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

PRINTED: 07/09/2018 **FORM APPROVED**

	OF DEFICIENCIES	MEDICAID SERVICES	AND THE RESERVE OF THE PERSON NAMED IN COLUMN TO PERSON NAMED IN COLUM		OMB NO. 0938-0391
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495419	B. WING_		00/00/0040
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	06/29/2018 DE
COVENA	NT WOODS NURSING H	OME		7090 COVENANT WOODS DRIVE	
				MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
E 000	Initial Comments		ΕO	00	
	survey was conducted 06/29/18. Corrections compliance with 42 C Requirement for Long	s are required for FR Part 483.73, I-Term Care Facilities. One			N
E 006 SS≃C	Plan Based on All Hat CFR(s): 483.73(a)(1)-	gated during the survey. zards Risk Assessment (2)	E 0	06	
	and maintain an emer	The [facility] must develop gency preparedness plan I, and updated at least ust do the following:]		y y	
	(1) Be based on and in facility-based and com- assessment, utilizing a	nclude a documented, nmunity-based risk an all-hazards approach.*		s.	
	on and include a docu community-based risk	[483.73(a)(1):] (1) Be based mented, facility-based and assessment, utilizing an including missing residents.			Ħ
	and include a docume community-based risk	.475(a)(1):] (1) Be based on nted, facility-based and assessment, utilizing an including missing clients.			IS
	(2) Include strategies events identified by the	for addressing emergency e risk assessment.		general section of the section of th)
	* [For Hospices at 641	8.113(a)(2):] (2) Include		JUL 2 4 2018	
No.	strategies for addressing identified by the risk as management of the contail disaste failures, natural disaste failures f	ng emergency events sessment, including the			
RATORY DI	RECTOR'S OR PROVIDER/SU	IPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(Xe) 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.

aur

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

Event ID: C1RQ11

Facility ID: VA0416

dmune

(X6) DATE

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NO TO US DEADER 100	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
<u></u>	496419	B. WING		06/29/2018	
NAME OF PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
PREFIX (EACH DEF	ARY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
by: Based on staff review it was de failed to have a preparedness p The facility staff facility risk asse approach specif the facility, and The findings inc On 06/28/18 at of the facility's e conducted with director of maint staff member) # facility's emerge evidence a com based on an all- geographic loca encompasses p that the facility of On 06/28/18 at a (administrative s ASM # 2, directo the above finding No further inform Procedures for 1 SS=C CFR(s): 483.73(interview and facility document atermined that the facility staff complete emergency lan. If ailed to develop a complete assment based on an all-hazards fic to the geographic location of encompasses potential hazards. If alled to develop a complete assment based on an all-hazards fic to the geographic location of encompasses potential hazards. In a review and interview and encompasses potential hazards plan was OSM (other staff member) # 5, tenance and ASM (administrative 1, administrator. Review of the ancy preparedness plan failed to plete facility risk assessment hazards approach specific to the tion of the facility and otential hazards. OSM # 5 stated lid not have it. In approximately 5:15 p.m., ASM staff member) # 1, administrator, or of nursing were made aware of gs.	E 006	 The Safety Committee evaluated ranked the top 20 of the most commonly identified hazards for location. Those with the highest rate will continue to be used as potential hazards as part of the current plan. The hazards will be reviewed at next Safety Committee Meeting ensure there are no new threats to considered and will continue to presented for review at least quarterly. Any new threats will initiate a new ranking, as well as annual evaluation and ranking exceptember. All changes will be directed to the Emergency Preparedness Team for incorport into and updates of the emergency plan. When the Emergency Preparedness Team meets to review the plan, the will review documentation that the hazards have been reviewed in Scommittee. 	the 08-Aug-18 to to be be s an ach ation cy ess they he	

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 2 of 104

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	48 25	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
-11	- 23	495419	B. WING			06	/29/2018
15.85CS 37.465CSP6.655(TS-60.777-65C) - 1-2	ROVIDER OR SUPPLIER	ME	1779	70	REET ADDRESS, CITY, STATE, ZIP CODE 190 COVENANT WOODS DRIVE ECHANICSVILLE, VA 23111		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	plan set forth in paragassessment at paragand the communication this section. The policies address the following: (2) A system to track and sheltered patients an emergency. If onpatients are relocated [facility] must docume location of the receiving: *[For PRTFs at §441. ICF/IIDs at §483.475(Policies and procedur location of on-duty state [PRTF's, LTC, ICF and after an emergency, the [PRTF must document the spatient of the receiving facility of the recei	es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of sies and procedures must be at at least annually.] At a sand procedures must at least annually. At a sand procedures must and procedures must and procedures must and procedures must are least annually. At a sand procedures must and procedures must are during the location of on-duty staff and sheltered during the emergency, the note that specific name and not facility or other location. 184(b), LTC at §483.73(b), b), PACE at §460.84(b):] es. (2) A system to track the lift and sheltered residents in relocated during the E's, LTC, ICF/IID or PACE] electific name and location of other location. The at §418.113(b)(6):] es. of care and treatment aff responsibilities; eation of evacuation y and alternate means of dernal sources of	E	018	 A new section of the Emergency Preparedness Plan manual will be labeled "tracking residents and so All paper forms used for tracking staff and residents will be located that section with multiple forms available for use. Any changes made to the tracking system used by facility will be updated in the "tracking resident staff" location of the manual. The Emergency Preparedness Towill review all sections of the main tandem with reviews of the plensure all documents are current readily available for staff use. 	taff". g d in g s and cam unual an to	24-Jul-18

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 3 of 104

PRINTED: 07/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 495419 B. WING 06/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE **COVENANT WOODS NURSING HOME** MECHANICSVILLE, VA 23111 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) E 018 Continued From page 3 E 018 hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop a tracking system to document locations of patients and staff

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

The findings include:

Event ID; C1RQ11

Facility ID: VA0416

If continuation sheet Page 4 of 104

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
23 25		495419	B. WING _	22		_ ر	12012049
	ROVIDER OR SUPPLIER)ME		70	TREET ADDRESS, CITY, STATE, ZIP CODE 1990 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111	1 00	3/29/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	κ .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
SS=C	On 06/28/18 at 11:00 of the facility's emerge conducted with OSM director of maintenance staff member) # 1, and facility's emergency pevidence a tracking sylocations of patients at that the facility did not the facility did not calculate the facili	a.m. a review and interview ency preparedness plan was (other staff member) # 5, be and ASM (administrative ministrator. Review of the reparedness plan failed to system to document and staff. OSM # 5 stated is have it. Eximately 5:15 p.m., ASM member) # 1, administrator, ursing were made aware of was provided prior to exit. (folunteers and Staffing edures. The [facilities] must ant emergency preparedness es, based on the emergency raph (a) of this section, in plan at paragraph (c) of ses and procedures must be at least annually. At a and procedures must less noted above] The use of gency or other emergency uding the process and role and Federally designated alls to address surge needs	EO		 A new section of the emergency manual will be labeled "volunted The section will include the politor use of volunteers and tracking system. Any changes in this regulation was be reviewed against the policies place and updated as necessary. The Emergency Preparedness Tewill review all sections of the main tandem with reviews of the placensure all documents are current readily available for staff use. 	ers". cies g vill in eam anual	24-Jul-18 24-Jul-18 10-Aug-18

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 5 of 104

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID 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 495419 B. WING 06/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE **COVENANT WOODS NURSING HOME** MECHANICSVILLE, VA 23111 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 024 Continued From page 5 E 024 procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to develop policies and procedures for the use of volunteers and other staffing strategies in the emergency plan. The findings include: On 06/28/18 at 11:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) #5, director of maintenance and ASM (administrative staff member) # 1, administrator. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for the use of volunteers and other staffing strategies are in the emergency plan. OSM # 5 stated that the facility did not have it. On 06/28/18 at approximately 5:15 p.m., ASM (administrative staff member) # 1, administrator, ASM # 2, director of nursing were made aware of the above findings. No further information was provided prior to exit. Roles Under a Waiver Declared by Secretary E 026

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

CFR(s): 483.73(b)(8)

[(b) Policies and procedures. The [facilities] must

SS=C

Event ID: C1RQ11

Facility ID: VA0416

E 026

If continuation sheet Page 6 of 104

PRINTED: 07/09/2018

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

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE S	
		495419	B. WING		06/2	29/2018
		OME ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	7 R	STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111 PROVIDER'S PLAN OF CORRECT	ION	(X5)
TAG		SC (DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	DPRIATE	COMPLETION DATE
E 026	develop and impleme policies and procedur plan set forth in paragrassessment at paragrand the communication this section. The policies reviewed and updated	nt emergency preparedness es, based on the emergency praph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of ies and procedures must be if at least annually. At a and procedures must	E 026	A new section of the emerg plan manual will be labeled Waiver". The section will it the process of how the facil respond. Any changes to the 1135 W	"1135 nclude ity will aiver 2	24-Jul-18 24-Jul-18
	(8) [(6), (6)(C)(iv), (7), [facility] under a waive in accordance with se provision of care and it care site identified by officials. *[For RNHCIs at §403 procedures. (8) The rewaiver declared by the with section 1135 of A at an alternative care a management officials. This REQUIREMENT by: Based on staff interviewie with was determined failed to have a complete preparedness plan.	or (9)] The role of the er declared by the Secretary, ction 1135 of the Act, in the treatment at an alternate emergency management .748(b):] Policies and ole of the RNHCI under a exerctary, in accordance ct, in the provision of care site identified by emergency is not met as evidenced ew and facility document led that the facility staff		plan will be updated in the research of the will review all sections of the manual in tandem with review the plan to ensure all document and readily available staff use.	ss Team 1 ne ews of nents are	0-Aug-18
	the facility's role in pro at altered care sites ur The findings include:	viding care and treatment				
		a.m. a review and interview ncy preparedness plan was				

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 7 of 104

JUL 242

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

PRINTED: 07/09/2018 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		495419	B. WING	-		OF	3/29/2018
	ROVIDER OR SUPPLIER NT WOODS NURSING HO)ME		70	TREET ADDRESS, CITY, STATE, ZIP CODE 090 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111		123720 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X6) COMPLETION DATE
E 041 SS=C	conducted with OSM director of maintenanstaff member) # 1, ad facility's emergency pevidence policies and emergency plan that oproviding care and treunder an 1135 waiver facility did not have it. On 06/28/18 at approximation (administrative staff mass) ASM # 2, director of mass that the above findings. No further information Hospital CAH and LTC CFR(s): 483.73(e) (e) Emergency and standard mass that the power systems based forth in paragraph (a) policies and procedure paragraphs (b)(1)(i) are \$483.73(e), \$485.625(e) Emergency and standard the emergency plan set this section.	(other staff member) # 5, ce and ASM (administrative ministrator. Review of the reparedness plan failed to procedures in the describe the facility's role in natment at altered care sites. OSM # 5 stated that the eximately 5:15 p.m., ASM nember) # 1, administrator, ursing were made aware of was provided prior to exit. Emergency Power andby power systems. The ent emergency and standby on the emergency plan set of this section and in the est plan set forth in and (ii) of this section. (e) andby power systems. The AH] must implement by power systems based on est forth in paragraph (a) of the contained of the paragraph (b) of the contained of the paragraph (c) of the paragraph (d) of the paragraph	EC	026	 A new section of the emergency manual will be labeled "emerger power". The section will include process of what the facility gene controls as well as any redundan alternate on-sire adjustments that be implemented. Any changes to the emergency p plan will be updated in the manu The Emergency Preparedness Te will review all sections of the main tandem with reviews of the plaensure all documents are current readily available for staff use. 	e the rator t or t can ower al.	24-Jul-18 24-Jul-18 10-Aug-18

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATI	E SURVEY
		495419	B. WING			OE	3/29/2018
	ROVIDER OR SUPPLIER		-	70	(REET ADDRESS, CITY, STATE, ZIP CODE 1990 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111	370	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	90,000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 041	12-5, and TIA 12-6), Land Tentative Interim. 12-2, TIA 12-3, and Twhen a new structure structure or building is 482.15(e)(2), §483.73 Emergency generator [hospital, CAH and LT the emergency power and maintenance requirement of the emergency generator LTC facilities] that mait to power emergency generator LTC facilities and the power emergency generator and component of the evacuates. *[For hospitals at §485 and CAHs §485.625(g) The standards incorposection are approved reference by the Direct federal Register in acceptable from the sour inspect a copy at the Center, 7500 Security or at the National Arch Administration (NARA availability of this mate 202-741-6030, or go to	2, TIA 12-3, TIA 12-4, TIA Life Safety Code (NFPA 101 Amendments TIA 12-1, TIA IA 12-4), and NFPA 110, Is built or when an existing a renovated. ((e)(2), §485.625(e)(2) Inspection and testing. The TC facility] must implement To system inspection, testing, uirements found in the Code, NFPA 110, and Life ((e)(3), §485.625(e)(3) Tuel. [Hospitals, CAHs and intain an onsite fuel source generators must have a plan hergency power systems TE emergency, unless it 2.15(h), LTC at §483.73(g), (i):] Torated by reference in this for incorporation by tor of the Office of the cordance with 5 U.S.C. TE 51. You may obtain the ces listed below. You may CMS Information Resource Boulevard, Baltimore, MD hives and Records (). For information on the perial at NARA, call	E	041			



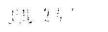
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY PLETED
		495419	B. WING _	and the second second		ne:	29/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	Æ		28/2010
(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 APPROPRIA		(X5) COMPLETION DATE
	incorporated by refere document in the Federal the changes. (1) National Fire Prote Batterymarch Park, Quincy, MA 02169, whose 1.617.770.3000. (i) NFPA 99, Health Condition, issued Augustii) Technical interim at NFPA 99, issued Augustii) TIA 12-3 to NFPA (v) TIA 12-4 to NFPA (vi) TIA 12-6 to NFPA (vii) NFPA 101, Life Scissued August 11, 201 (viii) TIA 12-1 to NFPA 2011. (ix) TIA 12-2 to NFPA 2011. (ix) TIA 12-3 to NFPA 2012. (xi) TIA 12-4 to NFPA 2013. (xii) NFPA 110, Stand Standby Power System TIAs to chapter 7, issued TIAs to chapter 8, issued TIAs to chapter 9, issued August 11, 2011 (iii) TIA 12-1 to NFPA 10, issued TIAs to NFPA 10, issued TIAs to NFPA 10, issued TIAs 12-1 to NFPA 1	ibr_locations.html. edition of the Code are ence, CMS will publish a eral Register to announce ection Association, 1 ww.nfpa.org, are Facilities Code, 2012 t 11, 2011. mendment (TIA) 12-2 to ust 11, 2011. 99, issued August 9, 2012. 99, issued March 7, 2013. 99, issued March 3, 2014. afety Code, 2012 edition, 1. t 101, issued August 11, 101, issued October 30, 101, issued October 22, ard for Emergency and ms, 2010 edition, including ued August 6, 2009. is not met as evidenced ew and facility document ed that the facility staff	EO	41			

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DAT	E SURVEY
		495419	B. WING_	-4.53		06	3/29/2018
	ROVIDER OR SUPPLIER NT WOODS NURSING HO	DME		7090	ET ADDRESS, CITY, STATE, ZIP CODE COVENANT WOODS DRIVE HANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ι.	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 041	systems or plans in poperations while shell how to keep the gene emergency unless the The findings include: On 06/28/18 at 11:00 of the facility's emergency conducted with OSM director of maintenants aff member) # 1, and facility's emergency pevidence documentate required emergency a has emergency power to maintain safe open place and a plan of hoperational during an to evacuate. OSM # not have it. On 06/28/18 at approvation of the above findings.	ms, has emergency power place to maintain safe tering in place and a plan of parator operational during an ey plan to evacuate. a.m. a review and interview ency preparedness plan was (other staff member) # 5, ce and ASM (administrative liministrator. Review of the preparedness plan failed it in that the facility has the land standby power systems, or systems or plans in place lations while sheltering in low to keep the generator emergency unless they plan is stated that the facility did eximately 5:15 p.m., ASM nember) # 1, administrator, bursing were made aware of a was provided prior to exit.	E				
F 000	survey was conducted	dicare/Medicaid standard d 6/27/18 through 6/30/18, equired for compliance with eral Long Term Care fe Safety Code	FO	00			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0	391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WING		00/20/2040	
	ROVIDER OR SUPPLIER	DME	24	STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	06/29/2018	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	ION
	The census in this 50 time of the survey. To f 25 current Resident 27, 2, 233, 24, 8, 22, 134, 15, 18, 20, 5, 3, closed Resident revie Resident Rights/Exer CFR(s): 483.10(a)(1)(f) §483.10(a) Resident has a rig self-determination, and access to persons and outside the facility, individuality in this section. §483.10(a)(1) A facility with respect and dignity resident in a manner appromotes maintenancher quality of life, recoindividuality. The facility promote the rights of the facility of condition, or must establish and mapractices regarding traprovision of services unresidents regardless of \$483.10(b) Exercise of the resident has the resident	bed facility was 32 at the he survey sample consisted at reviews (Residents #14, 9, 29, 32, 11, 26, 21, 10, 30, 19, 25, 135, 12) and three laws (#35, 33, 133). Coise of Rights (2)(b)(1)(2) Rights. (2)(b)(1)(2) Rights. (2)(b)(1)(2) Rights. (3)(b)(1)(2) Rights. (4)(b)(1)(2) Rights. (5)(b)(1)(2) Rights. (6)(c)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)(d)	F 000	This Plan of Correction constitute written allegation of compliance ideficiencies cited. Submission of Plan of Correction is not an admistrat a deficiency exists or that one	for the This Ssion E was Section is	
	§483.10(b)(1) The faci	ility must ensure that the				1



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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	38 99	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	OME	STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		00/23/2010
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 550	resident can exercise interference, coercior	his or her rights without	F 550	F 550 1. Residents #20, #24, and #29 were adversely affected.	re not 29-Jun-18
	free of interference, or reprisal from the facili- rights and to be supp- exercise of his or her	oercion, discrimination, and ty in exercising his or her orted by the facility in the		 All residents who participate in the Assistive dining program will be screened by rehab for appropriate and assistive devices. 	
	This REQUIREMENT by: Based on observation document review and was determined that the maintain dignity for the	n, staff interview, facility clinical record review, it the facility staff failed to ree of 28 residents in the		 Meal observation, conducted by DON or designee, in the dining real of the Assistive Dining program evaluate proper seating placement address resident dignity and enhancemental enhancement. 	room to nt to ance
	The facility staff staff staff 20, while feeding the	ood over Residents #24 and orn in the A-B dining room.		 CNA #6 was counselled regarding resident dignity at mealtime, as was a review of resident meal assistance and cueing technique. 	vell
	was served her lunch	meal when her tablemate's		 Education conducted with all stareviewing resident dignity during dining. 	
	The findings include: 1. The facility staff sto #20, while feeding the	ood over Residents #24 and m in the A-B dining room.		 DON or designee will conduct m observations 3x/week for 4 week then 1x/week for 2 weeks. 	
	adult failure to thrive, l disorder, atrial fibrillati osteoporosis, and high recent MDS (Minimum	oses of but not limited to neart failure, anxiety on, dysphasia, dementia, n blood pressure. The most			

PRINTED: 07/06/2018

CENTE		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 880	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495419	B. WING _		06/29/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
COVEN	ANT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 550	Continued From pa	ge 13	F 55	0	
	58)	2/26/18. The resident was		.50.	
		cognitively impaired in ability to			
		sions. The resident was total care for bathing;			
		ce for transfers, dressing,			
		d hygiene; and as incontinent			
	8/2/17 with the diag Alzheimer's disease stress fracture of hi pressure, psychosis most recent MDS (I quarterly assessme Reference Date) of	admitted to the facility on moses of but not limited to e, cardiomyopathy, dysphagia, p, diabetes, high blood and sacral fracture. The Minimum Data Set) was a ent with an ARD (Assessment 5/12/18. The resident was			
	make daily life deci	cognitively impaired in ability to sions. The resident was			
		total care for bathing and ve assistance for transfers,			
	dressing, eating, to	leting, and hygiene; and as			
	incontinent of bowe	l and bladder.			
	Assistant) was obse	6, CNA #6 (Certified Nursing erved in the A/B dining room #24 and Resident #20 with			

6/27/18 at 2:50 p.m. in an interview with CNA #6, when asked how staff provide feeding assistance, CNA #6 stated you set their plates up, beverages, and have clothing protectors on the residents.

over them.

PRINTED: 07/06/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED PROVIDERS PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED 100 PROVIDER'S PLAN OF CORRECTION (X5)	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
NAME OF PROVIDER OR SUPPLIER COVENANT WOODS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES TAGS TAG	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	20 2000				
COVENANT WOODS NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG WIST DEFICIENCY OR LSC IDENTIFYING INFORMATION) F 550 Continued From page 14 When asked if you stand next to residents or sit next to them while feeding them, CNA #6 stated, "We have to jump around so I don't sit next to the ones that need cueing I stand next to them, but the ones I actually feed I sit next to." The above observation were shared with CNA #6. When asked if this was a dignified dining experience, CNA #6 stated it was not. On 6/28/18 at 4:11 p.m. in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated that the observations was not a reasonable dining experience. ASM #2 stated, "This is not the way it was set up." A review of the facility policy, "Resident Satisfaction Communication" failed to include any direction for a dignified dining experience. This policy did document, "(name of facility) ensures that each resident is treated with dignity and respect, and that each resident is assisted in maintaining and enhancing his or her well-being and self-esteem. On 6/28/18 at approximately 6:00 p.m., the Administrator (ASM #1) and the Director of Nursing (ASM #2) were made aware of the findings.			495419	B. WING	ì		0	6/29/2018
(X4)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECIDED BY FULL TAG (EACH DEFICIENCY MIST BE PRECIDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) F 550 Continued From page 14 When asked if you stand next to residents or sit next to them while feeding them, CNA #6 stated, "We have to jump around so I don't sit next to the ones that need cueing I stand next to them, but the ones I actually feed I sit next to." The above observation were shared with CNA #6. When asked if this was a dignified dining experience, CNA #6 stated, it was not. On 6/28/18 at 4:11 p.m. in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated that the observations was not a reasonable dining experience. ASM #2 stated, "This is not the way it was set up." A review of the facility policy, "Resident Satisfaction Communication" falled to include any direction for a dignified dining experience. The facility policy, "Preservation of Resident Dignity" falled to include any direction for ensuring a dignified dining experience. This policy did document, "(name of facility) ensures that each resident is treated with dignly and respect, and that each resident is assisted in maintaining and enhancing his or her well-being and self-esteem. On 6/28/18 at approximately 6:00 p.m., the Administrator (ASM #1) and the Director of Nursing (ASM #2) were made aware of the findings.			G HOME		7	090 COVENANT WOODS DRIVE		
When asked if you stand next to residents or sit next to them while feeding them, CNA #6 stated, "We have to jump around so I don't sit next to the ones that need cueing I stand next to them, but the ones I actually feed I sit next to." The above observation were shared with CNA #6. When asked if this was a dignified dining experience, CNA #6 stated it was not. On 6/28/18 at 4:11 p.m. in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing), she stated that the observations was not a reasonable dining experience. ASM #2 stated, "This is not the way it was set up." A review of the facility policy, "Resident Satisfaction Communication" failed to include any direction for a dignified dining experience. The facility policy, "Preservation of Resident Dignity" failed to include any direction for ensuring a dignified dining experience. This policy did document, "(name of facility) ensures that each resident is treated with dignity and respect, and that each resident is assisted in maintaining and enhancing his or her well-being and self-esteem. On 6/28/18 at approximately 6:00 p.m., the Administrator (ASM #1) and the Director of Nursing (ASM #2) were made aware of the findings.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	ΊΧ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
The facility staff failed to ensure Resident #29 was served her lunch meal when her tablemate's	F 550	When asked if you next to them while it "We have to jump a ones that need cue the ones I actually observation were stacked if this was a CNA #6 stated it was On 6/28/18 at 4:11 #2 (Administrative S Nursing), she stated not a reasonable distated, "This is not A review of the facilistated, "This is not A review of the facilistated, "This is not Committee of the facility policy, "Dignity" failed to include a dignified dining explored document, "(name of the facility policy, "name of the facility policy, "name of the facility policy, "name of the facility policy, "Indinged the facility policy," (name of the facility failed to include a dignified dining explored that each resident is treated with the facility at approximately policy, and the facility staff." On 6/28/18 at approximately staff of the facility staff.	stand next to residents or sit feeding them, CNA #6 stated, around so I don't sit next to the ing I stand next to them, but feed I sit next to." The above hared with CNA #6. When dignified dining experience, as not. p.m. in an interview with ASM Staff Member, the Director of d that the observations was ning experience. ASM #2 the way it was set up." If y policy, "Resident unication" failed to include any fied dining experience. Preservation of Resident stude any direction for ensuring experience. This policy did of facility) ensures that each with dignity and respect, and is assisted in maintaining and er well-being and self-esteem. Eximately 6:00 p.m., the left) and the Director of were made aware of the on was provided.	F	550			

were also eating.

Resident #29 was admitted to the facility on

PRINTED: 07/06/2018 FORM APPROVED

	WENT OF HEALTH						MAPPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	T			OMB N	O. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	181 NC		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495419	B. WING			ا ر	6/29/2018	
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COL	E		
COVENA	NT WOODS NURSIN	CHOME		709	0 COVENANT WOODS DRIVE			
COVENA	INT WOODS NORSIN	GHOME		ME	CHANICSVILLE, VA 23111		02223 90220498226 8021	
(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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 550	heart failure, heart Sicca syndrome, dy Alzheimer's disease breath, and anxiety MDS (Minimum Da assessment with an Reference Date) of coded as severely of make daily life deci- coded as requiring	gnoses of but not limited to disease, dysphagia, kyphosis, ysphagia, osteoporosis, e, contractures, shortness of disorder. The most recent at Set) was a quarterly n ARD (Assessment 6/5/18. The resident was cognitively impaired in ability to sions. The resident was total care for all areas of ing and as incontinent of		550				
	brought to the dinin with two other resid bowls of soup. Reswith anything to eat p.m., one of the oth his lunch meal, and working on eating h#29 was still not professional of the control	O p.m., Resident #29 was ag room and placed at a table lents. The other residents had sident #29 was not provided to At approximately 12:25 her residents was provided with the other resident was still her bowl of soup. Resident povided with anything to eat. 2 p.m., one of the other his lunch meal, and left the 9 was observed still without to eat. At this time, CNA #6 his sistant) came over to the a plate of food for Resident #29						
	and sat down next to feeding her. Reside approximately 22 mate, and one had even	to Resident #29 and begin ent #29 was at the table for hinutes while her tablemate's ven completed his meal, ved anything to eat.						

6/27/18 at 2:50 p.m. in an interview with CNA #6, when asked about the dining experience for

191 24 ÷

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

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Nr. (1883)	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
	1877 TO -1811 CM	495419	B. WING		0	6/29/2018
	ROVIDER OR SUPPLIER	G НОМЕ		STREET ADDRESS, CITY, STATE, ZIP CO 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		50.30.a ²
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	cook 4 times that R food. When asked experience for Resiwas not. When ask Resident #29 to get for residents who have resident should not where residents whalready eating, because to be fed. On 6/28/18 at 4:11 #2 (Administrative S Nursing), she stated not a reasonable distated, "this is not the A review of the facility policy, "Presidiled to include any dignified dining expedicument, "(name a resident is treated with the teach resident is enhancing his or her content of the content	stated that she had told the desident #29 was ready for her if this was a dignified dining ident #29, CNA #6 stated it ked why it took so long for ther food, CNA #6, stated that ave to be fed, you are not effood in front of them until you are. CNA #6, stated that the have been placed at a table of eat independently are ause Resident #29 has to wait p.m. in an interview with ASM Staff Member, the Director of dithat the observations was ning experience. ASM #2 he way it was set up." ity policy, "Resident unication" failed to include any field dining experience. The ervation of Resident Dignity" of direction for ensuring a erience. This policy did of facility) ensures that each with dignity and respect, and as assisted in maintaining and er well-being and self-esteem. Eximately 6:00 p.m., the importance if the were made aware of the interval in the process of the were made aware of the interval in the process of the interval interval in the process of the interval in the process	F	550		

F 557 Respect, Dignity/Right to have Prsnl Property

F 557

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

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING			TRUCTION		(X3) DATE SURVEY COMPLETED	
	er woodenburg	495419	B. WING			04	3/29/2018	
NAME OF PR	ROVIDER OR SUPPLIER	· - w 		STREET	ADDRESS, CITY, STATE, ZIP CODE	1000		
COVENAN	IT WOODS NUBSING N	MF		7090 CC	OVENANT WOODS DRIVE			
COVENAN	IT WOODS NURSING HO	/MC		MECHA	ANICSVILLE, VA 23111			
(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 SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 557	Continued From page	17	F 55	; 7 F:	557			
SS=E	CFR(s): 483.10(e)(2)						**************************************	
	and dignity, including	th to be treated with respect		1.	Resident # 8 is already in posses of said furniture he plans on mo to new room. Resident # 21 had personal chair placed in room 06/30/18. Resident # 12 continues research furniture options. Resident # 12 continues arch furniture options.	ving ues to	10-Aug-18	
	possessions, includin as space permits, unl	g furnishings, and clothing, ess to do so would infringe alth and safety of other	ļ		# 233 continues to measure furnand assess placement.		10.4	
3	This REQUIREMENT by: Based on observatio	is not met as evidenced n, resident interview, staff ment review and clinical	14 25	2.	Policy established for personal furniture to be used in residents rooms as space and safety allow	•	10-Aug-18	
	record review, it was failed to to allow pers	determined facility staff onal possessions to provide ent for four of 28 residents in	1	3.	Notification to all residents will made as well as future residents		10-Aug-18	
	Magnet processor teacher operating contrates	esident #233, 8, 21 and 12.	g	4.	All staff will be provided inform on how to handle resident reque		10-Aug-18	
	The facility staff fai to have a recliner who	ed to allow Resident #233 en requested.		5.	During care plan meetings, residuil be asked about room	lents	10-Aug-18	
3	keep his recliner, upo	ed to allow Resident #8 to n the resident's move, from unit to the newly renovated	1		accommodations and any needs			
	3. The facility staff fail have a recliner when	ed to allow Resident #21 to requested.						
1	4. The facility staff fail have a recliner and a requested.	ed to allow Resident #12 to filing cabinet when						
	The findings include:			8) 10 11 11				
		admitted to the facility on s that included but were not		ti .				

Jul. 24.5

PRINTED: 07/09/2018 FORM APPROVED

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 093	OMB NO. 0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURV COMPLETED		
		495419	B. WING		06/29/20	018	
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP COO 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COI E APPROPRIATE	(X5) MPLETION DATE	
F 557	Continued From p	age 18	F 55	57			
	limited to: stroke, limite	high blood pressure, ain.		8	5		
	admission assess (assessment refer the resident as ha the BIMS (brief int indicating the resident make daily decision	MDS (minimum data set), an ment, with an ARD rence date) of 6/19/18 coded ving scored a 14 out of 15 on terview for mental status) dent was cognitively intact to ons. The resident was coded as ce from staff for all activities of		N.	20 13		
	2:00 p.m. with fou cognitively intact. residents stated, "own furniture. The property of (name room." When aske bring in their own were told there wa room. When aske could be moved to furniture, the resid there was no place	g was conducted on 6/27/18 at residents, three of whom were During the meeting the They say we can't have our furniture in the rooms is the of facility) and it will stay in the ed why they were not allowed to furniture, the residents said they as no space available in the d if the furniture in the room of accommodate the resident's lents stated they were told that e to store the furniture. The	8		£		
		d they would like to have their the chairs in the room were not					
	evidence docume being allowed to b	lity's admissions packet did not ntation regarding residents not oring their own furniture. The did document that the residents wn furniture.	10		ş		
	Paview of the faci	lity's resident handbook did not					

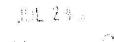
FORM CMS-2567(02-99) Previous Versions Obsolete

evidence documentation regarding residents not being allowed to bring their own furniture.

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 19 of 104



PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRI	UCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING			06/29/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE	1 00/20/2010
COVENAN	IT WOODS NUBSING III			7090 COVE	ENANT WOODS DRIVE	
COVERAN	IT WOODS NURSING H	OME		MECHAN	ICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 557	Continued From page	e 19	F	557		*
	Review of the resider	nt rights document provided				
		ility documented, "It is the				
	10.5	cility) that all residents shall	Pi.			
		hts and privileges: To retain				
	and use his/her person					
		e permits unless to do so				
		ights of other residents and				
a	the state of the s	traindicated as documented in his/her medical record"	D	10 10		21
		nt's clinical record did not				
	recliner being contrai	tion regarding the use of a indicated.				41
	Observations of resid	dent rooms was made during				e F
		rooms in the older section of				
		cliners and other personal				
		oms in the newly renovated cility provided furniture.				
		made on 6/27/18 at 3:15 p.m.	25			
		oom. The resident was in the				
		duding a bed, an armoire, a				
		table and a bedside table.				
	 Financial states in the reserve B State 	nt owned furniture in the				
	room. There was a la	irge empty space between	19			
	the bed and the wind	ow. Resident #233 stated	IH.	10		
3.	that she would like a	recliner by the window.	39	E .		題 初
	An interview was con	ducted on 6/28/18 at 3:50		124		69
		sed practical nurse) #1, the				
	7.4	en asked if residents were				
		personal furniture, LPN #1				
		ew side." When asked why,				
	-	say it's a safety hazard."				
	Minon acked what kir	nd of eafable hazard I DN #1				

stated, she wasn't sure but maybe it was because

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PROVIDER/SUPPLIER/SUPPL			(X3) DATE SURVEY COMPLETED		
		495419	B. WING		06/29/2018
NAME OF PI	ROVIDER OR SUPPLIER	7 2 200 x 2 200 2 2	s	TREET ADDRESS, CITY, STATE, ZIP CODE	
			7	090 COVENANT WOODS DRIVE	
COVENAN	IT WOODS NURSING H	OME	N	IECHANICSVILLE, VA 23111	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED (CROSS)	BE COMPLETION
F 557	Continued From pag	ne 20	F 557		
	DODGO POCAMINA DE COMPANSO DE COMPANSO DE POSTO	out of the chair. When asked		# #	
		out of the chair, when asked	ja	1	
			8	!	
		PN #1 stated yes they could.	**	* =	
		ybe we could compromise		i.	
		of the residents want a		2 2 3	
		ed if the resident's rooms			7
	were homelike, LPN	#1 Stated no.		:	ii.
	. A = i=t== vie	-dusted on 6/20/10 at 4:15			100 100
		nducted on 6/28/18 at 4:15			
		fied nursing assistant) #9, the			I I
		en asked if the resident had			
		CNA #9 stated, "She hasn't			
	The resident frameway and an entrangers	s to me." When asked if	49		
48		red to have a recliner in their			
		d, "Not to my knowledge." NA #9 stated, "Because of			
	19	n asked how a resident was	6)	A	i I
		sk, CNA #9 stated, "That	20	1	
		ought up to the DON (director			
		trative staff member- ASM		d.	
		it would be a nurse, PT	i i		
	175 175	or DON (who completed a	25 21		
	safety assessment).	s the issue did it matter if the			
		ner in the old section versus		3	B 15
		IA #9 stated, "No I guess it			
	doesn't matter."				46 19
	An intensious was co	inducted on 6/28/18 at 4:21			
		ninistrative staff member) #2,			N 1
		ng. When asked why			
		allowed to have recliners or	1.0		
		eir rooms in the new section of	80		
		ated, "That was decided	Ľ		10
		When asked what the reason		20) 201	
		n, ASM #2 sated, "What if			66
		ardiac arrest) in the recliner?		18	18
		get a Hoyer lift in there and	#}		92
		n asked why the resident	8		
	200 1110111 OUE: 44110			18	

PRINTED: 07/06/2018

		AND HUMAN SERVICES			FORM APPROVED			
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	т	AR SERVICE SERVICE	OMB NO. 0938-0391			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 MOS	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED			
		495419	B. WING	<u> </u>	06/29/2018			
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD				
COVENA	NT WOODS NURSIN	C HOME		7090 COVENANT WOODS DRIVE				
COVENA	IN I WOODS NORSIN	GHOME	MECHANICSVILLE, VA 23111					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION SH	OULD BE COMPLETION			
F 557	stated, "There are see would have to in-see ASM #2 stated, "We the door and it breat who is marking up wheelchair around that was a safety is need to have enough ASM #2 stated, "Arrissue with the chair stated, "Some of the them." When asked the resident's right belongings, ASM #2 when asked how not cardiac arrest or fair year, ASM #2 state was aware that Research ASM #2 did not research why resident could furniture, ASM #1 standpoint we had room in the rooms staff) to have additional When asked what the ASM #1 hesitated as would reside the room in the rooms staff) to have additional when asked what the ASM #1 hesitated as would reside the room in the rooms staff) to have additional when asked what the ASM #1 hesitated as would reside the room in the rooms.	wered to the floor, ASM #2 so many kinds of recliners, I ervice my staff on each type." hat if they hit the molding on aks off? We have a resident walls when he turns his in his room." When asked how sue, ASM #2 stated, "Well, we gh room to move around." and there's an infection control is." When asked why, ASM #2 he residents are incontinent in the how the facility was meeting to have their personal 2 did not have an answer. In any residents had suffered a ll from a recliner in the past id, "None." When asked if she sident #233 wanted a recliner,		557				

here for a short time and there are some residents that this is going to be their home." When asked how they were meeting the

resident's right to have personal belongings, ASM #1 stated, "We encourage them to bring in pictures and knick knacks." When asked how the decision not allowing personal furniture had been

PRINTED: 07/06/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495419	B. WING	ı	<i>p</i>	06	/29/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		3500 5 0
COVENA	NT WOODS NURSIN	G НОМЕ			090 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 557	Continued From pa	nge 22	F	557			
	1150	ents, ASM #1 stated, "Well we					
	were doing it one o	n one." When asked if there					
		ting to the residents regarding					
	this decision, ASM	#1 stated there was not.					
	An interview was co	onducted on 6/29/18 at 8:51					
		and OSM (other staff member)					
		naintenance. ASM #1 stated,					
		ct for renovation was started					
		specific objectives in the room					
		ated, "They had to be private					
		ws and a large bathroom." ne furniture was determined on					
		ns). We allowed ease of					
		m with the (Hoyer) lift. We					
		with a foot print for the					
		ked if she was aware that					
		ing for recliners and other					
		s, ASM #1 stated, we've had a he local ombudsman. We have					
		dialogue yet." When asked					
		facility's furniture could not be					
		ident's furniture could be					
		stated they did not have					
		en asked if the resident's					
		le possession of personal					
	belongings was bei	ing met by the facility, ASM #1					

stated, "I was messaging to the residents

because it evolved into a single message that the rooms were being fully furnished and we needed to maintain space." ASM #1 stated, "Those rooms aren't that big." When this writer offered to visit the resident's rooms and see if a recliner could fit safely in the rooms neither ASM #1 nor OSM #5 accepted the offer. When asked how the resident's individuality and needs were being met, ASM #1 stated, "I am accepting that our intent was for safety and individuality but safety first. Our intent was not every resident to be the same.

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

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					01	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED
		495419	B. WING			06/29/2018
	PROVIDER OR SUPPLIER	G НОМЕ		STREET ADDRESS, CITY, STATE 7090 COVENANT WOODS DR MECHANICSVILLE, VA 23	RIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD O THE APPROPE	BE COMPLETION
F 557	individualized and a their needs are bein role was as administ to meet the needs of #5 was asked if fact out of the room, Os rent a space." An interview was cop.m. with OSM #7, asked what her role have a resident with them." When asked complained about recliner or other perstated, "Not in a whore income to ensure that safely." When asked #7 stated, "It means home." When asked #7 stated, "It means home." When asked in, like a hospital." In needs were being rowe should meet the No further information. 2. The facility staff if keep his recliner, up the old section of the unit.	or accommodation and it's appropriate and to make sure of the residents. When OSM illity furniture could be moved SM #5 stated, "Yes, we could conducted on 6/29/18 at 1:37 the social worker. When a was, OSM #7 stated, "If I a concern I go and visit with dif she had any residents who not being able to have a resonal furniture, OSM #7 tille." When asked why allowed to have their own stated, "A couple reasons. If of there to be space in the test staff could get in there are what homelike meant, OSM is being in a place that's like of if the resident rooms in the homelike, "Before they move when asked if the residents' met, OSM #7 stated, "I think heir individual needs." I tion was provided prior to exit. I failed to allow Resident #8 to pon the resident's move, from the unit to the newly renovated	F 5	57		
	Resident #8 was ac	dmitted to the facility on				

10/3/17 with diagnoses that included but were not limited to: difficulty walking, heart disease, pain,

NR 276

PRINTED: 07/06/2018 FORM APPROVED

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 00 00	TIPLE CONSTR ING		1		E SURVEY PLETED	
		495419	B. WING			_	06/	29/2018	
	PROVIDER OR SUPPLIER	G HOME		7090 COVE	DRESS, CITY, STA ENANT WOODS (CSVILLE, VA 2	DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (Е/	ACH CORRECTIVE SS-REFERENCED	N OF CORRECTION E ACTION SHOULD O TO THE APPROPI CIENCY)	BE	(X5) COMPLETION DATE	
F 557	The most recent MI quarterly assessme reference date) of 4 having scored a 15 interview for mental was cognitively inta. The resident was of from facility staff for for eating which the independently after. A resident meeting 2:00 p.m. with four cognitively intact. D residents stated, "T own furniture. The form for the property of (name or form." When asked bring in their own furniture, the resident there was no place residents all stated recliners because that comfortable. Review of the facility evidence document being allowed to bring allowed their own.	DS (minimum data set), a ent, with an ARD (assessment l/13/18 coded the resident as out of 15 on the BIMS (brief status) indicating the resident ct to make daily decisions. Ended as requiring assistance activities of daily living except eresident could perform the tray was prepared. Was conducted on 6/27/18 at residents, three of whom were uring the meeting the they say we can't have our furniture in the rooms is the of facility) and it will stay in the day they were not allowed to urniture, the residents said they in o space available in the if the furniture in the room accommodate the resident's ents stated they were told that to store the furniture. The they would like to have their the chairs in the room were not extra admissions packet did not tation regarding residents not ing their own furniture. The lid document that the residents	F	557					

evidence documentation regarding residents not

being allowed to bring their own furniture.

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

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE	& MEDICAID SERVICES			OMR MO	. 0938-039
THE RESERVE AND ADDRESS OF THE PARTY OF THE	OF DEFICIENCIES F CORRECTION	DENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
ST ANDS		495419	B. WING _		06/	/29/2018
NAME OF P	ROVIDER OR SUPPLIER		\$6. \$6 \$6.	STREET ADDRESS, CITY, STATE, ZIP CODE		
				7090 COVENANT WOODS DRIVE		
COVENA	NT WOODS NURSIN	G HOME		MECHANICSVILLE, VA 23111		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 557	Continued From pa	ge 25	F 55	57		
	Review of the resid	ent rights document provided				

Review of the resident rights document provided to resident by the facility, documented: "It is the policy of (name of facility) that all residents shall have the following rights and privileges: To retain and use his/her personal clothing and possessions as space permits unless to do so would infringe upon rights of other residents and unless medically contraindicated as documented by his/her physician in his/her medical record..."

Review of the resident's clinical record did not evidence documentation regarding the use of a recliner being contraindicated.

A telephone interview was conducted on 6/27/18 at approximately 2:50 p.m. with OSM #8, the ombudsman. OSM #8 stated that Resident #8 had contacted her to complain that the facility was not going to allow him to take his recliner to his new room in the renovated part of the unit. OSM #8 stated, she did not think the facility was meeting the resident's needs but also wanted to make sure the resident was kept safe. OSM #8 stated she was in contact with the administrator of the facility.

On 6/28/18 at 9:30 a.m., an interview was conducted with Resident #8. The resident stated that he had to contact the ombudsman to help him get the facility to allow him to take his recliner to his new room on the renovated side of the unit. Resident #8 stated he was taken to see his new room the evening before and was told he could have his recliner. Resident #8 stated he didn't trust that the administration would allow him to have his recliner. Resident #8's room in the old section was cluttered with a dresser, the recliner (leather), a bed pushed against the wall, a

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

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		O	MB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
NAME OF P	ROVIDER OR SUPPLIER		S1	REET ADDRESS, CITY, STATE, ZIP CODE	
COVENAN	IT WOODS NUDSIN	CHOME	70	90 COVENANT WOODS DRIVE	
COVENA	NT WOODS NURSIN	G ROME	М	ECHANICSVILLE, VA 23111	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
-		***	-		

F 557 Continued From page 26

bedside table, an electric wheelchair and the resident sitting in a regular wheelchair. There was approximately a 3 foot by 4 foot open area in the room.

An interview was conducted on 6/28/18 at 4:21 p.m. with ASM (administrative staff member) #2, the director of nursing. When asked why residents were not allowed to have recliners or other furniture in their rooms in the new section of the unit, ASM #2 stated, "That was decided before I got here." When asked what the reason was for that decision, ASM #2 stated, "It's for safety. What if they code (have a cardiac arrest) in the recliner? How are we going to get a Hoyer lift in there and get them out?" ASM #2 stated, "There are so many kinds of recliners, I would have to in-service my staff on each type." When asked why Resident #8 was currently allowed to have a recliner in a very small and cluttered room, ASM #2 stated, "We compromised. He can keep the chair until he moves to the new room." When asked why it was safe for the resident to have a recliner in the very small room on the old section, but not safe in a larger room on the renovated section, ASM #2 stated, "We compromised." When informed the resident stated he had seen his new room the evening before and was told he could take his recliner, ASM #2 stated, "WHO told him that?" ASM #2 went on to say, "And there's an infection control issue with the chairs." ASM #2 was reminded that Resident #8's chair was leather and could be easily cleaned. When asked how the facility was meeting the resident's right to have their personal belongings, ASM #2 did not have an answer. When asked how many residents had suffered a cardiac arrest or fall from a recliner in the past year, ASM #2 stated, "None."

F 557

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 27 of 104

FT 241

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

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTERSIC	A MEDICAKI	E & MEDICAID SERVICES		The same of the sa	OMB NO. 0938-0391
STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	2000-2004	495419	B. WING		06/29/2018
NAME OF PROVID	ER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
COVENANT W	OODS NURSIN	IG HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRÓVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
		959 State St. No. 3885	produced design	v i	

F 557 Continued From page 27

An interview was conducted on 6/28/18 at 4:50 p.m. with ASM #1, the administrator. When asked why resident couldn't have recliners or other furniture, ASM #1 stated, "From a space standpoint we had to make sure there's enough room in the rooms to allow them (the resident and staff) to have access throughout the room. We don't have additional storage to swap furniture." When asked what the facility was to the resident, ASM #1 hesitated a moment and stated, "Well if they're skilled (receiving physical therapy) they're here for a short time and there are some residents that this is going to be their home." When asked what it meant to be home, ASM #1 stated, "To feel like you belong." When asked how they were meeting the resident's right to have personal belongings, ASM #1 stated, "We encourage them to bring in pictures and knick knacks." When asked how the decision not allowing personal furniture had been relayed to the residents, ASM #1 stated, "Well we were doing it one on one." When asked if there was anything in writing to the residents regarding this decision. ASM #1 stated there was not.

An interview was conducted on 6/29/18 at 8:51 a.m. with ASM #1 and OSM (other staff member) #5, the director of maintenance. ASM #1 stated, that when the project for renovation was started that they had very specific objectives in the room design. ASM #1 stated, "They had to be private rooms, more windows and a large bathroom." ASM #1 stated, "The furniture was determined on the regs (regulations). We allowed ease of access into the room with the (Hoyer) lift. We ultimately came up with a foot print for the furniture." When asked if she was aware that residents were asking for recliners and other

F 557

PRINTED: 07/06/2018

		& MEDICAID SERVICES				M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495419	B. WING		0	6/29/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
COVENA	NT WOODS NURSIN	CHOME		7090 COVENANT WOODS DRIVE		
COVENA	MI WOODS NURSIN	G HOWE		MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 557	Continued From pa	ge 28	F 5	557		
	a conversation with have not completed asked if a piece of moved out, so a resmoved in, ASM #1 storage space. Wherights for reasonable belongings was beistated, "I was messibecause it evolved rooms were being to maintain space." could not have a rerooms, ASM #1 stabig." When this writt resident's rooms ar safely in the room raccepted the offer. resident's individual ASM #1 stated, "I awas for safety and Our intent was not the same. Yes there and it's individualized make sure their neasked what her role #1 stated, it was to residents. When Our furniture could be make sure could be maked what her could be mak	s, ASM #1 stated, "We've had the local ombudsman. We if that dialogue yet." When the facility's furniture could be sident's furniture could be stated they did not have en asked if the resident's le possession of personaling met by the facility, ASM #1 saging to the residents into a single message that the fully furnished and we needed. When asked why a resident cliner in the newer larger ted, "Those rooms aren't that there offered to visit the end see if a recliner could fit neither ASM #1 nor OSM #5. When asked how the lity and needs were being met, and accepting that our intent individuality but safety first. Ithat every resident had to be see is room for accommodation and appropriate and to eds are being met." When ewas as administrator, ASM meet the needs of the SM #5 was asked if facility moved out of the room, OSM could rent a space."				

An interview was conducted on 6/29/18 at 1:37 p.m. with OSM #7, the social worker. When asked what her role was, OSM #7 stated, "If I have a resident with a concern I go and visit with them." When asked if she had any residents who complained about not being able to have a recliner or other personal furniture, OSM #7

1 1 2 6 1

PRINTED: 07/06/2018 FORM APPROVED

OCNITE	O FOR MEDICARE	A MEDICAID CEDVICES				MR NO 0030 0304
CALIFORNIA DE LA CARROLLA VICTORIA VI	e successi di 1200 menunga menungan pengangan pengangan pengan	& MEDICAID SERVICES	Lanconnel service	Supplemental State of	** 7. ***	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING			06/29/2018
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
COVENA	NT WOODS NURSIN	G НОМЕ		100 MARCH 100 M	0 COVENANT WOODS DRIVE CHANICSVILLE, VA 23111	r ar
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 557	residents were not furniture, OSM #7 s Infection control and room to ensure that safely." When asked #7 stated, "It means home." When asked new section looked in, like a hospital." Inneeds were being in we should meet the No further informated. 3. The facility staff is have a recliner when the section with the section of the section	alle." When asked why allowed to have their own stated, "A couple reasons. It don't here to be space in the tot staff could get in there and what homelike meant, OSM is being in a place that's like and if the resident rooms in the shomelike, "Before they move when asked is the residents met, OSM #7 stated, "I think heir individual needs." It ion was provided prior to exit. If alled to allow Resident #21 to be requested. If admitted to the facility on the poses that included but were not as, irregular heart beat, kidney of tract infection. In the posessment of	F	557		
	cognitively intact. D	ouring the meeting the hey say we can't have our				

own furniture. The furniture in the rooms is the property of (name of facility) and it will stay in the

Jan Jan

PRINTED: 07/09/2018 FORM APPROVED

CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
	ROVIDER OR SUPPLIER NT WOODS NURSING I	IOME	709	EET ADDRESS, CITY, STATE, ZIP CODE 0 COVENANT WOODS DRIVE CHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 557	bring in their own furwere told there was room. When asked could be moved to a furniture, the reside there was no place residents all stated recliners because the that comfortable. Removed to the facility needed more help, spent most of her divindow because sharound. Resident #room was not comformation was of Resident #21. The window, in a strather back and her resident stated the she wanted a reclining review of the facility review of the facility was not comformation.	why they were not allowed to miture, the residents said they no space available in the if the furniture in the room accommodate the resident's nts stated they were told that to store the furniture. The they would like to have their ne chairs in the room were not esident #21 stated she had a because she was blind and Resident #21 stated she ay in her room next to the needed so much help to get 21 stated that the chair in her portable. Is made on 6/27/18 at 4:15 a.m. he resident was sitting next to aight back chair with a pillow feet on an ottoman. The chair was not comfortable and her to rest in.	F 557		
	being allowed to bri	tation regarding residents not ing their own furniture. The id document that the residents in furniture.	e		p.
	evidence document	ty's resident handbook did not tation regarding residents not ing their own furniture.			
2	to resident by the fa	ent rights document provided acility documented, "It is the acility) that all residents shall			я

have the following rights and privileges: To retain

and use his/her personal clothing and

PRINTED: 07/09/2018

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				FORM APPROVED
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		NSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495419	B. WING_			
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	06/29/2018
COVENA	NT WOODS NURSING HO	OME	i		COVENANT WOODS DRIVE	
					HANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) BE COMPLETION ATE DATE
F 557	0	orwester.				
1 331	Page		F 5	57		
	possessions as space	permits unless to do so				
	would infinge upon n	ghts of other residents and		68		
	by his/her physician in	raindicated as documented n his/her medical record"				8
	by morner physician in	mismer medical record"				
	Review of the residen	t's clinical record did not		9		
	evidence documentati	ion regarding the use of a		31		10
	recliner being contrain	idicated.				
	p.m. with ASM (admin the director of nursing residents were not allo other furniture in their the unit, ASM #2 state before I got here." Who was for that decision, a safety. What if they co in the recliner? How an lift in there and get the the resident wouldn't ju ASM #2 stated, "There recliners, I would have each type." When asked meeting the resident's belongings, ASM #2 di When asked how man cardiac arrest or fall froyear, ASM #2 stated, "was aware that Reside ASM #2 stated, "We carecliner position." Whe	rooms in the new section of ad, "That was decided en asked what the reason ASM #2 stated, "It's for de (have a cardiac arrest) re we going to get a Hoyer of out?" When asked why just be lowered to the floor, are so many kinds of a to in-service my staff on ed how the facility was right to have their personal id not have an answer, y residents had suffered a form a recliner in the past None." When asked if she and #21 wanted a recliner, an put the bed into a in informed that the est to sit next to the window,				
		ucted on 6/28/18 at 4:50 administrator. When asked				

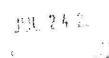
FORM CMS-2567(02-99) Previous Versions Obsolete

why residents couldn't have recliners or other furniture, ASM #1 stated, "From a space

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 32 of 104



PRINTED: 07/09/2018

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		NSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495419	B. WING			
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	06/29/2018
COVENA	NT WOODS NURSING H	011E			COVENANT WOODS DRIVE	
			İ		HANICSVILLE, VA 23111	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 557	Continued From page	e 32	F.5	57		19
		make sure there's enough	ale 10	107		
	room in the rooms to	allow them (the resident and				
	staff) to have access	throughout the room. We	70	10		
	don't have additional	storage to swap furniture."				30
	When asked what the	facility was to the resident,				33
	ASM #1 hesitated a m	noment and stated, "Well if				
	they're skilled (receivi	ng physical therapy) they're				
	here for a short time a	and there are some				
	residents that this is g	oing to be their home."				
	When asked how they	were meeting the		8		
	resident's right to have	e personal belongings, ASM				**
	#1 stated, "We encour	rage them to bring in				
	pictures and knick kna	acks." When asked how the				
	decision not to allow p	personal furniture had been				8.0
	were doing it one on a	ts, ASM #1 stated, "Well we one." When asked if there				
		to the residents regarding		27		
	this decision, ASM #1	stated there was not.				
		ducted on 6/29/18 at 8:51				
		OSM (other staff member)		88		3
		ntenance. ASM #1 stated				
		for renovation was started				19
		cific objectives in the room	E	93 74		18
		d, "They had to be private				ľ
		and a large bathroom."				
		urniture was determined on				
	the regs (regulations).			337		
		with the (Hoyer) lift. We				
	ultimately came up wit		*1	et e		
		d if she was aware that				
		for recliners and other				
		ASM #1 stated, "We've had e local ombudsman. We				
		at dialogue yet." When				
		facility's furniture could be				1
	moved out, so a reside					8
	moved in, ASM #1 star					
						(2)

storage space. When asked if the resident's

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 07/09/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED 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 495419 B. WING 06/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE COVENANT WOODS NURSING HOME MECHANICSVILLE, VA 23111 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 557 Continued From page 33 F 557 rights for reasonable possession of personal belongings was being met by the facility, ASM #1 stated, "I was messaging to the residents because it evolved into a single message that the rooms were being fully furnished and we needed to maintain space." When asked why a resident could not have a recliner in the newer larger rooms, ASM #1 stated, "Those rooms aren't that big." When this writer offered to visit the resident's rooms and see if a recliner could fit safely in the room neither ASM #1 nor OSM #5 accepted the offer. When asked how the resident's individuality and needs were being met, ASM #1 stated, "I am accepting that our intent was for safety and individuality but safety first. Our intent was not that every resident had to be the same. Yes there is room for accommodation and it's individualized and appropriate and to make sure their needs are being met." When asked what her role was as administrator, ASM #1 stated, it was to meet the needs of the residents. When OSM #5 was asked if facility furniture could be moved out of the room, OSM #5 stated, "Yes, we could rent a space." No further information was provided prior to exit. 4. The facility staff failed to allow Resident #12 to have a recliner and a filing cabinet when requested.

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

Resident #12 was admitted to the facility on 1/16/18 with diagnoses that included but were not limited to: obesity, high blood pressure, diabetes,

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment

depression and shortness of breath.

Event ID: C1RQ11

Facility ID: VA0416

if continuation sheet Page 34 of 104

JUL 24 1

PRINTED: 07/06/2018 EODM ADDDOVED

	NICINI OF TILALITI			01	MB NO. 0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		2000 No. 101 NO.	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	V-10-10	495419	B. WING		06/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
COVENA	NT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
F 557	having a ten out of interview for menta was moderately imported the resident was of from staff for activity exception of eating perform independent prepared. A resident meeting 2:00 p.m. with four cognitively intact. Do residents stated, "Town furniture. The property of (name of room." When asked bring in their own furniture was room. When asked could be moved to furniture, the residents all stated	age 34 A/25/18 coded the resident as 15 on the BIMS (brief I status) indicating the resident paired to make daily decisions. oded as requiring assistance ties of daily living with the which the resident could ntly after the tray was was conducted on 6/27/18 at residents, three of whom were buring the meeting the They say we can't have our furniture in the rooms is the of facility) and it will stay in the d why they were not allowed to urniture, the residents said they is no space available in the If the furniture in the room accommodate the resident's ents stated they were told that to store the furniture. The they would like to have their he chairs in the room were not	F 5	557	

An interview was conducted on 6/27/18 at 3:15 p.m. with Resident #12. Resident #12 was up in her room in an electric wheelchair. Resident #12 stated, "I had moved my partner over here last year and I was getting ready to move over when I found out I couldn't have my recliner. It was too late for me to change my mind. I have slept in a recliner for years and I don't sleep very well here." When asked if she had told staff about her difficulty sleeping, Resident #12 stated she had not. Resident #12 stated, "I still do my own finances and I asked if I could bring a two drawer

PRINTED: 07/06/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	102_100g		T)	OMB NO. 0938-03
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	58 S		NSTRUCTION	(X3) DATE SURVEY COMPLETED
	227	495419	B. WING			06/29/2018
	PROVIDER OR SUPPLIER ANT WOODS NURSIN	G HOME		7090	ET ADDRESS, CITY, STATE, ZIP CODE COVENANT WOODS DRIVE	
OUTENT	ari woodo nottolii	OTTOME		MEC	HANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLÉTIC
F 557	Continued From pa	1-7-1 (c)	F 5	557		
		ne so I could file my bills but				
		ave to pile my papers on the 12 to 14 inch pile of papers on				
		window. Resident #12 stated				
		have a computer table as				
		. When asked why the facility				
		straight back chair and put in the thick that the straight back chair and put in the straight that the				
		eir furniture and when we die				
	the furniture will stil					
		ty's admissions packet did not tation regarding residents not				
		ing their own furniture. The lid document that the residents n furniture.				
		ty's resident handbook did not tation regarding residents not				
		ing their own furniture.				
		ent rights document provided				
	Transport III and reasonable following the reason as a restrict and the reason an	acility documented, "It is the facility) that all residents shall				
		rights and privileges: To retain				
	and use his/her per	sonal clothing and				
		ace permits unless to do so				
	AND REAL PROPERTY OF THE PROPE	n rights of other residents and ontraindicated as documented				
		n in his/her medical record"				
		ent's clinical record did not				
		tation regarding the use of a				
	recliner being contr	amoicateo.				
		onducted on 6/28/18 at 4:21 ministrative staff member) #2,				

the director of nursing. When asked why residents were not allowed to have recliners or

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARI	E & MEDICAID SERVICES			<u> 1930-039 I</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
	495419	B. WING		06/29/2018
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
COVENANT WOODS NURSIN	IG HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
· ·	10-10 to 10	B.		

F 557 Continued From page 36

other furniture in their rooms in the new section of the unit, ASM #2 stated, "That was decided before I got here." When asked what the reason was for that decision, ASM #2 stated, "It's for safety. What if they code (have a cardiac arrest) in the recliner? How are we going to get a Hoyer lift in there and get them out?" When asked why the resident wouldn't just be lowered to the floor, ASM #2 stated, "There are so many kinds of recliners, I would have to in-service my staff on each type." When asked how the facility was meeting the resident's right to have their personal belongings, ASM #2 did not have an answer. When asked how many residents had suffered a cardiac arrest or fall from a recliner in the past year, ASM #2 stated, "None." When asked if she was aware that Resident #12 wanted a recliner. ASM #2 stated, "We can put the bed into a recliner position." When asked if she was aware that the resident had requested to bring a two drawer filing cabinet, ASM #2 stated she was not aware. When asked if a pile of papers on the floor was considered safe. ASM #2 stated no.

An interview was conducted on 6/28/18 at 4:50 p.m. with ASM #1, the administrator. When asked why residents couldn't have recliners or other furniture, ASM #1 stated, "From a space standpoint we had to make sure there's enough room in the rooms to allow them (the resident and staff) to have access throughout the room. We don't have additional storage to swap furniture." When asked what the facility was to the resident, ASM #1 hesitated a moment and stated, "Well if they're skilled (receiving physical therapy) they're here for a short time and there are some residents that this is going to be their home." When asked how they were meeting the resident's right to have personal belongings, ASM

F 557

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 07/06/2018

		AND HOWAR CERTICES						HAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0	<u>MB NC</u>	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V-250-24 MSL 24 Y (SHADAS) 124		STRUCTION			TE SURVEY MPLETED
		495419	B. WING_		3 2		06	/29/2018
NAME OF I	PROVIDER OR SUPPLIER	*	1	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
00)(5)(8)	NT 140000 NUIDON	0.110115		7090 CC	VENANT WOODS DRIV	/E		
COVENA	INT WOODS NURSIN	G HOME		MECHA	ANICSVILLE, VA 231	11		
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 557	Continued From pa	age 37	F 55	57				
	AND	ourage them to bring		2,				
		k knacks." When asked how						
	the decision not to	allow personal furniture had						
		residents, ASM #1 stated,						
		g it one on one." When asked						
	ASM #1 stated ther	ng in writing for the resident,						
	ACINI II I Stated the	C.Washiot.						
	An interview was co	onducted on 6/29/18 at 8:51						
		and OSM (other staff member)						
		naintenance. ASM #1 stated,						
		ct for renovation was started specific objectives in the room						
		ated, "They had to be private						
		ws and a large bathroom."						
	10 m	e furniture was determined on						
		s). We allowed ease of						
		m with the (Hoyer) lift. We with a foot print for the						
		ked if she was aware that						
		ing for recliners and other						
		s, ASM #1 stated, "We've had						
		the local ombudsman. We						
		that dialogue yet." When						
		the facility's furniture could be sident's furniture could be						
		stated they did not have						
		en asked if the resident's						
		e possession of personal						
		ng met by the facility, ASM #1						
		aging to the residents into a single message that the						
		ully furnished and we needed						
		When asked why a resident						
	The second secon	cliner in the newer larger						
		ted, "Those rooms aren't that						

big." When this writer offered to visit the resident's rooms and see if a recliner could fit safely in the room neither ASM #1 nor OSM #5

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
495419	B. WING	B. WNG		
	7	090 COVENANT WOODS DRIVE	00/28/2016	
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE COMPLE	ETION
When asked how the ality and needs were being met, am accepting that our intent individuality but safety first. that every resident had to be re is room for accommodation red and appropriate and to eds are being met." When e was as administrator, ASM meet the needs of the SM #5 was asked if facility moved out of the room, OSM a could rent a space." The right to and the facility must resident self-determination resident choice, including but ghts specified in paragraphs (f) this section. The right to choose is (including sleeping and lith care and providers of health ristent with his or her interests, plan of care and other has a right to make resident has a right to interact resident has a right to interact	F 561	F 561 1. Immediate action taken to shower schedule for reside reflect a Monday and Frid schedule on the 11-7 shift. 2. A Review of the current be schedule will be conducted – 11 RN Supervisor with a residents to assure the time is per resident preference. 3. Review by DON/designee to assure residents prefere communicated and docum 4. In-services with nursing st conducted focusing on residents of the services with s	ent #12 to ay athing 10-Aug d by the 3 all e and day with staff nces are ented. aff 10-Aug ident's	g-18 g-18
	IDENTIFICATION NUMBER:	### A BUILDING B. WING	HOME STREET ADDRESS, CITY, STATE, 2IP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	### A BUILDING ### A

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 39 of 104

19. 2 - .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second second second second	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
	(EACH DEFICIENC)	OME ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) E COMPLETION
F 561	supervision only with reality living). Resident #12 was adr 1/16/18 with diagnose limited to high blood p chronic kidney disease. Resident #12 (minimum data set) as assessment with an Adate) of 4/25/18. Resident #12 was adred to find the supervision only with reality living). Resident #12 supervision with reality living). Resident	sident has a right to ctivities, including social, unity activities that do not its of other residents in the is not met as evidenced sterview, staff interview, ew, and clinical record ined that the facility staff ident's preference for one of provey sample, Resident #12. I ged her shower days without ent and did not provide a her preference.	F 56	 F 561 Bathing schedules will be review by resident and/or RP during the of the Care Plan review meeting Don/designee will conduct audit monthly to assure that bathing/shower schedules are co-according to Resident preference 	e time

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS	S FOR MEDICAL	KE & MIEDICAID SEKVICES			OND 140. 0330-0	
	AID DI AN OF CORDECTION IDENTIFICATION NI MARED		384 380 383E	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495419	B. WING _		06/29/2018	
NAME OF PR	OVIDER OR SUPPLIE	R	T	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
COVENAN	IT WOODS NURS	ING HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLET	

F 561 Continued From page 40

On 06/27/18, an interview was conducted with Resident # 12 at approximately 9:05 a.m. Resident # 12 stated her shower days had suddenly been changed without her consent or being notified of the change. When asked to describe what had taken place. Resident # 12 stated, "They came in Thursday (06/28/18) at 7:30 in the morning and told me it was time for my shower. I refused. I wasn't asked or told about the change. I have a reason why I have my showers on Monday and Fridays. I get a massage on Thursdays and on Friday when I get my shower I get the lotion washed off from the massage." When asked if she said anything to the staff, Resident # 12 stated, "I told the CNA and the nurse but they didn't do anything." When asked how she felt about not being given a choice about her shower day being changed and not being notified of the change, Resident # 12 stated, "I'm upset with the change. It makes me feel like a second class citizen."

On 6/29/18 at 9:25 a.m., an interview was conducted with CNA (certified nursing assistant) #3, Resident #12's 7:00 a.m. to 3:00 p.m. shift CNA, regarding when Resident #12 was supposed to receive showers. CNA #3 looked at the shower sheet assignment and stated that the schedule was just changed that week on 6/25/18 and that Resident #12 received showers on Mondays and Thursday on the 11:00 (p.m.) to 7:00 (a.m.) shift. CNA #3 stated Resident #12 used to receive her showers Monday and Fridays on the 11:00 (p.m.) to 7:00 (a.m.) shift, and that was how the resident liked it. CNA #3 stated Resident #12 got a massage every Thursday and wanted the oils to be washed off on Friday. When asked who was responsible for changing the shower schedule, CNA #3 stated that any

F 561

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/06/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A) 35	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
	KONTHIS SHAPPING	495419	B. WING			06/29/2018
	PROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, ZIP COD 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111)E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 561	approved by the urshe was not sure we why the schedule we CNA #3 stated that #12 had complained CNA had told the reshower on Thursdain schedule. CNA #complaint to the 7:0 nurse (LPN #1), but done about it. CNA #12 did not receive 11 (p.m.) to 7:00 (a CNA #3 stated that aide had stated she shower but could not offer the shower. We Resident #12 a sho 3:00 shift, CNA #3 shower that mornin Resident #12 has re 3:00 shift because so 11:00 to 7:00 shift. Review of the curre Resident #12 receive Thursday on the 11 This shower schedule 6/25/18. On 6/29/18 at 10:21 conducted with ASM member) #2, the Downs also the stand When asked who we was asked who was asked who was asked who was asked who we was asked who w	wer schedule had to be nit manager. CNA #3 stated ho changed the schedule, or was changed for Resident #12. yesterday (6/28/18) Resident d to her that the 11-7 shift esident she had to take her y morning due to the change #3 stated she reported this 10 (am) to 3:00 (pm) shift the shower that morning was 143 confirmed that Resident her shower that morning on 15. In report, the 11:00 to 7:00 and not give Resident #12 her out recall why the aide did not when asked if she had offered over that morning on 7:00 to stated she did not offer her and group because in the past effused showers on 7:00 to she wants her showers on the 11 shower sheet revealed that we showers on Monday and 100 p.m. to 7:00 a.m. shift. The was changed/updated on 12 a.m., an interview was 14 (administrative staff on 15 on 16 o	F 5	61		

usually changed per resident preference. ASM #2 stated that once the requested change was

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 07/06/2018

				01	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1			(X3) DATE SURVEY COMPLETED
	495419	B. WING		_	06/29/2018
ROVIDER OR SUPPLIER	9				
NT WOODS NURSING	G HOME				7 <u>75.</u>
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	\$1000 XX	X (EACH CORRECTIVE CROSS-REFERENCED	E ACTION SHOULD TO THE APPROPE	BE COMPLETION
reported to the CNA relay this message manager would revichanges reflecting to ASM #2 stated if to given on a particular have to make changes hower days around stated she was not regarding Resident stated the nursing stated that stated the nursing stated that stated the nurse was that it as schedule. ASM #2 have also changed accident. ASM #2 sinformation with the nurse was on vacat shower schedule through the nurse to receive her Friday 11-7 shift. A problem to change schedule back to he on 6/29/18 at 11:36 conducted with LPN p.m. shift nurse on the being made aware of LPN #1 stated there day that she could reconstructed with the could reconstructed to the state of	A, the charge nurse would then to the unit manager. The unit iew the schedule and make the resident's preference. In order of the above seed of the above concern the above co	F 5	61		
conducted with LPN	I #5, the 11:00 p.m. to 7:00				
	SFOR MEDICARE OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER NT WOODS NURSING SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa reported to the CNA relay this message manager would rev changes reflecting to ASM #2 stated if to given on a particula have to make chang shower days around stated she was not regarding Resident stated the nursing s accommodate the r On 6/29/18 at 11:15 conducted with ASM remembered that sl assurance) nurse of schedule. ASM #2 have also changed accident. ASM #2 have also changed accident have also changed	F CORRECTION IDENTIFICATION NUMBER:	A BUILD ABOVE STATEMENT OF DEFICIENCIES (X2) MULTIPERS (X2) MULTIPERS (X2) MULTIPERS (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPERS (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPERS (X3) MURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 42 reported to the CNA, the charge nurse would then relay this message to the unit manager. The unit manager would review the schedule and make changes reflecting the resident's preference. ASM #2 stated if too many showers were to be given on a particular day or shift, they would also have to make changes and move resident's shower days around with their consent. ASM #2 stated she was not aware of the above concern regarding Resident #12's showers. ASM #2 stated the nursing staff should try to accommodate the resident. On 6/29/18 at 11:15 a.m., a further interview was conducted with ASM #2. ASM #2 stated she remembered that she had the QA (quality assurance) nurse change the skin assessment schedule so that it aligned better with the shower schedule ASM #2 stated the QA nurse must have also changed the shower schedule by accident. ASM #2 stated she could not verify this information with the QA nurse because the QA nurse was on vacation. ASM #2 brought the old shower schedule that verified that Resident #12 used to receive her showers on Monday and Friday 11-7 shift. ASM #2 stated it was not a problem to change Resident #12's shower schedule back to her original shower days. On 6/29/18 at 11:36 a.m., an interview was conducted with LPN #1, the 7:00 a.m. to 3:00 p.m. shift nurse on 6/28/18. LPN #1 did not recall being made aware of Resident #12's showers. LPN #1 stated there was so much going on that day that she could not remember. On 6/29/18 at 12:02 p.m., an interview was	ROVIDER OR SUPPLIER NT WOODS NURSING HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION A BUILDING BUILD	STOR MEDICARE & MEDICAID SERVICES Or DEFICIENCIES (X1) PROVIDER SUPPLIER CLAR A BUILDING A BUILDING

a.m. shift nurse on the mornings of 6/28/18 and

7 7 4 1

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	<u> </u>		OIVID INC). UB30-U3B I
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I \ '		Ed. 100 (2012) 4000	TE SURVEY MPLETED
: ::::::::::::::::::::::::::::::::::::		495419	B. WING		06	5/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
COVENA	NT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(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 BE HE APPROPRIATE	(X5) COMPLETION DATE

F 561 Continued From page 43

6/29/18. When asked what she recalled regarding Resident #12's showers, LPN #5 stated she remembered the aide coming to her saying that Resident #12 was refusing her shower scheduled on Thursday 11:00 to 7:00 shift. LPN #5 stated she had told Resident #12 that her shower schedule had changed. LPN #5 stated was when the resident refused and stated she wanted her shower on Friday morning as it had always been. LPN #5 stated she was not sure how to change the shower schedule or who was responsible for changing the shower schedule. LPN #5 stated, "I don't know what they do here." LPN #5 stated she was not even made aware of the schedule changing. LPN #5 stated she was not sure if she passed this information on to the oncoming nurse. LPN #5 stated she was the same nurse who also worked Friday morning on the 11:00 to 7:00 shift. LPN #5 stated she did not offer Resident #12 a shower on Friday morning because the resident did not say anything.

On 6/29/18 at 12:43 p.m., an interview was conducted with CNA #8, the 11:00 p.m. to 7:00 a.m. shift CNA on the mornings of 6/28/18 and 6/29/18. CNA #8 stated the shower schedule had changed and Resident #12 refused her shower for her on the morning of 6/28/18. CNA #8 stated the resident wanted her shower Friday morning. CNA #8 stated she had told the resident that the shower schedule had changed. CNA #8 stated she had reported Resident #12's refusal and complaint to the 11:00 p.m. to 7:00 a.m. nurse. CNA #8 stated that she was the same aide who worked the morning of 6/29/18. When asked if she had offered Resident #12 a shower per her request, CNA #8 stated she did not because the resident did not say anything that morning.

F 561

DEDARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/06/2018

A STATE OF THE STA		AND HUMAN SERVICES		O	MB NO. 0938-0391
		& MEDICAID SERVICES			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
COVENA	NT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION
F 561	On 6/29/18 at 1:10 conducted with Resistated she always in Mondays and Frida and wanted to control Resident #12 states staff had changed housent. Resident morning (11:00 p.m. 6/28/18, the aide has shower that day be had changed. Resident wanted her shower day. Resident aide and the number wanted her shower #12 stated on Frida a.m. shift), staff did Resident #12 states who were made awwere also working of 7:00 shift. Resident up and dressed on	p.m., a further interview was sident #12. Resident #12 received her showers on mys on the 11:00 to 7:00 shift inue with that schedule. It is desired that showers days without her interview was upset that nursing ther showers days without her interview into 7:00 a.m.) shift on the interview into 7:00 a.m.) shift on the interview into 7:00 a.m.) shift on the interview into 7:00 a.m. It is interview into 7:00 a.m. It is interview into 7:00 a.m. It is into 7:00 a.m. It is interview into 7:00 a.m. It is interview into 7:00 a.m. It is interview in Friday morning. Resident and interview into 7:00 a.m. It is interview in Friday morning 11:00 to a.m. It is interview into 7:00 a.m. It is interview in Friday morning 11:00 to a.m. It is interview in the resident #12 a.m. It is	F		
	at that time. Reside	ady had her hair appointment ent #12 stated she felt sticky ent #12 stated she didn't			3

Review of the 6/27/18 through 6/29/18 24 hour nursing reports, failed to evidence that nursing staff had passed on in report that Resident #12 would like her showers to return to the previous schedule (Mon and Fridays 11:00 to 7::00 shift).

understand why the staff would change her shower schedule without telling her.

Review of Resident #12's care plan dated 1/29/18, did not address honoring her shower preferences.



PRINTED: 07/09/2018 FORM APPROVED

STATEMENT	OF DEFICIENCIES	MEDIOAID SERVICES				MB NO. 0938-0391
AND PLAN O	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ¹ A. BUILDI	TIPLE CONSTRUCTION	1	X3) DATE SURVEY COMPLETED
		495419	B. WING			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		06/29/2018
COVENA	NT WOODS NUDONO			7090 COVENANT WOODS DRIVE	CODE	
COVERA	NT WOODS NURSING H	OME		MECHANICSVILLE, VA 23111		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES				
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION E DATE
F 561	Continued From page	e 45	F 5	561		
	On 6/29/18 at approxi administrator and ASI Nursing) were made a concerns.	imately 2 p.m., ASM #1, the M #2, the DON (Director of aware of the above				
						iii
F 607	No further information Develop/Implement Al CFR(s): 483.12(b)(1)-	was presented prior to exit. buse/Neglect Policies	F6	907		9
			8			
	§483.12(b) The facility implement written poli	r must develop and cies and procedures that:		8		íī
	§483.12(b)(1) Prohibit neglect, and exploitati misappropriation of re-	on of residents and	ii W			
	§483.12(b)(2) Establis to investigate any such	h policies and procedures n allegations, and	100	8		
	§483.12(b)(3) Include paragraph §483.95, This REQUIREMENT	training as required at				
80	by:	ew, facility document review				
	and clinical record revi the facility staff failed to	ew, it was determined that o implement their abuse		×		
	survey sample, Reside	one of 28 residents in the ent #10.		to to		100 100 100
		to report the findings of assistant) #9's abuse to appropriate reporting				
	The findings include:					50

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WING		06/29/2018	
	ROVIDER OR SUPPLIER	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 7080 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	1 00/20/2010	
(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 SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 607	4/16/18 with diagnost limited to: lung disease Alzheimer's disease at The most recent mini assessment, with an of 4/23/18 coded the 13 out of 15 on the bistatus indicating the rintact to make daily discoded as requiring as activities of daily living A review of the facility documented, "Incider involved: (Name of R. Allegations of abuse/incident, including loc Resident's family reportant for their mother Resident stated, "She pulled me." Physical a visible injuries. No coemployees(s) involve of CNA #9). Employee 1.) Assigned to anoth Employee suspended investigation docume regarding the CNAs a residents and the resimoved roughly. An interview was contained in the director of nursing outcome of the incide terminated the CNA.	mitted to the facility on es that included but were not se, diabetes, arthritis, and high blood pressure. mum data set, an admission assessment reference date resident as having scored ief interview for mental esident was cognitively ecisions. The resident was sistance from staff for all g. reported incidents (FRIs) at date: 5/23/18. Residents esident #10). Incident type: mistreat(ment). Describe ation, and action taken, orted to nurse that CNA	F 60	 Report to Board of Nursing submitted. Education and review of facility policy covering abuse will be conducted including all agencie must be notified. Summary of FRI and List of authorities notified will be revie at QA meetings. 	s that	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLÉTED	
		495419	8. WNG			06/29/2018
	ROVIDER OR SUPPLIER)ME	0 100	7090 COV	DDRESS, CITY, STATE, ZIP CODE ENANT WOODS DRIVE IICSVILLE, VA 23111	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 607	was abuse." When as the department of hea stated it had not. Whe	e 47 SM #2 stated, "Well yeah it sked if this was reported to alth professionals, ASM #2 en asked if it should have eir policy, ASM #2 stated,	F	607		g .
	documented, "Definiti infliction of injury, unrintimidating, or punish ham, pain or mental abuse of all residents or physical condition, pain or mental anguis The organization will	s policy titled, "ABUSE" ons: "Abuse" is the willful easonable confinement, ment resulting in physical anguishInstances of , irrespective of any mental can cause physical harm, h. Policy: 6) Reporting. a) i) report to the State Nurse sing authority [i.e. Board of	8			
F 609 SS=D	Pharmacy, etc.]" Reporting of Alleged 1 CFR(s): 483.12(c)(1)(§483.12(c) In response	/iolations	F	609		
	§483.12(c)(1) Ensure involving abuse, negle mistreatment, includir source and misappropare reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not resist the administrator of the	g injuries of unknown priation of resident property, tely, but not later than 2 ion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve all in serious bodily injury, to				e u n

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		496419	B. WING			06/29/2018
	ROVIDER OR SUPPLIER	HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 609	adult protective se for jurisdiction in lo accordance with S procedures. §483.12(c)(4) Rep investigations to the designated repressaccordance with S Survey Agency, wi incident, and if the appropriate correct This REQUIREME by: Based on staff interest and clinical record the facility staff fail finding of abuse to with State law throone of 28 residents Resident #10. The facility staff fail finding assistants as the all appropriate. The findings include Resident #10 was 4/16/18 with diagnoral limited to: lung disease. The most recent massessment, with a of 4/23/18 coded to 15 on the brief interest.	ort the results of all le administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. INT is not met as evidenced erview, facility document review review, it was determined that ed to report an allegation and other officials in accordance ugh established procedures for s in the survey sample,	F 60	1. Report to Board of Nursis submitted. 2. Education and review of policy covering abuse wis conducted including all a must be notified. 3. Summary of FRI and List authorities notified will be at QA meetings.	facility ll be gencies that	18-Jul-18 10-Aug-18 25-Jul-18

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS	S FOR MEDICARE	& MEDICAID SERVICES	960		OMB NO. 09)38-0391
15750	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLI	
		495419	B. WING		06/29	/2018
NAME OF PE	ROVIDER OR SUPPLIER	000 - 3		STREET ADDRESS, CITY, STATE, ZIP COD	E	
COVENAN	IT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(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 C	(X5) COMPLETION DATE
2 2 000 to			-			

F 609 Continued From page 49

make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

A review of the facility reported incidents (FRIs) documented, "Incident date: 5/23/18. Residents involved: (Name of Resident #10). Incident type: Allegations of abuse/mistreat(ment). Describe incident, including location, and action taken, Resident's family reported to nurse that CNA caring for their mother was rude and nasty. Resident stated, "She grabbed my shoulder and pulled me." Physical assessment conducted, No. visible injuries. No complaints of pain, Name of employees(s) involved and their positions: (Name of CNA #9). Employee action initiated or taken: 1.) Assigned to another assignment 5/23/18, 2.) Employee suspended 5/24/18." Review of the investigation documented concerns from staff regarding the CNAs attitude and treatment of residents and the resident's concern of being moved roughly.

An interview was conducted on 6/29/18 at 10:40 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked about the outcome of the incident, ASM #2 stated she had terminated the CNA. When asked if she had determined that there had been an act of abuse on the CNA's part, ASM #2 stated, "Well yeah it was abuse." When asked if this was reported to the department of health professionals, ASM #2 stated it had not. When asked if it should have been reported, ASM #2 stated, "Yes."

Review of the facility's policy titled, "ABUSE" documented, "Definitions: "Abuse" is the willful infliction of injury, unreasonable confinement, intimidating, or punishment resulting in physical

F 609

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 50 of 104

) N. 2 4 2.

PRINTED: 07/09/2018 FORM APPROVED

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	2002	***		OMB NO. 0938-0391
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING			ļ
NAME OF F	PROVIDER OR SUPPLIER		0.000	STR	REET ADDRESS, CITY, STATE, ZIP CODE	06/29/2018
COVENA	NT WOODS NURSING H	OME.			0 COVENANT WOODS DRIVE	
		JAIC .	50		CHANICSVILLE, VA 23111	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			
PREFIX TAG	The state of the s		PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RE COMPLETION
F 609	Continued From page	e 50		309		
		anguishInstances of	г	909		
	abuse of all residents	, irrespective of any mental				
	or physical condition,	can cause physical harm				
	pain or mental anguis	h. Policy: 6) Reporting. a) i)				
	Aide Registry or licens	report to the State Nurse				8
	Nursing, Board of Phy	sing authority [i.e. Board of				
	Pharmacy, etc.]"	Sideris, Board of				
	No further information	was provided prior to exit.				
F 656	Develop/Implement Co	omprehensive Care Plan	F6	56		1
SS=D	CFR(s): 483.21(b)(1)		, ,	JU		Ī
	§483.21(b) Comprehe	nsive Care Plans	9 1	Æ		ii.
	§483.21(b)(1) The faci	lity must develop and		劉		ı
	implement a comprehe	ensive person-centered		191		
	care plan for each resi	dent, consistent with the				
	resident rights set forth	at §483.10(c)(2) and				
	§483.10(c)(3), that incl	udes measurable nes to meet a resident's	ige			
	medical nursing and	mental and psychosocial	38			
	needs that are identifie	d in the comprehensive		180		*
	assessment. The comp	prehensive care plan must				
9	describe the following -	•				8
	(i) The services that are	e to be furnished to attain				
	or maintain the residen	t's highest practicable				
	priysical, mental, and p required under 6483.24	sychosocial well-being as 4, §483.25 or §483.40; and				
	(ii) Any services that we	ould otherwise be required				
	under §483.24, §483.2	5 or §483.40 but are not		į.		1
	provided due to the res	ident's exercise of rights		10		
	under §483.10, includir	ig the right to refuse		P.03		微
	treatment under §483.1					
	(iii) Any specialized ser					Î
	rehabilitative services to provide as a result of P.					
		ASAKK facility disagrees with the				
1	findings of the PASARF	R, it must indicate its		N		*

J. 1. 24 7

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495419	B. WING		06	29/2018
205 - 456,004 (CARCO)	ROVIDER OR SUPPLIER	DME		STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656 Continued From page 51 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for		F 65	1. Resident #26 was not found to adversely affected. Liter flow r was adjusted to deliver oxygen per MD order.	ate	29-Jun-18	
	future discharge. Faci whether the resident's community was asses local contact agencies	lities must document desire to return to the sed and any referrals to and/or other appropriate		100% audit was performed of a resident files for accuracy of M orders who receive oxygen.		10-Aug-18
	plan, as appropriate, i	se. In the comprehensive care In accordance with the In paragraph (c) of this		100% review and observation of concentrators for residents received oxygen for accuracy of flow rates.	ving	10-Aug-18
	This REQUIREMENT by: Based on staff intervie	is not met as evidenced ew, and clinical record ned that the facility staff		Maintenance check conducted of oxygen concentrators to assess need of repairs.		10-Aug-18
	review, it was determined that the fac failed to implement the comprehensiv for two of 28 residents in the survey s Resident # 26, and # 12.	e comprehensive care plan in the survey sample, 12.		 Review of nursing procedures for oxygen therapy with nursing sta In-service nursing staff on policiprocedures for oxygen therapy. 	ff.	10-Aug-18
	26's oxygen according and comprehensive ca	ed to administer Resident # I to the physician's orders are plan.		DON or designee will conduct weekly audits on residents.		10-Aug-18
	#12's physician ordere	not administer Resident of medications per the comprehensive care plan.			ļ	
	The findings include:					
	26's oxygen according and comprehensive ca Resident # 26 was adr					

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 52 of 104

JUL 24 7

PRINTED: 07/06/2018

		AND HUMAN SERVICES		•	FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL1	TIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED
177	2022	495419	B. WING		06/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE	
COVENA	NT WOODS NURSIN	G HOME		MECHANICSVILLE, VA 23111	
(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 CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 656	Continued From pa	age 52	F6	56	
	not limited to heart	failure, respiratory failure (1),			
		2), gastroesophageal reflux apnea (4), hypertension (5),			
	congestive heart fa disease (7) and hyp	ilure (6), coronary artery			
	Resident # 26's mo set), a quarterly ass (assessment refere Resident # 26 as so interview for menta - 15, 10 - being mo for making daily de coded as requiring staff member for ac section "O. Special	ost recent MDS (minimum data sessment with an ARD ence date) of 06/02/18, coded coring a 10 on the brief I status (BIMS) of a score of 0 derately impaired of cognition cisions. Resident # 26 was extensive assistance of one ctivities of daily living. Under Treatment, Procedures and at # 26 was coded for "C.			
	11:01 a.m., reveale her wheelchair rece cannula from (soft)	06/27/18 at approximately desident # 26 was sitting in eiving oxygen (O2) by nasal plastic prongs that fit in the gen) an oxygen concentrator.			

Observation of the O2 flow meter on the oxygen concentrator revealed the oxygen flow rate at two and a half liters.

An observation on 06/27/18 at approximately 2:10 p.m. revealed Resident # 26 was sitting in her wheelchair receiving oxygen (O2) by nasal cannula from an oxygen concentrator. Observation of the O2 flow meter on the oxygen concentrator revealed the oxygen flow rate at two and a half liters.

An observation on 06/27/18 at approximately 5:03 p.m. revealed Resident # 26 was sitting in her wheelchair receiving oxygen (O2) by nasal

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 53 of 104

111 241

PRINTED: 07/06/2018

250 50		AND HUMAN SERVICES				100 10	MAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		ATE SURVEY OMPLETED
		495419	B. WING			01	6/29/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CO		
COVENA	NT WOODS NURSIN	G HOME		70	90 COVENANT WOODS DRIVE		
OUTENA	THE			M	ECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From pa	nge 53	Fé	656			
	cannula from an ox						
	Observation of the	O2 flow meter on the oxygen led the oxygen flow rate at two					
	approximately 9:45 Resident # 26's roo oxygen cylinder on Resident # 26 was receiving oxygen (Coxygen concentrate flow meter on the o the oxygen flow rate three liters.	s made on 6/28/18 at a.m., a nurse entered om, exchanged the portable the back of her wheelchair. sitting in her wheelchair O2) by nasal cannula from an or. Observation of O2 of the xygen concentrator revealed e between two and a half and ers for Resident # 26 dated					
	June 2018 docume	nted, "Oxygen. Continuous ee) L/min (liters per minute)					
n d 3 C E F fr	The ETAR (electron record) dated June documented, "Oxyg 3 (three) L/min (liter Order Date: 02/08/2 ETAR documented Resident # 26 recei from the oxygen cominute.						
	dated 12/04/17 with documented, "Problems	e care plan for Resident # 26 a review date of 03/13/18 lem/Concern. Resident is at cardiac output related to:					

TAR."

congestive heart failure, coronary artery disease and hyperlipidemia." Under "Approach" it documented, "Administer oxygen per order, see

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 07/06/2018 FORM APPROVED

CENTER	S EOD MEDICADE	& MEDICAID SERVICES			ſ	OMB NO. 0938-0	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMPLETED	
		495419	B. WING	j		06/29/2018	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>	1	5000000	REET ADDRESS, CITY, STATE, ZIP CODE		
COVENA	NT WOODS NURSIN	G HOME		1000000	90 COVENANT WOODS DRIVE ECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPRO DEFICIENCY)	D BE COMPLET	
F 656	Continued From pa	age 54	F	656			
	"Problem/Concern. difficulty in breathin CHF (congestive he Under "Approach" i	Resident has potential for ng related to respiratory failure, eart failure and sleep apnea." it documented, "Administer					100 mm
	oxygen per order, s On 6/28/18 at appro						
	practical nurse) # 1 resident's oxygen fl	I. When asked how often a flow rate checked, LPN # 1 every time I go into the room					
	and every shift." W purpose of the care plan of care of how When asked why th followed LPN # 1 st resident's needs."	When asked to describe the e plan LPN # 1 stated, "It's a to take care of the resident." he care plan should be tated, "For safety to meet the When informed of the above					A STATE OF S
	Resident # 26"oxyg	ofter reviewing the care plan for gen, LPN # 1 stated that the followed for the time the tat three liters.					
	(administrative staff	proximately 5:15 p.m., ASM if member) # 1, administrator, of nursing were made aware of					
	No further informati	ion was provided prior to exit.					
	constant pressure of	vay treatment that applies a of forced air to keep the airway					
	website:	ation was obtained from the .gov/ency/imagepages/9685.ht					

(2) When not enough oxygen passes from your lungs into your blood. This information was

J 1 2 4 1 .

PRINTED: 07/06/2018 FORM APPROVED OMB NO 0938-0391

DATE OF THE PROPERTY OF THE PR	The St. Market and H. Dr. and A. H. Market and S. C.
	SURVEY PLETED
495419 B. WING 06/2	29/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION 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)	(X5) COMPLETION DATE
F 656 Continued From page 55 obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfa ilure.html. (3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm. (4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (5) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html. (6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highploodpr essure.html. (7) A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html	

information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarte

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/06/2018 FORM APPROVED

		AND HOMAN CERVICES			3	50 075000 0000	. 0938-03 <u>91</u>
		& MEDICAID SERVICES		- 20 200 5			-
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY MPLETED
		495419	B. WING			06/	/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1000	3
COVENIA	NT WOODS NURSIN	CHOME		N-10-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0	COVENANT WOODS DRIVE		
COVERA	INT WOODS NORSIN			ME	CHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 656	Continued From pa	ae 56	F (356			
	rydisease.html.	9	3. . 41 %	,,,,			
	your body needs to cholesterol can incide heart disease, strolomedical term for high disorder, hyperlipid This information was https://medlineplus 2. The facility staff #12's physician ord physician's orders at 1/16/18 with the dia asthma, diabetes, oblood pressure, chrinsomnia, periphera cervicalgia, depressartificial knee, hypomacular degenerat (Minimum Data Selwith an ARD (Asset 4/25/18. The residemoderately impaired decisions. The resextensive care for thygiene and dressi eating, and toileting and bladder. On 6/27/18 at 4:36 Practical Nurse) was administering the for Resident #12:	fat (also called a lipid) that work properly. Too much bad rease your chance of getting ke, and other problems. The gh blood cholesterol is lipid emia, or hypercholesterolemia. as obtained from the website: gov/ency/article/000403.htm. did not administer Resident ered medications per the and comprehensive care plan. admitted to the facility on agnoses of but not limited to beliac disease, obesity, high ronic kidney disease, stroke, al vascular disease, sion, dyspnea, pacemaker, athyroidism, heart failure, and fon. The most recent MDS to was a quarterly assessment sement Reference Date) of ent was coded as being d in ability to make daily life ident was coded as requiring bathing; limited assistance for ang; supervision for transfers, grand as continent of bowel of medical					

Baclofen {2} 10 mg, 1 tab Montelukast {3}10 mg, 1 tab

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/09/2018 FORM APPROVED

CENTER:	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING	C 6 0	A 294 19402 Moderal Brandwide	06/29/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	
COVENAN	IT WOODS NURSING H	OME			COVENANT WOODS DRIVE	
				MECH	HANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI)	(31 41	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	CATE
F 656	Continued From pag	e 57	Fi	356		
, 555	" Lomotil {4} 2.5/0		(0.77)	,50		
	" Humalog {5} 6 u					
	On 6/28/18 12:26 p.r	n. the physician's orders				
		curacy. The following order				20
	was noted: A physician's order for	or Omeprazole (6), dated	ă.			
	and the state of t	i, "Omeprazole 40 mg	×			
	capsule, two times d	aily."				
	Record) revealed that out as having been of the same time the of were also signed out	(Medication Administration at this medication was signed given on 6/27/18 at 4:51 p.m., her medications listed above as having been over, the Omeprazole was not	8			27 13 16 17
	1/29/18 for "Residen expressed/demonstr to:GERD (gastroe This care plan includ	plan revealed one dated t has ated pain/discomfort related sophageal reflux disease)." ed the intervention (undated) cation as prescribed by the	,	20 1		
·	(Registered Nurse) s address how to care specific diagnoses, p stated if the care pla medication as ordere the care plan was no	-				8
		y policy, "Care Planning" did that the care plan must be	it o			

On 6/28/18 at approximately 6:00 p.m., the

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
West minister and county the employees a consequence	ROVIDER OR SUPPLIER	DME	709	EET ADDRESS, CITY, STATE, ZIP CODE 0 COVENANT WOODS DRIVE CHANICSVILLE, VA 23111	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 656	Member) and the Dire	t1 - Administrative Staff ector of Nursing (ASM #2) the findings. No further	F 656		N
	conditions where the acid. Information obtained	reat ulcers, reflux, and stomach produces too much from ov/druginfo/meds/a687011.ht			5
	Information obtained	o treat muscle spasms. from ov/druginfo/meds/a682530.h	R		*
	by asthma. Information obtained	d to treat symptoms caused from ov/druginfo/meds/a600014.h	8		
	{4} Lomotil - used to t Information obtained https://medlineplus.go tml		a a		āl
	{5} Humalog - used to Information obtained https://medlineplus.go tml		u		11
	(6) Omeprazole - use Information obtained https://medlineplus.go tml		1		

111 241

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495419	B. WING _		06/29/2018
NAME OF PE	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
COMENIAN	T WOODS NUDSING U	Near":	1	7090 COVENANT WOODS DRIVE	
COVENAN	IT WOODS NURSING HO	JME		MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 657	Continued From page	e 59	F 6	57	
F 657	Care Plan Timing and	d Revision	F 6	57	
	CFR(s): 483.21(b)(2)			5	19
	§483.21(b) Compreh	ensive Care Plans prehensive care plan must			
	be-	prenerisive care plan must			:
		7 days after completion of			
	the comprehensive a				
	(ii) Prepared by an in	terdisciplinary team, that			
	includes but is not lim				
	(A) The attending phy				
	resident.	e with responsibility for the			
	(C) A nurse aide with	responsibility for the	181		
	resident.		4		
		d and nutrition services staff.	15	8.	
		cticable, the participation of	19		
		resident's representative(s).			
	Acceptance of the control of	be included in a resident's			
		participation of the resident presentative is determined			19
	not practicable for the				
	resident's care plan.	e development of the			
	SACA A CONTROL AND CARROLL AND A SACRAMAN AND A SAC	staff or professionals in			1
		lined by the resident's needs			
	or as requested by th				
	[12] A	rised by the interdisciplinary			
		essment, including both the			
	comprehensive and				
	assessments.	* •			
	This REQUIREMENT	F is not met as evidenced	99		
	by:				
	Based on staff interv	view, facility document review			
		view, it was determined that			
	Becomplete Resilvant Clarke Arthritish (Architectur)	to review and revised the			
	To be a series of the series o	plan for two of 28 residents			
	in the survey sample	, Resident # 26, and # 32.			
	1. The facility staff fa	iled to review and revise the			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
·		495419	B. WNG		06/2	29/2018
	ROVIDER OR SUPPLIER	OME	6	STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	1	(SI 20 10
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Resident # 26 after the 2. The facility staff fall comprehensive care #32's admission to he are fall to the findings include: 1. The facility staff fall comprehensive care Resident # 26 after the resident # 26 was accomplete to the fall to the f	plan to address falls for he resident fell on 5/27/18. siled to review and revise the plan to address the Resident ospice and hospice care. siled to review and revise the plan to address falls for he resident fell on 5/27/18. dmitted to the facility on ses that included but were ailure, respiratory failure (1), p. gastroesophageal reflux onea (4), hypertension (5), ure (6), coronary artery erlipidemia (8). It recent MDS (minimum data essment with an ARD seed ate) of 06/02/18, coded oring a 10 on the brief status (BIMS) of a score of 0 erately impaired of cognition sions. Resident # 26 was extensive assistance of one vities of daily living. electronic health record) for led an "SBAR (Situation, ment, Recommendation) in" dated 05/27/2018. The hat Resident # 26 had a fall	F 657		falls falls 1, t ons. audits eks.	28-Jun-18 27-Jul-18 10-Aug-18
	on 05/27/2018. The	SBAR documented Resident erring from the bed to the	000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/06/2018

DELVI	MENT OF HEALTH	MIND HOMMIN SELVICES					FORM	MAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0	MB NO	0.0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(ASKI) - MSIMORISMIN - E		NSTRUCTION			TE SURVEY MPLETED
		495419	B. WING	8088	<u> </u>		06	/29/2018
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIF	CODE		
			l l	7090 C	OVENANT WOODS DRIVE			
COVENA	INT WOODS NURSIN	G HOME	1	MECH	IANICSVILLE, VA 23111			
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE
F 657	Continued From pa wheelchair.	age 61	F6	57				
	Resident # 26 date	ehensive care plan for d 12/04/17 with a review date o evidence documentation of on 5/27/18.						
	conducted with RN (minimum data set how a care plan wa "Upon admission," meets with residen assistance, assistiv	3 a.m., an interview was (registered nurse) # 1, MDS) coordinator. When asked as developed, RN # 1 stated, The IDT (interdisciplinary team) t and identifies the level of we devices and preferences.	İ					
	changes from what resident told us. G resident's diagnosis comprehensive car the fall care plan for	at to see if there are any to we observed and what the o through the chart look at the s, and start to develop the re plan. When asked about or Resident # 26, RN # 1 d have a care plan for falls. I						
	don't know what ha reviewing and revis "The unit manager when it happened of and I'm not here I we morning meets. W	appened." When asked about sing a care plan RN # 1 stated, would report the fall to me or if it happened late in the day would get the information in the e, the IDT would discuss an n agreement I would add it to						
	the care plan." When purpose of the care	en asked to describe the plan RN # 1 stated, "It gives care the resident receives and						

their preferences of how they want to receive their care, address any risk factors they may have and provides a guideline for the staff." When asked why is it important for the care plan to be

accurate RN # 1 stated, "So the resident receives

the most comprehensive and correct care possible." RN # 1 reviewed the current care plan for Resident # 26 and stated, "I'm unable to find a

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/06/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES		& MEDICAID SERVICES					3 NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	THE RESIDENCE OF STREET AND ADDRESS.		LE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495419	B. WING		<u> </u>		06/29/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE.	ZIP CODE	
COVENA	NT WOODS NURSIN	G HOME		7	7090 COVENANT WOODS DRI	VE	
OOTENA	IN WOODS NOTON			M	MECHANICSVILLE, VA 231	11	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 657	Continued From pa	ne 62	F6	57			
	CONTRACTOR AND CONTRACTOR DO SECREDAR AND AND CONTRACTOR	I don't know what happened."	, 0				
	(administrative staff ASM # 2, director of the above findings.) No further informat (1) CPAP is an airw constant pressure copen. This informat website:	froximately 5:15 p.m., ASM f member) # 1, administrator, if nursing were made aware of ion was provided prior to exit. Yay treatment that applies a of forced air to keep the airway ation was obtained from the gov/ency/imagepages/9685.ht					
	lungs into your bloc obtained from the v	gh oxygen passes from your od. This information was vebsite: n.gov/medlineplus/respiratoryfa					
	(3) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.						
	the esophagus and was obtained from	nts to leak back, or reflux, into liritate it. This information the website: n.gov/medlineplus/gerd.html.					
	causes your breath	a common disorder that ing to stop or get very shallow.					

minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 No. 11		CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		495419	B. WING	i		06/29/2018					
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	1 00.20.20.0					
COVENA	NT WOODS NURSIN	G HOME	3	10000000	ECHANICSVILLE, VA 23111						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION					
F 657	obtained from the whites://www.nlm.nihessure.html. (7) A condition in we enough blood to me failure does not me or is about to stop wheart is not able to It can affect one or information was obhttps://medlineplus (8) A common type information was obhttps://www.nlm.nihrydisease.html. Chelipid) that your body much bad cholester of getting heart disciproblems. The me cholesterol is lipid of hypercholesterolem.	sure. This information was vebsite: a.gov/medlineplus/highbloodpr hich the heart can't pump eet the body's needs. Heart an that your heart has stopped working. It means that your pump blood the way it should. both sides of the heart. This tained from the website: a.gov/heartfailure.html of heart disease. This tained from the website: a.gov/medlineplus/coronaryarte blesterol is a fat (also called a v needs to work properly. Too rol can increase your chance ease, stroke, and other dical term for high blood disorder, hyperlipidemia, or nia. This information was	F	657							
	2. The facility staff comprehensive car	gov/ency/article/000403.htm. failed to review and revise the e plan to address the Resident									
	Resident #32 was a 4/26/17 and readm that included but w anxiety, heart failur. The most recent M significant change.	hospice and hospice care. admitted to the facility on itted on 6/3/18 with diagnoses ere not limited to: dementia, e, asthma and hypertension. DS (minimum data set), a assessment, with an noe date of 6/12/18 coded the									

resident as having scored a six out of 15 on the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100 (0) 1200	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WING	*	06/29/2018	
	PROVIDER OR SUPPLIER	OME	7	STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION	
F 657	brief interview for me resident was severel resident was coded a activities of daily living. Review of the June 2 documented, "Referre 6/6/18." Review of the reside evidence documentate hospice services. An interview was comp.m. with RN (register coordinator. When as plans, RN #1 stated, guideline for their new asked who used the "The healthcare staff the care plan updated there are changes." I would be updated if a services, RN #1 stated that's an advanced dasked to review Resistated, "I do not see should have been do An interview was comp.m. with LON (licens resident's nurse. Whe care plans, LPN #1 s guideline. It's about s and doesn't like." Whe plan, LPN #1 stated, it was important to keep the sident was sident	ental status indicating the ly impaired cognitively. The as requiring assistance for all ng. 2018 physician orders ral: Hospice Order Date: ent's care plan did not ation that the resident was on a care nurse) #1 the MDS sked why residents had care "So that the staff will have a reds and preferences." When care plan, RN #1 stated, F." When asked when was ed, RN #1 stated, "When when asked if the care plan a resident went on hospice ed, "Yes, we have a care plan ident #32's care plan, RN #1 it. I do try to update it that	F 657		28-Jun-18 audit 02-Aug-18 21-Jul-18 s for 10-Aug-18	

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 07/06/2018

CENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) D	ATE SURVEY			
		495419	B. WING		0	6/29/2018			
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		0,20,20,0			
COVENA	NT WOODS NUBSIN	CHOME		7090 COVENANT WOODS DRIVE					
COVENA	NT WOODS NURSIN	IG HOME		STREET ADDRESS. CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111 PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE BE APPROPRIATE	COMPLETION			
F 657	Continued From pa	age 65	F 6	57					
	member) #1, the addirector of nursing findings. Review of the facili PLANNING" documplan of care to mean needs shall be devitiventy-four (24) ho individualized compincludes measurable meet the resident's psychosocial needs resident. Procedure Planning/Interdiscipthe review and upd	p.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the ty's policy titled, "CARE nented, "Policy: A preliminary et the resident's immediate eloped for each resident within urs of admission. An orehensive care plan that the objectives and timetables to medical, nursing, mental and is is developed for each es: 8) The care plinary Team is responsible for lating of care plans: a) When ignificant change in the	ı.						
	resident's condition No further informat	i" ion was provide prior to exit.							
	Williams and Wilkin documented, "A wr communication too members that help careThe nursing information about t and goals. It conta achieving the goals and is used to direct revise and update to	amentals of Nursing Lippincott ns 2007 pages 65-77 itten care plan serves as a all among health care teams sensure continuity of care plan is a vital source of he patient's problems, needs, ains detailed instructions for sestablished for the patient of careexpect to review, the care plan regularly, when in condition, treatments, and (1)							

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO.	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495419	B. WING	<u> </u>		06/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER		·	STF	REET ADDRESS, CITY, STATE, ZIP CODE		0.0
0015114	NT 140000 NUIDON	O HOME		709	00 COVENANT WOODS DRIVE		
COVENA	NT WOODS NURSIN	G NOME	86 350,000	ME	CHANICSVILLE, VA 23111		
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	Continued From page 66 pages 65-77.			657			
	The same of the sa	Meet Professional Standards 3)(i)	F	658			
	The services provided as outlined by the commustive (i) Meet profession. This REQUIREME by: Based on staff interview, and clinical failed to follow proffor one of 32 resident #32. The facility staff fail Resident #32's oxy. The findings include Resident #32 was 4/26/17 with diagnolimited to anxiety dispersion.	e: admitted to the facility on oses that included but were not isorder, heart failure, high					
	chronic kidney dise recent MDS (minin a significant chang (assessment refere Resident #32 was impaired in cognitive possible 15 on the Mental Status) exa as requiring extens persons with bed re	ronic respiratory failure and case. Resident #32's most num data set) assessment was to assessment with an ARD ence date) of 6/12/18. coded as being severely by function scoring 06 out of BIMS (Brief Interview for am. Resident #32 was coded sive assistance from two plus nobility, and toileting; extensive the person with transfers, eating					v

and personal hygiene; and total dependence on

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	9	495419	B. WING		06/29/2018	
	ROVIDER OR SUPPLIER	ЭМЕ	70	TREET ADDRESS, CITY, STATE, ZIP CODE 090 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111	VW 26120 10	
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION	
F 658	staff with bathing. Resection O (Special tree Programs) as receiving Review of Resident # (physician order suming following order: "Continuated Continuation order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was initiated on the order was set at 11:30 and was set at 3 and 3/4 I on 6/27/18 at 12:58 pmade of Resident #32 was set at 3 and 3/4 I on 6/28/18 at 3:37 p. made of Resident #32 was set at 4 liters of the order: "Oxygen-continuation recording order: "Oxygen-continuation order: "Oxygen-continuatio	esident #32 was coded in eatments, Procedures, and ing Hospice Services. #32's June 2018 POS mary) documented the tinuous 02 (oxygen) via itrate up to 5 liters PRN (as ortness of breath)." This in 6/3/18. ##32's June 2018 POS mary) documented the tinuous 02 (oxygen) via itrate up to 5 liters PRN (as ortness of breath)." This in 6/3/18. ##32's June TAR (treatment of liters of oxygen. ##32's oxygen saturation.	F 658	F 658 1. Resident #32 experienced no adverse effects. 2. MD/NP notified for need of clarification of order for oxyge administration. 3. Order clarified and parameters added. 4. Nursing staff education address following MD orders and importance of documenting rea which validate MD order. 5. Review of residents file for 3 residents /week involving MD orders and documentation which support MD order x 4 weeks. 6. Random audits will be conduct DON/Designee for clarification MD order and supporting documentation.	28-Jun-18 sing 20-Jul-18 asons 10-Aug-18 ch ted by Ongoing	
	oxygen Resident #32 oxygen saturation wa	ce to show the exact liters of was receiving while her so obtained and documented.				

PRINTED: 07/06/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						O		APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		STRUCTION	Oi	(X3) DAT	E SURVEY MPLETED
		495419	B. WING				06/	/29/2018
	ROVIDER OR SUPPLIER	G НОМЕ		7090 CC	ADDRESS, CITY, STATE, ZI DVENANT WOODS DRIVI ANICSVILLE, VA 2311	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 658	intervention: "6/3/18 (medical doctor) or one of the conducted with LPN When asked what the meant, LPN #5 states to be clarified becahow many liters of an and there was a titrate her oxygen. should have documented if oxygen saturely level to titrate. On 6/29/18 at 1:00 conducted with LPN When asked how reliters to start Residence oxygen to 5 liters should be clarified.	mented the following administer oxygen per MD ders." It p.m., an interview was N (licensed practical nurse) #5. The above oxygen order needed use there was indication of oxygen to start Resident #32 also no parameters on when to LPN #5 stated that the order nented "titrate as needed" and rations were below a certain p.m., an interview was N #4, Resident #32's nurse. The nursing would know how many ent #32 on, and when to titrate rs, LPN #4 stated, "The order"	F	658				
ı	Nursing) were mad concerns. ASM #2 policies and/or Lipp standard.	ASM #2, the DON (Director of le aware of the above stated the facility used their bincott as a professional						
	Services," docume new medication or physician's order s	tled, "Pharmaceutical nts in part, the following: "All ders shall be transcribed on the heet or the telephone order aking the order from a person						

Name of resident Name of physician

on the order must include:

lawfully authorized to prescribe. The information



PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

OFILE	O I ON MILDIONIL	A MEDICAID OF LANGES			CIVID	140. 0800-0081
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	12	ILTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
37000 110		495419	B. WING	3		06/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	-
COVENA	NT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EX (EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION E DATE
F 658	Continued From pa	nge 69	F	658		*
	Name of the medica Strength of medica Dosage RouteThe license	ation tion ed nurse will read the order. If ar to the nurse, the physician				
	documents in part, Verify that there is a procedure. Review facility protocol for Adjust the oxygen of comfortable for the of oxygen is being completing oxygen following information	tled, "Oxygen Administration," the following: "Preparation: 1. a physician's order for this of the physician's order or oxygen administration10. delivery device so that it is resident and the proper flow administeredAfter set up or adjustment, the on should be recorded in the record:3. The rate of oxygen onale."				
	No further informat Quality of Care CFR(s): 483.25	ion was obtained prior to exit.	F	684		
	applies to all treatment facility residents. Be assessment of a restrict that residents received accordance with proportice, the comportance plan, and the This REQUIREMENT by: Based on observative record review, and	fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ive treatment and care in refessional standards of rehensive person-centered				

Facility ID: VA0416

STATEMENT	OF DEFICIENCIES	1			OWB M	<u>O. 0938-0391</u>
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3	CONSTRUCTION		E SURVEY
	<u> </u>	495419	B. WING		0.0	3/29/2018
	ROVIDER OR SUPPLIER NT WOODS NURSING H	OME	7	TREET ADDRESS, CITY, STATE, ZIP CODE 090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	<u></u>	7. E. G.
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	residents received traccordance with propractice and the comcare plan for 1 of 10 administration task, law the facility staff faile physician's orders for medication. The findings include: Resident #12 was ac 1/16/18 with the diag asthma, diabetes, ce blood pressure, chroinsomnia, peripheral cervicalgia, depressi artificial knee, hypothmacular degeneratio (Minimum Data Set) with an ARD (Assessing the second or s	eatment and services in fessional standards of inprehensive person-centered residents in the medication Resident #12 do to follow Resident #12's in the administration of a finitted to the facility on inoses of but not limited to diac disease, obesity, high nic kidney disease, stroke,	F 684	F 684 1. Resident #12 suffered no ad effects. 2. Nurse #2 was counselled an reviewed for medication past the rights for medication administration. 3. All staff educated on rights medication administration. 4. Medication administration observation will be conducted DON/Designee 3x/week for then random medication administration observations continue.	d policy s and of ed by 4 weeks	29-Jun-18 17-Jul-18 10-Aug-18
	decisions. The residextensive care for bathygiene and dressing eating, and toileting; and bladder. On 6/27/18 at 4:36 p Practical Nurse) was administering the foll Resident #12:	g, 1 tab				

PRINTED: 07/09/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID 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 _ 495419 06/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE **COVENANT WOODS NURSING HOME** MECHANICSVILLE, VA 23111 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 684 Continued From page 71 F 684 Humalog (5) 6 units On 6/28/18 12:26 p.m. the physician's orders were reviewed for accuracy. The following order A physician's order for Omeprazole (6), dated 1//16/18 documented, "Omeprazole 40 mg capsule, two times daily." A review of the MAR (Medication Administration Record) revealed that this medication was signed out as having been given on 6/27/18 at 4:51 p.m., the same time the other medications listed above were also signed out as having been administered. However, the Omeprazole was not given. A review of the care plan revealed one dated 1/29/18 for "Resident has expressed/demonstrated pain/discomfort related to: ...GERD (gastroesophageal reflux disease)." This care plan included the intervention (undated) for "Administer medication as prescribed by the physician." On 6/28/18 3:27 in an interview with LPN #2 (Licensed Practical Nurse) she stated that she gave whatever meds (medications) were left in the bag for Resident #12 for that day, except for one bedtime medication as it was too early to

A review of the facility policy, "Drug

I can't remember."

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

administer it. LPN #2 could not recall whether or not the Omeprazole was included. LPN #2 stated, "I don't know, maybe I didn't give it to her,

Administration" documented, "Medications are administered in accordance with written orders of

PRINTED: 07/09/2018

particular state of the state o		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495419	B. WING_		06/29/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
COVENA	NT WOODS NURSING H	OME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE COMPLETION
F 684	Continued From pag	e 72	E 4	68 4	
, 55,	of practice."	5 12	1.30	004	
	Administrator (ASM a	kimately 6:00 PM, the #1 - Administrative Staff rector of Nursing (ASM #2) the findings.			а
	No further informatio	n was provided.	## F		
	References:				
	conditions where the acid. Information obtained	treat ulcers, reflux, and stomach produces too much from lov/druginfo/meds/a687011.ht			
	Information obtained	o treat muscle spasms. from jov/druginfo/meds/a682530.h			
	by asthma. Information obtained	ed to treat symptoms caused from jov/druginfo/meds/a600014.h		× •	
	{4} Lomotil - used to Information obtained https://medlineplus.g tml				
	(5) Humalog - used to Information obtained https://medlineolus.com				

tml

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	187	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495419	B. WING		0	6/29/2018	
	ROVIDER OR SUPPLIER	PME		STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		012912010	
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE	
A. BOSESSER	(ii) A resident who is receives appropriate to	d to treat reflux from ov/druginfo/meds/a693050.h inence, Catheter, UTI (3) nce. cility must ensure that ent of bladder and bowel on ervices and assistance to unless his or her clinical es such that continence is ain. sident with urinary on the resident's esment, the facility must ers the facility without an not catheterized unless the dition demonstrates that eccessary; eres the facility with an subsequently receives one or a resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore	F 69	84	control catheter	29-Jun-18 10-Aug-18 10-Aug-18	
	in the common state of the constitution of the						

PRINTED: 07/09/2018 FORM APPROVED

	OT ON INCOMME	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
2000		495419	B. WING_		06/29/2018
NAME OF P	ROVIDER OR SUPPLIER		And Care	STREET ADDRESS, CITY, STATE, ZIP COD	
COVENAN	IT WOODS NURSING H	OME	1	7090 COVENANT WOODS DRIVE	
		autorianismo		MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 690	Continued From page	- 74	F	590	e
	stated as becausing analysis account as	treatment and services to	V-0	550	
	restore as much nom possible.		ī		
	38/L	is not met as evidenced			
		n, staff interview, facility			ij.
		d clinical record review it acility staff failed to provide			
		prevent infections for the	H H		c
	use of an indwelling t	urinary catheter for one of 28 by sample, Resident #25.			
		d to ensure Resident #25's and tubing were free from			
	The findings include:			n.	
	4/30/15 with diagnost to: heart failure, demonstrate, (an enla prostate) (1), urinary	retention (the inability to impletely) (2), high blood			
	assessment, a signifi- with an ARD (assess 5/29/18, coded the re- the BIMS (brief inter- indicating that he wai interview. Resident and long term memo moderate impairmen Resident #25 was co	S (minimum data set) cant change assessment, ment reference date) of esident as scoring a 99 on view for mental status) exam, s unable to complete the #25 was coded for both short ry impairment, as well as t of daily decision making, ided as requiring extensive or more person physical			

assistance for bed mobility, transfers, toileting,

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE	& MEDICAID SERVICES)MB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AN IMPED		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495419	B. WING		06/29/2018	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
COVENAN	F WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION	
-					W.W.	

F 690 Continued From page 75

personal hygiene, bathing and dressing. In Section H - Bladder and Bowel, the resident was coded as having an indwelling catheter during the look back period.

On 6/27/18 at 3:08 p.m., Resident #25 was observed sitting up in his bed. A urinary catheter bag, (a bag that is attached to tubing that is used to drain the urine from the bladder) (3), was observed directly on the floor.

On 06/28/18 at 11:55 a.m., Resident #25's urinary catheter bag was observed directly on the floor. During this observation period, LPN (licensed practical nurse) #4 entered the room and changed Resident #25's cover sheet. The urinary catheter bag remained directly on the floor.

On 06/28/18 at 12:02 p.m., CNA (certified nursing assistant) #7 entered Resident #25's room. CNA #7 observed the urinary catheter bag on floor. During an interview at that time, CNA #7 stated the urinary catheter bag, should be suspended off the floor. When asked why, she stated, "To decrease contamination." CNA #7 then placed the urinary catheter bag in a privacy bag and suspended the bag off the floor.

On 06/28/18 at 3:27 p.m., Resident #25's urinary catheter bag (within the privacy bag) was observed on the floor.

On 06/28/18 at 3:40 p.m., an interview was conducted with LPN #1. When asked how staff cares for a urinary catheter bag, LPN #1 stated the bag should hang lower than the bladder and the catheter tubing should be without kinks. When asked if a urinary catheter bag can touch or sit on the floor, LPN #1 stated, "No, it should

F 690

Facility ID: VA0416

PRINTED: 07/06/2018 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			10	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	6.1 CHO (6.00 MODEL	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495419	B. WING			06/29/2018
	PROVIDER OR SUPPLIER	G HOME		STREET ADDRESS, CITY, STATE, Z 7090 COVENANT WOODS DRIV MECHANICSVILLE, VA 2311	/E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPR	BE COMPLÉTION
F 690	catheter bag could privacy bag, LPN # why the urinary cath floor, LPN #1 said is and become an inferwas asked to obsercatheter bag, LPN is was touching the floon gloves and report bag to ensure that is A review of the physical documented in partical catheter tubingcatheter tubingcatheter tubing urretention that cannot medically or surgical of this problem it is and/or maintain accPosition in a man (when the urine flow or tubing into the bloom of 128/18 at 4:50 staff member) #2, the informed of the above concerns the sale of the above concerns the sale of the sale of the above concerns the sale of the sale of the above concerns the sale of the sale of the sale of the above concerns the sale of t	or." When asked if the urinary sit on the floor if it is in a 1 stated, "No". When asked neter bag should not be on the could become contaminated ection control risk. LPN #1 exe Resident #25's urinary #1 observed the catheter bag foor. LPN #1 proceeded to put sitioned the urinary catheter that was no longer on the floor. Sician's orders dated 4/20/18 exitioned the urinary catheter that was no longer on the floor. Sician's orders dated 4/20/18 exitioned the urinary catheter: change atheter bag once monthly." In prehensive care plan dated at recent revision on 6/13/18, exiting the process in the treated or corrected ally." In the approach section documented in part, "Insert cording to physician order ner to minimize "back flow", was back from the drainage bag adder) (4)." p.m., ASM (administrative he director of nursing, was ove findings. p.m., ASM #1, the aSM #2 were made aware of	F	690		

Facility ID: VA0416

their standards of practice were based on in part, Lippincott Manual of Nursing Practice and the

PRINTED: 07/06/2018 FORM APPROVED

OLIVIL	TO FOR MEDICANE	. a MEDICAID SERVICES		<u> </u>		MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 20 No	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495419	B. WING			06/29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
COVENA	NT WOODS NURSIN	G HOME		7090 COVENANT WOOD		
100/04/04/05/07 50009	010000000		1000	MECHANICSVILLE, VA	The second secon	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD CED TO THE APPROPMINICIENCY)	BE COMPLETION
F 690	Continued From pa	ge 77	Fi	§90		
	facility's policies an	(70)				
	No further informat	on was provided prior to exit.				
	Practice, Eighth Ed and Urinary Disorde Closed Urinary Dra (urinary tract infecti acquired organisms cross-contaminatio off the floor to prevent 1) This information National Institutes of https://medlineplus. 2) This information National Institutes of https://www.niddk.rogic-diseases/urina 3) This information National Institutes of https://medlineplus.00142.htm 4) This information National Institutes of https://medlineplus.outlinear.	n. 2. c. Keep the drainage bagent bacterial contamination". was obtained from the of Health at gov/ency/article/000381.htm was obtained from the of Health at hih.gov/health-information/urolary-retention was obtained from the of Health at gov/ency/patientinstructions/0 was obtained from the of Health at gov/ency/patientinstructions/0 was obtained from the of Health at gov/ency/article/003981.htm ostomy Care and Suctioning	F	695		
	tracheostomy care The facility must er needs respiratory c care and tracheal s care, consistent wit practice, the complete	and tracheal suctioning. asure that a resident who hare, including tracheostomy suctioning, is provided such the professional standards of the rehensive person-centered lents' goals and preferences,				

Facility ID: VA0416

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	AMERICAN CONTRACTOR AND CONTRACTOR	E CONSTRUCTION	(X3) D/	NO. 0938-0391 NTE SURVEY MPLETED
		495419	B. WING			06/29/2018
	ROVIDER OR SUPPLIER T WOODS NURSING H	DME		STREET ADDRESS, CITY, STATE, ZIP COE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 695	and 483.65 of this sur This REQUIREMENT by: Based on observation record review, it was staff failed to provide with professional star comprehensive person of 28 residents in the 26 and # 5. 1. The facility staff faze's oxygen accordinand failed to store the airway pressure) mass. The facility staff fanebulizer mask in a sur The findings include: 1. The facility staff fanebulizer mask in a sur The findings include: 1. The facility staff faze's oxygen accordinand failed to store the airway pressure) mass. Resident # 26 was an an an an an an an an an an an an an	bpart. is not met as evidenced in, staff interview and clinical determined that the facility respiratory care, consistent indards of practice, and the on-centered care plan for two survey sample, Resident # giled to administer Resident # g to the physician's orders a C-PAP (continuous positive sk in a sanitary manner. illed to store Resident # 5's fanitary manner. illed to administer Resident # g to the physician's orders and the physician's orders a C-PAP (continuous positive sk in a sanitary manner. difficult to the physician's orders a C-PAP (continuous positive sk in a sanitary manner. difficult to the facility on ses that included but were sillure, respiratory failure (1), gastroesophageal reflux inea (4), hypertension (5), are (6), coronary artery artipidemia (8).	F 695	1. Residents #26 and #5 effects. 2. CPAP masks cleaned into a storage bag. Na discarded and new tub dated and placed into 3. Education with nursin proper care of oxygen and correct infection of 4. Audit of all residents of proper storage of oxygen 5. DON/Designee will convery week for 4 week monthly.	and placed usal cannola usal cannola usal cannola astorage bag. g staff on equipment control. on oxygen for gen equipment. onduct audits	29-Jun-18 29-Jun-18 10-Aug-18 10-Aug-18

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

<u> </u>		THE GUILDIONID SERVICES			OIVID I 10	<u>. 0930-</u> 039
	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		00.00 TOOL 50	TE SURVEY MPLETED		
		495419	B. WING _		06	/29/2018
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, Z	DA DESCRIPTION	
COVENAN	T WOODS NURS	SING HOME		7090 COVENANT WOODS DRIVI MECHANICSVILLE, VA 2311		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE

F 695 Continued From page 79

- 15, 10 - being moderately impaired of cognition for making daily decisions. Resident # 26 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 26 was coded for "C. Oxygen therapy" and "G. BiPAP/CPAP."

An observation on 06/27/18 at approximately 11:01 a.m., revealed Resident # 26 was sitting in her wheelchair receiving oxygen (O2) by nasal cannula from an oxygen concentrator. Observation of O2 of the flow meter on the oxygen concentrator revealed the oxygen flow rate at two and a half liters. Further observation of Resident # 26's room revealed a C-PAP (1) mask on table next to the bed uncovered.

An observation on 06/27/18 at approximately 02:10 p.m. revealed Resident # 26 was sitting in her wheelchair receiving oxygen (O2) by nasal cannula from an oxygen concentrator.

Observation of O2 of the flow meter on the oxygen concentrator revealed the oxygen flow rate at two and a half liters. Further observation of Resident # 26's room revealed a C-PAP mask on table next to the bed uncovered.

An observation on 06/27/18 at approximately 05:03 p.m. revealed Resident # 26 was sitting in her wheelchair receiving oxygen (O2) by nasal cannula from an oxygen concentrator. Observation of O2 of the flow meter on the oxygen concentrator revealed the oxygen flow rate at two and a half liters. Further observation of Resident # 26's room revealed a C-PAP mask on table next to the bed uncovered.

F 695

PRINTED: 07/06/2018 EODM ADDDOVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ne	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING	***	06/29/2018
NAME OF F	PROVIDER OR SUPPLIER	2 3.0.00 s	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
COVENA	NT WOODS NURSIN	G HOME	209-0	090 COVENANT WOODS DRIVE RECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 695	Continued From pa	ige 80	F 695		
	08:33 a.m., reveale	06/28/18 at approximately ed Resident # 26's C-PAP to the bed uncovered.			
	a.m., a nurse enter exchanged the port back of her wheelchair recannula from an ox Observation of the concentrator reveal between two and a observation of Resingle C-PAP mask on taken	flow meter on the oxygen led the oxygen flow rate half and three liters. Further ident # 26's room revealed a ble next to the bed uncovered.			
	June 2018 docume	ders for Resident # 26 dated ented, ""Oxygen. Continuous ee) L/min (liters per minute) Date: 02/08/2018."			
		re airway pressure (CPAP). sleeping and remove when e: 11/22/2017."			
	record) dated June documented, ""Oxy	nic treatment administration 2018 for Resident # 26 ygen. Continuous O2 (oxygen) ers per minute) humidified. 2018."			
	Further review of the	he TEAR documented			

Resident # 26 received oxygen on 06/01/18 through 06/28/18 by nasal cannula from the oxygen concentrator at three liters per minute."

Apply C-pap when sleeping and remove when awake. Order date: 11/22/2017." Further review

"Continuous positive airway pressure (CPAP).

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495419	B. WING			06	/29/2018
	PROVIDER OR SUPPLIER	G HOME		709	REET ADDRESS. CITY, STATE, ZIP CODE 90 COVENANT WOODS DRIVE ECHANICSVILLE, VA 23111		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	C-PAP mask each 06/28/18. The comprehensive dated 12/04/17 with documented, "Prob	nented Resident # 26 used the evening from 06/01/18 through e care plan for Resident # 26 n a review date of 03/13/18 elem/Concern. Resident is at	F 6	i95		n	
	congestive heart fa and hyperlipidemia documented, "Adm TAR." ""Problem/Concern difficulty in breathin CHF (congestive heart)	cardiac output related to: ilure, coronary artery disease ." Under "Approach" it inister oxygen per order, see Resident has potential for ig related to respiratory failure, eart failure and sleep apnea." it documented, "Administer see TAR."					
	interview was cond practical nurse) # 1 resident's oxygen f stated, "Normally e and every shift." Won the oxygen constated, "The liter lir of the ball. You get the meter. When a check a resident's stated, "It could be changed so it's not oxygen rate could out or die or be in was asked to read Resident # 26's oxentered Resident #	croximately 1:17 p.m., an ucted with LON (licensed . When asked how often a low rate checked, LPN # 1 exery time I go into the room /hen asked how the flow rate centrator is read, LPN # 1 expasses through the middle down and get eye level with asked why it is important to oxygen flow rate, LPN # 1 turned off, or accidently at the correct rate or their get to low and they could pass respiratory distress." LPN # 1 the oxygen flow rate on ygen concentrator. LPN # 1 # 26's room, walked over to your concentrator.					

down in front of the oxygen concentrator to eye level with the flow meter and stated, "It's at three

PRINTED: 07/06/2018

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OI	FORM APPROVE MB NO. 0938-039	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	70	495419	B. WING				06/29/2018	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP	CODE		_
COVENA	ANT WOODS NURSIN	G HOME			090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111			
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE COMPLETIO	N
F 695	Resident # 26 oxyg 06/28/18 being at le minute, LPN # state have been checked C-PAP mask on the bed and stated, "It sasked to describe t C-PAP mask when "The C-PAP mask cover stated, "To keep it s in them and the residuring their treatme infection." On 06/28/18 at app (administrative staff ASM # 2, director of the above findings. No further informat References: (1) CPAP is an airw constant pressure copen. This informat website: https://medlineplus m.	med of the observations of ten flow rate on 06/27/18 and tess than three liters per ed the oxygen flow rate should d. LPN # 1 observed the etable next to Resident # 26's should be in a bag." When he procedure for storing a not in use, LPN # 1 stated, should go in a bag when not in why is it important to keep the ed when not in use, LPN # 1 sanitary. They could have dust sident could breathe the dust in ent causing coughing, or proximately 5:15 p.m., ASM of member) # 1, administrator, of nursing were made aware of	F6	695				
	obtained from the							

ilure.html.

https://www.nlm.nih.gov/medlineplus/respiratoryfa

(3) A chronic disease in which the body cannot

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CEIAIE	19 LOK MIEDICAKE	A MIEDICAID SERVICES	100		OMB NO	<i>J.</i> 0938 -0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
4 1		495419	B. WING		06	5/29/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
COVENA	NT WOODS NUDSIN	0 H045		7090 COVENANT WOODS DRIVE			
COVENA	NT WOODS NURSIN	G HOME		MECHANICSVILLE, VA 23111			
(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 X (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 695	Continued From pa	nge 83	F6	95			
, 550	regulate the amour information was ob	nt of sugar in the blood. This tained from the website: n.gov/medlineplus/ency/article/	r 0	33			
	(4) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.						
	(5) Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html			·			
	obtained from the v	sure. This information was vebsite: n.gov/medlineplus/highbloodpr					
	enough blood to me failure does not me or is about to stop theart is not able to It can affect one or information was ob	hich the heart can't pump eet the body's needs. Heart ean that your heart has stopped working. It means that your pump blood the way it should. both sides of the heart. This tained from the website: .gov/heartfailure.html					
	information was ob	of heart disease. This tained from the website: n.gov/medlineplus/coronaryarte					
		fat (also called a lipid) that work properly. Too much bad					

cholesterol can increase your chance of getting

PRINTED: 07/06/2018 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OI	MB NO. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495419	B. WING			06/29/2018
	PROVIDER OR SUPPLIER	G НОМЕ		STREET ADDRESS, CITY, STATE, 2 7090 COVENANT WOODS DRIV MECHANICSVILLE, VA 2311	/E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE COMPLETION
F 695	medical term for high disorder, hyperlipided This information was https://medlineplus. 2. The facility staff nebulizer mask in a Resident # 5 was an 09/25/17 with diagram not limited to chronic disease (2), dysphaland chronic kidney. Resident # 5's mosset), a quarterly asset, a quarterly asset (assessment reference Resident # 5 as socinterview for mentalistic on the staff member for the section "O. Sand Programs" Resident # 5 as socinterview for mentalistic one staff member for Under section "O. Sand Programs" Resident # 5 as socinterview for mentalistic one staff member for the section "O. Sand Programs" Resident # 11:11 a mask on bedside tall was not in her room. On observation of for observation observation of for observation of for observation of for observation of for observation observation of for observation observation of for observation observation observation observation observation observation observation observation observation observation observation observation observation observation observation observatio	de, and other problems. The gh blood cholesterol is lipid emia, or hypercholesterolemia. It is obtained from the website: gov/ency/article/000403.htm. failed to store Resident # 5's a sanitary manner. dmitted to the facility on loses that included but were ic obstructive pulmonary logia (3), atrial fibrillation (4) disease (5). It recent MDS (minimum data sessment with an ARD ence date) of 04/04/18, coded foring a 3 (three) on the brief I status (BIMS) of a score of 0 log severely impaired of godily decisions. Resident # quiring limited assistance of or activities of daily living. Special Treatment, Procedures sident # 5 was coded for "C. Resident # 5's room on .m., revealed a nebulizer able uncovered. Resident # 5	F 6	95		

Event ID: C1RQ11

On observation of Resident # 5's room on

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/09/2018 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	1901		OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
NAME OF P	ROVIDER OR SUPPLIER	Scott State Con-	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	Section of the sectio
COVENAN	IT WOODS NURSING H	OME	200 00000	COVENANT WOODS DRIVE	
				CHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 695	Continued From page	e 85	F 695		
	06/27/18 05:01 p.m.,	revealed a nebulizer mask overed. Resident # 5 was			
	06/28/18 08:29 a.m.,	esident # 5's room on revealed a nebulizer mask overed. Resident # 5 was			
	in the room with her	esident # 5's room on revealed Resident # 5 was husband watching television. was lying on the floor next to			
	June 2018 document	rs for Resident # 5's dated ted, "Ipratropium-albuterol nebulization. Four times /25/2017."			ब
	record) dated June 2 documented, "Ipratro (milliliter) nebulizatio date: 10/25/2017." F documented Resider	ic medication administration (018 for Resident # 5 opium-albuterol 3(three) ml n. Four times daily. Order orther review of the EMAR of the 18 opium (18 opium) from 06/01/18 through	e e		
	interview was condu- practical nurse) # 1. nebulizer mask in Re- bedside table and st When asked to desc	oximately 1:17 p.m., an octed with LPN (licensed LPN # 1 observed the esident # 5's room on the ated, "It should be in a bag." ribe the procedure for storing then not in use, LON # 1	a a		

stated, "The nebulizer mask should go in a bag when not in use." When asked why is it important to keep the nebulizer mask covered when not in

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		495419	B. WING			06/21	9/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
COVENAN	NT WOODS NURSING H	OME		7090 C	COVENANT WOODS DRIVE		
OOTENAN		OME		MECH	HANICSVILLE, VA 23111		13
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From pag	e 86	, Ft	695			
	e avenue ser a	"To keep it sanitary. They		101			
		em and the resident could					
	breathe the dust in d		10				
	coughing, or infection						
	On 06/28/18 at appro	oximately 5:15 p.m., SAM					
	AND AND AND AND AND AND AND AND AND AND	member) # 1, administrator,					
		nursing were made aware of					
	the above findings.					10	
	No further informatio	n was provided prior to exit.		710			
	References:					10	
		of albuterol and ipratropium					
	is used to prevent wi	heezing, difficulty breathing,					
	remarkation and the contract of the contract o	coughing in people with		100		98	
	18 L 25	oulmonary disease (COPD; a at affect the lungs and					
	(1974) 1974	ronic bronchitis (swelling of					
	71 51	t lead to the lungs) and					
	-	ge to the air sacs in the					
	Transfer and a series of the second of the s	ipratropium combination is					
	A CONTRACT OF STREET STREET STREET STREET STREET STREET STREET STREET STREET STREET STREET STREET STREET STREET	se symptoms have not been					
		e inhaled medication. pium are in a class of					
	***	pronchodilators. Albuterol and				8	
		ition works by relaxing and					
		ages to the lungs to make		101		69	
		nis information was obtained					
	from the website: https://medlineplus.g						
	tml.	yo a. agiinoiiii adalaa oo i oo diii					
	(2) Disease that mal	kes it difficult to breath that					
		ss of breath). This information				10	
	was obtained from the						
í	nttps://www.nlm.nih.	.gov/medlineplus/copd.html.					

(3) A swallowing disorder. This information was

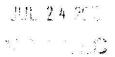
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		496419	B. WING _			06/29/2018
50 2504 (Herekat violates) - 1,004	ROVIDER OR SUPPLIER	OME		7090 C	T ADDRESS, CITY, STATE, ZIP CODE COVENANT WOODS DRIVE MANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	5 P	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION
F 695	Continued From page		F 6	95		
	obtained from the we https://www.nlm.nih.g sorders.html.	ebsite: gov/medlineplus/swallowingdi				
	heartbeat. This informathe website:	e speed or rhythm of the mation was obtained from gov/medlineplus/atrialfibrillati		ii s		Þ
	(5) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.htm			n		
	Label/Store Drugs an CFR(s): 483.45(g)(h)		F 7	61		
	Drugs and biologicals	y and cautionary	I			9
	§483.45(h) Storage of	of Drugs and Biologicals				1
7.00	Federal laws, the faci biologicals in locked	ordance with State and illity must store all drugs and compartments under proper , and permit only authorized coess to the keys.				
	locked, permanently storage of controlled	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and		.5 20 30		# \$ *

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
area estas		495419	B. WING _			06.	/29/2018	
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	7090 CC	ADDRESS, CITY, STATE, ZIP CODE OVENANT WOODS DRIVE ANICSVILLE, VA 23111 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N BE	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	dATE	DATE	
F 761	abuse, except when package drug distribing quantity stored is mindered by the readily detected. This REQUIREMEN' by: Based on observation document review, the and secure medication for one of one medication room. The facility staff failed vial of Tuberculin solumedication room. The findings include: On 6/28/18 at 8:30 a medication room on conducted with LPN A vial of Tuberculin Swith no open date lated the vial was more the expiration date documentered vial should be LPN #1 confirmed the the vial. LPN #1 stated when the vial was opnurses are supposed medications/biological On 6/28/18 at 1:00 p	and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can It is not met as evidenced on, staff interview, and facility a facility staff failed to store ons in an appropriate manner ation rooms. If to label the open date of a ution in one of one If the nursing unit was (licensed practical nurse) #1. Solution was found opened on the vial or the box, an halfway full. The mented the vial was "10/19." and there was no open date on the discarded after 30 days." at there was no open date on the discarded that she was not sure the ened. LPN #1 stated that the label als when opened. If it is not met as sevidenced in the state of the facility and the state of the facility and the state of the facility and the state of the facility and the facilit	F 7	1.	replacement ordered. Nursing staff will be educated policy regarding medication s DON/Designee will perform a room audits for proper medications storage and proper date.	d a l on torage. med ation	29-Jun-18 29-Jun-18 10-Aug-18 10-Aug-18	
	The vial also docume entered vial should b LPN #1 confirmed the the vial. LPN #1 state when the vial was opnurses are supposed medications/biological On 6/28/18 at 1:00 p staff member) #1, the was made aware of the state of th	ented the following: "Once e discarded after 30 days." at there was no open date on ed that she was not sure ened. LPN #1 stated that I to label als when opened. .m., ASM (administrative e DON (Director of Nursing)						

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

OLIVILI	C I OIT MEDIO TILE	A MEDIONID OF MOLO			CIVID	10. 0930-039 I	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495419	B. WING			06/29/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	***	
COVENA	NT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111			
20015	CUMMADV CTA	TEMENT OF DESIGNATION		NOW AND SINCE THE PROPERTY OF THE WORLD AND THE PROPERTY OF THE WORLD AND THE PROPERTY OF THE	DDECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE	(X5) COMPLETION DATE	
F 761	Continued From pa	ge 89	F 7	'61			
	Solution documente Vials in use more the discarded due to pe	ed the following: "Storage: nan 30 days should be ossible oxidation and may affect potency."	* 344				
	documents in part, pharmacy, when re vaccines, will store with the manufactu	tled, "Medication Storage," the following: "1. The ceiving biological and the preparation in accordance rer's recommendations to se of potency and ensure nts."					
	No further informat Facility Assessmen CFR(s): 483.70(e)(F 8	38			
	facility-wide assess resources are necessources are necessources are necessources are necessources. Update that assess least annually. The update this assess facility plans for, an substantial modification.	ment to determine what essary to care for its residents both day-to-day operations. The facility must review and ment, as necessary, and at facility must also review and ment whenever there is, or the y change that would require a action to any part of this acility assessment must			Ÿ		
	including, but not lin (i) Both the number resident capacity; (ii) The care require	facility's resident population, mited to, of residents and the facility's ed by the resident population es of diseases, conditions					

physical and cognitive disabilities, overall acuity,



PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION	(X3) DATE SURVEY COMPLETED		
		495419	B. WING	11,300	·	0	6/29/2018	
	ROVIDER OR SUPPLIER IT WOODS NURSING H	OME		7090 C	T ADDRESS, CITY, STATE, ZIP CODE COVENANT WOODS DRIVE IANICSVILLE, VA 23111			
(X4) ID PREFIX TAG	(EACH DEFICIENC	AYEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(=	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOTCH CORRECTIVE ACTION SHOTCH CROSS-REFERENCED TO THE APPROPRIES.	OULD BE	(X5) COMPLETION DATE	
F 838	Continued From pag	e 90	F	338				
	that population; (iii) The staff compet provide the level and resident population; (iv) The physical env services, and other p that are necessary to (v) Any ethnic, cultur may potentially affect	ects that are present within encies that are necessary to types of care needed for the ironment, equipment, thysical plant considerations o care for this population; and al, or religious factors that t the care provided by the t not limited to, activities and rvices.	2 2	es est				
	but not limited to, (i) All buildings and/o and vehicles; (ii) Equipment (medic	cility's resources, including or other physical structures cal and non-medical); d, such as physical therapy,		ŧ				
	pharmacy, and spec (iv) All personnel, ind employees and those contract), and volunt	ific rehabilitation therapies; cluding managers, staff (both e who provide services under eers, as well as their ning and any competencies		8				
	or other agreements services or equipme normal operations at (vi) Health information such as systems for	randums of understanding, with third parties to provide int to the facility during both and emergencies; and on technology resources, electronically managing electronically sharing	e	2				
	all-hazards approach	sk assessment, utilizing an		Œ			20	

by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495419	B. WING		06	/29/2018
	ROVIDER OR SUPPLIER	OME	7			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 838 F 880 SS=F	Based on staff interview, it was determ failed to develop a control of the facility assessment, utilizing the findings include: Review of the facility evidence of a facility-community-based rising all-hazards approach to 100.06/28/18 at approximate approach to 100.06/28/18 at approximate approach to 100.06/28/18 at approximate	riew and facility document sined that the facility staff simplete facility assessment. ent failed to address a mmunity-based risk an all-hazards approach. assessment failed to reveal based and k assessment, utilizing an extend with ASM (administrative administrator. ASM # 1 are a complete facility eximately 5:15 p.m., ASM enember) # 1, administrator, nursing were made aware of the was provided prior to exit. Control (2)(4)(e)(f) entrol blish and maintain an and control program	F 838	 F 838 Facility Assessment will be reviewed and updated to include all eleme of the requirement. The Facility Assessment will be reviewed at the next Safety Committee Meeting and future Quality Assurance meetings. Assessment will be updated according to guidelines and revie in Safety and QA meetings. 	nts	10-Aug-18 08-Aug-18
		nent and to help prevent the nsmission of communicable ns.				

PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-0391					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495419	B. WING	ş		06/29/2018		
NAME OF PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
COVENANT WOODS NURSING	C HOME	:	7090	COVENANT WOODS DRIVE			
COVERANT WOODS NORSHIN	3 HOME		ME	CHANICSVILLE, VA 23111			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 880 Continued From pa	ge 92	F	380				
§483.80(a) Infection program. The facility must es and control program a minimum, the following services us arrangement based conducted according accepted national services of the put are not limited to (i) A system of survey possible communication infections before the persons in the facili (ii) When and to who communicable disereported; (iii) Standard and the to be followed to precipe the persons in the facili (iv) When and how it resident; including to (A) The type and dudepending upon the involved, and (B) A requirement to	tablish an infection prevention (IPCP) that must include, at owing elements: stem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals under a contractual upon the facility assessment to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; from possible incidents of ease or infections should be used for a		380				

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495419	B. WING_			06	/29/2018
COVENA	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E KTE	(X5) COMPLETION DATE
F 880	Continued From page 93 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the		F 8	380	F 880 (Finding 1) 1. Policy labeled "Water Manager Program to prevent Legionnaire Disease" updated to include all aspects of the requirement	e's	10-Aug-18
	corrective actions tak			Any changes to the requirement be reflected in the plan.	will	10-Aug-18	
	§483.80(e) Linens. Personnel must hand transport linens so as infection.			 Policy will be reviewed / update a minimum during annual polic and procedure review. 		10-Aug-18	
	IPCP and update their This REQUIREMENT by: Based on observation document review, clir determined that the facomplete infection couby the failure to devel follow infection control residents in the medic (Residents #2, #20, at 1. The facility staff	ct an annual review of its r program, as necessary. is not met as evidenced in, staff interview, facility program, as evidenced in a cility staff failed to ensure a natrol program, as evidenced op a legionella protocol; and in practices for three of 10 cation administration task and #12). It is ded to develop a legionella it is ded to sanitize their hands evidential edited to sanitize entity and failed to sanitize entity and failed to sanitize entity and administering medications to reparing and administering					

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0038-0301

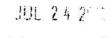
CENTERS FOR MEDICARE & MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·		OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	35 - 43	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
4		495419	B. WING		06/29/2018	
2011100214 1011100	ROVIDER OR SUPPLIER)ME		STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	0025/2010	
(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 SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION	
	3. The facility staff far glucometer before us use, and after droppir. The findings include: 1. On 06/28/18 at appinterview was conduct member) # 5, director the facility's legionella "We don't have a legion process of developing. On 06/28/18 at approximation (administrative staff of ASM # 2, director of nother above findings. No further information 2. The facility staff fair after administering meand before preparing and before preparing medications to Reside their hands after administering meand before preparing medications to Reside their hands after administering meand before preparing medications to Reside their hands after administering medications to Reside their hands after a	proximately 2:45 p.m., an an an anted with OSM (other staff of maintenance regarding protocol. OSM # 5 stated, onella protocol. We're in the one." Eximately 5:15 p.m., ASM member) # 1, administrator, ursing were made aware of was provided prior to exit. led to sanitize their hands edications to Resident #27 and administering and administering medications to reparing and administering medications to reparing and administering and administering medications to reparing and administering and administering medications to reparing and administering medications to reparing and administering and administering and administering medications to reparing and administering and admi	F 88	1. Resident #12 was not found to adversely affected. 2. Nurse #2 was counselled and re of policy for handwashing conducted. 3. DON/Designee will provide education to all licensed nurses proper hand washing when administering medication. 4. DON/Designee will conduct ha washing demonstrations with material licenses. 5. DON/Designee will conduct rate audits.	on 01-Aug-18 on 20-Jul-18	
9		n 10.				

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 95 of 104



CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495419	B. WING			01	6/29/2018
	PROVIDER OR SUPPLIER NT WOODS NURSING HO	OME		7090 CO	ADDRESS, CITY, STATE, ZIP CODE OVENANT WOODS DRIVE ANICSVILLE, VA 23111		HEUIEV.
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Resident #2 was adm 12/8/17 with the diagr heart disease, vertigo fibrillation, hypothyroid	nitted to the facility on gnoses of but not limited to o, dysphagia, atrial pidism, high blood pressure,	F 880	BO F 8	880 (Finding 3) Resident #12 was not found to adversely affected.	be	28-Jun-18
	heart disease and der MDS (minimum Data assessment with an A Reference Date) of 6/	ementia. The most recent a Set) was a quarterly		2.	of policy for properly cleaning equipment.		08-Jul-18
	daily life decisions		3,	DON/Designee will provide education to all licensed nurses proper equipment cleaning.	s on	01-Aug-18	
	Practical Nurse) was	.m., LPN #2 (Licensed observed preparing and iowing medications for illigrams)		4.	equipment cleaning demonstra with nurses 1x/week for 4 wee	tions ks.	20-Jul-18
	Baclofen {2} 10 mg			5.	DON/Designee will conduct ra audits.	ındom	Ongoing
	and was discarded, ar from the pharmacy. T and put into applesaud medication to the roor the resident the apple	on top of the medication cart and was to be reobtained. The Baclofen was crushed uce. LPN #2 then took the em of Resident #20 and fed esauce with the medication sh or sanitize her hands after edications.					
	On 6/27/18 at 4:17 p.r the following medication Senna 8.6 mg.	.m., LPN #2 next prepared tion for Resident #2:					
	unit looking for Reside locate the resident. LF medication and stated medications to Reside was not able to locate	served walking around the lent #2, and was unable to PN #2 then discarded the d she would give lent #2 later. Although she a Resident #2 to administer I #2 did not sanitize her			ë		

PRINTED: 07/06/2018

	RE & MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	B. WING		06/29/2018
NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	
COVENANT WOODS NURSI	NG HOME	31 2 2	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
Resident #2 and a medications to the medications to the Medications to the Resident #20 was 8/2/17 with the dia Alzheimer's disea stress fracture of pressure, psychos most recent MDS quarterly assessm Reference Date) of coded as severely make daily life decoded as severely make daily life decoded as great following medicati "Coreg {3} 3.12" Potassium {4} tab LPN #2 crushed the potassium capsule with applesauce.	paring the medications for attempting to administer the e resident. s admitted to the facility on agnoses of but not limited to se, cardiomyopathy, dysphagia, hip, diabetes, high blood sis and sacral fracture. The (Minimum Data Set) was a nent with an ARD (Assessment of 5/12/18. The resident was y cognitively impaired in ability to	F 880		

washing or sanitizing her hands prior to preparing and administering the medications for Resident

A review of the facility policy, "Handwashing / Hand Hygiene" documented, "Employees must

wash their hands....before and after direct

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

#20.

PRINTED: 07/06/2018

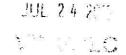
		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	CIENCIES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING	<u> </u>	06/29/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
COVENA	NT WOODS NURSIN	G HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 880	Continued From pa	age 97	F 8	80	
	use an alcohol-bas ethanol or isopropa situations:before medicationsAfter immediate vicinity of the control of the con	oximately 6:00 p.m., the ##1 - Administrative Staff Director of Nursing (ASM #2) of the findings. No further ovided. o treat constipation ed from .gov/druginfo/meds/a601112.ht			
	Information obtaine https://medlineplus.tml	.gov/druginfo/meds/a682530.h to treat heart failure			
	https://medlineplus. tml	gov/druginfo/meds/a697042.h			

Information obtained from

https://medlineplus.gov/potassium.html

pressure.

to work properly. It is a type of electrolyte. It helps your nerves to function and muscles to contract. It helps your heartbeat stay regular. It also helps move nutrients into cells and waste products out of cells. A diet rich in potassium helps to offset some of sodium's harmful effects on blood



PRINTED: 07/06/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495419	B. WING			06	/29/2018
NAME OF PROVIDER OF		G HOME		STREET ADDRESS, C 7090 COVENANT W MECHANICSVILL			
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH COF	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOUL RENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880 Continues	d From na	ine 98	F	280			

3. The facility staff failed to sanitize Resident #12's glucometer after dropping it on the floor.

Resident #12 was admitted to the facility on 1/16/18 with the diagnoses of but not limited to asthma, diabetes, celiac disease, obesity, high blood pressure, chronic kidney disease, stroke, insomnia, peripheral vascular disease, cervicalgia, depression, dyspnea, pacemaker, artificial knee, hypothyroidism, heart failure, and macular degeneration. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/25/18. The resident was coded as being moderately impaired in ability to make daily life decisions.

On 6/27/18 at 4:36 p.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering the following medications to Resident #12:

Pepcid {1} 20 mg (milligrams), 1 tab (tablet) Baclofen {2} 10 mg, 1 tab Montelukast {3}10 mg, 1 tab Lomotil {4} 2.5/0.025 1 tab Humalog {5} 6 units

During the preparation of medications, LPN #2 performed Resident #12's blood glucose check , prior to administering the Humalog. The glucometer was in a zipped pouch with Resident #12's name on it. The glucometer was removed from the pouch and LPN #12 then used the glucometer to check the glucose level of Resident #12. LPN #2 then dropped the glucometer on the floor after obtaining the blood sample from Resident #12. She picked the glucometer off the

<u> </u>	DI ON MEDIOANE G	MEDIONID OCITATOCO			ONID 110: 0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
NAME OF PROVIDER OR SUPPLIER COVENANT WOODS NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP C 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 880	Continued From page	e 99	F	880	5
	floor and returned it to sanitize the glucomet	to the pouch. She did not ter after it had been on the urning it to the pouch, for	***		e
	Disinfection of Reside Equipment" document	y policy, "Cleaning and ent-Care Items and nted, "Single resident-use sinfected between uses by a		et et en en en en en en en en en en en en en	e e e e e e e e e e e e e e e e e e e
	On 6/28/18, at 3:24 p	o.m., in an interview with LPN he should have sanitized the ad fallen on the floor.	St.		
	Administrator (ASM # Member) and the Dire	kimately 6:00 p.m., the #1 - Administrative Staff ector of Nursing (ASM #2) the findings. No further rided.			
	conditions where the acid. Information obtained	treat ulcers, reflux, and stomach produces too much from ov/druginfo/meds/a687011.ht		¥	·
	Information obtained	o treat muscle spasms. from ov/druginfo/meds/a682530.h		g.	
	by asthma. Information obtained			t e	
	https://medlineplus.go tml	ov/druginfo/meds/a600014.h		*	M

PRINTED: 07/09/2018 FORM APPROVED

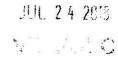
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495419	B. WING		06/29/2018
NAME OF P	ROVIDER OR SUPPLIER	328 B. G	***************************************	STREET ADDRESS, CITY, STATE, ZIP CODE	
COVENAN	IT WOODS NURSING H	OME		090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 880	Continued From page	e 100	, F 880		
	{4} Lomotil - used to Information obtained https://medlineplus.g. tml			i	15 12 15
	{5} Humalog - used to Information obtained https://medlineplus.gr tml			:	
	(6) Omeprazole - use Information obtained https://medlineplus.gr tml				T.
	Safe/Functional/Sani CFR(s): 483.90(i)	tary/Comfortable Environ	F 921		IX
	The facility must provisanitary, and comfort residents, staff and the This REQUIREMENT by: Based on staff interview, it was determined to the same of the staff interview, it was determined to the same of the s	ne public. I is not met as evidenced riew and facility document rined facility staff failed to onal, environment for			
	The facility staff failed marshal when the fire	d to notify the local fire a panel was turned off, and to implement a fire watch			a
	The findings include:		Ø		
		timately 9:30 a.m., an nent was made at the facility.			

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 101 of 104



x x

PRINTED: 07/09/2018 FORM APPROVED OMB NO. 0938-0391

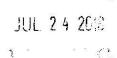
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495419	B. WING	<u> </u>	06/29/2018	
NAME OF PROVIDER OR SUPPLIER COVENANT WOODS NURSING HOME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		7	TREET ADDRESS, CITY, STATE, ZIP CODE 090 COVENANT WOODS DRIVE IECHANICSVILLE, VA 23111 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	(X5) E COMPLETION		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
F 921	going to be taken off I were to call 911 if the An interview was conda.m. with OSM (other director of maintenance staff member) #1, the	I that the fire panel was ine until 3:00 p.m. and staff re was a fire. ducted on 6/28/18 at 11:10 staff member) #5, the ce and ASM (administrative administrator. When asked	F 921	 F 921 Original plan did not include th 2012 Virginia State Fire Code requirements. Fire Watch plan updated and sent to the State Fi Marshall for review. The Local Fire Marshall met with 	was	
	who was notified whe off line, OSM #5 state the local fire marshal stated, "No. I don't ne code." When asked w have to because I have went on to say, "The state of the center if there fire watch was being of "Only near where the independent living but there was no fire watch facility, OSM #5 state looking and the sprink fire." When asked how was inspected, OSM annually." When aske room sprinklers were "On our last annual in he could be sure that working order, OSM # inspection." When asl aware of a fire when to OSM #5 stated, "All the talkies and the other stalert goes to all of the aware of the concern not been notified as pino fire watch in place."	In the fire panel was taken d, "No one." When asked if had been called, OSM #5 ed to according to the hy, OSM #5 stated, "I don't we the sprinklers." OSM #5 sprinklers and smoke doesn't automatically notify is a fire." When asked if a conducted, OSM #5 stated, work is being done in the lding." When asked why ish being conducted in the id, "Staff are around and itlers would go off if there's a woften the sprinkler system #5 stated, "Every quarter ad it when all the resident checked, OSM #5 stated, spection." When asked how all the sprinklers were in its stated, "From the ked how staff were made the fire panel was off line,"		staff to review the plan and discussed facility protocol. No other issues noted. All staff witrained on revised procedure. 3. Any changes to the NFPA 101 Virginia State Fire Code will be reviewed against the fire watch and updated as necessary. 4. Documentation of all comprom to the alarm system and staff response will be reviewed by th Quality Assurance Committee to monitor compliance.	or 25-Jul-18 plan ises 25-Jul-18	

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

Event ID: C1RQ11

Facility ID: VA0416

If continuation sheet Page 102 of 104



PRINTED: 07/06/2018

A THE RESIDENCE OF THE PROPERTY OF THE PARTY		AND HUMAN SERVICES			-		1 APPROVED 0. 0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	ASS WITH	TIPI	LE CONSTRUCTION	1	re survey
	F CORRECTION	IDENTIFICATION NUMBER:	TO SHELL BE STORT OF SHEET				MPLETED
		495419	B. WING			_06	/29/2018
NAME OF P	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
COVENA	NT WOODS NURSING	G HOME	38 39		7090 COVENANT WOODS DRIVE		
COAFIE	MI WOODS NOROIN.			N	MECHANICSVILLE, VA 23111		9
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE
F 921	Continued From pa	age 102	F 9	921			
	facility's policy on fit time.	ire watch was requested at that			**		
	An interview was cr	onducted on 6/28/18 at 11:30					
	a.m. with CNA (cert	tified nursing assistant) #2.					
		received an alert if there was					
		ed, "Not that I know of." When as to do if she found a fire					
		was off line, CNA #2 stated,					
	"All I heard was to d						
		onducted on 6/28/18 at 11:36 nsed practical nurse) #1.					
		ses had walkie-talkies, LPN #1					
		ne in the nurse's station and if					
		gency staff would turn on the					
	walkie-talkie and tu further instructions.	ırn it to channel three for					
	On 6/28/18 at 12:20	0 p.m. OSM #5 stated, "I don't					
	have a policy on fire	e watch. It's just a process."					
		the process OSM #5 stated					
		inducted a fire watch at the being done, as that would					
	have the highest ris						
		ew was conducted on 6/28/18					
		prinkler system inspection					
		tative. The representative aspection for all resident room					1
		ducted on 8/25/17 and any					3
	issues were correct	ted at the time of the					
	inspection.						
	At approximately 12	2:45 p.m., an overhead					
	announcement was	s made that the fire panel was					
	back in service.						

Review of the facility's policy titled, "FIRE

CENTERS !	<u>FOR MEDICARE</u>	& MEDICAID SERVICES			<u>OMB NO. 0938-039</u>
STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	CD-57 - 2757-0757-0757-0757-075	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495419	B. WING	· · · · · · · · · · · · · · · · · · ·	06/29/2018
NAME OF PRO	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE	1_ 00.20.20.0
COVENANT	WOODS NURSING	G HOME		MECHANICSVILLE, VA 23111	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLÉTION
PF do Pr (4 Fir A1 un ha	cumented, "Polic otection System v) hours or more, re Marshall's office fire watch will be p protected by the s s been restored."	TEMS SERVICE OUTAGES" y: When a required Fire will be out-of-service for four the local fire department and e will be notified immediately, provided for all occupants left service outage until service	F 9:	200000000000000000000000000000000000000	

