STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/27/18 through 06/29/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide	E 006		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carrie Sears, LNHA	Administrator	7-20-18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 006	Continued From page 1 care. 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 complete facility risk assessment based on an all-hazards approach specific to the geographic location of the facility, and encompasses potential hazards. 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 a complete facility risk assessment based on an all-hazards approach specific to the geographic location of the facility and encompasses potential hazards. 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.	E 006	E 006 1. The Safety Committee evaluated and ranked the top 20 of the most commonly identified hazards for our location. Those with the highest risk rate will continue to be used as potential hazards as part of the current plan. 2. The hazards will be reviewed at the next Safety Committee Meeting to ensure there are no new threats to be considered and will continue to be presented for review at least quarterly. Any new threats will initiate a new ranking, as well as an annual evaluation and ranking each September. All changes will be directed to the Emergency Preparedness Team for incorporation into and updates of the emergency plan. 3. When the Emergency Preparedness Team meets to review the plan, they will review documentation that the hazards have been reviewed in Safety Committee.	11-Jul-18 08-Aug-18 24-Jul-18
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 018		

JUL 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 2 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, 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. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the	E 018	E 018 1. A new section of the Emergency Preparedness Plan manual will be labeled "tracking residents and staff". All paper forms used for tracking staff and residents will be located in that section with multiple forms available for use. 2. Any changes made to the tracking system used by facility will be updated in the "tracking residents and staff" location of the manual. 3. The Emergency Preparedness Team will review all sections of the manual in tandem with reviews of the plan to ensure all documents are current and readily available for staff use.	24-Jul-18 24-Jul-18 10-Aug-18

JUL 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 018	Continued From page 3 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. The findings include:	E 018		

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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E 018	Continued From page 4 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 a tracking system to document locations of patients and staff. 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.	E 018		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and	E 024	E 024 1. A new section of the emergency plan manual will be labeled "volunteers". The section will include the policies for use of volunteers and tracking system. 2. Any changes in this regulation will be reviewed against the policies in place and updated as necessary. 3. The Emergency Preparedness Team will review all sections of the manual in tandem with reviews of the plan to ensure all documents are current and readily available for staff use.	24-Jul-18 24-Jul-18 10-Aug-18

JUL 24 2

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E 024	Continued From page 5 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.	E 024		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must	E 026		

JUL 2

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E 026	Continued From page 6 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. 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 in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. The findings include: On 06/28/18 at 11:00 a.m. a review and interview of the facility's emergency preparedness plan was	E 026	E 026 1. A new section of the emergency plan manual will be labeled "1135 Waiver". The section will include the process of how the facility will respond. 2. Any changes to the 1135 Waiver plan will be updated in the manual. 3. The Emergency Preparedness Team will review all sections of the manual in tandem with reviews of the plan to ensure all documents are current and readily available for staff use.	24-Jul-18 24-Jul-18 10-Aug-18

JUL 24 2

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COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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E 026	Continued From page 7 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 in the emergency plan that describe the facility's role in providing care and treatment at altered care sites under an 1135 waiver. 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.	E 026		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim	E 041	E 041 1. A new section of the emergency plan manual will be labeled "emergency power". The section will include the process of what the facility generator controls as well as any redundant or alternate on-sire adjustments that can be implemented. 2. Any changes to the emergency power plan will be updated in the manual. 3. The Emergency Preparedness Team will review all sections of the manual in tandem with reviews of the plan to ensure all documents are current and readily available for staff use.	24-Jul-18 24-Jul-18 10-Aug-18

JUL 24

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E 041	Continued From page 8 Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of	E 041		

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 9 _federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. 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 evidence documentation that the facility has the required emergency and	E 041		

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E 041	Continued From page 10 standby power systems, has emergency power systems or plans in place to maintain safe operations while sheltering in place and a plan of how to keep the generator operational during an emergency unless they plan to evacuate. 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 evidence documentation that the facility has the required emergency and standby power systems, has emergency power systems or plans in place to maintain safe operations while sheltering in place and a plan of how to keep the generator operational during an emergency unless they plan to evacuate. 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.	E 041		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/27/18 through 6/30/18. Corrections are are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.	F 000		

JUL 2

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F 000	Continued From page 11 The census in this 50 bed facility was 32 at the time of the survey. The survey sample consisted of 25 current Resident reviews (Residents #14, 9, 27, 2, 233, 24, 8, 22, 29, 32, 11, 26, 21, 10, 30, 134, 15, 18, 20, 5, 3, 19, 25, 135, 12) and three closed Resident reviews (#35, 33, 133).	F 000	F 000 This Plan of Correction constitutes a written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Covenant Woods is committed to sustaining compliance with regulations.	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 12 resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain dignity for three of 28 residents in the survey sample, Resident #24, #20, and #29. 1. The facility staff stood over Residents #24 and #20, while feeding them in the A-B dining room. 2. The facility staff failed to ensure Resident #29 was served her lunch meal when her tablemate's were also eating. The findings include: 1. The facility staff stood over Residents #24 and #20, while feeding them in the A-B dining room. Resident #24 was admitted to the facility on 2/19/18 with the diagnoses of but not limited to adult failure to thrive, heart failure, anxiety disorder, atrial fibrillation, dysphasia, dementia, osteoporosis, and high blood pressure. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment	F 550	F 550 1. Residents #20, #24, and #29 were not adversely affected. — 29-Jun-18 2. All residents who participate in the Assistive dining program will be screened by rehab for appropriateness and assistive devices. — 10-Aug-18 3. Meal observation, conducted by DON or designee, in the dining room of the Assistive Dining program to evaluate proper seating placement to address resident dignity and enhance resident dining experience. — 10-Aug-18 4. CNA #6 was counselled regarding resident dignity at mealtime, as well as a review of resident meal assistance and cueing technique. — 10-Aug-18 5. Education conducted with all staff reviewing resident dignity during dining. — 10-Aug-18 6. DON or designee will conduct meal observations 3x/week for 4 weeks, then 1x/week for 2 weeks. — 10-Aug-18	

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	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 550	Continued From page 13	F 550		

Reference Date) of 2/26/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for transfers, dressing, eating, toileting, and hygiene; and as incontinent of bowel and bladder.

Resident #20 was admitted to the facility on 8/2/17 with the diagnoses of but not limited to Alzheimer's disease, cardiomyopathy, dysphagia, stress fracture of hip, diabetes, high blood pressure, psychosis and sacral fracture. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/12/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and ambulation; extensive assistance for transfers, dressing, eating, toileting, and hygiene; and as incontinent of bowel and bladder.

On 6/27/18 at 12:36, CNA #6 (Certified Nursing Assistant) was observed in the A/B dining room assisting Resident #24 and Resident #20 with feeding. She was then observed getting up and going over to another table, to check on another resident. CNA #6 then returned to the table with Residents #24 and #20 and resumed assisting both residents. CNA#6 was observed standing in between Resident #20 and Resident #24, feeding one resident and then the other, while standing over them.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 550	Continued From page 14	F 550		

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.

No further information was provided.

2. The facility staff failed to ensure Resident #29 was served her lunch meal when her tablemate's were also eating.

Resident #29 was admitted to the facility on

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 550	Continued From page 15	F 550		

5/5/15 with the diagnoses of but not limited to heart failure, heart disease, dysphagia, kyphosis, Sicca syndrome, dysphagia, osteoporosis, Alzheimer's disease, contractures, shortness of breath, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/5/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living and as incontinent of bowel and bladder.

On 6/27/18 at 12:20 p.m., Resident #29 was brought to the dining room and placed at a table with two other residents. The other residents had bowls of soup. Resident #29 was not provided with anything to eat. At approximately 12:25 p.m., one of the other residents was provided with his lunch meal, and the other resident was still working on eating her bowl of soup. Resident #29 was still not provided with anything to eat.

On 6/28/18 at 12:42 p.m., one of the other residents finished his lunch meal, and left the table. Resident #29 was observed still without anything provided to eat. At this time, CNA #6 (Certified Nursing Assistant) came over to the table and brought a plate of food for Resident #29 and sat down next to Resident #29 and begin feeding her. Resident #29 was at the table for approximately 22 minutes while her tablemate's ate, and one had even completed his meal, before she was served anything to eat.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 550 Continued From page 16

Resident #29, she stated that she had told the cook 4 times that Resident #29 was ready for her food. When asked if this was a dignified dining experience for Resident #29, CNA #6 stated it was not. When asked why it took so long for Resident #29 to get her food, CNA #6, stated that for residents who have to be fed, you are not supposed to put the food in front of them until you are ready to feed them. CNA #6, stated that the resident should not have been placed at a table where residents who eat independently are already eating, because Resident #29 has to wait to be fed.

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.

No further information was provided.

F 550

F 557 Respect, Dignity/Right to have Prsnl Property

F 557

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557 SS=E	Continued From page 17 CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined facility staff failed to to allow personal possessions to provide a homelike environment for four of 28 residents in the survey sample, Resident #233, 8, 21 and 12. 1. The facility staff failed to allow Resident #233 to have a recliner when requested. 2. The facility staff failed to allow Resident #8 to keep his recliner, upon the resident's move, from the old section of the unit to the newly renovated section of the unit. 3. The facility staff failed to allow Resident #21 to have a recliner when requested. 4. The facility staff failed to allow Resident #12 to have a recliner and a filing cabinet when requested. The findings include: 1. Resident #233 was admitted to the facility on 6/12/18 with diagnoses that included but were not	F 557	F 557 1. Resident # 8 is already in possession of said furniture he plans on moving to new room. Resident # 21 had personal chair placed in room 06/30/18. Resident # 12 continues to research furniture options. Resident # 233 continues to measure furniture and assess placement. 10-Aug-18 2. Policy established for personal furniture to be used in residents rooms as space and safety allow. 10-Aug-18 3. Notification to all residents will be made as well as future residents. 10-Aug-18 4. All staff will be provided information on how to handle resident requests. 10-Aug-18 5. During care plan meetings, residents will be asked about room accommodations and any needs. 10-Aug-18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 557	Continued From page 18	F 557		

limited to: stroke, high blood pressure, depression and pain.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 6/19/18 coded the resident as having scored a 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living.

A resident meeting was conducted on 6/27/18 at 2:00 p.m. with four residents, three of whom were cognitively intact. During the meeting the residents stated, "They 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 room." When asked why they were not allowed to bring in their own furniture, the residents said they were told there was no space available in the room. When asked if the furniture in the room could be moved to accommodate the resident's furniture, the residents stated they were told that there was no place to store the furniture. The residents all stated they would like to have their recliners because the chairs in the room were not that comfortable.

Review of the facility's admissions packet did not evidence documentation regarding residents not being allowed to bring their own furniture. The admission packet did document that the residents could have their own furniture.

Review of the facility's resident handbook did not evidence documentation regarding residents not being allowed to bring their own furniture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 557	Continued From page 19	F 557		

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.

Observations of resident rooms was made during the survey. Resident rooms in the older section of the unit contained recliners and other personal furniture. Resident rooms in the newly renovated section contained facility provided furniture.

An observation was made on 6/27/18 at 3:15 p.m. of Resident #233's room. The resident was in the room in a wheelchair. The room had facility provided furniture including a bed, an armoire, a dresser, an over-bed table and a bedside table. There was no resident owned furniture in the room. There was a large empty space between the bed and the window. Resident #233 stated that she would like a recliner by the window.

An interview was conducted on 6/28/18 at 3:50 p.m. with LPN (licensed practical nurse) #1, the resident's nurse. When asked if residents were allowed to bring their personal furniture, LPN #1 stated, "Not on the new side." When asked why, LPN #1 stated, "They say it's a safety hazard." When asked what kind of safety hazard LPN #1 stated, she wasn't sure but maybe it was because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 20	F 557		

a resident could fall out of the chair. When asked if residents could fall out of recliners in the older section of the unit, LPN #1 stated yes they could. LPN #1 stated, "Maybe we could compromise with it because a lot of the residents want a recliner." When asked if the resident's rooms were homelike, LPN #1 stated no.

An interview was conducted on 6/28/18 at 4:15 p.m. with CNA (certified nursing assistant) #9, the resident's aide. When asked if the resident had asked for a recliner, CNA #9 stated, "She hasn't voiced any concerns to me." When asked if residents were allowed to have a recliner in their room, CNA #9 stated, "Not to my knowledge." When asked why, CNA #9 stated, "Because of fall concerns." When asked how a resident was assessed as a fall risk, CNA #9 stated, "That would have to be brought up to the DON (director of nursing, [administrative staff member- ASM #2]). I would guess it would be a nurse, PT (physical therapist) or DON (who completed a safety assessment)." When asked if the resident's safety was the issue did it matter if the resident had a recliner in the old section versus the new section, CNA #9 stated, "No I guess it doesn't matter."

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 sated, "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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 21	F 557		

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." ASM #2 stated, "What if they hit the molding on the door and it breaks off? We have a resident who is marking up walls when he turns his wheelchair around in his room." When asked how that was a safety issue, ASM #2 stated, "Well, we need to have enough room to move around." ASM #2 stated, "And there's an infection control issue with the chairs." When asked why, ASM #2 stated, "Some of the residents are incontinent in them." 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 #233 wanted a recliner, ASM #2 did not respond.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 22	F 557		

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 personal furnishings, ASM #1 stated, we've had a conversation with the local ombudsman. We have not completed that dialogue yet." When asked why a piece of the facility's furniture could not be moved out so a resident's furniture could be moved in, ASM #1 stated they did not have storage space. When asked if the resident's 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." 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 23	F 557		

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."

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 stated, "Not in a while." When asked why residents were not allowed to have their own furniture, OSM #7 stated, "A couple reasons. Infection control and for there to be space in the room to ensure that staff could get in there safely." When asked what homelike meant, OSM #7 stated, "It means being in a place that's like home." When asked if the resident rooms in the new section looked homelike, "Before they move in, like a hospital." When asked if the residents' needs were being met, OSM #7 stated, "I think we should meet their individual needs."

No further information was provided prior to exit.

2. The facility staff failed to allow Resident #8 to keep his recliner, upon the resident's move, from the old section of the unit to the newly renovated section of the unit.

Resident #8 was admitted to the facility on 10/3/17 with diagnoses that included but were not limited to: difficulty walking, heart disease, pain,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 24	F 557		

reduced mobility and high blood pressure.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/13/18 coded the resident as having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from facility staff for activities of daily living except for eating which the resident could perform independently after the tray was prepared.

A resident meeting was conducted on 6/27/18 at 2:00 p.m. with four residents, three of whom were cognitively intact. During the meeting the residents stated, "They 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 room." When asked why they were not allowed to bring in their own furniture, the residents said they were told there was no space available in the room. When asked if the furniture in the room could be moved to accommodate the resident's furniture, the residents stated they were told that there was no place to store the furniture. The residents all stated they would like to have their recliners because the chairs in the room were not that comfortable.

Review of the facility's admissions packet did not evidence documentation regarding residents not being allowed to bring their own furniture. The admission packet did document that the residents could have their own furniture.

Review of the facility's resident handbook did not evidence documentation regarding residents not being allowed to bring their own furniture.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 25	F 557		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 26	F 557		

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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 27	F 557		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 28	F 557		

personal furnishings, ASM #1 stated, "We've had a conversation with the local ombudsman. We have not completed that dialogue yet." When asked if a piece of the facility's furniture could be moved out, so a resident's furniture could be moved in, ASM #1 stated they did not have storage space. When asked if the resident's 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."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 29	F 557		

stated, "Not in a while." When asked why residents were not allowed to have their own furniture, OSM #7 stated, "A couple reasons. Infection control and for there to be space in the room to ensure that staff could get in there safely." When asked what homelike meant, OSM #7 stated, "It means being in a place that's like home." When asked if the resident rooms in the new section looked homelike, "Before they move in, like a hospital." When asked is the residents needs were being met, OSM #7 stated, "I think we should meet their individual needs."

No further information was provided prior to exit.

3. The facility staff failed to allow Resident #21 to have a recliner when requested.

Resident #21 was admitted to the facility on 5/10/18 with diagnoses that included but were not limited to: blindness, irregular heart beat, kidney disease and urinary tract infection.

The most recent MDS (minimum data set), an admission assessment, with an ARD Assessment reference date) of 5/17/18 was coded as having a BIMS (brief interview for mental status) of 14 indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from staff for all activities of daily living (ADL).

A resident meeting was conducted on 6/27/18 at 2:00 p.m. with four residents, three of whom were cognitively intact. During the meeting the residents stated, "They 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 30	F 557		

room." When asked why they were not allowed to bring in their own furniture, the residents said they were told there was no space available in the room. When asked if the furniture in the room could be moved to accommodate the resident's furniture, the residents stated they were told that there was no place to store the furniture. The residents all stated they would like to have their recliners because the chairs in the room were not that comfortable. Resident #21 stated she had moved to the facility because she was blind and needed more help. Resident #21 stated she spent most of her day in her room next to the window because she needed so much help to get around. Resident #21 stated that the chair in her room was not comfortable.

An observation was made on 6/27/18 at 4:15 a.m. of Resident #21. The resident was sitting next to the window, in a straight back chair with a pillow at her back and her feet on an ottoman. The resident stated the chair was not comfortable and she wanted a recliner to rest in.

Review of the facility's admissions packet did not evidence documentation regarding residents not being allowed to bring their own furniture. The admission packet did document that the residents could have their own furniture.

Review of the facility's resident handbook did not evidence documentation regarding residents not being allowed to bring their own furniture.

Review of the resident rights document provided to resident by the facility documented, "It is the police of (name of facility) that all residents shall have the following rights and privileges: To retain and use his/her personal clothing and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 31	F 557		

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.

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?" 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 #21 wanted a recliner, ASM #2 stated, "We can put the bed into a recliner position." When informed that the resident stated she likes to sit next to the window, ASM #2 did not have a response.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 32	F 557		

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 #1 stated, "We encourage them to bring in pictures and knick knacks." When asked how the decision not to allow 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 personal furnishings, ASM #1 stated, "We've had a conversation with the local ombudsman. We have not completed that dialogue yet." When asked if a piece of the facility's furniture could be moved out, so a resident's furniture could be moved in, ASM #1 stated they did not have storage space. When asked if the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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.

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, depression and shortness of breath.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 34	F 557		

reference date) of 4/25/18 coded the resident as having a ten out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living with the exception of eating which the resident could perform independently after the tray was prepared.

A resident meeting was conducted on 6/27/18 at 2:00 p.m. with four residents, three of whom were cognitively intact. During the meeting the residents stated, "They 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 room." When asked why they were not allowed to bring in their own furniture, the residents said they were told there was no space available in the room. When asked if the furniture in the room could be moved to accommodate the resident's furniture, the residents stated they were told that there was no place to store the furniture. The residents all stated they would like to have their recliners because the chairs in the room were not that comfortable.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 35	F 557		

filing cabinet with me so I could file my bills but they said no so I have to pile my papers on the floor." There was a 12 to 14 inch pile of papers on the floor under the window. Resident #12 stated she was allowed to have a computer table as long as it folded up. When asked why the facility didn't move out the straight back chair and put in a recliner, Resident #12 stated, "We're only allowed to have their furniture and when we die the furniture will still be here."

Review of the facility's admissions packet did not evidence documentation regarding residents not being allowed to bring their own furniture. The admission packet did document that the residents could have their own furniture.

Review of the facility's resident handbook did not evidence documentation regarding residents not being allowed to bring their own furniture.

Review of the resident rights document provided to resident by the facility documented, "It is the police 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 36	F 557		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 37	F 557		

#1 stated, "We encourage them to bring inpictures and knick knacks." When asked how the decision not to allow 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 for the resident, 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 personal furnishings, ASM #1 stated, "We've had a conversation with the local ombudsman. We have not completed that dialogue yet." When asked if a piece of the facility's furniture could be moved out, so a resident's furniture could be moved in, ASM #1 stated they did not have storage space. When asked if the resident's 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

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	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 557	Continued From page 38 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.	F 557		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F 561	F 561 1. Immediate action taken to adjust shower schedule for resident #12 to reflect a Monday and Friday schedule on the 11-7 shift. 2. A Review of the current bathing schedule will be conducted by the 3 – 11 RN Supervisor with all residents to assure the time and day is per resident preference. 3. Review by DON/designee with staff to assure residents preferences are communicated and documented. 4. In-services with nursing staff conducted focusing on resident's right to participate in decision making.	29-Jun-18 10-Aug-18 10-Aug-18 10-Aug-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 561	Continued From page 39 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to meet the resident's preference for one of 28 residents in the survey sample, Resident #12. The facility staff changed her shower days without Resident #12's consent and did not provide a shower on the day of her preference. The findings include: Resident #12 was admitted to the facility on 1/16/18 with diagnoses that included but were not limited to high blood pressure, diabetes mellitus, chronic kidney disease, and peripheral vascular disease. Resident #12's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 4/25/18. Resident #12 was coded as being moderately impaired in the ability to make daily decisions scoring 10 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #12 was coded as requiring supervision only with most ADLs (activities of daily living). Resident #12 was coded as needing extensive assistance from one staff member with bathing.	F 561	F 561 5. Bathing schedules will be reviewed by resident and/or RP during the time of the Care Plan review meeting. 6. Don/designee will conduct audits monthly to assure that bathing/shower schedules are correct according to Resident preference.	10-Aug-18 10-Aug-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 40	F 561		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 41	F 561		

changes to the shower schedule had to be approved by the unit manager. CNA #3 stated she was not sure who changed the schedule, or why the schedule was changed for Resident #12. CNA #3 stated that yesterday (6/28/18) Resident #12 had complained to her that the 11-7 shift CNA had told the resident she had to take her shower on Thursday morning due to the change in schedule. CNA #3 stated she reported this complaint to the 7:00 (am) to 3:00 (pm) shift nurse (LPN #1), but was not sure if anything was done about it. CNA #3 confirmed that Resident #12 did not receive her shower that morning on 11 (p.m.) to 7:00 (a.m.) shift per her request. CNA #3 stated that in report, the 11:00 to 7:00 aide had stated she did not give Resident #12 her shower but could not recall why the aide did not offer the shower. When asked if she had offered Resident #12 a shower that morning on 7:00 to 3:00 shift, CNA #3 stated she did not offer her a shower that morning because in the past Resident #12 has refused showers on 7:00 to 3:00 shift because she wants her showers on the 11:00 to 7:00 shift.

Review of the current shower sheet revealed that Resident #12 received showers on Monday and Thursday on the 11:00 p.m. to 7:00 a.m. shift. This shower schedule was changed/updated on 6/25/18.

On 6/29/18 at 10:21 a.m., an interview was conducted with ASM (administrative staff member) #2, the DON (Director of Nursing), who was also the stand in unit manager for the week. When asked who was able to change the shower schedule, ASM #2 stated the schedule was usually changed per resident preference. ASM #2 stated that once the requested change was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 42	F 561		

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 conducted with LPN #5, the 11:00 p.m. to 7:00 a.m. shift nurse on the mornings of 6/28/18 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 43	F 561		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 44	F 561		

On 6/29/18 at 1:10 p.m., a further interview was conducted with Resident #12. Resident #12 stated she always received her showers on Mondays and Fridays on the 11:00 to 7:00 shift and wanted to continue with that schedule. Resident #12 stated she was upset that nursing staff had changed her showers days without her consent. Resident #12 stated on Thursday morning (11:00 p.m. to 7:00 a.m.) shift on 6/28/18, the aide had told her she had to take a shower that day because her shower schedule had changed. Resident # 12 stated she refused her shower because that was not her normal shower day. Resident #12 stated she had told the aide and the nurse working that shift that she wanted her shower on Friday morning. Resident #12 stated on Friday morning (11:00 p.m. to 7:00 a.m. shift), staff did not offer her a shower. Resident #12 stated the same aide and nurse who were made aware on Thursday morning were also working on Friday morning 11:00 to 7:00 shift. Resident #12 stated she was already up and dressed on 7:00 a.m. to 3:00 p.m. shift before staff offered her a shower. Resident #12 stated she had already had her hair appointment at that time. Resident #12 stated she felt sticky from the oil. Resident #12 stated she didn't understand why the staff would change her shower schedule without telling her.

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).

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 45	F 561		

On 6/29/18 at approximately 2 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

No further information was presented prior to exit.

F 607 SS=D — Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) — F 607

§483.12(b) The facility must develop and implement written policies and procedures that:

§483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,

§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement their abuse and neglect policy for one of 28 residents in the survey sample, Resident #10.

The facility staff failed to report the findings of CNA (certified nursing assistant) #9's abuse to Resident #10 to the all appropriate reporting agencies.

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 46 Resident #10 was admitted to the facility on 4/16/18 with diagnoses that included but were not limited to: lung disease, diabetes, arthritis, Alzheimer's disease and high blood pressure. The most recent minimum data set, an admission assessment, with an assessment reference date of 4/23/18 coded the resident as having scored 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to 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	F 607	F 607 1. Report to Board of Nursing submitted. 18-Jul-18 2. Education and review of facility policy covering abuse will be conducted including all agencies that must be notified. 10-Aug-18 3. Summary of FRI and List of authorities notified will be reviewed at QA meetings. 25-Jul-18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 47 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 per their policy, 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 harm, pain or mental anguish....Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish. Policy: 6) Reporting. a) i) The organization will report to the State Nurse Aide Registry or licensing authority [i.e. Board of Nursing, Board of Physicians, Board of Pharmacy, etc.] ..."	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 48 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an allegation and finding of abuse to other officials in accordance with State law through established procedures for one of 28 residents in the survey sample, Resident #10. The facility staff failed to report CNA (certified nursing assistant) #9's abuse to Resident #10 to the all appropriate reporting agencies. The findings include: Resident #10 was admitted to the facility on 4/16/18 with diagnoses that included but were not limited to: lung disease, diabetes, arthritis, Alzheimer's disease and high blood pressure. The most recent minimum data set, an admission assessment, with an assessment reference date of 4/23/18 coded the resident as having 13 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to	F 609	F 609 1. Report to Board of Nursing submitted. 2. Education and review of facility policy covering abuse will be conducted including all agencies that must be notified. 3. Summary of FRI and List of authorities notified will be reviewed at QA meetings.	18-Jul-18 10-Aug-18 25-Jul-18

JUL 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 49	F 609		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 50 harm, pain or mental anguish....Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish. Policy: 6) Reporting. a) i) The organization will report to the State Nurse Aide Registry or licensing authority [i.e. Board of Nursing, Board of Physicians, Board of Pharmacy, etc.] ..." No further information was provided prior to exit.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

JUL 2 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for two of 28 residents in the survey sample, Resident # 26, and # 12. 1. The facility staff failed to administer Resident # 26's oxygen according to the physician's orders and comprehensive care plan. 2. The facility staff did not administer Resident #12's physician ordered medications per the physician's orders and comprehensive care plan. The findings include: 1. The facility staff failed to administer Resident # 26's oxygen according to the physician's orders and comprehensive care plan. Resident # 26 was admitted to the facility on 11/22/17 with diagnoses that included but were	F 656	F 656 1. Resident #26 was not found to be adversely affected. Liter flow rate was adjusted to deliver oxygen at rate per MD order. 2. 100% audit was performed of all resident files for accuracy of MD orders who receive oxygen. 3. 100% review and observation of all concentrators for residents receiving oxygen for accuracy of flow rate. 4. Maintenance check conducted on oxygen concentrators to assess for need of repairs. 5. Review of nursing procedures for oxygen therapy with nursing staff. In-service nursing staff on policy and procedures for oxygen therapy. 6. DON or designee will conduct weekly audits on residents.	29-Jun-18 10-Aug-18 10-Aug-18 10-Aug-18 10-Aug-18 10-Aug-18

JUL 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 52	F 656		

not limited to heart failure, respiratory failure (1), diabetes mellitus, (2), gastroesophageal reflux disease (3), sleep apnea (4), hypertension (5), congestive heart failure (6), coronary artery disease (7) and hyperlipidemia (8).

Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/02/18, coded Resident # 26 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 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."

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 (soft plastic prongs that fit in the nose to deliver oxygen) 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 53	F 656		

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 was made on 6/28/18 at approximately 9:45 a.m., a nurse entered Resident # 26's room, exchanged the portable oxygen cylinder on the back of her wheelchair. 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 between two and a half and three liters.

The physician's orders for Resident # 26 dated June 2018 documented, "Oxygen. Continuous O2 (oxygen) 3 (three) L/min (liters per minute) humidified. Order Date: 02/08/2018."

The ETAR (electronic treatment administration record) dated June 2018 for Resident # 26 documented, "Oxygen. Continuous O2 (oxygen) 3 (three) L/min (liters per minute) humidified. Order Date: 02/08/2018." Further review of the ETAR documented on 06/01/18 through 06/28/18, Resident # 26 received oxygen by nasal cannula, from the oxygen concentrator at three liters per minute.

The comprehensive care plan for Resident # 26 dated 12/04/17 with a review date of 03/13/18 documented, "Problem/Concern. Resident is at risk for alteration in cardiac output related to: congestive heart failure, coronary artery disease and hyperlipidemia." Under "Approach" it documented, "Administer oxygen per order, see TAR."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 54	F 656		

"Problem/Concern. Resident has potential for difficulty in breathing related to respiratory failure, CHF (congestive heart failure and sleep apnea." Under "Approach" it documented, "Administer oxygen per order, see TAR."

On 6/28/18 at approximately 1:17 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked how often a resident's oxygen flow rate checked, LPN # 1 stated, "Normally every time I go into the room and every shift." When asked to describe the purpose of the care plan LPN # 1 stated, "It's a plan of care of how to take care of the resident." When asked why the care plan should be followed LPN # 1 stated, "For safety to meet the resident's needs." When informed of the above observations and after reviewing the care plan for Resident # 26"oxygen, LPN # 1 stated that the care plan was not followed for the time the oxygen was not set at three liters.

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.

References:
(1) CPAP is an airway treatment that applies a constant pressure of forced air to keep the airway open. This information was obtained from the website:
https://medlineplus.gov/ency/imagepages/9685.htm.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 55	F 656		

obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.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/highbloodpressure.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

(8) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarte

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 56	F 656		

rydisease.html.

(9) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.
2. The facility staff did not administer Resident #12's physician ordered medications per the physician's orders and comprehensive care plan.

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. The resident was coded as requiring extensive care for bathing; limited assistance for hygiene and dressing; supervision for transfers, eating, and toileting; and as continent of bowel and bladder.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 57	F 656		

" Lomotil {4} 2.5/0.025 1 tab
" Humalog {5} 6 units

On 6/28/18 12:26 p.m. the physician's orders were reviewed for accuracy. The following order was noted:
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 3:01 in an interview with RN #1 (Registered Nurse) she stated that the purpose to address how to care for the resident with their specific diagnoses, preferences, etc. RN #1 stated if the care plan documents to administer medication as ordered, and was not given, then the care plan was not being followed.

A review of the facility policy, "Care Planning" did not include direction that the care plan must be followed.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 58	F 656		

Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided.

{1} Pepcid - used to treat ulcers, reflux, and conditions where the stomach produces too much acid.
Information obtained from https://medlineplus.gov/druginfo/meds/a687011.html

{2} Baclofen - used to treat muscle spasms.
Information obtained from https://medlineplus.gov/druginfo/meds/a682530.html

{3} Montelukast - used to treat symptoms caused by asthma.
Information obtained from https://medlineplus.gov/druginfo/meds/a600014.html

{4} Lomotil - used to treat diarrhea
Information obtained from https://medlineplus.gov/druginfo/meds/a601045.html

{5} Humalog - used to treat diabetes
Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html

{6} Omeprazole - used to treat reflux
Information obtained from https://medlineplus.gov/druginfo/meds/a693050.html

JUL 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=D	Continued From page 59 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657	F 657	

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revised the comprehensive care plan for two of 28 residents in the survey sample, Resident # 26, and # 32.

1. The facility staff failed to review and revise the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 60 comprehensive care plan to address falls for Resident # 26 after the resident fell on 5/27/18. 2. The facility staff failed to review and revise the comprehensive care plan to address the Resident #32's admission to hospice and hospice care. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan to address falls for Resident # 26 after the resident fell on 5/27/18. Resident # 26 was admitted to the facility on 11/22/17 with diagnoses that included but were not limited to heart failure, respiratory failure (1), diabetes mellitus, (2), gastroesophageal reflux disease (3), sleep apnea (4), hypertension (5), congestive heart failure (6), coronary artery disease (7) and hyperlipidemia (8). Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/02/18, coded Resident # 26 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 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. Review of the EHR (electronic health record) for Resident # 26 revealed an "SBAR (Situation, Background, Assessment, Recommendation) Communication Form" dated 05/27/2018. The SBAR documented that Resident # 26 had a fall on 05/27/2018. The SBAR documented Resident # 26 fell while transferring from the bed to the	F 657	F 657 (Finding 1) 1. Resident #26 was not found to be adversely affected. Care plan for falls reviewed and revised to reflect correct updates. 2. 100% audit on all care plans for falls will be conducted by MDS Coordinator, going back to June 1, 2018 to ensure care plans reflect current problems and interventions. 3. MDS Coordinator will perform audits to fall care plans weekly x 4 weeks. 4. Random audits will be performed by MDS Coordinator to fall care plans continually.	28-Jun-18 27-Jul-18 10-Aug-18 10-Aug-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 657	Continued From page 61	F 657		

wheelchair.

The current comprehensive care plan for Resident # 26 dated 12/04/17 with a review date of 03/13/18 failed to evidence documentation of Resident #26's fall on 5/27/18.

On 06/29/18 at 8:33 a.m., an interview was conducted with RN (registered nurse) # 1, MDS (minimum data set) coordinator. When asked how a care plan was developed, RN # 1 stated, "Upon admission, The IDT (interdisciplinary team) meets with resident and identifies the level of assistance, assistive devices and preferences. Monitor the resident to see if there are any changes from what we observed and what the resident told us. Go through the chart look at the resident's diagnosis, and start to develop the comprehensive care plan. When asked about the fall care plan for Resident # 26, RN # 1 stated, "She should have a care plan for falls. I don't know what happened." When asked about reviewing and revising a care plan RN # 1 stated, "The unit manager would report the fall to me when it happened or if it happened late in the day and I'm not here I would get the information in the morning meets. We, the IDT would discuss an intervention and if in agreement I would add it to the care plan." When asked to describe the purpose of the care plan RN # 1 stated, "It gives an overview of the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 657	Continued From page 62	F 657		

care plan for falls. I don't know what happened."

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.
(1) CPAP is an airway treatment that applies a constant pressure of forced air to keep the airway open. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9685.htm.

(2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.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.

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 657	Continued From page 63	F 657		

(6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.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

(8) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html. Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.
2. The facility staff failed to review and revise the comprehensive care plan to address the Resident #32's admission to hospice and hospice care.

Resident #32 was admitted to the facility on 4/26/17 and readmitted on 6/3/18 with diagnoses that included but were not limited to: dementia, anxiety, heart failure, asthma and hypertension.

The most recent MDS (minimum data set), a significant change assessment, with an assessment reference date of 6/12/18 coded the resident as having scored a six out of 15 on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 64 brief interview for mental status indicating the resident was severely impaired cognitively. The resident was coded as requiring assistance for all activities of daily living. Review of the June 2018 physician orders documented, "Referral: Hospice Order Date: 6/6/18." Review of the resident's care plan did not evidence documentation that the resident was on hospice services. An interview was conducted on 6/28/18 at 2:46 p.m. with RN (registered nurse) #1 the MDS coordinator. When asked why residents had care plans, RN #1 stated, "So that the staff will have a guideline for their needs and preferences." When asked who used the care plan, RN #1 stated, "The healthcare staff." When asked when was the care plan updated, RN #1 stated, "When there are changes." when asked if the care plan would be updated if a resident went on hospice services, RN #1 stated, "Yes, we have a care plan that's an advanced directive and hospice." When asked to review Resident #32's care plan, RN #1 stated, "I do not see it. I do try to update it that should have been done already." An interview was conducted on 6/28/18 at 3:50 p.m. with LON (licensed practical nurse) #1, the resident's nurse. When asked why residents had care plans, LPN #1 stated, "The plan of care is a guideline. It's about safety, what the patient likes and doesn't like." When asked who used the care plan, LPN #1 stated, "Everybody." When asked if it was important to keep the care plan updated, LPN #1 stated, "Yes because anything could change."	F 657	F 657 (Finding 2) 1. Resident #32 was not found to be adversely affected. 2. Care plan immediately updated to reflect date of Hospice admission. 3. MDS Coordinator/designee will audit residents' hospice care plans for accuracy. 4. Weekend supervisor will be responsible to audit hospice files for appropriate care plans and interventions every week. 5. MDS coordinator will perform random audits continuously to ensure accuracy and completion.	28-Jun-18 28-Jun-18 02-Aug-18 21-Jul-18 10-Aug-18

FEL 242

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 65	F 657		

On 6/28/18 at 5:15 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility's policy titled, "CARE PLANNING" documented, "Policy: A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission. An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident. Procedures: 8) The care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a) When there has been a significant change in the resident's condition..."

No further information was provide prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 657	Continued From page 66 pages 65-77.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for one of 32 residents in the survey sample, Resident #32.

The facility staff failed to clarify an order for Resident #32's oxygen.

The findings include:

Resident #32 was admitted to the facility on 4/26/17 with diagnoses that included but were not limited to anxiety disorder, heart failure, high blood pressure, chronic respiratory failure and chronic kidney disease. Resident #32's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 6/12/18. Resident #32 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #32 was coded as requiring extensive assistance from two plus persons with bed mobility, and toileting; extensive assistance from one person with transfers, eating and personal hygiene; and total dependence on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 658	Continued From page 67 staff with bathing. Resident #32 was coded in Section O (Special treatments, Procedures, and Programs) as receiving Hospice Services. Review of Resident #32's June 2018 POS (physician order summary) documented the following order: "Continuous 02 (oxygen) via nasal cannula. May titrate up to 5 liters PRN (as needed) for SOB (shortness of breath)." This order was initiated on 6/3/18. The order did not specify liters of oxygen to start Resident #32 on and did not include parameters of when to titrate her oxygen. On 6/27/18 at 11:30 a.m., an observation was made of Resident #32. Her oxygen concentrator was set at 3 and 3/4 liters of oxygen. On 6/27/18 at 12:58 p.m., an observation was made of Resident #32. Her oxygen concentrator was set at 3 and 3/4 liters of oxygen. On 6/28/18 at 3:37 p.m., an observation was made of Resident #32. Her oxygen concentrator was set at 4 liters of oxygen. Review of Resident 32's June TAR (treatment administration record) revealed the following order: "Oxygen- continuous 02 via nasal cannula. May titrate up to 5 liters PRN (as needed) for SOB (shortness of breath)." Further review of the TAR revealed that nursing staff were documenting Resident #32's oxygen saturation. There was no evidence to show the exact liters of oxygen Resident #32 was receiving while her oxygen saturation was obtained and documented. Review of Resident #32's respiratory care plan	F 658	F 658 1. Resident #32 experienced no adverse effects. 2. MD/NP notified for need of clarification of order for oxygen administration. 3. Order clarified and parameters added. 4. Nursing staff education addressing following MD orders and importance of documenting reasons 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 conducted by DON/Designee for clarification of MD order and supporting documentation.	28-Jun-18 28-Jun-18 28-Jun-18 20-Jul-18 10-Aug-18 Ongoing

JUL 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 658	Continued From page 68	F 658		

dated 4/26/17 documented the following intervention: "6/3/18 administer oxygen per MD (medical doctor) orders."

On 6/29/18 at 12:31 p.m., an interview was conducted with LPN (licensed practical nurse) #5. When asked what the above oxygen order meant, LPN #5 stated the oxygen order needed to be clarified because there was indication of how many liters of oxygen to start Resident #32 on and there was also no parameters on when to titrate her oxygen. LPN #5 stated that the order should have documented "titrate as needed" and then if oxygen saturations were below a certain level to titrate.

On 6/29/18 at 1:00 p.m., an interview was conducted with LPN #4, Resident #32's nurse. When asked how nursing would know how many liters to start Resident #32 on, and when to titrate her oxygen to 5 liters, LPN #4 stated, "The order should be clarified."

On 6/29/18 at approximately 2 p.m., ASM #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. ASM #2 stated the facility used their policies and/or Lippincott as a professional standard.

The facility policy titled, "Pharmaceutical Services," documents in part, the following: "All new medication orders shall be transcribed on the physician's order sheet or the telephone order form by the nurse taking the order from a person lawfully authorized to prescribe. The information on the order must include:
Name of resident
Name of physician

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 69	F 658		

Name of the medication
Strength of medication
Dosage
Route...The licensed nurse will read the order. If the order is not clear to the nurse, the physician will be contacted for clarification."

The facility policy titled, "Oxygen Administration," documents in part, the following: "Preparation: 1. Verify that there is a physician's order for this procedure. Review of the physician's order or facility protocol for oxygen administration...10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered...After completing oxygen set up or adjustment, the following information should be recorded in the resident's medical record:...3. The rate of oxygen flow, route and rationale."

No further information was obtained prior to exit.

F 684 SS=D Quality of Care
CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, it was determined the facility staff failed to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 70 residents received treatment and services in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 10 residents in the medication administration task; Resident #12 The facility staff failed to follow Resident #12's physician's orders for the administration of a medication. The findings include: 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. The resident was coded as requiring extensive care for bathing; limited assistance for hygiene and dressing; supervision for transfers, eating, and toileting; and as continent of bowel and bladder. 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	F 684	F 684 1. Resident #12 suffered no adverse effects. 2. Nurse #2 was counselled and policy reviewed for medication pass and the rights for medication administration. 3. All staff educated on rights of medication administration. 4. Medication administration observation will be conducted by DON/Designee 3x/week for 4 weeks then random medication administration observations will continue.	29-Jun-18 17-Jul-18 10-Aug-18 10-Aug-18

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 was noted:
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 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, I can't remember."

A review of the facility policy, "Drug Administration" documented, "Medications are administered in accordance with written orders of attending physicians, and professional standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 72	F 684		

of practice."

On 6/28/18 at approximately 6:00 PM, the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #2) were made aware of the findings.

No further information was provided.

References:

{1} Pepcid - used to treat ulcers, reflux, and conditions where the stomach produces too much acid.
Information obtained from https://medlineplus.gov/druginfo/meds/a687011.html

{2} Baclofen - used to treat muscle spasms.
Information obtained from https://medlineplus.gov/druginfo/meds/a682530.html

{3} Montelukast - used to treat symptoms caused by asthma.
Information obtained from https://medlineplus.gov/druginfo/meds/a600014.html

{4} Lomotil - used to treat diarrhea
Information obtained from https://medlineplus.gov/druginfo/meds/a601045.html

{5} Humalog - used to treat diabetes
Information obtained from https://medlineplus.gov/druginfo/meds/a697021.html

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 73 {6} Omeprazole - used to treat reflux Information obtained from https://medlineplus.gov/druginfo/meds/a693050.html	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel	F 690	F 690 1. Resident #25 does not exhibit any ill effects. 29-Jun-18 2. Educate staff on infection control and proper care of urinary catheter and urinary catheter bag. 10-Aug-18 3. DON/Designee will conduct audits for urinary bag placement twice a week for 4 weeks then monthly. 10-Aug-18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 74	F 690		

receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review it was determined the facility staff failed to provide care and services to prevent infections for the use of an indwelling urinary catheter for one of 28 residents in the survey sample, Resident #25.

The facility staff failed to ensure Resident #25's urinary catheter bag and tubing were free from touching the floor.

The findings include:

Resident #25 was admitted to the facility on 4/30/15 with diagnoses including but not limited to: heart failure, dementia, benign prostatic hyperplasia, (an enlarged, non-cancerous prostate) (1), urinary retention (the inability to empty the bladder completely) (2), high blood pressure, and muscle weakness.

The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 5/29/18, coded the resident as scoring a 99 on the BIMS (brief interview for mental status) exam, indicating that he was unable to complete the interview. Resident #25 was coded for both short and long term memory impairment, as well as moderate impairment of daily decision making. Resident #25 was coded as requiring extensive assistance from two or more person physical assistance for bed mobility, transfers, toileting,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 75	F 690		

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

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 690	Continued From page 76	F 690		

never touch the floor." When asked if the urinary catheter bag could sit on the floor if it is in a privacy bag, LPN #1 stated, "No". When asked why the urinary catheter bag should not be on floor, LPN #1 said it could become contaminated and become an infection control risk. LPN #1 was asked to observe Resident #25's urinary catheter bag, LPN #1 observed the catheter bag was touching the floor. LPN #1 proceeded to put on gloves and repositioned the urinary catheter bag to ensure that it was no longer on the floor.

A review of the physician's orders dated 4/20/18 documented in part, "Indwelling catheter: change catheter tubing ...catheter bag once monthly."

A review of the comprehensive care plan dated 5/12/17, with a most recent revision on 6/13/18, documented in part, "Problem: Resident requires use of indwelling urinary catheter due to urinary retention that cannot be treated or corrected medically or surgically." In the approach section of this problem it is documented in part, "Insert and/or maintain according to physician order ...Position in a manner to minimize "back flow", (when the urine flows back from the drainage bag or tubing into the bladder) (4)."

On 6/28/18 at 4:50 p.m., ASM (administrative staff member) #2, the director of nursing, was informed of the above findings.

On 6/28/18 at 5:20 p.m., ASM #1, the administrator and ASM #2 were made aware of the above concerns.

On 6/29/18 at 10:29 a.m., ASM #2 confirmed that their standards of practice were based on in part, Lippincott Manual of Nursing Practice and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 77 facility's policies and procedures. No further information was provided prior to exit. According to Lippincott Manual of Nursing Practice, Eighth Edition 2006, chapter 21, Renal and Urinary Disorders, page 757, "Maintaining a Closed Urinary Drainage System: Many UTI's (urinary tract infections) are due to extrinsically acquired organisms transmitted by cross-contamination. 2. c. Keep the drainage bag off the floor to prevent bacterial contamination". 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000381.htm 2) This information was obtained from the National Institutes of Health at https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/patientinstructions/000142.htm 4) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003981.htm	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 78 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to provide respiratory care, consistent with professional standards of practice, and the comprehensive person-centered care plan for two of 28 residents in the survey sample, Resident # 26 and # 5. 1. The facility staff failed to administer Resident # 26's oxygen according to the physician's orders and failed to store the C-PAP (continuous positive airway pressure) mask in a sanitary manner. 2. The facility staff failed to store Resident # 5's nebulizer mask in a sanitary manner. The findings include: 1. The facility staff failed to administer Resident # 26's oxygen according to the physician's orders and failed to store the C-PAP (continuous positive airway pressure) mask in a sanitary manner. Resident # 26 was admitted to the facility on 11/22/17 with diagnoses that included but were not limited to heart failure, respiratory failure (1), diabetes mellitus, (2), gastroesophageal reflux disease (3), sleep apnea (4), hypertension (5), congestive heart failure (6), coronary artery disease (7) and hyperlipidemia (8). Resident # 26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/02/18, coded Resident # 26 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0	F 695	F 695 1. Residents #26 and #5 suffered no ill effects. — 29-Jun-18 2. CPAP masks cleaned and placed into a storage bag. Nasal cannola discarded and new tubing obtained, dated and placed into a storage bag. — 29-Jun-18 3. Education with nursing staff on proper care of oxygen equipment and correct infection control. — 10-Aug-18 4. Audit of all residents on oxygen for proper storage of oxygen equipment. — 10-Aug-18 5. DON/Designee will conduct audits every week for 4 weeks, then monthly. — 10-Aug-18	

JUL 24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 79	F 695		

- 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.

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 80	F 695		

An observation on 06/28/18 at approximately 08:33 a.m., revealed Resident # 26's C-PAP mask on table next to the bed uncovered.

An observation on 06/28/18 at approximately 9:45 a.m., a nurse enter Resident # 26's room, exchanged the portable oxygen cylinder on the back of her wheelchair. Resident # 26 was sitting in her wheelchair receiving oxygen (O2) by nasal cannula from an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate between two and a half and three liters. Further observation of Resident # 26's room revealed a C-PAP mask on table next to the bed uncovered.

The physician's orders for Resident # 26 dated June 2018 documented, ""Oxygen. Continuous O2 (oxygen) 3 (three) L/min (liters per minute) humidified. Order Date: 02/08/2018."

"Continuous positive airway pressure (CPAP). Apply C-pap when sleeping and remove when awake. Order date: 11/22/2017."

The TEAR (electronic treatment administration record) dated June 2018 for Resident # 26 documented, ""Oxygen. Continuous O2 (oxygen) 3 (three) L/min (liters per minute) humidified. Order Date: 02/08/2018."

Further review of the 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."

"Continuous positive airway pressure (CPAP). Apply C-pap when sleeping and remove when awake. Order date: 11/22/2017." Further review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 81	F 695		

of the TEAR documented Resident # 26 used the C-PAP mask each evening from 06/01/18 through 06/28/18.

The comprehensive care plan for Resident # 26 dated 12/04/17 with a review date of 03/13/18 documented, "Problem/Concern. Resident is at risk for alteration in cardiac output related to: congestive heart failure, coronary artery disease and hyperlipidemia." Under "Approach" it documented, "Administer oxygen per order, see TAR."
""Problem/Concern. Resident has potential for difficulty in breathing related to respiratory failure, CHF (congestive heart failure and sleep apnea." Under "Approach" it documented, "Administer oxygen per order, see TAR."

On 06/28/18 at approximately 1:17 p.m., an interview was conducted with LON (licensed practical nurse) # 1. When asked how often a resident's oxygen flow rate checked, LPN # 1 stated, "Normally every time I go into the room and every shift." When asked how the flow rate on the oxygen concentrator is read, LPN # 1 stated, "The liter line passes through the middle of the ball. You get down and get eye level with the meter. When asked why it is important to check a resident's oxygen flow rate, LPN # 1 stated, "It could be turned off, or accidently changed so it's not at the correct rate or their oxygen rate could get to low and they could pass out or die or be in respiratory distress." LPN # 1 was asked to read the oxygen flow rate on Resident # 26's oxygen concentrator. LPN # 1 entered Resident # 26's room, walked over to Resident # 26's oxygen concentrator, squatted down in front of the oxygen concentrator to eye level with the flow meter and stated, "It's at three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 82	F 695		

liters." When informed of the observations of Resident # 26 oxygen flow rate on 06/27/18 and 06/28/18 being at less than three liters per minute, LPN # stated the oxygen flow rate should have been checked. LPN # 1 observed the C-PAP mask on the table next to Resident # 26's bed and stated, "It should be in a bag." When asked to describe the procedure for storing a C-PAP mask when not in use, LPN # 1 stated, "The C-PAP mask should go in a bag when not in use." When asked why is it important to keep the C-PAP mask covered when not in use, LPN # 1 stated, "To keep it sanitary. They could have dust in them and the resident could breathe the dust in during their treatment causing coughing, or infection."

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.

References:
(1) CPAP is an airway treatment that applies a constant pressure of forced air to keep the airway open. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9685.htm.

(2) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

(3) A chronic disease in which the body cannot

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 83	F 695		

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/highbloodpressure.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

(8) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(9) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 84	F 695		

heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

2. The facility staff failed to store Resident # 5's nebulizer mask in a sanitary manner.

Resident # 5 was admitted to the facility on 09/25/17 with diagnoses that included but were not limited to chronic obstructive pulmonary disease (2), dysphagia (3), atrial fibrillation (4) and chronic kidney disease (5).

Resident # 5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/04/18, coded Resident # 5 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 (three) - being severely impaired of cognition for making daily decisions. Resident # 5 was coded as requiring limited assistance of one staff member for activities of daily living. Under section "O. Special Treatment, Procedures and Programs" Resident # 5 was coded for "C. Oxygen therapy."

On observation of Resident # 5's room on 06/27/18 at 11:11 a.m., revealed a nebulizer mask on bedside table uncovered. Resident # 5 was not in her room.

On observation of Resident # 5's room on 06/27/18 01:59 p.m., revealed a nebulizer mask on bedside table uncovered. Resident # 5 was not in her room.

On observation of Resident # 5's room on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 85	F 695		

06/27/18 05:01 p.m., revealed a nebulizer mask on bedside table uncovered. Resident # 5 was not in her room.

On observation of Resident # 5's room on 06/28/18 08:29 a.m., revealed a nebulizer mask on bedside table uncovered. Resident # 5 was not in her room.

On observation of Resident # 5's room on 06/28/18 01:10 p.m., revealed Resident # 5 was in the room with her husband watching television. The nebulizer mask was lying on the floor next to the bed.

The physician's orders for Resident # 5's dated June 2018 documented, "Ipratropium-albuterol 3(three) ml (milliliter) nebulization. Four times daily. Order date: 10/25/2017."

The EMAR (electronic medication administration record) dated June 2018 for Resident # 5 documented, "Ipratropium-albuterol 3(three) ml (milliliter) nebulization. Four times daily. Order date: 10/25/2017." Further review of the EMAR documented Resident # 5 used the nebulizer mask four times a day from 06/01/18 through 06/28/18.

On 06/28/18 at approximately 1:17 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. LPN # 1 observed the nebulizer mask in Resident # 5's room on the bedside table and stated, "It should be in a bag." When asked to describe the procedure for storing a nebulizer mask when not in use, LON # 1 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

JUL 24 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 695	Continued From page 86	F 695		

use, LON # 1 stated, "To keep it sanitary. They could have dust in them and the resident could breathe the dust in during their treatment causing coughing, or infection."

On 06/28/18 at approximately 5:15 p.m., SAM (administrative staff member) # 1, administrator, SAM # 2, director of nursing were made aware of the above findings.

No further information was provided prior to exit.

References:
(1) The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html.

(2) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(3) A swallowing disorder. This information was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 695	Continued From page 87 obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (4) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. (5) Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 761	Continued From page 88 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to store and secure medications in an appropriate manner for one of one medication rooms. The facility staff failed to label the open date of a vial of Tuberculin solution in one of one medication room. The findings include: On 6/28/18 at 8:30 a.m., inspection of the medication room on the nursing unit was conducted with LPN (licensed practical nurse) #1. A vial of Tuberculin Solution was found opened with no open date labeled on the vial or the box. The vial was more than halfway full. The expiration date documented the vial was "10/19." The vial also documented the following: "Once entered vial should be discarded after 30 days." LPN #1 confirmed that there was no open date on the vial. LPN #1 stated that she was not sure when the vial was opened. LPN #1 stated that nurses are supposed to label medications/biologicals when opened. On 6/28/18 at 1:00 p.m., ASM (administrative staff member) #1, the DON (Director of Nursing) was made aware of the above concern. The manufacturer's instructions for Tuberculin	F 761	F 761 1. No resident suffered any adverse effect. — 29-Jun-18 2. Medication was destroyed and a replacement ordered. — 29-Jun-18 3. Nursing staff will be educated on policy regarding medication storage. — 10-Aug-18 4. DON/Designee will perform med room audits for proper medication storage and proper date. — 10-Aug-18 5. Weekly audits will be continuous. — 10-Aug-18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 761	Continued From page 89 Solution documented the following: "Storage: Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The facility policy titled, "Medication Storage," documents in part, the following: "1. The pharmacy, when receiving biological and vaccines, will store the preparation in accordance with the manufacturer's recommendations to ensure maintenance of potency and ensure safety to the residents." No further information was presented prior to exit.	F 761		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity,	F 838		

JUL 24 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 838	Continued From page 90	F 838		

and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 838	Continued From page 91 Based on staff interview and facility document review, it was determined that the facility staff failed to develop a complete facility assessment. The facility assessment failed to address a facility-based and community-based risk assessment, utilizing an all-hazards approach. The findings include: Review of the facility assessment failed to reveal evidence of a facility-based and community-based risk assessment, utilizing an all-hazards approach. On 06/28/18 at approximately 2:25 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM # 1 stated, "We don't have a complete facility assessment." 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.	F 838	F 838 1. Facility Assessment will be reviewed and updated to include all elements of the requirement. 2. The Facility Assessment will be reviewed at the next Safety Committee Meeting and future Quality Assurance meetings. 3. Assessment will be updated according to guidelines and reviewed in Safety and QA meetings.	10-Aug-18 08-Aug-18 10-Aug-18
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 92 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review it was determined that the facility staff failed to ensure a complete infection control program, as evidenced by the failure to develop a legionella protocol; and follow infection control practices for three of 10 residents in the medication administration task (Residents #2, #20, and #12). 1. The facility staff failed to develop a legionella protocol. 2. The facility staff failed to sanitize their hands after administering medications to Resident #27 and before preparing and administering medications to Resident #2 and failed to sanitize their hands after administering medications to Resident #2, before preparing and administering medications to Resident #20.	F 880	F 880 (Finding 1) 1. Policy labeled "Water Management Program to prevent Legionnaire's Disease" updated to include all aspects of the requirement 2. Any changes to the requirement will be reflected in the plan. 3. Policy will be reviewed / updated at a minimum during annual policy and procedure review.	10-Aug-18 10-Aug-18 10-Aug-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 94 3. The facility staff failed to sanitize the glucometer before use for Resident #12, after use, and after dropping it on the floor. The findings include: 1. On 06/28/18 at approximately 2:45 p.m., an interview was conducted with OSM (other staff member) # 5, director of maintenance regarding the facility's legionella protocol. OSM # 5 stated, "We don't have a legionella protocol. We're in the process of developing one." 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. 2. The facility staff failed to sanitize their hands after administering medications to Resident #27 and before preparing and administering medications to Resident #2 and failed to sanitize their hands after administering medications to Resident #2, before preparing and administering medications to Resident #20. Resident #27 was admitted to the facility on 8/11/09 with the diagnoses of but not limited to Pick's disease, dysthymic disorder, breast cancer, hypothyroidism, seizures, cataracts, macular degeneration, peripheral retinal degeneration, high blood pressure, and stroke. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/4/18.	F 880	F 880 (Finding 2) 1. Resident #12 was not found to be adversely affected. — 28-Jun-18 2. Nurse #2 was counselled and review of policy for handwashing conducted. — 08-Jul-18 3. DON/Designee will provide education to all licensed nurses on proper hand washing when administering medication. — 01-Aug-18 4. DON/Designee will conduct hand washing demonstrations with nurses 1x/week for 4 weeks. — 20-Jul-18 5. DON/Designee will conduct random audits. — Ongoing	

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 880	Continued From page 95 Resident #2 was admitted to the facility on 12/8/17 with the diagnoses of but not limited to heart disease, vertigo, dysphagia, atrial fibrillation, hypothyroidism, high blood pressure, heart disease and dementia. The most recent MDS (minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/20/18. The resident was coded as being cognitively intact in ability to make daily life decisions. . On 6/27/18 at 4:09 p.m., LPN #2 (Licensed Practical Nurse) was observed preparing and administering the following medications for Resident #27: Senna {1} 8.6 mg (milligrams) Baclofen {2} 10 mg The Senna dropped on top of the medication cart and was discarded, and was to be reobtained from the pharmacy. The Baclofen was crushed and put into applesauce. LPN #2 then took the medication to the room of Resident #20 and fed the resident the applesauce with the medication in it. She did not wash or sanitize her hands after administering the medications. On 6/27/18 at 4:17 p.m., LPN #2 next prepared the following medication for Resident #2: Senna 8.6 mg. LPN #2 was then observed walking around the unit looking for Resident #2, and was unable to locate the resident. LPN #2 then discarded the medication and stated she would give medications to Resident #2 later. Although she was not able to locate Resident #2 to administer the medications, LPN #2 did not sanitize her	F 880	F 880 (Finding 3) 1. Resident #12 was not found to be adversely affected. — 28-Jun-18 2. Nurse #2 was counselled and review of policy for properly cleaning equipment. — 08-Jul-18 3. DON/Designee will provide education to all licensed nurses on proper equipment cleaning. — 01-Aug-18 4. DON/Designee will conduct proper equipment cleaning demonstrations with nurses 1x/week for 4 weeks. — 20-Jul-18 5. DON/Designee will conduct random audits. — Ongoing	

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	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 880	Continued From page 96	F 880		

hands before preparing the medications for Resident #2 and attempting to administer the medications to the resident.

Resident #20 was admitted to the facility on 8/2/17 with the diagnoses of but not limited to Alzheimer's disease, cardiomyopathy, dysphagia, stress fracture of hip, diabetes, high blood pressure, psychosis and sacral fracture. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 5/12/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions.

On 6/27/18 at 4:27 p.m., LPN #2 then was observed preparing and administering the following medications to Resident #20:
" Coreg {3} 3.125 milligrams, 1 tab (tablet)
" Potassium {4} ER 10 meq (milliequivalents) 1 tab

LPN #2 crushed the Coreg, opened the potassium capsule and mixed the medications with applesauce. She then went to Resident #20's room to administer the medications, without washing or sanitizing her hands prior to preparing and administering the medications for Resident #20.

On 6/28/18 at 3:24 p.m., in an interview with LPN #2, she stated she thought she had sanitized her hands between residents but did not specifically recall.

A review of the facility policy, "Handwashing / Hand Hygiene" documented, "Employees must wash their hands....before and after direct

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 880	Continued From page 97	F 880		

resident contact....If hands are not visibly soiled, use an alcohol-based rub containing 60-95% ethanol or isopropanol for all the following situations:....before preparing or handling medications...After contact with objects in the immediate vicinity of the resident...."

On 6/28/18 at approximately 6:00 p.m., the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided.

{1} Senna - used to treat constipation
Information obtained from
https://medlineplus.gov/druginfo/meds/a601112.html

{2} Baclofen - used to treat muscle spasms.
Information obtained from
https://medlineplus.gov/druginfo/meds/a682530.html

{3} Coreg - is used to treat heart failure
Information obtained from
https://medlineplus.gov/druginfo/meds/a697042.html

{4} Potassium - is a mineral that your body needs 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 pressure.
Information obtained from
https://medlineplus.gov/potassium.html

JUL 24 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495419	A. BUILDING _____ B. WING _____	06/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENANT WOODS NURSING HOME	7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111

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F 880	Continued From page 98	F 880		

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

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F 880	Continued From page 99	F 880		

floor and returned it to the pouch. She did not sanitize the glucometer after it had been on the floor, and before returning it to the pouch, for future use.

A review of the facility policy, "Cleaning and Disinfection of Resident-Care Items and Equipment" documented, "...Single resident-use items are cleaned/disinfected between uses by a single resident..."

On 6/28/18, at 3:24 p.m., in an interview with LPN #2, she stated that she should have sanitized the glucometer after it had fallen on the floor.

On 6/28/18 at approximately 6:00 p.m., the Administrator (ASM #1 - Administrative Staff Member) and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided.

{1} Pepcid - used to treat ulcers, reflux, and conditions where the stomach produces too much acid.
Information obtained from https://medlineplus.gov/druginfo/meds/a687011.html

{2} Baclofen - used to treat muscle spasms.
Information obtained from https://medlineplus.gov/druginfo/meds/a682530.html

{3} Montelukast - used to treat symptoms caused by asthma.
Information obtained from https://medlineplus.gov/druginfo/meds/a600014.html

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F 880	Continued From page 100	F 880		

{4} Lomotil - used to treat diarrhea
Information obtained from
https://medlineplus.gov/druginfo/meds/a601045.html

{5} Humalog - used to treat diabetes
Information obtained from
https://medlineplus.gov/druginfo/meds/a697021.html

{6} Omeprazole - used to treat reflux
Information obtained from
https://medlineplus.gov/druginfo/meds/a693050.html

F 921 SS=F — Safe/Functional/Sanitary/Comfortable Environ — CFR(s): 483.90(i) — F 921

§483.90(i) Other Environmental Conditions
The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined facility staff failed to provide a safe, functional, environment for residents, staff and the public.

The facility staff failed to notify the local fire marshal when the fire panel was turned off, and the facility staff failed to implement a fire watch while the fire panel was turned off.

The findings include:

On 6/28/18 at approximately 9:30 a.m., an overhead announcement was made at the facility.

JUL 24 2018

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F 921	Continued From page 101 The announcer stated that the fire panel was going to be taken off line until 3:00 p.m. and staff were to call 911 if there was a fire. An interview was conducted on 6/28/18 at 11:10 a.m. with OSM (other staff member) #5, the director of maintenance and ASM (administrative staff member) #1, the administrator. When asked who was notified when the fire panel was taken off line, OSM #5 stated, "No one." When asked if the local fire marshal had been called, OSM #5 stated, "No. I don't need to according to the code." When asked why, OSM #5 stated, "I don't have to because I have the sprinklers." OSM #5 went on to say, "The sprinklers and smoke detectors work. It just doesn't automatically notify the fire center if there's a fire." When asked if a fire watch was being conducted, OSM #5 stated, "Only near where the work is being done in the independent living building." When asked why there was no fire watch being conducted in the facility, OSM #5 stated, "Staff are around and looking and the sprinklers would go off if there's a fire." When asked how often the sprinkler system was inspected, OSM #5 stated, "Every quarter ad annually." When asked when all the resident room sprinklers were checked, OSM #5 stated, "On our last annual inspection." When asked how he could be sure that all the sprinklers were in working order, OSM #5 stated, "From the inspection." When asked how staff were made aware of a fire when the fire panel was off line, OSM #5 stated, "All the nurses have walkie talkies and the other staff have phones and the alert goes to all of these." ASM #2 was made aware of the concern that the fire marshal had not been notified as per code and that there was no fire watch in place to monitor the facility during the time the fire panel was off line. A copy of the	F 921	F 921 1. Original plan did not include the 2012 Virginia State Fire Code requirements. Fire Watch plan was updated and sent to the State Fire Marshall for review. 2. The Local Fire Marshall met with staff to review the plan and discussed facility protocol. No other issues noted. All staff will be trained on revised procedure. 3. Any changes to the NFPA 101 or Virginia State Fire Code will be reviewed against the fire watch plan and updated as necessary. 4. Documentation of all compromises to the alarm system and staff response will be reviewed by the Quality Assurance Committee to monitor compliance.	06-Jul-18 10-Jul-18 25-Jul-18 25-Jul-18

JUL 24 2018

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F 921	Continued From page 102	F 921		

facility's policy on fire watch was requested at that time.

An interview was conducted on 6/28/18 at 11:30 a.m. with CNA (certified nursing assistant) #2. When asked if she received an alert if there was a fire, CNA #2 stated, "Not that I know of." When asked what she was to do if she found a fire when the fire panel was off line, CNA #2 stated, "All I heard was to contact 911."

An interview was conducted on 6/28/18 at 11:36 a.m. with LPN (licensed practical nurse) #1. When asked if nurses had walkie-talkies, LPN #1 stated there was one in the nurse's station and if there was an emergency staff would turn on the walkie-talkie and turn it to channel three for further instructions.

On 6/28/18 at 12:20 p.m. OSM #5 stated, "I don't have a policy on fire watch. It's just a process." When asked about the process OSM #5 stated they had always conducted a fire watch at the location of the work being done, as that would have the highest risk of fire.

A telephone interview was conducted on 6/28/18 at 12:32 with the sprinkler system inspection company representative. The representative stated the annual inspection for all resident room sprinklers was conducted on 8/25/17 and any issues were corrected at the time of the inspection.

At approximately 12:45 p.m., an overhead announcement was made that the fire panel was back in service.

Review of the facility's policy titled, "FIRE

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F 921	Continued From page 103 PROTECTION SYSTEMS SERVICE OUTAGES" documented, "Policy: When a required Fire Protection System will be out-of-service for four (4) hours or more, the local fire department and Fire Marshall's office will be notified immediately. A fire watch will be provided for all occupants left unprotected by the service outage until service has been restored." No further information was provided prior to exit.	F 921		

JUL 24 2018