circle was and the word 'Pressure'). real inner ankle. Initial 6/16. Initial Stage: DTI. antact/Deep purple. Length (cm by Width (cm) 1.0" A dated 8/16/16 documented an the area with normal saline, pat rey clean dressing daily. Note: skin integrity report, this area an 8/18/16 but the treatment was be medihoney (2). On 8/31/16 to an unstageable pressure 1.0 cm length by 1.0 cm width.	F3	114			
	documented: "Circle Primary Ty documented arou Anatomical Locat Wound Date: 8/16 Appearance: 100 1.5. Width (cm) 1 8/16/16 documen with normal saline dressing daily. No integrity report, th pressure ulcer on	grity report initiated on 8/16/16  /pe of Wound- (a circle was and the word 'Pressure'). ion- R outer ankle. Initial 6/16. Initial Stage: II.  // G (Granulation). Length (cm) I.O" A physician's order dated ted an order to cleanse the area and apply a dry clean ote: according to the skin is area remained a stage two 8/18/16 but the treatment was be medihoney. On 8/31/16 the					

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TE SURVEY MPLETED	
		495246	B. WING		12	2/08/2016
	PROVIDER OR SUPPLIER ONT CENTER			STREET ADDRESS, CITY, STATE, ZIF 11 DAIRY LANE FREDERICKSBURG, VA 2240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From pa	age 75	F 3	14		
		unstageable pressure ulcer length by 1 cm width. The 4/16.		•		
	conducted with LP (the wound care not resident's brace shakin underneath. I what the physician patient. LPN #1 waif there was no ord	4 a.m., an interview was N (licensed practical nurse) #1 urse). LPN #1 was asked if a ould be removed to assess the LPN #1 stated it depended on ordered and varied for each as asked what should be done er to remove the brace. LPN ng staff would call the one.				
	conducted with RN was asked to descresident with an arorthopedist office a assess the skin un stated if there was	p.m., an interview was (registered nurse) #1. RN #1 ribe what should be done if a kle fracture returns from the and has no specific orders to derneath the brace. RN #1 no order then she would call be to find out what they wanted a place.				
	conducted with AS member) #2 (the normal (licensed practical nurse). LPN #1 state went to the orthope air splint. LPN #1 order for a sock to air splint to protect 8/16/16, a skin checular were identificated on the orthopedist and	p.m., an interview was M (administrative staff urse executive) and LPN nurse) #1 (the wound care ated on 8/4/16, Resident #10 edist who ordered a clam shell stated the orthopedist wrote an be placed under the clam shell the skin. LPN #1 stated on eck was performed, pressure ed and treatment was initiated. his day (12/7/16), she called direceived clarification to hell brace and sock daily to				

	MENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES			FORM	D: 12/15/2016 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495246	B. WING_		12	C 2/08/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
WOODM	ONT CENTER	-		11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 314	the brace was orde granted that facility assessments under written. LPN #1 predated 12/7/16 that obrace/sock daily to sock and brace bace (Note- at this time, already been discord At this time, ASM # provide evidence the underneath the brace 8/4/16 through 8/16 were performing we was made aware the	s. LPN #1 stated at the time red, the orthopedist took for staff would perform daily skin rethe brace and no order was esented the orthopedist order documented, "Remove ankle perform skin checks. Place esk on ankle when complete." the clam shell brace had natinued and was not in place). 2 and LPN #1 were asked to last Resident #10's skin ce was being assessed from 1/16. ASM #2 stated nurses eekly skin checks. ASM #2 the last documented skin	F 3′	14		
	ulcers were found) made aware on 8/9 skin concerns but a did not have a brac provide evidence th underneath the brac last few days prior t could identify who w	o 8/16/16 when the pressure was on 8/9/16. ASM #2 was /16, the nurse documented no also documented the resident e. ASM #2 was asked to part Resident #10's skin ce was assessed within the o 8/16/16. ASM #2 stated she worked with the resident during ain statements. ASM #2 was				

the morning.

with those nurses.

made aware this surveyor would need to speak

On 12/7/16 at 6:45 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 were made aware of the above findings and the concern for harm. ASM #1 and ASM #2 were asked to provide any further information in

On 12/8/16 at approximately 8:00 a.m., ASM #2 was asked to provide nurses who cared for Resident #10 during the days leading up to

DEPARTMENT	OF	HEALTH	AND	HUN	SERVICES
CENTERS FOR	MF	DICARE	8 M	=DIC	AD SERVICES



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION  IG		COM	E SURVEY IPLETED
		495246	B. WING_				C <b>08/2016</b>
	PROVIDER OR SUPPLIER  ONT CENTER	-		STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405	DE	# #Sin 2	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 314	conducted with RN was asked to descriprovided to resident brace. RN #5 state removes the splint resident's circulatio and makes sure the dryness and no prewould also check for should be on or off members who provasked how often shassessments. RN she was instructed morning and aftern what should be don RN #5 stated she with the rehab depainterpretation was to consults for devices to the rehab (rehab with them. RN #5 sconducts scheduled (certified nursing as skin concerns to the an unspoken nursing underneath a brace was unclear nurse practitioner's was read Resident dated 8/4/16 and as brace to assess the	a.m., an interview was (registered nurse) #5. RN #5 ribe care that should be ts who have a lower extremity, with care, assesses the n, capillary refill, discomfort, e skin has moisture, no ssure. RN #5 stated she or the times when the brace and instructions to staff ide direct care. RN #5 was be would perform these #5 stated it depended on how to do so but it could be with con care. RN #5 was asked the if there were no instructions, would go directly to the actitioner, find out instructions, recommendations and check artment. RN #5 stated her that the rehab department gets as so she would give the orders distated the nursing department diskin checks and CNAs that the resident is stated it was as practice to assess the skin to but if the order regarding the she would put a note in the book. At this time, RN #5 #10's clam shell brace order sked if she would remove the skin underneath. RN #5 ink nursing staff would need		4			

# DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

				3) DATE SURVEY COMPLETED		
		495246	B. WING _		12	C /08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	Continued From pa	age 78	F 31	14		
	worked with Residinterview during sutherapist who prim was no longer emp 12/8/16 at 8:40 a.m with OSM (other stoccupational thera resident). OSM #8 role in the care of extremity brace in OSM #8 stated it documented to resident where the brace until follow #8 stated she based documents. OSM Resident #10's 8/4 doesn't clarify." Occupational thera orders because the bathing and dressidocumented to we would hesitate to restated a lot of time ask the physician to stated each shift, to stated each shift, to stated each shift, to stated a lot of the stated each shift, to extend the primary stated each shift, to stated each shift, to stated each shift, to stated each shift, to extend each shift, to stated each shift, to state each shift, to state each shift, to state each shift.	pational therapy assistant who ent #10 was unavailable for revey. The occupational arily worked with Resident #10 ployed at the facility. On an, an interview was conducted aff member) #8 (another pist who worked with the was asked to describe her a resident who wore a lower regards to skin assessments. The ended on what the order red she thought if the order reverse documented to not remove the brace every shift for the nursing staff would be restroyed to not remove ow up with the physician. OSM resident who was made aware of was made aware of was made aware of was made aware of was made aware at all times. It is says wear at all times. It is says wear at all times was made at all times on the pists will get a copy of brace reavely work with residents on red. OSM #8 stated the order ar the brace at all times so she amove the brace. OSM #8 she would write notes and for clarification.  The a.m., an interview was the resident's toe color, skin reverse the provided for wer extremity brace. LPN #5 the resident's toe color, skin reverse the provided be assessed.				

DEPARTMENT	OF HEALT	'H AND HU	M SERVICE	S
CENTERS FOR	RMEDICAR	RE & MEDIO	CAID SERVICES	3



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		E SURVEY MPLETED
		495246	B. WING		1	C /08/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	breakdown. LPN remove the brace LPN #5 stated, "It clarification." LPN are not supposed call the physician awas asked to describe that sealed physician had not brace then she would not assume.  On 12/8/16 at 10:0 conducted with AS physician). ASM # background because an orthopedic hose was asked to describe the sealed physician. ASM #4 stremoved once a distribution of the sure there is no residence. ASM #4 stremoved once a distribution of the sustain tissue injurcause pressure arpressure ulcers so assess the skin ur.  On 12/8/16 at 10:3 conducted with LP LPN #1 stated she consulting orthoped.	nurse should also look for skin #5 was asked if she would to assess the skin underneath. depends. I would have to get #5 stated sometimes braces to be removed so she would and get clarification. LPN #5 cribe a clam shell brace. LPN shell brace was made of two together. LPN #5 stated if the documented to remove the build call the physician and the brace could be removed.  18 a.m., an interview was 18 m #4 (Resident #10's attending #4 stated he had an orthopedic use he had previously worked at pital for many years. ASM #4 cribe the care that should be lent with a lower extremity ated the brace should be any or at least 48 hours to make dness of the skin under the ated residents with braces can ries. ASM #4 stated braces and create a potential for or it's good for nursing staff to inderneath the brace.  19 a.m., this surveyor attempted 10's consulting orthopedist's did not answer the phone.  29 a.m., an interview was end create a potential for orderneath the brace.  29 a.m., this surveyor attempted 10's consulting orthopedist's did not answer the phone.	F3	14		

DEPARTMENT OF HEALTH AND	HIIN SERVICES
DEFAR INIENT OF REALTH AND	HOINE SELVICES
<b>CENTERS FOR MEDICARE &amp; MI</b>	EDICAID SERVICES



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING	WHITE WAS ARREST AND A STATE OF THE STATE OF			C 08/2016
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP OF 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
F 314	orthopedist's progrand brace. LPN #' orthopedist's nurse be removed for ski yes the brace was skin checks but no	e facility and was looking at the ess note regarding the sock I stated she asked the if the brace was supposed to n checks and the nurse stated supposed to be removed for t written on the order because k for granted that the facility	F 3	14			
	conducted with LPI a CMS check for R shift on 8/15/16). I checked Resident the resident could the resident was no confirmed she did	p.m., another interview was N #1 (the nurse who signed off esident #10 during the day .PN #1 stated on 8/15/16 she #10's capillary refill, made sure move her toes and made sure of experiencing pain. LPN #1 not remove the resident's clame there was no physician's					
	to call the nurse whethe 11:00 p.m. to 7	p.m., this surveyor attempted no cared for Resident #10 on :00 a.m. shift beginning on 6. The nurse did not answer					
	to call the nurse when the 3:00 p.m. to 11 8/14/16. The nurse	p.m., this surveyor attempted no cared for Resident #10 on :00 p.m. shift on 8/13/16 and e also cared for the resident n. to 3:00 p.m. shift on 8/14/16. answer the phone.					
	8/13/16, 8/14/16 ar interview. Another nurse that	cared for Resident #10 on nd 8/15/16 was unavailable for cared for Resident #10 on ger employed at the facility.					

DEPARTMENT	OF HEAL	TH AND H	HUM SERVICES
			DICAID SERVICES



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495246	B. WING		12	C 2 <b>/08/2016</b>		
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP OF 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	Continued From particles of the continued From provided in accordance of the continued From provided in accordance of the continued From particles of the continued From particles of the continued From provided in accordance of the continued From particles of the continued From provided From provided in accordance of the continued From provided From	p.m., ASM #1 was made urses did not answer the died, "13.2 Splints, Hand Rolls, do Other Supportive/Protective ted, "POLICY: Residents are ary by trained staff with the noval of preventative devices and rolls, heel protectors, or otective devices as specified. The measures/devices are ance with an order from the novel of the norder from the novel of the norder from the norder to a well being and prevent injury plints, braces, and other tive devices: 8.1 Wash area r; dry with towel. 8.1.1 Ensure from the norder is directions (if nt/resident representative from the norder is directions. 8.4 are device as outlined in the observe skin while applying the note any redness or other 8.7 Record date, time are not any observed.	F 31	DEFICIENCY)				
	"Pressure Injury: A pressure injury is and underlying soft	ion was presented prior to exit.  localized damage to the skin tissue usually over a bony						
		ted to a medical or other can present as intact skin or an				:		

DEPARTMENT	OF HEALTH AND	HUM SERVICES
<b>CENTERS FOR</b>	R MEDICARE & ME	EDICAID SERVICES



AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	_	(X3) DATE SURVEY COMPLETED		
		B. WING		1	C <b>12/08/2016</b>		
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, ST 11 DAIRY LANE FREDERICKSBURG, V			00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPORTICIENCY)	BE	(X5) COMPLETION DATE
F 314	as a result of intension pressure in complete the complete soft tismay also be affected perfusion, co-morbitissue  Stage 2 Pressure It loss with exposed of Partial-thickness loadermis. The wound moist, and may also ruptured serum-filled visible and deeper Granulation tissue, present. These injuication and the pelvis and shear should not be used associated skin dain incontinence associated skin injury ((skin tears, burns, at Unstageable Pressfull-thickness skin extent of tissue dare be confirmed became schar. If slough or or Stage 4 pressure eschar (i.e. dry, addingter tissue Pressure of tissu	y be painful. The injury occurs se and/or prolonged pressure bination with shear. The sue for pressure and shear ed by microclimate, nutrition, idities and condition of the soft of the s	F				
		skin with localized area of chable deep red, maroon.		:			

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	The state of the s		PRIN FO OMB
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3

TED: 12/15/2016 ORM APPROVED NO. 0938-0391

) DATE SURVEY COMPLETED C B. WING 495246 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 83 F 314 purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue. subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible. this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions..." This information was obtained from the website: http://www.npuap.org/resources/educational-andclinical-resources/npuap-pressure-injury-stages/ (2) Medihoney is medical grade honey used in the treatment of wounds. This information was obtained from the website: http://www.dermasciences.com/medihoney F 334 1. Resident #5 was given the F 334 483.80(d)(1)(2) INFLUENZA AND SS=D PNEUMOCOCCAL IMMUNIZATIONS influenza vaccine on 12/10/16. 2. A review of resident records was (d) Influenza and pneumococcal immunizations completed by the Nurse Practice (1) Influenza. The facility must develop policies Educator (NPE), to confirm each and procedures to ensure thatrecord had evidence of either a signed consent or declination for a (i) Before offering the influenza immunization, vaccination, and if a resident did each resident or the resident's representative consent they did receive the receives education regarding the benefits and potential side effects of the immunization; vaccination. No other residents

(ii) Each resident is offered an influenza

immunization October 1 through March 31

practice.

were affected by this deficient

## DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES



	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLETED				
		495246	B. WING	***************************************		C <b>08/2016</b>	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE  FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE	
F 334	contraindicated or immunized during  (iii) The resident or has the opportunity  (iv) The resident's documentation that following:  (A) That the reside was provided educand potential side immunization; and  (B) That the reside immunization or dimmunization due refusal.  (2) Pneumococcal develop policies and immunization, eacrepresentative recibenefits and potentimmunization;  (ii) Each resident is immunization, unle medically contrained already been immunication of the resident of the resid	the resident has already been this time period;  If the resident's representative y to refuse immunization; and medical record includes at indicates, at a minimum, the ent or resident's representative cation regarding the benefits effects of influenza and not receive the influenza and not receive the influenza at omedical contraindications or disease. The facility must and procedures to ensure that the pneumococcal the resident or the resident's elives education regarding the attal side effects of the	F 33	<ol> <li>Nursing staff on all shifts we receive re-education by the CNE/designee on influenza/pneumococcal vaccination and procedure.</li> <li>The CNE/designee will contain an an another and monthly audits to determine compliance regarded residents, or their RP, receitimely notification and educe regarding the vaccine, and who consent do receive the vaccine in a timely manner Results of the audit will be reviewed at the monthly Quantite meeting x3 months.</li> </ol>	a policy nduct arding cation those	1/21/17	

	IMENT OF HEALTH	AND HUM SERVICES				FORM	): 12/15/2016 1APPROVED ): 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495246	B. WING	,		12	C / <b>08/2016</b>
	PROVIDER OR SUPPLIER  ONT CENTER			11	REET ADDRESS, CITY, STATE, ZIP CO DAIRY LANE REDERICKSBURG, VA 22405	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 334	documentation that following:  (A) That the reside was provided educand potential side elimmunization; and  (B) That the reside pneumococcal immediate pneumococcal contraindication or	medical record includes to indicates, at a minimum, the ent or resident's representative ation regarding the benefits effects of pneumococcal ent either received the nunization or did not receive immunization due to medical	F :	334			

The findings include:

sample, Resident #5.

Resident #5 was admitted to the facility on 3/2/2011 and readmitted on 9/9/16 with diagnoses that included but were not limited to type two diabetes, unspecified dementia without behavioral disturbance, muscle weakness, difficulty in walking, hypertension, osteoporosis, breast cancer, heart failure, and hypothyroidism.

Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to offer the influenza vaccination to one of 26 residents in the survey

Facility staff failed to follow up with the responsible party regarding consent for the

influenza vaccine for Resident #5.

Resident #5's most recent MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 11/22/16. Resident # 5 was coded as being cognitively

		AND HUM SERVICES  & MEDICAID SERVICES					M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		495246	B. WING	-		1	C <b>2/08/2016</b>
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		_,,
WOODM	ONT CENTER				1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	scoring 07 out of 18 for mental status) e as requiring extens staff members with toileting, bathing, are Review of Resident an ARD of 11/22/16 under Section O028 resident receive the facility for this year's A "0" (zero) was confluenza vaccine where the section of the section	ty to make daily decisions on the BIMS (brief interview xam. Resident #5 was coded ive assistance from two plus transfers, bed mobility, and locomotion off the unit.  #5's most recent MDS with documented the following 50. Infuenza Vaccine: "Did the influenza vaccine in this influenza season?"  ded indicating that the ras not received.  0250. documented the za vaccine not received, state dicating that the vaccination  #5's clinical record revealed a rethat documented the for our annual Influenza m. This program is designed and of influenza and its severe repatients. In order to the patient, we need a review the enclosed thed, "Influenza Vaccine ent." After reading the complete the Influenza orm by signing your name in the Please return the form by	F3	334			
	Informed Consent f the bottom if the for October 14, 2016	orm by signing your name in m. Please return the form by					

DEPARTMENT OF HEALTH AND HUM SERVICES

PRINTED: 12/15/2016

	TMENT OF HEALTH	AND HUN SERVICES				FORM	): 12/15/2019 MAPPROVEI ): 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		DNSTRUCTION		TE SURVEY MPLETED
		495246	B. WING_			12	C 2/ <b>08/2016</b>
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				NRY LANE DERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	AND	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 334	There was no evide vaccination was ad On 12/7/16 at 3:19 conducted with RN nurse responsible f program. RN #2 st readmission so she on 10/7/16 about th consent form. RN follow up with the fa	the influenza vaccination. ence that the influenza	F 33	i4			
	staff member) #1, t the Director of Nurs above concerns. N presented prior to e requested was not	TRITIVE VALUE/APPEAR,	F 36		For residents that were a during these meal passes offered to warm the food time it was delivered. So	, staff at the	

Each resident receives and the facility provides-

(d)(1) Food prepared by methods that conserve

(d)(2) Food and drink that is palatable, attractive,

Based on observation, staff interview, and facility

document review, it was determined that facility

staff failed to serve food in a palatable manner.

nutritive value, flavor, and appearance;

and at a safe and appetizing temperature;
This REQUIREMENT is not met as evidenced

declined.

residents accepted the offer, some

affected by this deficient practice.

(FSD/designee will: Ensure that

food temperatures are achieved

temps before tray line starts to

temperatures, and re-educate

directions, monitor & record food

2. Multiple residents could be

3. The Food Services Director

consistent with all recipe

ensure proper holding

PRINTED: 12/15/2016 DEPARTMENT OF HEALTH AND HUN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICARD SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495246 B. WING 12/08/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION DATE PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) Continued From page 88 F 364 department staff on recording temps and calibrating Facility staff failed to serve food at a palatable thermometers per facility policy. temperature. During survey, Regional FSD ordered new domes and The findings include: undershields with a higher On 12/6/16 at 2 p.m., a group interview was temperature-retaining rating. conducted with seven cognitively intact residents. 4. Tray assessments will be Most residents stated that food was cold when it conducted 3 times per week, one was served to them on the hallways. for each meal (breakfast, lunch On 12/6/16 at 5:15 p.m., observation of tray line and dinner). Results of these was conducted. The following food items and assessments will be shared at the temperatures were recorded on tray line (degrees monthly QA Committee meetings Fahrenheit). until x3 months. 1/21/17 1. Brussels sprouts- 140

- 2. Maple cranberry turkey- 180
- 3. Potatoes- 150
- 4. Green beans- 160
- 5. Advanced potatoes- 140
- 6. Puree bread- 160
- 7. Puree potatoes-160
- 8. Puree green beans-150
- 9. Fish- 170

On 12/6/16 at 6: 30 p.m., the test tray was conducted. The following food items and temperatures were recorded (degrees Fahrenheit).

- 1. Brussels sprouts- 98.8
- 2. Maple cranberry turkey-100.6
- Potatoes- 100.9
- 4. Green beans-101.1
- 5. Puree bread-106.0
- 6. Puree green beans-107.2

On 12/6/16 at approximately 6:35 p.m., an

DEPARTMENT OF HEALTH A	ND HUM SERVICES
CENTERS FOR MEDICARE &	MEDICAID SERVICES



	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		MPLETED  C
		495246	B. WING		1:	2/08/2016
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(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)	IOULD BE	(X5) COMPLETION DATE
F 364	member) #10, the the Regional Dieta they thought of the the test tray, OSM When asked what palatable temperat 120 degrees Fahre resident's have every temperatures of the "Complained in the they resolved these #11 stated that the assessment every provide evidence of #11 stated, "I will he on 12/7/16 at appr (administrative star Administrator, and Nursing) were made OSM #11 could no tray assessment week.  Facility policy titled part, the following: for safety food must temperature of 41 or 135 degrees Faheld for serviceD from the kitchen to patient/resident rocare is taken to ke	dicted with OSM (other staff dietary manager and OSM #11, ry Manager. When asked what food after tasting a sample of #10 stated, "Ya, it is cold." they would consider a ture, OSM #11 stated usually enheit or above. When asked if er complained about the er food, OSM #10 stated, e past, yes." When asked how er complaints of cold food, OSM facility should be doing a tray week. When asked if he could for a test tray assessment, OSM ave to check."  Toximately 6:45 p.m., ASM ff member) #1, the ASM #2, the DON (Director of the aware of the above concern. It provide evidence that a test has being completed every  "Food handling" documents in "All time/temperature control at maintain an internal degrees Fahrenheit or lower, threnheit or higher while being buring transportation of food		54	•	
	Control for Safety f	tures or Time/Temperature food, refer to the Food and n's (FDA's) Food Code."				

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES



	F CORRECTION	IDENTIFICATION NUMBER:	1 1	VG			PLETED
		495246	B. WING_				C <b>08/2016</b>
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				11 DAIR	ADDRESS, CITY, STATE, ZIP CODE Y LANE RICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364	Continued From pa	ge 90 ion was presented prior to exit.	F 36	64			
	(i)(1) - Procure food considered satisfact authorities.  (i) This may include from local producer and local laws or referred (ii) This provision defacilities from using gardens, subject to safe growing and food (iii) This provision defrom consuming food from consuming food (iii) This provision defrom consuming food from consuming food (iii) This provision defrom consuming food the safety.  (ii) This provision defrom consuming food from consuming from consuming food from consuming food from consuming food from consuming from consuming from consuming food from consuming from consuming food from consuming from co	OD PROCURE, /SERVE - SANITARY  If from sources approved or story by federal, state or local of food items obtained directly is, subject to applicable State igulations.  Does not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices.  Idoes not preclude residents bods not procured by the facility.  The distribute and serve food in offessional standards for food in offessional standards for food in a sanitary storage, tumption.  Note that is not met as evidenced that facility was determined that facility food in a sanitary manner.	F 3	<ol> <li>3.</li> <li>4.</li> </ol>	No residents were affected deficient practice.  Multiple residents could be affected by this deficient properties. The Food Services Director (FSD) will ensure that: Properties inspected for quality upon receipt, product out-of-date discarded, all opened items date-labeled per policy, a "Date" guide is posted in all production areas, and dietar is re-inserviced on proper labeling and dating of product labeling and dating daily basis for compliance, results shared at the month! Committee meetings x3 most product labeling and dating daily basis for compliance, results shared at the month!	actice.  duce n are are Use by ry staff act. on a with y QA	1/21/17
	Facility staff failed t	o ensure the facility's kitchen					
							: !

	MENT OF HEALTH	**************************************					D: 12/15/2016 MAPPROVED
CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION		TE SURVEY MPLETED
		495246	B. WING _			12	C 2/08/2016
NAME OF PROVIDER OR SUPPLIER				STREE	T ADDRESS, CITY, STATE, ZIP COD	E	
1400001	01/T 051/TED			11 DAI	RY LANE		
WOODM	ONT CENTER			FRED	ERICKSBURG, VA 22405		
(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 AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 91 e from expired food items.	F 37	71			
	reingerator was ire	e from expired food items.					
	The findings include	e:					
	kitchen was conduct of the kitchen refrig	a.m., inspection of the cted. At 11:13 a.m., inspection erator was conducted. The e observed to be expired:					
	12/3/16. No open of container.	eam with an expiration date of date was labeled on the ree wholesome skim milk with of 12/3/16.					
		n that appeared to be growing I in a container full of lemons.			,		
	4. Two zip lock bag	s of shredded carrots were					
		pen date or expiration date  5. The carrots appeared to be		:			
	rotten with cloudy li	quid in the bags.					
	<ol> <li>One zip lock bag open or expiration of</li> </ol>	of ham was observed with no date.					
				1			
		3 a.m., an interview was M (other staff member) #3, the					
		the expiration date of the					
		43 agreed that the expiration					:
		2/3/16. When asked how		:			1
		frigerator was checked for	· ·				
		he stated, "Well technically	1				
		seven days after expiration. I					:
		way three days after					:
		asked when the sour cream		:			:

was opened, OSM #3 stated that he was not sure. OSM #3 stated, "I open things like this up to see if it still good, and this is still good. When it was opened, I don't know." OSM #3 stated an open date should have been written on the sour cream container. OSM #3 stated, "I am trying to

	TMENT OF HEALTH	AND HUM SERVICES  & MEDICAID SERVICES				FOF	ED: 12/15/2016 RM APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) E	ATE SURVEY OMPLETED
		495246	B. WING	i			C   <b>2/08/2016</b>
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP C		
WOODM	ONT CENTER				IAIRY LANE EDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 371	conducted with OS in the two zip lock the OSM #3 stated, "Trecarrots but they are how old the carrots was not sure becauzip lock bag. When labeled on the zip lowhen it was placed that there was no dithat the ham had jut the day before but a bag. OSM #3 state been labeled.  On 12/8/16 at apprinterview was condimember) #11, the F	•	F	371			
	the facility's refriger OSM #11 stated that responsible. When away food items, Othe food. If it has a throw it away when like oranges, we wow When informed aboutems, OSM #11 statems, OSM #11 bag full of ham with was still fresh; the bag full fresh; the bag full of ham with was still fresh; the bag full of ham with was still fresh; the bag full of ham with the statement of the food of the	rator for expired food items, at the entire kitchen staff was a asked when he would throw SM #11 stated, "It depends on an expiration date, we would it expires. If it's something ould have to get a visual." but the above expired food ated that even though the milk then will still use the milk for also stated that the zip lock in no open date or use by date bag was just not labeled. OSM just put in there and we didn't					

On 12/7/16 at approximately 6:45 p.m., ASM

DEPARTMENT	OF HEALTH	AND H	UM SER	VICES
CENTERS FOR	<b>MEDICARE</b>	& MED	ICAID SERV	VICES



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED		
		495246	B. WING			C /08/2016		
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE  FREDERICKSBURG, VA 22405					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 371	Continued From pa	•	F 37	71		***************************************		
	administrator and A	SM (administrative staff ON (Director of Nursing) was						
	in part, the following with the manufacture properly stored can long as the product any other food or product	"Food Handling" documents g: " Foods that are marked rer's "use by" date that are be used until that date as has not been combined with repared in any way including cility policy did not address						
	Storage" document is dated when received when opened. Mar used until opened container. If remove	"Refrigerated/Frozen ed in part, the following: "Food ved and with "use by" date nufacturer use by dates are .Foods are kept in the original red from the original container, ly covered and labeled with ad "use by" date."						
	483.45(a)(b)(1) PH ACCURATE PROC (a) Procedures. At	facility must provide	facility.  2. CNE/designee reviewer records to determine to management of pain. residents were affected and deficient practice.		ed resident imely	es esta por esta esta esta esta esta esta esta esta		
	that assure the acc dispensing, and ad	vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident.			d by this			
	employ or obtain th pharmacist who	ation. The facility must e services of a licensed	:	identify whether pain is required for any re- or new admissions, th	management admissions at these	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	(1) Provides consul	tation on all aspects of the		individuals receive the	e pain			

DEPARTMENT OF HEALTH AND	HUM SERVICES
CENTERS FOR MEDICARE & MI	EDICAID SERVICES



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495246	B. WING				C
NAME OF	PROVIDER OR SUPPLIER	1 1032.0			REET ADDRESS, CITY, STATE, ZIP CODE	121	08/2016
	ONT CENTER			11	DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 425	provision of pharma. This REQUIREMEI by: Based on staff into and facility docume that facility staff fail available for one of sample, Resident # The facility staff fail 7.5/325 mg (milligra administration as or Resident #26.  The findings included Resident #26 was a 3/11/16 with diagnoral limited to aftercare surgery, presence osteoarthritis, high cholesterol, anemia and anxiety disorded MDS (minimum daday scheduled asserterence date of 3 coded as being cogmake daily decision BIMS (brief intervier Resident #26 was with transferring, we personal hygiene, a with meals and local Review of Resident (physician order shorder: "Hydrocodor mg/325 mg (millignation)."	acy services in the facility; NT is not met as evidenced erview, clinical record review ent review it was determined ed to ensure medications were 26 Residents in the survey 26.  ded to ensure Norco (1) am) tablet was available for redered by the physician for  e:  admitted to the facility on uses that included but were not following joint replacement of right artificial hip joint, blood pressure, high a, major depressive disorder, er. Resident #26 most recent ta set) assessment was a five essment with an assessment /16/16. Resident #26 was gnitively intact in the ability to as scoring 15 out of 15 on the ew for mental status exam). coded as requiring supervision alking, dressing, toileting, and bathing; and independent	F4	<b>125</b>	medication prior to transfer facility, and the individual at the facility with a correst physician order so that the medication can be requested immediately by the admitting nurse from the pharmacy, admissions will be assessed pain behaviors using pain assessment and their pain managed appropriately. The pharmacy will be immediated by the admitting numbers whenever an ordered medication available in the stat box Nursing staff on all shifts we re-educated by the CNE/designee will regular review the stat box with the pharmacy representative, a review all admissions and timely procurement of medications so that the resultant has an easy transition. An audit will be conducted CNE/designee specific to pain management, with primeasures to minimize pair be addressed daily. Resultant here is a substant to the review the monthly QA Committee the monthly QA Committee the monthly QA Committee the second conducted the monthly QA Committee the m	arrives ponding  ed ing All new d for  dediately urse cation is c. vill be esignee ment. rly ne and provide sident d by the timely o-active n will ts of red at	1/21/17

	MENT OF HEALTH	AND HUM SERVICES				FORM	): 12/15/2016 1 APPROVED ): 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
-		495246	B. WING			12	C / <b>08/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COI		
WOODM	ONT CENTER				DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	Continued From pa	ge 95	F4	25			
	following: "Give 1 N prn mild to moderate	ified on 3/14/16 to the lorco 7.5/325 mg po q 4 hours te painGive 2 Norco 7.5/325 nours prn mod (moderate) to					
	following note dated (patient) became ver medication. Pharms medication was redelivered stat. This offered non-pharms until Norco arrived requested an ice paprovided to patient position in bed. This contact the physicia or ibuprophen on his stating, "If I take that the Norco when it gplaced her c-pap medication."	ng notes revealed the d 3/16/16 at 1:06 a.m.: "Pt ery upset about pain acy contacted, and pain ordered and reported to be nurse went to patient and acological pain interventions from pharmacy. Pt (patient) ack and to lie in bed. Ice pack and pt assisted into reclining a nurse offered to contact to an and request either Tylenol er behalf. Pt denied offer at now, I won't be able to take lets here. I will just wait." Pt ask on and stated "I'll just trying me my medicine when it					
	#26's last dose of N A pain score was no	otic log revealed that Resident lorco was on 3/15/16 at 5 p.m. of documented. A note nedication effectiveness was					

Further review of the narcotic log for Norco 7.5/325 mg revealed that Resident #26 did not receive her Norco until 3:40 a.m. on 3/16/16. A pain score was not documented when she received her medication. A note could not be

found documenting pain medication

not found.

	TMENT OF HEALTH	AND HUM SERVICES				FORM	D: 12/15/2016 MAPPROVED D: 0938-0391
STATEMENT	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
· · · <u>- · · · · · · · · · · · · · · · ·</u>		495246	B. WING	3		12	C 2/08/2016
	PROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE  DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	·IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 425	Continued From pa	age 96	F	425			
:	(Immediate) box re was not available in On 12/8/16 at 9:04 conducted with LPN	a.m., an interview was N (licensed practical nurse) #9,			,		
:	asked about the pro- resident pain medic nursing staff should it runs out. LPN #9 or 12 tablets are lef will refill the medica- never ok to run out if they are narcotics can arise with narco- process such as ph LPN #9 stated that	ad with Resident #26. When ocess staff follows for refilling cations, LPN #9 stated that d refill pain medications before 9 stated that she waits until 10 ft in the package before she ation. LPN #9 stated that it is of pain medication especially s. LPN #9 stated that issues otics further delaying the refill narmacy needing a hard script. If a resident does run out of the physician must be notified to					
Androne	get an alternative m On 12/8/16 at 9:37 conducted with ASM member) #2, the Do ASM #2 stated that available because t	a.m., an interview was M (administrative staff ON (Director of Nursing). t Resident #26's Norco was not the facility did not have a hard ted that the resident had a					
	conducted with RN stated that she refill before it runs out. I runs out of pain me pharmacy and have	6 a.m., an interview was (registered nurse) #4. RN #4 lls medications three days RN #4 stated that if a resident edication she would call e them STAT (Immediate) out N #4 stated that she will also					

call pharmacy to obtain a code to get the medication out of the STAT box. When asked

	MENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES			FORM	: 12/15/2016 I APPROVEC : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DAT COM	TE SURVEY MPLETED
		495246	B. WING _			C / <b>08/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 425	not in the STAT box the MD (medical do prescription." RN # allegation.  On 12/8/16 at 10:17 conducted with LPN with Resident #26. refill a medication we the package. He st pharmacy will requi	staff follows if the medication is a, RN #4 stated, "I would call octor) for a different '4 could not recall the above '7 p.m., an interview was N #8, a nurse who was familiar LPN #8 stated that he would when about 6 pills are left in that the that sometimes a hard script for pain portant to refill these	F 42	25		
	On 12/8/16 at 11:11 conducted with RN shift when Resident out. RN #6 stated to pain medication thromedication running (3/16/16) pharmacy have the original proposed this medication was have the original proposed the original proposed the original proposed Resident #26 tried of the original proposed Resident was have the original proposed Resident with pharmacy, but	a.m., an interview was #6, the nurse who worked the t #26's pain medication ran hat she will usually re-order				

she went to go give it.

of the above concerns.

the medication was out before it was refilled. RN #6 stated that her Norco ran out on her shift when

On 12/8/16 at 12:02 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the DON (Director of Nursing) were made aware

DEPARTMENT OF HEALTH	AND HUN SERVICES
<b>CENTERS FOR MEDICARE</b>	& MEDICAID SERVICES
TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA



	OF CORRECTION	IDENTIFICATION NUMBER:		IG	COMPLETED	
		495246	B. WING_		12/08/2016	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTIC	ON
F 425	Continued From pa	ge 98	F 42	25		
	Discontinuing Orde refill medications or	"Reordering, Changing, and rs" did not address when to r the process when t available on the unit.			Approximation managements and managements and	
		ion was presented prior to exit.		1. Resident #3 had a physi for a stool specimen that	cian order	
	Complaint deficience 483.50(a)(1) ADMII		F 50	obtained No ovidence a	of c-diff	
SS=D	(a) Laboratory Serv	ices		resident; formed stools noted after the order was	were	
	services to meet the facility is responsible of the services. This REQUIREMENT by:  Based on staff intered and clinical record of facility staff failed to	t provide or obtain laboratory e needs of its residents. The le for the quality and timeliness NT is not met as evidenced erview, facility document review review, it was determined that o obtain a laboratory specimen order for one of 26 residents le, Resident #3.		The resident was not dia with c-diff infection.  2. Review of resident record conducted to determine deficient practice affected residents. None were idented to the administration of laws reviewed by the NP deficient practices corrected.	rds was if the ed other entified. b services E, with cted.	
		ed to obtain clostridium pecimen ordered by the 6 for Resident #3.		3. Nursing staff on all shif re-educated by CNE/desthe the facility policy specific physician orders, labora	signee on fic to	
	The findings include			services and diagnostic 4. Laboratory process and	tests.	
	with diagnoses that	dmitted to the facility on 6/6/16 included but were not limited bod pressure, kidney disease,		documentation will be a daily for accuracy by the Unit Managers and Super Results of the audits will	udited e Nurse ervisors.	
		DS (minimum data set), a ent, with an ARD (assessment	:	reviewed at the monthly Committee meetings x6	' QA	7

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



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495246	B. WING			12/08/2016		
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				STREET ADDRESS, CITY, STATE, 11 DAIRY LANE FREDERICKSBURG, VA 22				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 502	having a 15 out of for mental status, cognitively intact t resident was code staff for all activitic eating once the track. Review of the physigned on 8/22/16 "Collect stool same Review of the Augadministration rec Stool for C-diff."  Review of the nurs 11:10 p.m. docum	10/31/16 coded the resident as 15 on the BIMS (brief interview indicating the resident was o make daily decisions. The ed as requiring assistance from es of daily living except for	F	02				
	Review of the clin documentation of On 12/7/16 at 6:4: ASM (administrati	ical record did not evidence the laboratory result. 5 p.m. a request was made to ve staff member) #2, the nurse sident #3's c-diff specimen						
	On 12/8/16 at 12: c-diff specimen) w nurse who did not	15 p.m. ASM #2 stated, "It (the vas not done because we had a follow through. I checked and wo formed stools after that."						
	p.m. with LPN (lice When asked about a physician orders	conducted on 12/8/16 at 2:58 ensed practical nurse) #5.  It the process staff follows when a laboratory specimen, LPN #5 are order and put it into the						

DEPARTMENT	OF HEALTH AND	HUN SERVICES
<b>CENTERS FOR</b>	R MEDICARE & MI	EDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495246	B. WING		C <b>12/08/2016</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/06/2016	
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		BE COMPLETION	
F 502	computer. You tran MAR (medication at the RP (responsible note." When asked had been collected 11 to 7 (11:00 p.m. know." When asked c-diff specimen, LP concerned for contact Review of the facilit Tests" documented including laboratory ordered. Laboratory ordered. Laboratory on-site seven days PURPOSE. To mor condition and therat	dministration record) and let e party) know and you make a how staff knew if a specimen, LPN #5 stated, "Usually the to 7:00 a.m.) shift will let us d if it was important to obtain a N #5 stated, "Yes we're very amination."  by's policy titled, "Diagnostic, "POLICY. Diagnostic tests	F 5	i02		
	more commonly "C that claims the lives year. Most at risk a requiring prolonged the unfortunate side natural, good bacte bad bugs like C. dif 483.70(i)(1)(5) RES RECORDS-COMPLE  (i) Medical records. (1) In accordance vistandards and practices.	LETE/ACCURATE/ACCESSIB	F 5	<ol> <li>Resident #8 had another resilab results filed in their chart was corrected during the sur</li> <li>A review of resident charts we conducted to determine if othersidents were affected by the deficient practice. None were identified.</li> <li>CED/designee will confirm to</li> </ol>	t. It vey. was her is	

	MENT OF HEALTH	AND HUN SERVICES				FORM	12/15/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E .		CONSTRUCTION	(X3) DATI COM	SURVEY PLETED
		495246	B. WING	·	· · · · · · ·	1	D 0 <b>8/2016</b>
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				11 1	REET ADDRESS, CITY, STATE, ZIP COD DAIRY LANE EDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	- ;	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 514	(ii) A record of the r (iii) The compreher provided;	mented; ble; and organized	F	514	filing system used, the responsible for filing (e medical records/health information coordinator identify potential gaps is system that can potential a deficient practice.  4. Chart checks complete nurses must include a ractual documents in the individual charts to ensuccurate filing of information Random chart audits we conducted by the CNE to determine compliant of the audits will be re-	r), and n the ally lead to d by the review of e sure mation. vill be /designee ce. Results	

The findings include:

Resident #8.

by:

and resident review evaluations and

professional's progress notes; and

determinations conducted by the State;

(v) Physician's, nurse's, and other licensed

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record review, it was determined that the facility failed to maintain a complete and accurate clinical record for one of 26 residents in the survey sample,

For Resident #8, the facility staff filed laboratory results for another resident on his clinical record.

the monthly QA Committee

meetings x6 months.

1/21/17

DEPARTMENT	OF HEALTH A	AND HUM	SERVICES
CENTERS FOR	MEDICARE 8	& MEDICĂID	SERVICES



AND PLAN OF CORRECTION  (X1) PROVIDENSOPPLIENCLIA  IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		495246	B. WING		1:	C 2/08/2016
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COI 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 514	facility on 9/27/16 limited to bladder blood pressure, b arthritis, Alzheimed dysphagia, lymph encephalopathy, a The most recent I significant change (Assessment Referesident was code impaired in ability The resident was bathing; extensive eating, and hygier incontinent of bow bladder.  A review of the cliculture test results have an order for this lab result was and was misfiled on 12/7/16 at app (Licensed Practic misfiled and shour record.	most recently readmitted to the with the diagnoses of but not cancer, atrial fibrillation, high enign prostate hypertrophy, er's disease, psychosis, apraxia, alytic leukemia, and congestive heart failure.  MDS (Minimum Data Set) was a eassessment with an ARD erence Date) of 10/4/16. The ed as severely cognitively to make daily life decisions. coded as requiring total care for e care for transfers, dressing, ne, and was coded as vel and as having a catheter for nical record revealed a urine is for which the resident did not. Further investigation revealed actually for another resident on Resident #8's clinical record.  Proximately 5:00 p.m., LPN #1 al Nurse) stated that it was lid not be on Resident #8's	F 5			
				:		

~				•
State	~+	1111	486	
. TI AIR	[ ]1	VIII	111	11.



FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

495246

B. WING

12/08/2016

NAME OF PROVIDER OR SUPPLIER

**WOODMONT CENTER** 

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING \_\_\_

11 DAIRY LANE

TOODING	FRED	ERICKSBURG,	VA 22405	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE	
F 000	Initial Comments	F 000		
F 001	An unannounced biennial State Licensure Inspection was conducted 12/6/16 through 12/8/16. Corrections are required for complian with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safet Code survey/report will follow.  The census in this 1118 certified bed facility was 1113 at the time of the survey. The survey sar consisted of 20 current resident reviews (Residents #1 through #20) and six closed recreviews (Residents #21 through #26).  Non Compliance  The facility was out of compliance with the following state licensure requirements:  This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and procedures Based on staff interview and facility document review, it was determined that the facility staff failed to provide written record of an annual poland procedure review.  The findings include:  On 12/6/16 at approximately 11:00 a.m. during entrance conference, ASM #1 (the executive director) and ASM #2 (the nurse executive) we asked to provide documentation to evidence a facility policies had been annually reviewed for last two years.  On 12/7/16 at 11:05 a.m., an interview was conducted with ASM #2. ASM #2 stated the facility policies were online and updated by the corporation. ASM #2 stated the quality assura coordinator receives the policies and then the	ce y as nple ord F 001	<ol> <li>No residents were affected by the deficient practice.</li> <li>Multiple residents could be affected by this deficient practice.</li> <li>The Center Executive Director (CED) will in-service centermanagement personnel on the facility policy Facility Policies and Procedures – Annual Reviews.</li> <li>The CED will ensure that all facility policies are annually reviewed, with evidence for review that said reviews have been conducted per regulation and policy.</li> </ol>	1/21/17
L				: <u></u>

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

(X6) DATE

STATE FORM

RCPG11

If continuation sheet 1 of 5

State of Virginia





PRINTED: 12/15/2016 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495246		B. WING		12/0	08/2016
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
WOODM	ONT CENTER		11 DAIRY FREDERI	LANE CKSBURG, V	⁄A 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
F 001	administrative team this process occurs assurance meeting policies or updated aware this surveyo all policies had bee stated all policies he documented in a diasked to provide de On 12/8/16 at 12:0 presented a form the "(Name of corporate Center Operations SIGNATURE PAGI (Name of facility) 007-2014 (Revision Number) To adopt this manureviewed and acce Assurance Commit be signed by the for implementing a policies for the Certhe care provided."  The form was signed the medical director the section for the date was blank (Nowas no longer empourment administrate three weeks). At the just found this form corporate office. Tand ASM #2 to classigned by the nurse director this day sinday. ASM #1 and a survey as a survey of the section for the date was blank (Nowas no longer empourment administrate three weeks). At the just found this form corporate office. Tand ASM #2 to classigned by the nurse director this day sinday. ASM #1 and a survey of the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks). At the section for the date was blank (Nowas no longer empourment administrate three weeks).	n signs them. ASM #s during the monthly gs and is only done for policies. ASM #2 were needed to see eviden annually reviewed and been reviewed build been reviewed build been reviewed build been to evident and been reviewed build been revision and been revision, it is proceed by your Center's tree. The Signature build b	quality or new as made ence that . ASM #2 at this was ence this. ASM #2 dures dures during a guide to cutive and ed 1/28/16 ature and nistrator and the ed there for ted he had do the ASM #1 at been dical to found this the form had the form				

the form was dated 1/28/16 if it had been signed

021199

State	of	Virg	gin	iia





STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING \_\_\_ B. WING 495246 12/08/2016

NAME OF PROVIDER OR SUPPLIER

#### WOODMONT CENTED

STREET ADDRESS, CITY, STATE, ZIP CODE

11 DAIRY LANE

WOODMO	ONT CENTER	11 DAIRY LANE FREDERICKSBURG,	/ LANE ICKSBURG, VA 22405			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
F 001	Continued From Page 2	F 001				
F 001	this day. ASM #2 stated the facility policity reviewed on 1/28/16 but she couldn't find to evidence this.  The facility policy titled, "Facility Policies Procedures- Annual Reviews" document "Our facility reviews its operational policies procedures and resident care policies as and at least annually. Policy Interpretation Implementation: 1. To ensure that our factory operational policies and procedures are maintained on a current basis, the quality assurance and assessment committee wour operational policies and procedures are regulations dictate such revisions; b. Whenever char regulations dictate such revisions; b. Whenever new procedures are necessal ensure that each resident's needs and seare met in accordance with his/her assess and plan of care; and d. at least annually No further information was presented print 12VAC5-371-220. Nursing services cross reference to F314.  12VAC5-371-250. Resident assessment planning cross reference to F280.	ies were If the form  and ed in part es and needed on and cility's  y vill review and nges in henever equire res; c. ry to ervices ssment  y"				
	12VAC5-371-360. Clinical records cross reference to F514.					
	12VAC-371-250-A.7 cross references to	F250				
	12VAC-371-220-C.1 cross references to	F314				
	12VAC-371-110-B.3 cross references to	F225	<u> </u>	: :		
STATE FOR	<b>IM</b>	021199	RCPG11 If conti	nuation sheet 3 of 5		





PRINTED: 12/15/2016

FORM APPROVED

Otoro or ringrito	OCCUTING THE STATE OF THE STATE							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED				
	495246		B. WING	12/08/2016				
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STATE, ZIP CODE					

NAME OF PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	, STATE, ZIP CODE
WOODM	ONT CENTER	11 DAIRY FREDERIC		, VA 22405
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETE DATE
F 001	Continued From Page 3		F 001	
STATE FOR	Review of five employee records was coduring the survey. Two of the five employed not have a Virginia State Police backgro completed.  On 12/8/16 at 8:15 a.m. a request was most of the two employees. OSM #9 stated that employees were from the rehabilitation department and the background checks done by the rehabilitation staff and compute corporate office. OSM #9 stated she the office.  On 12/8/16 at 4:08 p.m. ASM (administrate member) #1, the executive director state corporate people told me they do not have vidence of the Virginia background check those two employees. Review of the fact policy titled, "Abuse Prohibition" docume "Process. 2. The Facility shall screen poemployees for a history of abuse, negled exploitation, or mistreating residents included checking with the appropriate licensing and registries. 2.1 The Facility shall not on individuals who: 2.1.1. Have been found court of law of abusing, neglecting, or mothers"  No further information was provided prior 12VAC5-371-140 E. cross reference to F2 12VAC5-371-250. cross reference to F2 12VAC5-371-250. cross reference to F2 12VAC5-371-220. cross reference to F2	empleted yees did und check nade to in ecks for these were eleted at would call ative staffed, "Our ve ecks on elity's ented, tential est, uding coards employ guilty by a istreating or to exit.		<ol> <li>No residents were affected by the deficient practice.</li> <li>Multiple residents could be affected by this deficient practice. HR/Benefits Coordinator reviewed all employee records to determine if there was evidence of a completed a negative Virginia State Police background check. No other deficiency was identified.</li> <li>Center Executive Director (CED) will ensure that all employment candidates, irrespective of department, have a Virginia State Police background check completed as part of the hiring/screening process, the results of the check documented in their file, and that any individual with a record of abusing, neglecting or mistreating others will be flagged and not hired.</li> <li>CED/designee will randomly audit personnel files for a period of six months to determine compliance, with corrective actions take as warrants and results of the audits shared at the monthly QA Committee</li> </ol>





PRINTED: 12/15/2016 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROADD PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	I MIIMBED:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495246		B. WING _		12/0	8/2016	
NAME OF P	ROVIDER OR SUPPLIER	1		DRESS, CITY, S	STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·		
WOODMO	ONT CENTER		11 DAIRY FREDERIC	LANE CKSBURG, V	VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM/	FULL	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
F 001 Continued From Page 4				F 001			:	
	12VAC5-371-180.	cross reference to F3	334					
	12VAC5-371-340A	. cross reference to l	F364, F371					
	12VAC5-371-300.	cross reference to F	<b>125</b>					
				: :				
***************************************								
		t						
				:				
				:				
				:				
				v 				
				:				
					: : :			

021199



#### COMMONWEALTH of VIRGINIA

#### Virginia Department of Fire Programs

Meivin D. Carter EXECUTIVE DIRECTOR

State Fire Marshal's Office Northern Region 471 James Madison Hwy Ste.101 Culpaper, VA 22701 Phone: 540/317-7670

Fax: 540/ 727-7041

Kathaleen Creegan-Tedeschi, Director Office of Licensure/Certification Division of Long Term Care Virginia Department of Health 9960 Mayland Drive Perimeter Center Suite 401 Henrico, VA 23233

RE: Woodmont Center 11 Dairy Lane

> Fredericksburg, VA 22404 File Number: N-0326-001

CMS Certification Number: <u>495246</u> Event ID Number: <u>UKHU21</u>

The attached report is forwarded to you with the following comments:

I.	SURVEY [X]
[ X	Recommend certification based on acceptable POC.  Recommend certification based on acceptable POC.  Recommend certification based on acceptable POC and a scarce and acceptable poculation based on acceptable poculation.
i J	Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
	Recommend certification based on compliance with LSC by requested continuous waiver.
	Recommend certification based on compliance with LSC by requested Time Limited waiver.
	Recommend certification based on satisfactory results from application of the FSES.
[ ]	Do not recommend certification.
П.	POST SURVEY[]
[]	All deficiencies corrected:
[]	All deficiencies not corrected:
	[ ] Recommend certification based on acceptable POC
	<ul> <li>Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.</li> </ul>
	[ ] Recommend certification based on approved or requested continuous waiver.
	[ ] Recommend certification based on approved or requested Time Limited waiver. [ ] Do not recommend certification.
If y	you have any questions or if we may be of further assistance, please contact me at 804-371-0220
	Sincerely,
	Ronald C. Reynolds - JCC Ronald C. Reynolds
	Ronald C. Reynolds

Deputy State Fire Marshal

Survey Date: 12/20/2016 SOD Sent: 12/21/2016 POC Rec 'd: 12/30/2016 POC to HQ: 01/10/2017

Highest Scope/Severity: F



11 Dairy Lane; PO Box 419 Fredericksburg, VA 22405-2663 Tel 540-371-9414 Fax 540-371-4501

December 30, 2016

Virginia Department of Fire Programs
State Fire Marshal's Office – Northern Region
ATTN: Robert Parker
471 James Madison Highwy, Ste 101
Culpeper, VA 22701

Re: Plan of Correction - Life Safety Code Survey

Mr. Parker:

Woodmont Center is in receipt of your notice of deficiencies as a result of the Life Safety Code survey conducted by your office on December 20, 2016. Enclosed is the Plan of Correction without admitting or denying the validity or existence of the alleged deficiencies. This Plan of Correction is prepared and executed solely because it is required by the provisions of the Federal and State law.

We request that you consider this Plan of Correction as this facility's allegation of substantial compliance effective February 2, 2017.

If you have any questions, or further clarification/information, please do not hesitate to contact me at 540/371-9414, Ext 4122, or by e-mail: <a href="mailto:james.harris@genesishcc.com">james.harris@genesishcc.com</a>

Sincerely,

James M. Harris, MA, LNHA Center Executive Director

Enclosure

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

Printed: 12/21/2016 FORM APPROVED OMB NO, 0938-0391

				1			TOWR MC	) <u>, 0938-039</u>
			2) MULTIPLE CONSTRUCTION Building <b>01 - Woodmont Center</b>		(X3) DATE SURVEY COMPLETED			
		495246		B. WING			12/2	0/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	DESS CITY	CTA	TE, ZIP CODE		
1	MONT CENTER					IE, ZIF CODE		
14000	MOIAL CEMIEK			RY LANE				
			FREDE	HICKSBU	UKG	i, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST OR LSC IDE	ATEMENT OF DEFICIENCIE TBE PRECEDED BY FULL P ENTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JI D RE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs		K 000				
	An unannounced re Survey was conduct accordance with 42 Part 483: Requirem Facilities. The facilities and Medicaid.  NFPA 101 Discharge. Discharge from Exit Exit discharge from Exit Exit discharge is arr provides a level wall provisions of 7.1.7 we elevation and shall be obstructions. Addition to be a hard packed all accordance with CM Letter 05-38.  18.2.7, 19.2.7, S&C	ecertification Life Safeted on 12/19/2016 in code of Federal Regients for Long Term City was surveyed for the LSC 2012 Existing cility was not in complete for Participation Market for Participation Market for Exits  Is a saged in accordance king surface meeting with respect to change on ally, the exit dischaul-weather travel surfacts Survey and Certification 105-38	lance liance ledicare with 7.7, the es in rge shall ce in cation	K 271		On 12/21/16, facility Main Director requested a quote local, general contractor to approximately 450 linear f sidewalk at rear exits, to prhard surface for emergency resident evacuations.  The facility Maintenance E personnel walked the outside the building to address are	from a install eet of rovide a Dept de of	
			<b>y</b> .			exits in need of hard surface	ec for	
Ì						emergency evacuation	c9 10L	
					2	Distance Evacuation,	entirest vetebles	
1		lity to affect 50% of th	ne		3.	KISK Assessment document	s will	
3	be a hard packed all-weather travel surface in accordance with CMS Survey and Certification Letter 05-38.  18.2.7, 19.2.7, S&C 05-38  This Standard is not met as evidenced by: Based on observation the facility does not have a all weather surface at exit discharge.  This has the possibility to affect 50% of the residents.  resident evacuation  2. The facility Mainter personnel walked the building, to address in need of hard emergency evacuation  A survey and Certification  Comparison of the personnel walked the building, to address in need of hard emergency evacuation  Risk Assessment do be put into place to a survey and Certification  A survey and Certification  Comparison of the personnel walked the building, to address in need of hard emergency evacuation  Risk Assessment do be put into place to a survey and Certification  Comparison of the personnel walked the building, to address in need of hard emergency evacuation  Risk Assessment do be put into place to a survey and Certification  Comparison of the personnel walked the building, to address in need of hard emergency evacuation  Risk Assessment do be put into place to a survey and Certification  Comparison of the personnel walked the building, to address in need of hard emergency evacuation  Risk Assessment do be put into place to a survey and Certification  Comparison of the personnel walked the building, to address in need of hard emergency evacuation.		be put into place to address	anv				
	The Findings Include	e:	1			facility exits that do not me	et the	
		proximately 10:45 AM	A hours			K-271 regulation.	or and	
	it		·· !!Vu!3,	Ì	1	Maintenance District		
ĺ		servation that the faci	lity failed		₹.	Maintenance Director/desig	nee	
-	to		i			will monitor and evaluate al	ll Risk	
	have a all weather su	urface at the exit disc	harge			Assessment documents to e	nsure	
	from Cardinal and Do	ove Hallways.				operation meets hard-surfac	e	
K 353	NEPA 101 Sprinkler	System - Maintenanc	e and	K 353		requirements. Results of the	ese R A	
SS=F	Testing	ojotom Mantenanc	- and	N 333		evaluations will be shared a	t the	1

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

Sprinkler System - Maintenance and Testing

TITLE

x3 months.

monthly QA Committee meetings

2/2/17 (X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		100 mg	7
DEDADTMENIT	E 11E ALTII ANID	. 7 11 15 4 4 5 1	OFMINARA
DEPARTMENT O	T DEAL! D AND	HUMAN	ントインル・トラ
	4	110100	
	#EDICADE 9. 1/4		CEDIACEO
CENTERS FOR I		CUIUAIU :	SERVICES

Printed: 12/21/2016
FORM APPROVED

		T T T T T T T T T T T T T T T T T T T		<del></del>		<u> </u>	IJ٦
STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			TIPLE CONSTRUCTION ING 01 - WOODMONT CENTER	(X3) DATE SURVEY COMPLETED	
		495246		B. WING		12/20/2016	
NAME OF PROVID WOODMONT			11 DAI	RY LANE	STATE, ZIP CODE	<u> </u>	
(X4) ID PREFIX (EACH TAG	DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETIO	N
Auto inspe with Testi Prote main main avail a) D	ected, tested, a NFPA 25, Stan ng, and Mainta ection Systems tenance, inspe tained in a sec able. Date sprinkler s	and standpipe syste and maintained in accordant for the Inspection ining of Water-based. Records of system ction and testing are ure location and reaccystem last checked	cordance on, I Fire design,	K 353			
resident the factor of the fac	ny non-required m.  9.7.7, 9.7.8, a Standard is not don observation of the sprinkle mas the possibility of t	upply source  S information on covid or partial automatic and NFPA 25 t met as evidenced by an and records review er system. Bity to affect 35% of the cords review and observation 14 sprinkler and an automatic point of the cords as detailed in Namined by a formal aressment procedure and personnel.	sprinkler  by: v the he he heads. em ies ategory IFPA 99.	K 901	1. On 11/29/16, the facility hannual sprinkler-system in completed by VSC Fire & Security, which identified need of replacement. On 1 the facility Maintenance D received a price quote from contracted vendor to replace identified heads with heads non-corrosive material. We scheduled to be completed not prior to the compliance.  2. Maintenance Director will a that the sprinkler system is inspected on both a quarterly annual basis by VSC Fire & Security, with any issues addressed and resolved in a manner.  3. Along with the aforemention inspections, the Maintenanc Director/designee will mon (visualize) sprinker heads throughout the facility, with	spection heads in 2/6/16, irector this these of ork is by if date. ensure  y and timely  ned e itor	

DEPAR	TMENT OF HEALTH	AND HUMAN SERV	/ICES			Printed	1: 12/21/20
CENTE	RS FOR MEDICARE	& MEDICAID SERV	'ICES	Tarot tara		FOR OMB NO	M APPROV <u>D. 0938-03</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER		/SUPPLIER/CLIA ITION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - WOODMONT CENTER		SURVEY LETED	
		495246	<b>;</b>	B. WING		12/2	20/2016
					STATE, ZIP CODE		
ועטטע	MONI CENTER			RY LANE RICKSBU	JRG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL I NTIFYING INFORMATION)	ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOUDE	(X5) COMPLETIO DATE
K 901	Continued From pa	ige 2		K 901			
	Based on interview perform a Risk Asse This has the possible residents. The Findings Include On 12/20/2016 at ap it	essment. ility to affect 100% of e: oproximately 10:00 A erview the facility fail	f the		1. The facility Maintenan contacted the Corporate Director, Eastern Region requesting assistance, go and support in creating Assessment Policy & Properties of this operation, consisted the New Life Safety conducted and documentation requirements compliance of the new Life Safety conducted facility inspection. Center Executive Direct ensure the Risk Assessments is implemented, and per assessments conducted of with the requirements un NFPA 99.  4. Results of the risk assessment will be shared and review monthly QA Committee as part of the standard metagenda.	e Safety on, guidance a Risk rocedure stent with  y eviewed es to with other on with ons. or will nent Policy riodic risk consistent der ments wed at the meetings eeting	2/2/17