DB

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed 09/30/2016 FORM APPROVED OMB NO 0938-0391

f I	1	COMPLETED
495107 B WING		C 09/22/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZI	PCODE	
PINEY FOREST HEALTH AND REHABILITATIO 450 PINEY FOREST RD		
DANVILLE, VA 24540		
	PROVIDER'S PLAN OF CORRECTIC ACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 000 INITIAL COMMENTS F 000		
An unannounced Medicare/Medicaid standard survey was conducted 9/20/16 through 9/22/16 not an adm One complaint was investigated during the survey Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was.	ents made on this plan of corsission to and do not constitute with the alleged deficiencies ompliance with all federal and the center has taken or will forth in the following plan of ing plan of correction constitute gation of compliance. All also cited have been or will be consecutive.	te an herein. To herein. To herein. To he herein take the foorrection. Lates the leged
The facility must conduct initially and periodically a comprehensive, accurate standardized reproducible assessment of each resident's functional capacity A facility must make a comprehensive assessment of a resident's needs using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following. Identification and demographic information. Customary routine. Cognitive patterns. Communication. Vision. Mood and behavior patterns. Psychosocial well-being. Physical functioning and structural problems. Continence. Disease diagnosis and health conditions. Dental and nutritional status. Skin conditions. Activity pursuit.	RECEIVED OCT 11 2016 VDH/OLC	

Any deficiency statement ending with an aster sk (*) 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.

If continuation sheet Page 1 of 23

Printed: 09/30/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/SUIA IDENTIFICATION NUMBER	1	PLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED				
	495107	B WING		09/22/2016				
NAME OF PROVIDER OR SUPPLIER PINEY FOREST HEALTH AN	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 450 PINEY FOREST RD DANVILLE, VA 24540							
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY NTIFYING INFORMATION:	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION				
F 272 Continued From pa	ge 1	F 272						
Medications, Special treatments a Discharge potential. Documentation of s the additional asses	and procedures ummary information regarding sment performed on the care ne completion of the Minimum	F 272	MDS' for residents #3, #6, #11, #1 and #8 have been reviewed.	2, #5, #8, #1, #13				
	articipation in assessment		Current residents MDS assessmen and information was documented location of substantiated informat	on the CAA for the				
This Requirement is not met as evidenced by Based on staff interview and clinical record review, the facility staff failed to document the date and location of clinical record documentation in Section V Care Area Assessment (CAA) Summary used to complete the comprehensive minimum data set (MDS) assessments for 10 of 23 residents (Resident #3, #6, #11, #12, #5, #9, #1, #13, #7, and #8) The findings included			MDS coordinator, Dietician, Activity Director of Discharge Planning received how to document location of suppression documentation on the CAA. The following audit process will be 4 resident's MDS' will be audited exweeks 3 resident's MDS' will be audited exweeks 2 resident's MDS' will be audited exweeks	eived education on orting implemented: ach week for 4 ach week for 4				
Care Area Assessmenthe date and location complete the significant MDS (minimum data) The clinical record of 9/20/16 and 9/21/16 to the facility 7/5/13 with not limited to Alzh			weeks Any issues identified during the auditorized. Any non-compliance will be review committee for progressive discipling	lit process will be				

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

36RM11

if continuation sheet Page 2 of 2.1



Printed: 09/30/2016 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1.	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107	B WING		C 09/22/2016
NAME OF PROVIDER OR SUPPLIER PINEY FOREST HEALTH AN	D REHABILITATIO 450 P	INEY FOREST	RD	
PREFIX LEACH DEFICIENCY MUST	TEMENT OF OFFICIENCIES BE PRECEDED BY FULL REGULATOR ITIFYING INFORMATION:	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 272 Continued From page	ge 2	F 272		
MDS (minimum data reference date (ARD resident with short to term memory proble cognitive skills for data section V Care Area reviewed 9/20/16. Rethese areas with the each Cognitive Los Communication Uring Indwelling catheter, Enutritional Status, Presychotropic Drug U	Assessment (Summary) was esident #3 triggered for decision made to care plan s/Dementia, Visual Function, nary Incontinence and Behavioral Symptoms, Falls, essure Ulcer and se Location and date of ection V read 'CAA WS			
worksheet read "See No specific notes listed MARs identified (6-16). Function read "See No dates or consultation include the notation to Communication work dates included. Urina MARs 6-16 thru 6-22'. Conditions' then unded documentation read "Behavioral Symptoms cognitively impaired become combative at specific location or dates.	gnitive Loss/dementia MD (medical doctor) notes " ed There were specific of through 6-22) Visual MD consults " No specific was identified The area did o "see MARs 6-16-6-22." sheet read 'See MARs " No ary worksheet read "See " under "Diseases and er "Medications" the see mars"-no specific dates is read "Pt. (patient) remains Pt. will refuse care and it times during care." No intes where the information ksheet read "see mars 6-12			

If continuation sheet Page 3 of 23



documentation to identify why the area was triggered and care planned. Pressure ulcer



Printed 09/30/2016 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO. 0938-0391
	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A BUILDING_	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495107		B WING		09/22/2016
NAME OF	PROVIDER OR SUPPLER		STREET ADDR	ESS CITY STA	TE ZIP CODE	
PINEY	FOREST HEALTH AN	ID REHABILITATIO		EY FOREST LE, VA 2454		
PREFIX TAG	ACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 272	The surveyor intervinurse on 9/20/16 at registered nurse stath documentation is screen. The MDS F dates needed to be but that was all. The recently been re-edu worksheets. The surveyor inform director of nursing, a nurse of the above file.	e mars." No other tion was identified ise worksheet read." ewed the MDS regists 4.45 p.m. The MDS ted she was unable in Section V on the color of the administrator, and the corporate registed about dates of the color of the corporate registed in the corporate registed in the composition of the color of	tered to see computer new MARs e had in the the gistered 2:50 p m e facility eted the to the on V included sed to	F 272	DEPICIENCY)	
	The clinical record of 9/20/16 Resident #6 9/28/15 and readmitt that included but not spectrum beta lactam pressure ulcer, parapfailure, acute osteom (methicillin resistant shyperlipidemia, colos	was admitted to the ed 7/7/16 with diagnostimited to ESBL (extended in urine, sacral elegia, hypertension, yelitis, dysphagia, Mataphylococcus aure	e facility oses ended heart RSA us).			

RECEIVED

If continuation sheet Page 4 of 23





and gastroesophageal reflux disease

Printed 09/30/2016

		& MEDICAID SERV					0938-0391
	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT		100.00	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY ETED	
		495107		B WING	Non-production of the Name of the section of the se	09/2	C 22/2016
	VIDER OR SUPPLIER REST HEALTH AN	ID REHABILITATIO	450 PIN	RESS CITY ST EY FORES LE, VA 245			
X41ID PREHX (ŁA TAG	CH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION		D PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	COMPLETION DATE
F 272 C	ontinued From pa	ge 4		F 272			
M re re of A re for Lo Un Be Pr do an W W we an	DS (minimum data ference date (ARI sident with a cograto). The view of the signiferenced above reached the following are essible to the following are essure Ulcer. The incumentation for each the decision mass (worksheet) data ell-Being and Dehere not triggered a	icant change in assess a set) with an assess D) of 3/18/16 assess D) of	triggered nitive tatation, heter, and FCAA ggered "CAA boocial enance bocation				
co los ad M/ Fu rec ide an do be wo tim die (as	inducted 9/20/16 is/dementia listed ministration record ARs listed to review nctional/Rehabilitatords." There were tiffed. The worked indwelling cathed cumented Psychhavior CAA "The rksheet read "Pt (les, pt noted ringinges." Nutritional Starry notes, nursing isessment referen	worksheet for 3/21/1 The worksheet for co "See MARS (medicals)" There were no worksheet for co ation read "See wourd e no specific wound sheet for urinary inco ter had no informatio osocial Well-Being re Behavioral Symptom (patient) noted yelling g call bell constantly tatus worksheet read g notes. MAR with an ce date) of 3/18/16." rsing notes identified	ognitive ation specific or ADL and records ontinence on ead "See as g at d "See rd				

If continuation sheet Page | 5 of 23



Dehydration/Fluid Maintenance had no

Printed 09/30/2016 FORM APPROVED MB NO 0938-0391

CENTERS FOR MEDICARE	<u>: & MEDICAID SERV</u>	'ICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IX11 PROVIDER/SUPPLIE IDENTIFICATION NUM		1.	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107		B WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER		1	RESS CITY STA	ATE ZIP CODE	
PINEY FOREST HEALTH A	ND REHABILITATIO		VEY FOREST		
		DANVIL	LLE, VA 245	40	
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIE IT BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 272 Continued From pa	age 5		F 272		
•	to location and date v	where			
	und that was used to				
	MDS Pressure Uic				
	ee adls (activities of d	Jaily living)			
and see h&p (h sto	ry and physical).				
The surveyor interv	viewed the MDS regis	stered			
	t 4:45 p.m. The MDS				
	ated she was unable				
the documentation	in Section V on the c	computer			
	RN also stated she ke				
••••	documented with the				
	e MDS RN stated she ducated about dates o				
worksheets	DURIGO ADODE GALES C	Al me			
The surveyor inform	med the administrator	r tha			
	and the corporate reg				
	finding on 9/21/16 at				
	stered nurse stated th				
had "QA'ed" the iss	sue but had not compl				
5 points					
No further information	ion was provided prio	r to the			
	failed to ensure Secti	ion V			
	nent (CAA) summary				
	sed to complete the s				
	ent MDS (minimum d				
for Resident #11					
	of Resident #11 was r				
	Resident #11 was				
	with diagnoses that is e-syncope secondary				
	e-syncope secondary rthostasis secondary				
	a, heart failure, hyper				
	mentia, rheumatoid a				ĺ
	disease (stage 3), a				
encephalopathy					

Il continuation sheet Page 6 of 23



Resident #11's annual minimum data set (MDS)

Printed: 09/30/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES IX1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR	(X3) DATE SURVEY	
	COMPLETED	
495107 B WING 09/22/	2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE		
PINEY FOREST HEALTH AND REHABILITATIO 450 PINEY FOREST RD		
DANVILLE, VA 24540		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	-Х	
PREFIX FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX FACH CORRECTIVE ACTION SHOULD BE	DATE	
TAG OR LSC IDENTIFYING INFORMATION) TAG CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 272 Continued From page 6 F 272		
F 272 Continued From page 6 F 272 assessment with an assessment reference date		
(ARD) of 1/18/16 assessed the resident with a		
cognitive summary score of 9 out of 15 in Section		
C		
Section V Care Area Assessment (CAA)		
Summary was reviewed for accuracy Resident		
#11 was triggered for the following areas:		
Cognitive Loss/Dementia, ADL		
Functional/Rehabilitation, Urinary Incontinence		
and Indwelling Catheter, Behavioral Symptoms		
Falls, Nutritional Status, Dehydration/Fluid		
Maintenance, Pressure Ulcer, and Psychotropic		
Drug Use. The location and date to find		
documentation that was used to complete the annual MDS read "CAA WS dated 1/20/16."		
The cognitive loss/dementia worksheet read "See		
MARs" as the location but there were no specific		
dates ADL worksheet read "See C N.A. (certified		
nursing assistant) documentation " There were		
no specific dates or documentation where the		
information was located. Urinary worksheet read	ĺ	
"See MARs"-no specific dates or location to find		
documentation Behavioral worksheet read "Pt		
has not been feeling well and refused shower on		
1 occasion." No specific areas or dates to find	}	
the information were documented Falls worksheet read "See MARs." Nutritional Status		
read "See nutrition assessment, dietary notes,		
nursing notes, and MAR for ard of 1/18/16."		
There were no specific dates identified with the		
location of information Dehydration/Fluid	i	
Maintenance worksheet did not include any		
documentation. Pressure Ulcer worksheet read		
"See C.N.A. documentation and see MARs."		
me a comparation datas facilities of N.A. no		
There were no specific dates for the C N A, or		
MARs documentation Psychotropic drug use		
MARs documentation Psychotropic drug use read "See MARs" There were no specific dates		
MARs documentation Psychotropic drug use		

If continuation sheet Page 7 of 23



Printed: 09/30/2016 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	495107			09/22/2016		
NAME OF PROVIDER OR SUPPLIER	STREE	T ADDRESS CITY STA	TE ZIP CODE			
PINEY FOREST HEALTH AN	D REHABILITATIO 45	O PINEY FOREST	RD			
	DA	ANVILLE, VA 245	40			
PREFIX (LACH DEFICIENCY MUST	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULAT NTIFYING INFORMATION	ID TORY PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION		
F 272 Continued From pa	ge 7	F 272				
registered nurse sta the documentation in screen. The MDS Re dates needed to be but that was all. The	ted she was unable to see in Section V on the compute N also stated she knew documented with the MAR is MDS RN stated she had acated about dates on the	er				
director of nursing, a nurse of the above fi The corporate regist	ed the administrator, the and the corporate registere inding on 9/21/16 at 2 50 pered nurse stated the facilitie but had not completed the	.m.: ity		İ		
exit on 9/22/16 4 The facility staff factore Area Assessme accurate to include the documentation used change in assessme for Resident #12 The clinical record of 9/20/16 and 9/21/16 to the facility 12/20/1 included but not limit hypertension, psychologoprostate hypertrophy diabetes mellitus, dysparkinson 's disease Resident #12's annual ARD of 8/17/16 was 9/21/16 Resident #1 cognitive summary so C. Section V Care Al Summary identified the Cognitive Loss/Demonstrates of the continence, Falls, N	al MDS assessment with a reviewed for accuracy on 12 was assessed with a core of 8 out of 15 in Sections Assessment (CAA) are following triggered area.	ed ed on,				

If continuation sheet Page 8 of 23



Printed 09/30/2016 FORM APPROVED MR NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IX11 PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495107	B WING		09/22/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS CITY STA	ATE ZIP CODE	
PINEY FOREST HEALTH AT	ND REHABILITATIO 450 PIL	NEY FORES	T RN	
- FINE TORES TICALITY AT		LLE, VA 245	340	
PREFIX EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION:	PREF:X TAG	PROVIDER'S PLAN OF CORRECT IEACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRI DEFICIENCY)	JED BE COMPLETION
F 272 Continued From pa	age 8	F 272		
-	omplete the annual MDS read			
	18/16." ADL function read			
	nentation ' There were no			
	e the information was found			
	ce and Falls worksheets read			
	ru 8-17 " Nutritional Status			
	e nutrition assessment			
dietary notes, nursi	ng notes MAR for ard of			
8/17/16." There we	ere no specific dates			
	sure Ulcer worksheet read			
	entation and see MARS			
8-11-thru 8-17 "				
	iewed the MDS registered			
	445 pm The MDS			
	ated she was unable to see			
	in Section V on the computer			
	RN also stated she knew			
	documented with the MARs			
	e MDS RN stated she had			
•	ucated about dates on the			
worksheets				
The auniques inform	and the administrator, the			
	ned the administrator, the and the corporate registered			}
	finding on 9/21/16 at 2 50 p m			
	tered nurse stated the facility			
had "OA'ed" the issu	ue but had not completed the			1
5 points	se but had not completed the]
3 points				1
No further information	on was provided prior to the			
exit on 9/22/16	on the protected prior to the			{
	the facility staff failed to			
	of the CAA documentation in			
	a assessment (CAA)			
summary) of the Re	sidents significant change in			
	m data set) assessment with			ļ
	nt reference date) of 02/16/16			
an and the face of				1
The record review re	evealed that Resident #5 had			

If continuation sheet Page 9 of 23



been admitted to the facility 12/13/11 Diagnoses

Printed. 09/30/2016 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1'	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495107		B WING		09/22/2016	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	TE ZIP CODE		
PINEY F	OREST HEALTH AN	ID REHABILITATIO	450 PIN	EY FOREST	RD		
			DANVIL	LE, VA 245	40		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	REGULATORY	D PREFIX TAG	PROVIDER'S PLAN OF CORRECT SEACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 272	Continued From pa	ige 9		F 272			
		not limited to, demen ildism, gout, hyperter					
	Section C (cognitive patterns) of the Residents significant change in status MDS assessment with an ARD of 02/16/16 had a BIMS (brief interview for mental status) summary score of 9 out of a possible 15 points						
	Location and Date of	r section V of this part "3 Indicate in the CAA Documentation of CAA callated to the C	on column				
	CAA documentation documented "CAA V 2/18/2016" for the tri loss. ADL (activities behavioral symptom dehydration/ fluid, ar	s, nutritional status,	d ed Initive Itinence,				
	When reviewing the only able to locate disupporting document of nutrition	ates and location of	the				
	On 09/20/16 at approinterview with RN (rethe MDS coordinator missing documentation surveyor that this MI before she had been the missing dates	egistered nurse) #1, v r, was asked about th on RN #1 verbalize OS had been comple	who was he d to the eted				

If continuation sheet Page 10 of 23



The administrative team was made aware of the

Printed 09/30/2016 FORM APPROVED MR NO 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES)		טאו פואוט	0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 1	E CONSTRUCTION	(X3) DATE S COMPLI	ETED
	495107	B WING		09/2	C 2/2016
NAME OF PROVIDER OR SUPPLIER	STR	EET ADDRESS CITY ST	ATE ZIP CODE		
PINEY FOREST HEALTH AN	ID DEHABILITATIO	150 PINEY FORES	T PN		
FINE FOREST HEALTH AN		DANVILLE, VA 245			
PREFIX FACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGUL NTIFYING INFORMATION)	ID ATORY PREF X TAG	PROVIDER'S PLAN OF COR EACH CORRECTIVE ACTION CROSS REFERENCEO TO THE DEFICIENCY)	SHOULD BE	X5 COMPLETION DATE
F 272 Continued From pa	ige 10	F 272			
•	nation during meetings wi				
	09/21/16 and 09/22/16	ATT.			
At . S. with an information	an annualing this issue	•			
	on regarding this issue wa rey team prior to the exit	dS			
include the location section V (care area summary) of the Re (minimum data set)	the facility staff failed to of the CAA documentation assessment (CAA) sidents admission MDS assessment with an ARD noe date) of 01/19/16				
been admitted to the included, but were n diabetes, atrial fibrill	evealed that Resident #9 e facility 01/12/16 Diagno lot limited to, hemiplegia, ation, hypertension, , and chronic kidney disea	oses			
admission MDS ass 01/19/16 had a BIMS	patterns) of the Resident essment with an ARD of S (brief interview for ment ore of 14 out of a possible	tai			
Location and Date of	r section V of this part "3. Indicate in the f CAA Documentation col elated to the CAA can be		RECEI	VED	
امل محمد باهم مطة سمام وا	beled "Location and Date	a of	, , , ,		
\$1100. 1110	the facility staff had	: 01	OCT 11	2016	
	VS (worksheet) dated		001 11	2010	
	ggered areas of ADL's		101110	11.0	
	ng), incontinence, falls,		VDH/C	1FC	
	ind psychotropic drug use	2			
The actual location(s		-			;

36RM11

If continuation sheet Page 11 of 23



Printed 09/30/2016 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO.	<u>0938-0391</u>
	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DATE SUR COMPLET	ED
		495107		B WING		09/22	
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS CITY STA	TE, ZIP CODE		
PINEY	FOREST HEALTH AN	ND REHABILITATIO	l.	EY FOREST			
			DANVIL	LE, VA 245	40		
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C EACH CORRECTIVE ACTIV CROSS REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
F 272	2 Continued From page	age 11		F 272			
	unable to locate the	e CAA WS the survey dates and location on ntation for the above	of the				
	interview with RN (rethe MDS coordinate missing documental surveyor that this M	roximately 3:50 p.m. egistered nurse) #1, ir, was asked about tion. RN #1 verbalize DS had been complen re-educated in regi	who was the ed to the eted				
	missing MDS inform	eam was made awar ation during meeting 09/21/16 and 09/22/	s with				
	provided to the survicenterence. 7 The facility staff fa	on regarding this issue team prior to the called to complete the ummary (CAA) on the called Resident #1.	exit Care				
		mitted to the facility on sis of hypertension, on gia, and pneumonia					
	with a reference date The MDS assessed score of "4" of "15" requiring extensive a	ge Minimum Data Se e of 8/16/16 was revi the resident with a c The resident was ass assistance of 1-2 per rs, dressing, eating,	ewed ognitive sessed sons for			CEIVED	
		Area Assessment S . The area for locat				DH/OLC	

VDH/OLC

date of CAA documentation stated, "CAA WS

Printed 09/30/2016 FORM APPROVED MB NO 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO. 0938-0391
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495107		B WING		C 09/22/2016
	PROVIDER OR SUPPLIER FOREST HEALTH AN	ND REHABILITATIO	450 PIN	RESS CITY STA IEY FOREST LE, VA 2454	T RD	
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 272	the areas triggered making noted the lothe "CAA WS dated 8/18/16" Some of the notation to see "Die MAR for ARD of 8/1 were not identified. The MDS coordinate computer system die "Section V" and so and location of CAA where the information. The administrator, decorporate nurse confindings during a me 9/21/16 at 4 00 pm. 8 The facility staff Area Assessment State Minimum Data Set for Resident #13 was as 3/10/16 with diagnoshypertension, depresent at rial fibrillation. The admission Minimum ference date of 3/1 MDS assessed the rof "13" of "15" The requiring extensive as	8/18/16" Each work for care planning decoration of documental 8/17/16" or "CAA When the areas contained etary notes, nursing in 16/16". The dates for the callow viewing of she was not aware the information did not allow viewing on was located. Information did not a not	ecision ation was /S dated additional notes, and the notes end of the date reveal and ed of the y team on the Care ne ed on colon, s, anemia, e ulcer.	F 272		
	Section "V" for Care	e Area Assessment S	ummary			

(CAA) was reviewed. The area for location and

Printed 09/30/2016 FORM APPROVED

	RS FOR MEDICARE						NO. 0938-0391
	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIES (DENTIFICATION NUM		1	CONSTRUCTION		E SURVEY
		495107		B WING			C 9/22/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADDI	RESS CITY STA	TE ZIP CODE		
PINEY	FOREST HEALTH AN	ND REHABILITATIO		EY FOREST			
				LE, VA 245			
IX4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECT!) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE RICIENCY)	COMPLETION DATE
F 27	Continued From page 2	ige 13		F 272			
	date of CAA docum (work sheet) dated the areas triggered making noted the lo the "CAA WS dated 8/18/16". Some of the notation to see "Die MAR for ARD of 3/2 were not identified. The MDS coordinate computer system die "Section V" and so see	entation stated, "CA 3/21/16". Each work for care planning decreation of documentar 3/21/16" or "CAA Withe areas contained attary notes, nursing notes, nursing notes or (RN#2) stated the dignoral not allow viewing on the was not aware the information did not response.	sheet for cision tion was S dated additional otes, and the notes				
	where the information of corporate nurse confindings during a me 9/21/16 at 4:00 p.m. 9 The facility staff for location of where the found in Resident #7 V of the Care Area at 127/16 with the follo limited to Atrial Fibrill disorder, depression	irector of nursing, an sultant were informe seting with the survey ailed to document the documentation cour's clinical record for issessment (CAA) So a Set (MDS) admitted to the facility owing diagnoses of, blation, dementia, anx, mood disorder, thy	nd d of the r team on e ld be r Section ummary r on but not ciety roid				
	disorder and high ch MDS was a significal an ARD (Assessment scored the resident at term memory problet coded as requiring estaff member for bath The resident is totally member for bathing. The surveyor reviews	olesterol. The most rent change assessment Reference Date) of the session of the most resident was a transive assistance of the clinical record the clinical record to the surveyor not the clinical record.	recent ent with f 7/28/16 and long s also of one giene staff	H		RECEIVED UCI 11 2016 /DH/OLC	

Printed: 09/30/2016 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO. 093	8-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTIPLE A BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495107		B WING		09/22/201	6
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS CITY STA	TE, ZIP CODE		
PINEY FOREST HEALTH A	ND REHABILITATIO	(EY FOREST LE, VA 2454			
PREFIX EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCH T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM	PLETION PATE
F 272 Continued From p	age 14		F 272			
on the significant of 7/28/16 in Section location and/or date support the triggere not documented: (Visual Function, Coand Psychotropic Enot documented or for 7/29/16. The MDS nurse was approximately 3 proposition of the above MDS nurse stated location on the CAVeducated about this The administrator, assistant director of above documented conference on 9/21 No further informatic surveyor prior to the 10. The facility state location of where the found in Resident #V of the Care Area of the Minimum Date Resident #8 was re 7/10/15 with the foll limited to high blood disease seizures, a osteoporosis, and deposition of MDS was a signification and ARD (Assessme scored the resident Interview Mental State possible score of 15 coded as requiring the staff member for dresident interview Mental State of the member for dr	hange MDS with an AV of the CAA Summares of the documentated area for the following dispersion. Presson the CAA Worksheet of the cate of the cat	ary the ion to ing were ntia, ure Ulcer were also s dated 1/16 at high was gs. The es or een at d. I of the f the day 2 30 pm he eld be or Section summary y on but not all vascular ecent ent with of 7/9/16 rief f a allso of one hygiene.	F 212			

Printed 09/30/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		- in	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495107		B WING		C 09/22/2016	
NAME OF PROVIDER OR SUPPLIER PINEY FOREST HEALTH A		450 PINE	SS CITY STAT	RD		
		DANVILL	E, VA 2454	0		
PREFIX EACH DEFICIENCY MUS	ATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REG ENTIFYING INFORMATION)	SULATORY F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION	
F 272 Continued From p	age 15		F 272			
The surveyor revie Resident #8 on 9/2 on the significant of 7/10/16 in Section location and/or date support the trigger not documented. Over the trigger of the support of the trigger of the support of	wed the clinical record of 1/16. The surveyor note thange MDS with an ARE of the CAA Summary the soft the documentation of area for the following cognitive Loss/Dementia chavior Symptoms, and Use. The dates were also CAA Worksheets dated in the MDS office and we documented findings of the dates of section but I have been	ed that O of the to were I so not I for S at was The or the e day o pm				
F 309 483 25 PROVIDE C SS=D HIGHEST WELL BI			F 309		i	
provide the necessa or maintain the high mental, and psycho	receive and the facility r iry care and services to est practicable physical, social well-being, in comprehensive assess	attain		RECEIVE OCT 11 201	1	
Based on observation record review, the fa	s not met as evidenced to in, staff interview, and clicitity failed to follow phy f 23 residents (Resider	linical sician		VDH/OL	C	

Printed 09/30/2016

		AND HUMAN SERV & MEDICAID SERVI				FORM APPROVED OMB NO 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM		1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495107		B WNG		C 09/22/2016
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY ST	ATE ZIP CODE	
PINEY FO	REST HEALTH AN	ID REHABILITATIO		EY FORES .LE, VA 24!		
(X4) ID PREFIX (E TAG	ACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)	S REGULATORY	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROPRICIENCY)	ULD BE COMPLETION
F 309	Continued From pa	ige 16		F 309		
					Resident #14's physician was no	tified of the
7	he findings include	ed:			medication error at the time of	
1 li S	2/1/14 with the folk mited to high blood schizophrenia, and	eadmitted to the facil owing diagnoses of, I pressure, arthritis, o peripheral vascular o linimum Data Set) w	but not dementia, disease.		Current residents that are recei- audited and orders were verified for correct dosage.	_
c II P	RD (Assessment Foded Resident #14 Interview for Mental assible score of 15 Indeed as requiring 6	Reference Date) of 7 las having a BIMS (I Status) score of 3 of i. The resident was a extensive assistance g and personal hygie	727/16 Brief ut of a also of 1 staff		Licensed staff were educated or of medication administration us resident, right medication, right and right time by the Staff Deve (SDC).	ing the 5 R's. Right route, right dose,
0	п 9/21/16 at 9:10 a	on Administration Ob m, the surveyor obs	erved		SDC/Unit Manager/DON/Design medication pass observations as	="
		itical Nurse) #4 giving on 40 mg (milligram)			4 per week for 4 weeks	
C	apsule by mouth	The surveyor reviewe sident #14 on 9/21/1	ed the		3 per week for 4 weeks	
d.	ated and signed for	am. In the physicia r 9/1/16, the following	g order		2 per week for 4 weeks	
		on 20 mg give 1 caps sy and Geodon 40			Any issues will be corrected at the	ne time of the
C	apsule by mouth or	ne time a day " O	n the		observation.	ı
		Iministration Record			Any non- compliance will be rev	iewed in the QA
w	as noted: " Geodo nouth one time a da	etember, 2016, the form on 20 mg give 1 caps by " and the time to be resident was 1000 (*	sule by be		committee for progressive discl	· ·
ai M ca	m. The surveyor a IAR for September apsule by mouth or	iso noted on the resi " Geodon 40 mg giv ne time a day" an	dent's ve 1 id the			IVED
a	dministrated this me	AR for the resident to edication was 2200 (OCT 1	1 2016
·	M). he survevor intervie	ewed LPN #4 on 9/2	1/16 at		VDH/	OLC

The surveyor interviewed LPN #4 on 9/21/16 at approximately 11:00 am. LPN #4 stated to the

Printed 09/30/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		495107		B WING		09/	C 22/2016	
	OVIDER OR SUPPLIER REST HEALTH AN	ID REHABILITATIO	450 PINE	ESS CITY STA E Y FOREST L E, VA 245 4	RD			
(X4) ID PREFIX (EA TAG	ACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL RE NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	IX5 COMPLETION DATE	
S S C Ith T read property of the Art	the doctor know." the administrator, of the administrator, of the surveyor and medication administration administration and the director of nursification and Merzeyor that in administration policy "4.1 Facility states are correct dose, at the correct dose, at the correct rate, at	have given the 20 mg the 40 mg that I gave director of nursing and orporate were notified findings on 9/21/16 at asked for a copy of the nistration. Ing gave the surveyor 6.0 General Dose dication Administration ately 9 am. It was no Section 4 of the Medicy it stated the following aff should the correct medical the correct medical the correct route, at the orrect time, for the common was provided to the exit conference on 9/ITIAL EQUIPMENT, Section and patient care	I will let I the of the t 2.30 e policy a copy n " on ted by cation g: tion, at ne rrect 22/16. SAFE	F 309		RECEIVE OCT 11 2016 VDH/OLO		
Th	ne findings included	t.			•	ANH/OFC	a de la companya de l	

Printed 09/30/2016 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		495107		B WING		C 09/22/2016
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS CITY S	TATE, ZIP CODE	
PINEY	FOREST HEALTH AN	ND REHABILITATIO		EY FORES		
(X4) ID PREFIX TAG	EA H DEFIC ENCY MUST	ATEMENT OF DEFICIENCIE I BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 456	Continued From pa	ige 18		F456	Area around the washer and the	laundry room was
		he washing machine			cleaned at the time of survey.	•
	observed by the sur	ot been cleaned and rveyor to have debris	s that		Laundry staff have been educate	ed by the
		angers, paper, and li			Environmental Services Director	
	scattered behind and beside the washing machines				laundry room clean and free of o	
	On 00/04/46 hoosen	and of oppositely	10:20		Environmental Services Director	/Designee will
	p m., the surveyor to	ing at approximately oured the laundry roo	om.		inspect the laundry room as follows:	ows:
	During this observation the surveyor noted that the area beside and behind the washing				3 times per week for 5 weeks	
		een cleaned. The su e lint, broken coat ha			2 times per week for 4 weeks	
		ds scattered around			1 time per week for 3 weeks	
	machines. During this observation LP (laundry personnei) #3 was asked who was responsible for cleaning this area. LP #3 stated she was unsure LP #2 then verbalized that we are responsible.		ning this		Any non-compliance will be rep committee for tracking and tren disciplinary action as needed.	
	housekeeping/laund approximately 12 40 the laundry room an around the wash ma	sked to speak with the supervisor On 09 p.m. the supervisor d was shown the deluctines. The supervise the area cleaned to	/21/16 at entered bris sor			
		taff were notified of t survey team on 09/ o.m.				
		in regarding this issues team prior to the e				I 2016
	483 75(J)(1) ADMINIS	STRATION		F 502	OCT 1	1 2010
SS=D	services to meet the	vide or obtain labora needs of its resident for the quality and ti	ts The		VDH/	OLC

Printed: 09/30/2016

	ERS FOR MEDICARE					OMB NO 0938-039
STATEME	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENT/FICATION NUM	R/CL/A	1 '	IPLE CONSTRUCTION PG	(X3) DATE SURVEY COMPLETED
		495107		B WING _		09/22/2016
NAME (II	PROVIDER OR SUPPLIER		STREET ADDI	RESS CITY	STATE ZIP CODE	<u> </u>
PINEY	FOREST HEALTH AN	ID REHABILITATIO	1	IEY FORE		
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION:	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE COMPLETION
F 50	2 Continued From pa of the services	ige 19		F502	Resident #6's physician was noti survey that the lab test was not	fied at the time of obtained.
	Based on staff inter- review the facility st	is not met as evidend view and clinical recontains staff failed to obtain a test for 1 of 23 reside	ord physician		Current residents receiving Vanc orders were reviewed and lab w obtained from the physician as n of any missing lab test.	ork orders were
	The findings included. The facility staff failed to obtain a vancomycin trough and creatinine level for Resident #6 as ordered for 8/15/16.				Licensed staff were educated on policy for medication administration Development Coordinator (SDC).	tion by Staff
					SDC/DON/ Unit Manager/Designatracking form daily to assure that	all ordered labs are
		of Resident #6 was re #6 was admitted to the			obtained and If not notify the phy	ysiclan.
	9/28/15 and readmit that included but not spectrum beta lactar pressure ulcer, para failure, acute osteon (methicillin resistant	tted 7/7/16 with diagn t limited to ESBL (ext mase) in urine, sacra iplegia, hypertension, myelitis, dysphagia, M staphylococcus aure stomy, depressive dii	noses Itended al I, heart MRSA eus),		Any non- compliance will be repo committee for tracking and trend disciplinary action as needed.	rted to the QA ing and progressive
	MDS (minimum data reference date (ARD resident with a cogni	cant change in asses a set) with an assess b) of 3/18/16 assesse itive summary score	sment ed the			
	of 15.	· Anna in the sales			RECEI	VFD
	dated 8/9/16 that rea creatinine-one time of				OCT 11	With
	8/15/ 16 "	mly for vanc therapy	untii		VDH/O	2010
	A review of the labora	atory section, both e	lectronic		* DI1/U	LC

documentation and paper charting, failed to produce the results of both laboratory tests

Printed 09/30/2016 FORM APPROVED OMB NO. 0938-0391

OCITIO!	OTTIMEDIOTITE	O MEDICINIO OLIV	1000			ONID NO. 0330-0331
STATEMENT OF C	DEFICIENCIES	IX1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495107		B WING	AP - A =	C 09/22/2016
NAME OF PROV	DER OR SUPPLIER		STREET ADDR	ESS CITY STAT	E ZIP CODE	
-		ID REHABILITATIO		EY FOREST LE, VA 2454		
W 4 L 10	CHAMADV ST	ATEMENT OF DEFICIENCE	c	45	PROVIDER'S DI AN CE COI	RRECTION IX'S
(X4) ID PREFIX (EAC TAG	CH DEFICIENCY MUST	BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	ontinued From pa dered for 8/15/16	_		F 502		
The derivative of the formal f	e surveyor report velopment coordie SDC provided (aboratory testing ugh and creatinin done 8/15/16 was a contracting laboratory testing ugh and creatinin done 8/15/16 was a contracting laboratory of the laboratory of the laboratory of the laboratory of nursing a second the failure of the laboratory of the failure of the	ted the concern to the inator on 9/21/16 at 8 the tracking form that g. On the form, the vie ordered on 8/9/16 is entered. The SDC ratory initialed the tracking test had been initialed DC stated the laborated and wanted to charactery office. The definition of the facility staff to composite the facility staff to com	at the stated acking obtained. by "PM." attory eck her istered obtain the end of to the CESSIB	F 514	RE 00 VC	ECEIVED T 11 2016 OH/OLC
		nts; the plan of care				

Printed: 09/30/2016 FORM APPROVED MB NO: 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVIC	ES			OMB NO 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/OIDENTIFICATION NUMB			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495107		8 WING _		C 09/22/2016	
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY,	STATE, ZIP CODE		
PINEY FOREST HEALTH AN	ID REHABILITATIO		EY FORE			
		DANVIL	LE, VA 2	4540		
PREFIX EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES I BE PRECEDED BY FULL RE INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 514 Continued From pa	ge 21		F514	Resident #4's MAR was corrected	i at the time of the	
services provided t			****	survey.	I DE LINE SHINE OF LINE	
	ning conducted by the	State		501 VEy.		
and progress notes				Current resident's MARs were au	dited for the month	
				and any holes were corrected at 1	the time, physicians	
This Requirement	This Requirement is not met as evidenced by Based on staff interview and clinical record			were made aware of any missed medications.		
				•		
review, the facility failed to maintain a complete				Licensed staff were educated on	the documentation	
and accurate clinica	and accurate clinical record for 1 of 23 residents.			policy for medication administrat	ion by Staff	
(Resident #4)				Development Coordinator (SDC).		
The findings include	ad.			Hait Managare /DON /Docignos wi	:11	
THE Intollige molecule	:u			Unit Managers/DON/Designee wi		
Resident #4 was rea	admitted to the facility	on		administration report daily and had made as indicated.	ave corrections	
	owing diagnoses of, bu			made as indicated.		
	igh blood pressure, dia			Any non-compliance will be repor	rted to QA	
	chizophrenia and dysp			committee for tracking and trend		
	(Minimum Data Set) wi Reference Date) of 6/2			disciplinary action as needed.	mig and brobicagisc	
	g a BIMS (Brief Intervi			disciplinally accion as necess.		
	e of 4 out of a possible					
	was also coded as req					
extensive assistance	e of 1 staff member for					
	nal hygiene. The reside					
	1 staff member for ba	thing				
according to this MD	IS.					
The surveyor review	ed Resident #4 's clin	ical				
	On the MAR (Medication					
Administrated Record	d) dated for Septembe	er,				
	umentation missing on				<u> </u>	
	ng shift that the medic	ations		RECE	IVED	
were administrated.						
The administrator di	rector of nursing and			OCT 1	2016	
	corporate was asked to	0				
	MAR for Resident #4			VDH/	OLC	
	tember, 2016 on 9/21/	16 at				
2:30 pm.					(

Printed 09/30/2016 FORM APPROVED MB NO. 0938-0391

CENTERS	FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	(X2) MULTIPLE A BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495107		B WNG		09/22/2016
	OVIDER OR SUPPLIER REST HEALTH AN	ID REHABILITATIO	450 PIN	RESS CITY STA EY FOREST LE, VA 245	T RD	
(X4) ID PREFIX E TAG	ACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTED TO THE APPROPRIES OF THE APPROPRIES O	ULD BE COMPLETION
()	provided the above that to the surveyor. MAR that was giver the MAR for missing or the evening shift nursing reviewed the surveyor. The soft nursing (DON) the Would look into this. Surveyor at 9 am will atted for the month surveyor reviewed to holes or missing the evening shift. The bout this and show ust gave the surveyor that need the was working too have the permission ke this. Only the need that day and shift.	am, the director of na requested MAR for The surveyor review in. The holes were not go documentation on the At 8:40 am, the director of the missing document stated to the surveyor The DON returned the copies of the above of September, 2016 hese copies and the documentation on 9 he surveyor asked the the MAR that for The DON stated edded to document the day, so she fixed it. In the computer to fourse that was document to an in the computer to fourse that was document to an exit conference on the exit conference on the exit conference on the confer	Resident yed the oted on 9/11/16 rector of #4 with director ation on or that she to the ye MAR is The re were //11/16 for ne DON to the the DON to the DON	F 514		

State of	Virginia			· · · · · · · · · · · · · · · · · · ·			1 011111	711 1 110 V L L
	OF DEFICIENCIES DI LORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTIPLE A BU-LDING_	CONSTRUCTION	_ (X3) DATE SO COMPLE	
		495107		8 WING		_	09/22	2/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS CITY STA	TE ZIP CODE	1.		
PINEY FO	OREST HEALTH AND	REHABILITATION CE		Y FOREST RD E, VA 24540				
PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS REFERENCED T DEFICIE	ACTION SHOULD O THE APPROP) BE	(X5) COMPLETE DATE
F 000	Initial Comments			F 000				
	survey and biennial was conducted 9/20 complaint was invest Correct ons are requirements and V for the Licensure of Safety Code survey. The census in this 1 107 at the time of the consisted of 19 curr	Irginia Rules and Re Nursing Facilities. To Ireport will follow. 120 certified bed facilities survey. The surve ent Resident reviews th 19) and 4 closed re	opection One urvey with 42 gulations he Life ity was by sample					
F 001	Non Compliance			F 001				
	The facility was out following state licens	of compliance with th sure requirements	ne					
	The facility was not i	net as evidenced by in compliance with th iles and Regulations g Facilities						
	care planning	Resident assessmer						
	to F-309	A THRU G) Cross re				RECE OCT 11	IVEC	
		Physical Environmer o) Cross reference to				VDH/C) (

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

TITLE

(X6) CATE

12 VAC 5-371-310 Administration

State of Virginia

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
	495107		B WING		09/2	22/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS CITY S	TATE ZIP CODE		
PINEY FOREST HEALTH	AND REHABILITATION CE	450 PINEY DANVILLE				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL). TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION FEACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETE DATE
F 001 Continued Fr	om Page 1		F 001			

001 Continued From Page 1

12 VAC 5-371-310 (A) Cross reference to F-502

12 VAC 5-371-360 Clinical Records 12 VAC 5-371-360 (A, E, f, j) Cross Reference to F-514

