## PRINTED: 05/11/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A BUILDING С 495240 B WING 04/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID. (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 000 INITIAL COMMENTS F 000 This Plan of Correction does not constitute an admission or An unannounced Medicare/Medicaid standard agreement by the Provider of the survey was conducted 4/25/17 through 4/28/17. truth of the facts alleged or Four complaints were investigated during the conclusions set forth in this survey. Significant corrections are required for Statement of Deficiencies. This compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Plan of Correction is prepared survey/report will follow. solely because it is required by state and Federal law. The census in this 177 certified bed facility was 111 at the time of the survey. The survey sample F153 consisted of 24 current Resident reviews 1. Resident #31 medical records were (Residents # 1 through # 20, #28 through #30) and #32) and eight closed record reviews copied and provided to the family. (Residents # 21 through #27 and #31). 2. The Administrator re-educated the F 153 483.10(q)(2)(3) RIGHT TO ACCESS/PURCHASE F 153 Medical Records Coordinator on the 6-5-17 SS=D COPIES OF RECORDS medical records request process. 3. The Medical Records Coordinator (g)(2) The resident has the right to access personal and medical records pertaining to him or will communicate requests for herself. medical records in stand-up with the date records were provided for (i) The facility must provide the resident with approved requests. The access to personal and medical records Administrator/Director of Nursing pertaining to him or herself, upon an oral or written request, in the form and format requested will audit medical records requests by the individual, if it is readily producible in such weekly times four weeks and then form and format (including in an electronic form monthly times two months. or format when such records are maintained 4. The Administrator/Medical electronically), or, if not, in a readable hard copy Records Coordinator/designee will form or such other form and format as agreed to by the facility and the individual, within 24 hours report the audit results monthly to the (excluding weekends and holidays); and Quality Assurance Performance Improvement committee for (ii) The facility must allow the resident to obtain a continued compliance and/or revision. copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon (X6 DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE WI U ania W

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.

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			FORM APPRO OMB NO. 0938-
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED
		495240	B. WING		C
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE,	ZIP CODE 04/28/201
FREDER	ICKSBURG HEALTH			3900 PLANK ROAD	
TREDER				FREDERICKSBURG, VA 22	2407
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLE
F 153	Continued From pa	ge 1	F 1	53	
	•	ing days advance notice to the			
	facility. The facility cost-based fee on t	may impose a reasonable, he provision of copies,			
	provided that the fe	e includes only the cost of:			
		ng the records requested by her in paper or electronic form;			
	electronic media if t	ating the paper copy or he individual requests that the provided on portable media;			
	(C)Postage, when t the copy be mailed.	he individual has requested			
	paragraphs $(g)(2)$ a facility must ensure each resident in a fo	on of information described in nd (g)(11) of this section, the that information is provided to orm IT is not met as evidenced			
	Based on staff inter review, and in the co investigation, it was staff failed to provide to the family in a tim	view, facility document burse of a compliant determined that the facility e copies of the clinical record ely manner for one of 32 rey sample, Resident #31.			
		ed to release the medical			
	The findings include	:			
	10/16/14 with diagno not limited to: hypoth	eadmitted to the facility on oses that included but were nyroidism (1), macular ema (3) and depression.			

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		AND HUMAN SERVICES			PRINTED: 05/11/201 FORM APPROVED OMB NO: 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP COL	
FREDER	CICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 153	Continued From pa	-	F 1	53	
	annual assessment reference date) of 0 scoring a 15 on the status (BIMS) of a s cognitively intact. T requiring extensive member for activitie	-			
	had expired on 03/2	al record revealed the resident 28/16.			
	a copy of the medic request was sent AS member) # 1, the ac the responsible part (Resident #31). Dat Dear (ASM # 1), I ac me complete electro records, including in	e by the responsible party for al record on 09/20/16. This SM (administrative staff dministrator. The request by y documented in part, "Re: e of Service: 2008 TO 2016. m requesting that you send onic format copy of medical naging studies and billing ve listed patient for her entire of Facility)."			
	(OSM [other staff m medical records]), o relinquish custody o Records: Medical Cl resident (Name of R Facility) to (Name of 27th day of Septemb	of Custody" documented, "I, ember # 20, director of f (Name of Facility) do hereby f the following original hart, 5 (five) volume(s) of tesident # 31) of (Name of ASM # 7, paralegal) on this per, 2016." The "Chain of cumented, "I, (Name of ASM #		en c <sup>al</sup> s kan u V pres and an Angel Angel V pres and	
	7, paralegal) on this hereby acknowledge	27th day of September, 2016 by my signature, receipt of		3 3 3 m	
		isted above." The "Chain of ne signature of Name of ASM		DH/OLC	

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		AND HUMAN SERVICES				FOR	D: 05/11/201 MAPPROVEI D. 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	;		0	C 4/28/2017
NAME OF I	PROVIDER OR SUPPLIER		1	1	REET ADDRESS, CITY, STATE, ZIP CODE		+/20/2011
FREDER	ICKSBURG HEALTH	AND REHAB			00 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 153	Continued From pa	ide 3	F.	153			
	On 04/25/17 at 2:50 conducted with OSI records, regarding party obtaining copi records. OSM # 20 medical records rec a request for a copy records, email the r officer at the corpor back when I can go make copies of what When asked how lo copies of medical records	D p.m. an interview was M # 20, the director of medical the process of the responsible ies of a resident's clinical 0 sated, "They complete a quest form or send a letter for y of a resident's medical request to the chief clinical rate office then they email me a head and get the chart and at was requested and send it." ong it takes for a request of ecords to be completed OSM me with 48 hours of receiving	F	153			
	conducted with OSM records, regarding t party (the son) for a medical records. O letter from the son to I got it from the adm for corporate to app record. I don't reme got a phone call fror # 7), the paralegal, v	9 p.m. an interview was M # 20, the director of medical he request by the responsible copy of Resident # 31's SM # 20 stated, "I emailed the o the corporate office the day ninistrator (ASM # 1). I waited rove the release of the ember how long it took. I also m corporate stating that (ASM would come and pick up the was made to speak with					
		5 a.m. during an interview			anna para d'a sana a a para bina di ang		
		stated that phone calls had prning to the corporate office					
t		at 7: 20 a.m., 8:00 a.m. and			VDH/OLC		
	During the days of th ASM # 7 for an inter	ne survey attempts to contact view to ask when the Resident # 31 received the			¥ 1111 × 1 V		
	7(02.00) Provious Versions (						

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		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 05/11/201 FORM APPROVE MB NO. 0938-039	D
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495240	B. WING			C 04/28/2017	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 04/20/2011	
FREDER	CKSBURG HEALTH	AND REHAB			00 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	4
F 153	Continued From page	ae 4	F 1	53			
		ecord were unsuccessful.	1 1	55			
	10/26/2016 was rev in documented, "10- called the hotline an were received." On 04/27/17 at 3:10 conducted with ASM OSM # 20. This sur had not received a r corporate office to s and OSM # 20 were in Resident # 31's so copies of Resident # 1 stated, "Once we r	tion" on the Virginia th complaint form dated iewed. Under "Intake Detail" -25-2016 the complainant d indicated that the records p.m. an interview was 1 # 1, the administrator, and veyor was then informed they eturn phone call from the peak with ASM # 7. ASM # 1 asked why there was a delay on receiving the requested to 31's clinical record. ASM # notify the (corporate) office re and give us directions as					
	revealed documenta resident's clinical red agreement documer Records. You have records, including cli home must provide y your request (exclud You also have the rig of your record of a co standard rate in your	nted, "RECORDS: Access to the right to access your nical records. The nursing you access within 24 hours of ing weekends and holidays). yht to purchase photocopies post that is no more than the community. The nursing you with the photocopies					
	On 04/27/17 at 3:25	p.m. ASM (administrative					
	staff member) # 1, th 2, the director of nurs above findings.	e administrator and ASM # sing, were made aware of the			VDH/OLC		

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		AND HUMAN SERVICES				FOR	ED: 05/11/2017 RM APPROVED O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER	La tra y construction de la constru La construction de la construction d		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	RICKSBURG HEALTH	AND REHAB			00 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC		15-C)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 153	Continued From pa	ge 5	F	153			
	No further informati	on was provided prior to exit.					
	COMPLAINT DEFI	CIENCY					
	References						
	body's needs. This from the website:	oid hormone to meet your information was obtained .gov/medlineplus/hypothyroidi					
	vision. You need cer clearly and to do tas driving. This inform website:	estroys your sharp, central htral vision to see objects ks such as reading and ation was obtained from the gov/maculardegeneration.htm					
	(3) A swelling cause tissues. This inform website:	d by fluid in your body's ation was obtained from the					
	https://www.nlm.nih.	gov/medlineplus/edema.html. TO VOICE GRIEVANCES AL	F 1	65			
	that hears grievance	as the right to voice cility or other agency or entity s without discrimination or fear of discrimination or			RECEIVED		
	reprisal. Such grieva	nces include those with			NAV 3 CAL		
	furnished as well as	reatment which has been that which has not been ior of staff and of other			VDH/OLC		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLETION
F 165	facility stay. This REQUIREME by: Based on resident interview, facility de record review, it wa failed to act on a g 32 residents in the After Resident #13 that she did not wa administering her r suggested to the re- medications by whi that she should tell The findings includ Resident #13 was a 6/5/15 and readmit including, but not li- disorder (1), conge schizoaffective disc MDS (minimum da with an assessmen was coded as havin making daily decisi A review of the pro- revealed the follow OSM (other staff m "SW (social worker issues of concern to over the past week compromise, received from any of the nur	er concerns regarding their LTC NT is not met as evidenced interview, facility staff ocument review, and clinical as determined that facility staff rievance expressed by one of survey sample, Resident #13. told the facility social worker nt a particular nurse nedications, the social worker esident that she should take omever offers them to her, and that nurse thank you. e: admitted to the facility on ted on 3/31/17 with diagnoses mited to: Diabetes, bipolar stive heart failure, and order (2). On the most recent ta set), a quarterly assessment it reference date of 2/6/17, she ng no cognitive impairment for	F	<ul> <li>F165</li> <li>F165</li> <li>Resident #13 grievance and resolved.</li> <li>The Social Services Direct educated the Social Service Assistant on the concern p</li> <li>The Social Service Direct Social Service Assistant wit communicate concerns in stoto ensure concern forms and completed, investigations conducted and follow-up of A random review of concerns will be audited three times at times four weeks and month times two months.</li> <li>The Social Services Diret Designee will report the aud results monthly to the Qualit Assurance Performance Improvement committee for continued compliance and/or revision.</li> <li>RECEIVED</li> <li>KAY 31 2 VDH/OLC</li> </ul>	ector re- es 6-5-17 rocess. etor/ II etand up e ccurred. n forms a week nly ctor/ lit ty

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		AND HUMAN SERVICES			PRINTED: 05/11/20 FORM APPROVI OMB NO. 0938-03
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>		STREET ADDRESS, CITY, STA	
FREDER	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD	
				FREDERICKSBURG, VA	22407
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE IENCY)
F 165	Continued From pa	ige 7	F 1	165	
		lity grievance/concern log ce of any concerns expressed ring March 2017.			
	services director, w her role, once a corresident through state log and proceed to a stated staff member details of the conce form to the social w "When we receive a with the necessary of They work to resolve contact the complain any follow up action #5 stated: "I now do put the resolution ar When asked to loca concerns expressed 2017, OSM #5 revie don't see any. If it's grievance, it does no	a.m., OSM #5, the social ras interviewed. She stated neern is expressed by a aff, is to log it in the concern resolve the concern. She rs fill out a form with the rn, and then they submit the orkers. OSM #5 stated: any type of concern, we meet departments and inform them. e the issue, and then they nant." She stated she records s on the concern log. OSM the logs] month by month. I nd the action plan in the log." the the log entry regarding d by Resident #13 in March ewed the log and stated: "I not given to me as a ot go on the log." OSM #5 uld have more information" on			
	was asked to provide expressed by Reside 3/15/17. OSM #4 sta occurred on a Sunda relationship [Resider the nursing staff. Sh some particular nurs I always say thank yo	eviewing the above had written on 3/15/17, she e the details of the concerns ent #13 in the week prior to ated: "It was something that ay. It goes back to a personal nt #13] had established with he had wanted not to have ses assigned to her. I told her ou when I get a med		RECEIVED MAN 31 2007 VDH/OLC	
ORM CMS-256	67(02-99) Previous Versions C	Obsolete Event ID: 6R5B1	1	Facility ID: VA0088	If continuation sheet Page 8 of 27

		AND HUMAN SERVICES				FOR	ED: 05/11/201
STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
		495240	B. WING	3		0	C 4/28/2017
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODI		4/20/2011
FREDER	ICKSBURG HEALTH	AND REHAB		1	3900 PLANK ROAD		
(24) 10	SHMMADY ST	ATEMENT OF DEFICIENCIES		1	FREDERICKSBURG, VA 22407	071011	
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F 165	Continued From pa	age 8	F	165			
	thank you." When she stated to the re resident to express stated: "That is not	told her I expected her to say asked to clarify exactly what sident about the need for the gratitude to the staff, OSM #4 t being respectful. Whatever edication, you need to accept it					
	and offer a thank yo way we are going to if it is a resident's re	bu. I told her that's the only o get past this." When asked esponsibility to "get past"					
	responsibility to nav OSM #4 stated: "W	aff, or if, rather, it is the staff's vigate around the resident, /ell don't you say thank you ers you something? It is just					
	courtesy." When as nurses named by R	sked if she talked to any of the esident #13, OSM #4 stated					
	concern log. When logged the concern, seek us out with a p	tated she did not put it on the asked why she had not , OSM #4 stated: "When they particular complaint, I will put it ou are violating their right to					
	confide certain thing they say on the log.	gs with me if I put everything "					
	interviewed. When	p.m., Resident #13 was asked what happened with , she stated some of the					
	nurses "told lies abo "They sent some of	out me." Resident #13 stated: them back in here to					
	stated she asked for take care of her any	but how they treated me." She r one particular nurse not to more, and the next thing she					
	She stated OSM #4 allowed to say which	#4 coming in to talk with her. told her that residents are not nurses will or will not give					
	whomever administe	nd that she should tell ers her medications thank describe her response to				,	
	OSM #4, Resident #	13 stated: "What else was I just said okay. My daughter			VDH/OLC		

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TATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETIC
F 165	Continued From pa	ge 9	F 165	5	
		e not to get in any trouble. h shut and do what they tell			
	staff member) #1, to director of nursing,	ng resident			
	Process" revealed, identification of a pa- concern, staff comp identifying the issue Administrator or des Care Keepers meet designee logs the c- and on the Morning administrator or des the concern form to head for follow-up a morning meetingC concern is identified resolve the issue for potential systemic c recurrence or occurr assigned departmen	ity policy entitled "Concern in part, the following: "Upon atient or representative letes the Concern Form and forward the form to the signee. During the morning ing, the Administrator or oncern on the Concern Log Meeting agenda. The ignee copies and forwards the appropriate department nd resolution during the Once the root cause of the , corrective action is taken to the identified party as well as hanges to reduce risk of rence for others. The thead contacts the ce resolution has been			
	No further information	on was provided prior to exit.		RECEIVED	
	(1) "Bipolar disorder			MA 31 2.1	
		ness, is a brain disorder that is in mood, energy, activity		VDH/OLC	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED MB NO. 0938-0391
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF PROV	IDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CODE	
COROCOLOU				3900 PLANK ROAD	
FREDERICK	SBURG HEALTH	AND KEHAB		FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 165 Co tas http ord (2) dis and we http zop F 167 483 SS=C RE (g)( (i) of t sur res (g)( (i) F and res	os://www.nimh.ni ler/index.shtml. "Schizophrenia i order that affects d acts." This info bsite os://www.nimh.ni ohrenia-booklet/ir 3.10(g)(10)(i)(11) SULTS - READII (10) The resident Examine the resident efacility conduct veyors and any p pect to the facility (11) The facility n Post in a place real family members	ation is taken from the website h.gov/health/topics/bipolar-dis s a chronic and severe s how a person thinks, feels, ormation is taken from the h.gov/health/publications/schi ndex.shtml. RIGHT TO SURVEY _Y ACCESSIBLE t has the right to- ults of the most recent survey cted by Federal or State blan of correction in effect with y; and	F 16	55	ty of the ey results ir ns. linical ce of the $5-8-17$ ceding ns.
cer res yea res to r	lifications, and co becting the facilit rs, and any plan bect to the facility eview upon requ Post notice of th	e availability of such reports in		<ul> <li>ensure the last three preceding y survey results are available week four weeks and then monthly tir months.</li> <li>4. The Administrator/designee v report the monitoring results to the Quality Assurance Performance</li> </ul>	rear's kly times nes two vill the
	as of the facility t essible to the pu	hat are prominent and blic.		Improvement committee for con compliance and/or revision.	tinued
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MAY 31 2017

VDH/OLC

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 05/11/201 FORM APPROVE OMB NO. 0938-039
STATEMEN	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		– C – 04/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD	
				FREDERICKSBURG, VA	22407
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	NOF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 167	information about of This REQUIREMEI by: Based on observa determined that the notice of the availal preceding year's su corresponding plan A notice was not por responsible parties three years of surve corrections, were a The findings include Observations were book in the front lob approximately 7:30 approximately 7:30 approximately 11:30 p.m. A framed sign "ATTENTION: SUR POSTED AT THE F	Il not make available identifyin complainants or residents. NT is not met as evidenced tion and staff interview, it was a facility staff failed to post a bility of the last three urvey results and their of corrections. Dested to the residents and that the results of the previous ey results, with the plan of vailable for review. Det made of the survey results oby on 04/25/17 at a.m., 04/25/17 at a.m., 04/25/17 at 0 a.m. and on 4/25/17 at 3:00 that documented, VEY RESULTS ARE RECEPTIONIST'S DESK" was	-	57	
	from the main entra Observation of the r facility's lobby revea The cover of the bla "(Name of City and Inspection Survey R contained survey re	er cabinet in the lobby across ince door to the facility. receptionist's desk in the aled a black three ring binder. ack binder documented, State) Annual State Results." The three ring binder sults and plan of corrections vey ending on 06/17/16 and			
	the revisit survey en observation of the c	nd plan of corrections from ding on 08/10/16. Further ontents of the book failed to		RECEIVED	
	evidence the survey corrections for the p			VDH/OLC	
DRM CMS-256	7(02-99) Previous Versions (	Dbsolete Event ID: 6R5B1	1 F	acility ID: VA0088	If continuation sheet Page 12 of 278

		AND HUMAN SERVICES			PRINTED: 05/11/20 FORM APPROVE OMB NO. 0938-03
TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
FREDEF	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ( EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETI
F 167	Continued From pa	-	F 1	67	
	asked who is resporesults, ASM #1 states about the framed sites availability of the sur- three years ASM #1 needed to be poster survey results for the located ASM #1 states desk. An observation was conducted with receptionist's desk for results for the previous stated that the result ASM #1 asked OSM the receptionist, who 3:35 p.m. OSM #23 a white binder. The documented, "Annu Results 2015, 2014 three ring binder com- plan of corrections for on 07/29/15, the annu 06/12/15, 06/19/201 where the white bindes stated, "It was in the there isn't enough ro	f member) #1, the 4/25/17 at 3:10 p.m. When nsible for posting the survey ited, "I am." When asked gn in the lobby posting the rvey results for the previous stated she didn't know it d." When asked were the reprevious three years were ted they're at the receptionist's on of the receptionist's desk ASM #1. Observation of the failed to evidence survey ous three years. ASM #1 ts were in a white binder. A (other staff member) # 23, ere the white binder was. At presented this surveyor with cover on the binder al State Inspection Survey & (and) 2013." The white ntained survey results and rom the revisit survey ending nual surveys ending on 4 and 06/30/13. When asked der was found OSM # 23 business office because bom on my desk."			
	revealed documenta resident's clinical rec	r's admission agreement tion regarding access to the cord. The admission		PEOEVIN	
	Results. You have the	nted, "Examination of Survey the right to examine the		MAY 31 2017	
	nursing home condu	ecent survey results of the cted by federal or state ursing home's plan to correct		VDH/OLC	

Facility ID: VA0088

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY
		495240	B. WING	0	C 4/28/2017
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
REDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
F 167	Continued From pa	ige 13	F 16	7	
	staff member) # 1, 2, the director of nu above findings. No further informati	5 p.m. ASM (administrative the administrator and ASM # irsing, were made aware of the ion was provided prior to exit.		F226 1.Employee #11 identified with a hire date of	
	483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES	33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC	F 22	<sup>6</sup> 1-21-16 is no longer employed with Fredericksburg Health and Rehab. Employee with a hire date of 1-21-16 had a license	#12
	483.12 (b) The facility must written policies and	t develop and implement procedures that:		verification performed by the facility on 12-29-16 and reverified on 5-12-17. Employe CNA #13 with a hire date of 11-7-16 is a	
		vent abuse, neglect, and ents and misappropriation of		Licensed Practical Nurse, licensed verified on 10-31-16 and the facility did not obtain refere checks prior to employment. 2. The Human Resource Coordinator will	
	investigate any such	-		conduct an audit of current employees to ensu appropriate screening per the abuse policy pri-	6517
	§483.95,	as required at paragraph		to employment. 3. The Administrator re-educated the Human Resource Coordinator on the Abuse policy. Th	he
	the freedom from all requirements in § 48	and exploitation. In addition to buse, neglect, and exploitation 83.12, facilities must also heir staff that at a minimum		Administrator/Human Resource Coordinator v conduct random audits of new employees' file weekly times four weeks and then monthly tim two months. 4. The Administrator/Human Resource	vill s nes
		constitute abuse, neglect, sappropriation of resident at § 483.12.		Coordinator will report the audit results month to the Quality Assurance Performance Improvement committee for continued compliance and/or revision.	ly

Event ID: 6R5B11 RECTELIND VAD088

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MAY 31 2007 VDH/OLC

		AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		ł	STF	REET ADDRESS, CITY, STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB				
				FR	EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 226	Continued From pa	ae 14	Ε¢	226		
,	resident property	90 / /	1 2	.2.0		
	(c)(3) Dementia ma prevention. This REQUIREMEN by: Based on staff inter and facility document that facility staff fail their abuse policy pu five employee recorn nursing assistant] #	nagement and resident abuse NT is not met as evidenced rview, clinical record review, nt review, it was determined ed to screen employees per rior to employment for three of ds reviewed, CNA [certified 12, CNA #11 and CNA #13.				
	obtain reference che	ecks on two of five employees , CNA #11 and CNA #13.				
	Review of CNA (cerr employment record employee was hired verified on 12/29/16 was no evidence of employee's sworn si employee's schedule 10:10 a.m. from OS payroll and human r "This is what corpora dated from 5/23/16 t worked with residen	tified nursing assistant) #12's documented that the on 1/21/16. The license was , eleven months later. There documentation regarding the tatement. A copy of the partial e was obtained on 4/27/17 at M (other staff member) #6, esource, OSM # 6 stated, ate sent." The schedule was to 12/29/16. The employee ts a total of 603.61 hours			RECEVED	
	during that time fram	10.			VDH/OLC	
	documented the em	≇13's employee record ployee was hired on 11/7/16. ified on 12/29/16 almost two			VLT!/VLV	

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		AND HUMAN SERVICES				FORM	): 05/11/201 1 APPROVEI ). 0938-039
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIO		(X3) DAT COM	TE SURVEY MPLETED
		495240	B. WING				C / <b>28/2017</b>
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS 3900 PLANK ROA	CITY, STATE, ZIP CODE		
FREDER	CKSBURG HEALTH	AND REHAB		FREDERICKSB			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORREC DRRECTIVE ACTION SHO FERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 15	F2	226			
	months later. There	e was no evidence of arding reference checks.					
	documented that th 1/21/16. There was	's employee record a employee was hired on a no evidence of arding reference checks being					
	a.m. OSM #6. Whe reference checks, ( over HR (human re HR person is suppo When asked why th #6 stated, "To make good employees." V a background chec sure but they need check before they s why licenses were v	onducted on 4/26/17 at 11:15 on asked who obtained DSM #6 stated, "We just took sources) two weeks ago. The osed to get the references." hey do reference checks, OSM e sure that these people are When asked when they obtain k, OSM #6 stated, "I'm not to have a criminal background tart working." When asked verified, OSM #6 stated, "To re a valid license and there's the resident abuse."					
	member) #1, the ac	p.m. ASM (administrative staff Iministrator and ASM #2, the vere made aware of the					
	ASM #1, the admini reference checks w ASM #1 stated, "We	onducted on 4/28/17 at 9:50 strator. When asked why ere completed on employees, e do reference checks to work history and character.		y water for the second se	and the second s		
	To confirm what the	y have put on their resume."			lle de la companya de La companya de la comp		
	background checks stated, "Barrier crim	were completed, ASM #1 es for background check and e to confirm they can operate		VDH/	OLC		
		· · ·	·				

Facility ID: VA0088

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						NTED: 05/11/2013 FORM APPROVED <u>B NO: 0938-039</u>
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY,	STATE, ZIP CODE	04/20/2011
FREDER				3900 PLANK ROAD		
				FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	AN OF CORRECTION       IDENTIFICATION NUMBER:       A BUILDING         495240       B. WING         IOF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         DERICKSBURG HEALTH AND REHAB       STREET ADDRESS, CITY, STATE, ZIP CODE         ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         ID       RESULTORY OR LSC DENTIFING INFORMATION)       TAG         CONTINUE FOR DATE OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         2260       Continued From page 16       F 226       F       F         ID       Monor the facility of each resident facility					
F 226	Continued From pa	age 16	F 2	26		
	•	RRECTION       IDENTIFICATION NUMBER:       A. BUILDING         495240       B. WING         DER OR SUPPLIER       STREET ADDRESS, CITY, 3900 PLANK ROAD FREDERICKSBURG,         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         titinued From page 16 ne scope of their practice."       ID       PREVIDENCY TAG       PROVIDENS (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       F 226         titinued From page 16 ne scope of their practice."       F 226         iew of the facility's policy titled, "Resident se" documented, "POLICY: It is inherent in nature and dignity of each resident at Facility hershe be afforded basic human rights, juding the right to be free from abuse, neglect, reatment, and/or misappropriation of berty. The management of the Facility ggnizes these rights and hereby establishes following statements, policies and procedures rotect these rights and hereby establishes following statements, policies and procedures rotect these rights and to escapened for a ory of abuse, neglect, or mistreating residents clude: A. References from previous or ent employers (with applicant permission). B. ninal Background check. C. Abuse check with opriate licensing board and registries, prior to D. Swore Disclosure Statement prior to hire."       F 240         A facility must treat each resident with ect and dignity and care for each resident in anner and in an environment that promotes tenance or enhancement of his or her quality, a, recognizing each resident's individuality. facility must protect and promote the rights of esident.       F 240 <td></td> <td></td>				
	Abuse" documenter the nature and digr that he/she be affo including the right t mistreatment, and/ property. The mana recognizes these right disciplinary policy, w the following statem to protect these right disciplinary policy, w the fair and timely t resident abuse. Sci employment with F history of abuse, ner to include: A. Refer current employers ( Criminal Backgrour appropriate licensin hire. D. Swore Disc E. Verify license or	ed, "POLICY: It is inherent in hity of each resident at Facility rded basic human rights, to be free from abuse, neglect, for misappropriation of agement of the Facility ights and hereby establishes nents, policies and procedures hts and to establish a which policy, which results in creatment of occurrences of reening. Persons applying for acility will be screened for a eglect, or mistreating residents rences from previous or (with applicant permission). B. nd check. C. Abuse check with ng board and registries, prior to closure Statement prior to hire."				
F 240 SS=D	483.10(a)(1)(2) CA	RE AND ENVIRONMENT	F 2	40		
	respect and dignity a manner and in an maintenance or enh of life, recognizing e	and care for each resident in environment that promotes nancement of his or her quality each resident's individuality.				
		ust provide equal access to ess of diagnosis, severity of		VDH/OLC		
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6R5B1	1	Facility ID: VA0088	If continuation sh	neet Page 17 of 278

		HAND HUMAN SERVICES			PRINTED: 05/11/20 FORM APPROVE OMB NO. 0938-039
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B WING		04/28/2017
NAME OF I	PROVIDER OR SUPPLIEF		J ST	REET ADDRESS, CITY, STATE	, ZIP CODE
			39	00 PLANK ROAD	
REDER	ICKSBURG HEALTH	I AND REHAB	F	REDERICKSBURG, VA 2	2407
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 240	Continued From p	age 17	F 240	F240 1. Resident #13 gr	ievance initiated
		ent source. A facility must		and resolved.	
		ntain identical policies and		2. The Social Servi	ces Director re-
	practices regardin	g transfer, discharge, and the es under the State plan for all			Services Assistant 6-5-17
		ss of payment source.		on the concern proc	
		NT is not met as evidenced		3. The Social Servi	
	by:			Service Assistant w	
	Based on residen	t interview, facility staff		concerns in stand u	p to ensure concern
		ocument review and clinical as determined that the facility		forms are complete	-
		a resident with dignity and		occurred. A random	-
		g the quality of life for one of 32	•	forms will be audite	
		rvey sample, Resident #13.		week times four we monthly times two	eeks and then
		B told the facility social worker		4. The Social Servi	
	that she did not wa	ant a particular nurse medications, the social worker		designee will report	
		esident that she should take		monthly to the Qua	
	medications by wh	omever offers them to her, and	ł	Performance Impro	
		I that nurse thank you.		for continued comp	
	The findings inclue	je:		revision.	
	6/5/15 and readmi including, but not l disorder (1), conge schizoaffective dis MDS (minimum da	admitted to the facility on tted on 3/31/17 with diagnoses imited to: Diabetes, bipolar estive heart failure, and order (2). On the most recent ata set), a quarterly assessmen	t		
	with an assessme was coded as hav making daily decis	nt reference date of 2/6/17, she ing no cognitive impairment for ions.	<b>3</b>	PECENCED	
	revealed the follow OSM (other staff r "SW (social worke issues of concern	ogress notes for Resident #13 ving entry written 3/15/17 by nember) #4, the social worker: r) met with resident to discuss that resident has voiced to staf <. Suggested resident	f	VDH/OLC	
	567/02-99) Previous Version		Eac	ility ID: VA0088	If continuation sheet Page 18 of

Facility ID: VA0088

		AND HUMAN SERVICES				FORM	D: 05/11/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495240	B. WING			04	C /28/2017
NAME OF I	PROVIDER OR SUPPLIER	L	1	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
FREDER	ICKSBURG HEALTH	AND REHAB					
				FRE	DERICKSBURG, VA 22407	-011	······
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 240	Continued From pa	ge 18	F 2	240			
	from any of the nur	ve her meds (medications) ses, and offer a thank you. would. SW to observe and					
		lity grievance/concern log ce of any concerns expressed ring March 2017.					
	services director, w her role, once a corr resident through sta log and proceed to stated staff member details of the concer form to the social w "When we receive a with the necessary They work to resolv contact the complain any follow up action #5 stated: "I now de put the resolution at When asked to local concerns expressed 2017, OSM #5reviet don't see any. If it's grievance, it does n	a.m., OSM #5, the social as interviewed. She stated neern is expressed by a aff, is to log it in the concern resolve the concern. She rs fill out a form with the trn, and then they submit the torkers. OSM #5stated: any type of concern, we meet departments and inform them. re the issue, and then they nant." She stated she records is on the concern log. OSM o [the logs] month by month. I nd the action plan in the log." ate the log entry regarding d by Resident #13 in March wed the log and stated: "I a not given to me as a ot go on the log." OSM #5 uld have more information" on			RECEIVED		
	On 4/26/17 at 10:05 interviewed. After r	eviewing the above					
	was asked to provid expressed by Resid 3/15/17. OSM #4 s	e had written on 3/15/17, she le the details of the concerns lent #13 in the week prior to tated: "It was something that ay. It goes back to a personal			VDH/OLC		

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Facility ID: VA0088

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		AND HUMAN SERVICES			F	NTED: 05/11/2017 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	TIPLE CONSTRUCTION	T	(3) DATE SURVEY COMPLETED
		495240	B. WING	j		C 04/28/2017
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STA	TE, ZIP CODE	
				3900 PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIA CIENCY)	
F 240	the nursing staff. S some particular nur I always say thank told her I expected asked to clarify exa resident about the r express gratitude to "That is not being ro offers the medicatio offer a thank you. I we are going to get a resident's respon with the staff, or if, responsibility to nav OSM #4 stated: "W when someone offer courtesy." When a nurses named by F had not. She state concern log. When logged the concern seek us out with a p on that. I feel like y confide certain thin they say on the log On 4/26/17 at 12:50 interviewed. When her nurses in March nurses "told lies ab "They sent some of apologize to me ab stated she asked for take care of her an remembers is OSM She stated OSM #4 allowed to say which	ent #13] had established with she had wanted not to have reses assigned to her. I told her you when I get a med, and I her to say thank you." When notly what she stated to the need for the resident to the staff, OSM #4 stated: espectful. Whatever nurse on, you need to accept it and I told her that's the only way past this." When asked if it is sibility to "get past" anything rather, it is the staff's vigate around the resident, Vell don't you say thank you ers you something? It is just sked if she talked to any of the Resident #13, she stated she d she did not put it on the n asked why she had not a, OSM #4 stated: "When they particular complaint, I will put it you are violating their right to gs with me if I put everything		240 RECEIVE	2	
FORM CMS-2	567(02-99) Previous Versions	S Obsolete Event ID: 6R5B1	1	Facility ID: VA0088	If continuation	sheet Page 20 of 278

	MENT OF HEALTH						FOF	RM APPROVED
STATEMENT		(X1) PROVIDER/SUF IDENTIFICATIO	PPLIER/CLIA	1 1		CONSTRUCTION		OMPLETED
		4952	40	B. WING				C )4/28/2017
	PROVIDER OR SUPPLIER			1	STR	EET ADDRESS, CITY, STATE, 2		
					3900	) PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB			FRE	DERICKSBURG, VA 224	407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 240	Continued From pay whomever adminis you. When asked OSM #4, Resident supposed to say? had already told mo Just keep my mout me. It's what I did. "just trying to do wh here. I am trying to On 4/26/17 at 6:30 staff member) #1, ft director of nursing, regional director of informed of this co procedures regard concerns/grievance On 4/27/17 at 11:44 nurse) #11, a unit r When asked to rev #4 on 3/15/17, she know anything abo resident's concern further, LPN #11 st worker should have asked if it is approp a resident to accep administers them a stated: "No, it is no A review of the fac Process" revealed.	ters her medicati to describe her n #13 stated: "Wi I just said okay. e not to get in an h shut and do wi "Resident #13 s nat I have to do to be nice." p.m., ASM (adm he administrator and ASM #3, the clinical services ncern. Policies a ng resident es were requeste D a.m., LPN (lice nanager, was int iew the note writ did so and state ut this." When a should have bee ated: "Absolutel e at least looked oriate for a socia at medications fro and to say thank of appropriate in lity policy entitled in part, the follor	esponse to hat else was I My daughter y trouble. hat they tell stated she is o get out of inistrative , ASM #2, the e interim , were and ed. nsed practical erviewed. ten by OSM d: "I did not sked if the en investigated y. The social into it." When I worker to tell om whomever you, LPN #11 any way." d "Concern wing: "Upon		240	RECEIVED		
	identification of a p concern, staff com identifying the issu Administrator or de Care Keepers mee designee logs the	pletes the Conce e and forward the signee. During sting, the Adminis	ern Form e form to the the morning strator or			VDH/OLC		
FORM CMS-2	567(02-99) Previous Version		Event ID: 6R5B	11	Facili	ty ID: VA0088	If continuation she	eet Page 21 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				FO	ED: 05/11/2017 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495240	B. WING	S			04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		4	S	REET ADDRESS, CITY, STATE, ZIP COI		
FREDER	ICKSBURG HEALTH	AND REHAB		1	000 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	and on the Morning administrator or des the concern form to head for follow-up a morning meeting( concern is identified resolve the issue fo potential systemic or recurrence or occur assigned departmen appropriate party or completed." No further information 483.40(d) PROVISIN RELATED SOCIAL (d) The facility must social services to at practicable physical well-being of each re This REQUIREMEN by: Based on resident i interview, facility door record review, it was staff failed to provide services to one of 32 sample, Resident #7	Meeting agenda. The signee copies and forwards the appropriate department and resolution during the Drace the root cause of the l, corrective action is taken to r the identified party as well as hanges to reduce risk of rence for others. The the head contacts the face resolution has been on was provided prior to exit. ON OF MEDICALLY SERVICE provide medically-related tain or maintain the highest , mental and psychosocial esident. IT is not met as evidenced nterview, facility staff cument review and clinical s determined that the facility e medically related social 2 residents in the survey 13. orker failed to investigate and ht #13's concern about a		240			
	The findings include	:					
		dmitted to the facility on ed on 3/31/17 with diagnoses			VDH/OLC		

Facility ID: VA0088

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ATEMENT OF DEFICIENCIES	ARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMP	LETED	
	495240	B. WING		04/2	8/2017	
PREFIX (EACH DEFICIE		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
disorder (1), col schizoaffective MDS (minimum with an assess was coded as h making daily de A review of the revealed the foll OSM (other stat "SW (social wor issues of conce over the past we compromise, re from any of the Resident said s monitor."	ot limited to: Diabetes, bipolar ngestive heart failure, and disorder (2). On the most recent data set), a quarterly assessment nent reference date of 2/6/17, she aving no cognitive impairment for cisions. progress notes for Resident #13 owing entry written 3/15/17 by f member) #4, the social worker: ker) met with resident to discuss rn that resident has voiced to staff eek. Suggested resident ceive her meds (medications) nurses, and offer a thank you. he would. SW to observe and		<ol> <li>F250</li> <li>Resident #13 grievance and resolved.</li> <li>The Social Services Dire educated the Social Service on the concern process, cor investigations and resolution 3. The Social Service Direct Service Assistant will common concerns in stand-up to ensign forms are initiated, investign conducted and follow-up of random review of concern be audited three times a we four weeks and then month two months.</li> <li>The Social Services Direct</li> </ol>	ector re- es Assistant nducting ons. etor/Social municate ure concern gations ccurred. A forms will ek times ly times	6-5-17	
revealed no evid by Resident #13 On 4/26/17 at 9 services directo her role, once a resident through log and proceed stated staff mer details of the co	dence of any concerns expressed a during March 2017. 45 a.m., OSM #5, the social r, was interviewed. She stated concern is expressed by a n staff, is to log it in the concern to resolve the concern. She nbers fill out a form with the ncern, and then they submit the al workers. OSM #5 stated:		Designee will report the au- monthly to the Quality Ass Performance Improvement for continued compliance a revision.	urance committee		
"When we recei with the necess	ve any type of concern, we meet ary departments and inform them. solve the issue, and then they		RECEIVED			
They work to re	plainant." She stated she records		March S. A. Land			

Facility ID: VA0088

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	MENT OF HEALTH						INTED: 05/11/201 FORM APPROVEI IB NO. 0938-039		
STATEMENT		(X1) PROVIDER/			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		49	5240	B. WING			C 04/28/2017		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY	, STATE, ZIP CODE			
EDENED	ICKSBURG HEALTH				3900 PLANK ROAD				
TREDER					FREDERICKSBURG	, VA 22407			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREF TAG	IX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD E NCED TO THE APPROPRI DEFICIENCY)	And a second		
F 250	Continued From pa	ae 23		F	250				
	concerns expresse 2017, OSM #5 revie don't see any. If it's grievance, it does n stated OSM #4 "wo Resident #13. On 4/26/17 at 10:05 interviewed. After n referenced note she was asked to provid expressed by Resid 3/15/17. OSM #4 s occurred on a Sund relationship [Reside the nursing staff. S some particular nur I always say thank y told her I expected I asked to clarify exa- resident about the n express gratitude to "That is not being re offers the medicatio offer a thank you. I we are going to get a resident's respons with the staff, or if, n responsibility to nav OSM #4 stated: "W when someone offe courtesy." When as nurses named by Re she had not. She st concern log. When logged the concern,	ewed the log as a not given to r lot go on the lo uld have more 5 a.m., OSM # eviewing the as a had written of the details of lent #13 in the tated: "It was lay. It goes bas he had wanted ses assigned for you when I get her to say that citly what she s need for the re- the staff, OSI espectful. What n, you need to told her that's past this." Whis biblity to "get p ather, it is the igate around t ell don't you s rs you someths ked if she talk esident #13, C ated she did r asked why sh	and stated: "I me as a og." OSM #5 e information" on 4 was above on 3/15/17, she of the concerns week prior to something that ack to a personal stablished with d not to have to her. I told her a med, and I ak you." When stated to the sident to M #4 stated: atever nurse o accept it and the only way hen asked if it is past" anything staff's he resident, ay thank you ing? It is just aed to any of the DSM #4 stated hot put it on the e had not		RECEIVED				
	seek us out with a p on that. I feel like yo confide certain thing	articular comp ou are violating	laint, I will put it g their right to		VDH/OLC				
DRM CMS-256	7(02-99) Previous Versions (	Dbsolete	Event ID: 6R5B11		Facility ID: VA0088	If continuation s	sheet Page 24 of 27		

Ν.

TATEMENT OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		IG	COMPLETED
	495240	B. WING _		C 04/28/2017
NAME OF PROVIDER OR SUPPLIER	<b>K</b> ananan manangan kananan kanan dari kanan kana	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	
FREDERICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLET
F 250 Continued From page	ge 24	F 25	0	
they say on the log.	n			
interviewed. When her nurses in March nurses "told lies abo "They sent some of apologize to me abo stated she asked fo take care of her any remembers is OSM She stated OSM #4 allowed to say which them medications, a whomever administe you. When asked to OSM #4, Resident # supposed to say? I had already told me Just keep my mouth me. It's what I did."	<ul> <li>p.m., Resident #13 was asked what happened with h, she stated some of the but me." Resident #13 stated: them back in here to but how they treated me." She r one particular nurse not to more, and the next thing she #4 coming in to talk with her. told her that residents are not n nurses will or will not give and that she should tell ers her medications thank b describe her response to f13 stated: "What else was I just said okay. My daughter not to get in any trouble.</li> <li>a shut and do what they tell Resident #13 stated she is at I have to do to get out of be nice."</li> </ul>			
staff member) #1, th director of nursing, a	b.m., ASM (administrative le administrator, ASM #2, the and ASM #3, the interim clinical services, were			
procedures regardin worker were request	g responsibilities of the social			
worker were request On 4/27/17 at 11:40	g responsibilities of the social		ECEIVED	
worker were request On 4/27/17 at 11:40 nurse) #11, a unit ma When asked to revie	g responsibilities of the social led. a.m., LPN (licensed practical		ECENED Mai 3 1 207	

Event ID: 6R5B11 Facility ID: VA0088

If continuation sheet Page 25 of 278

		AND HUMAN SERVICES			ſ	NTED: 05/11/2017 FORM APPROVED B NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION		(3) DATE SURVEY COMPLETED
		495240	B. WING	j		C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG,	VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI/ EFICIENCY)	(X5) E COMPLETION ATE DATE
F 250	asked if it is approp a resident to accep administers them a stated: "No, it is no A review of the facil Services Director" r "The primary duties organize, develop a of the facility's Soci according to federa The ideal candidate communications ar interact with the fac the staff members to maintained on an in	e at least looked into it." When oriate for a social worker to tell t medications from whomever and to say thank you, LPN #11 of appropriate in any way." lity document entitled "Social revealed, in part, the following: s of this position are to plan, and direct the overall operation al Service department al, state, and local guidelines. es will possess good nd interpersonal skills to cility's residents and work with to ensure residents' needs are	1	250		
	causes unusual shi levels, and the abili tasks." This inform https://www.nimh.n order/index.shtml. (2) "Schizophrenia disorder that affects and acts." This info website https://www.nimh.n zophrenia-booklet/i (1) "Bipolar disorde manic-depressive il causes unusual shi	Ilness, is a brain disorder that ifts in mood, energy, activity ity to carry out day-to-day nation is taken from the website ih.gov/health/topics/bipolar-dis is a chronic and severe s how a person thinks, feels, prmation is taken from the ih.gov/health/publications/schi ndex.shtml.	5	RECEIVER MAR 31 244 VDH/OLC		
FORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID: 6R5E	11	Facility ID: VA0088	If continuation	sheet Page 26 of 278

CENT DESCRIPTION       Display the processing of the solution of the processing of the solution of the	CENTIFICS FOR DECIDENCES       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY         AND OF PROVIDER OF SUPPLY       495240       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY         AND OF PROVIDER OF SUPPLY       495240       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY         FREDERICKSBURG HEALTH AND REHAB       STREET ADDRESS, CITY, STATE, ZP CODE       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY         FREDERICKSBURG HEALTH AND REHAB       STREET ADDRESS, CITY, STATE, ZP CODE       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY         FREDERICKSBURG, VA 22407       PROVEMENT OF USE OF SUPPLY       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPPLY         F250       SUBMARY STATEMENT OF DEPOSITIONES OF ADDRESS, CITY, STATE, ZP CODE       (C) PROVIDER OF SUPPLY       (C) PROVIDER OF SUPLY       (C) PROVIDER OF SUPLY <th></th> <th></th> <th>AND HUMAN SERVICES</th> <th></th> <th></th> <th>KINTED: 05/11/2017 FORM APPROVED MB NO, 0938-0391</th>			AND HUMAN SERVICES			KINTED: 05/11/2017 FORM APPROVED MB NO, 0938-0391
495240         B. WING         04/28/2017           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZP CODE         STREET ADDRESS, CITY, STATE, ZP CODE           (X4) ID TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCIES ON AND READ REDUCTION SHOULD BE (EACH OFFICIENCIES TO THE APROPRIATE DEFICIENCIES ON AND READ REDUCTION SHOULD BE (EACH OFFICIENCIES THE ADD (EACH OFFICIENCIES ON AND READ REDUCTION SHOULD BE (EACH OFFICIENCIES THE ADD (EACH OFFICIENCIES THE ADD (EAC	495240         b wind         04/28/2017           NAME OF RROWDER OR SUPPLER         STREET ADDRESS. CITY, STATE, 2P CODE         3900 PLANK ROAD           FREDERICKSBURG, VA 22407         FREDERICKSBURG, VA 22407         FREDERICKSBURG, VA 22407           (X) ID PRETER TRG         BUMMARY STATEMENT OF DEFICIENCIES (EACH DEFINITION OF DEFICIENCIES (EACH DEFINITION (EACH DEFINITION OF DEFICIENC	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ( )	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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PREDERICKSBURG HEALTH AND REHAB       3900 PLANK ROAD         PREDERICKSBURG HEALTH AND REHAB       3900 PLANK ROAD         PREDERICKSBURG HEALTH AND REHAB       Image: Construction of the construction construction of the construction of the construction c	FREDERICKSBURG HALTH AND REHAB       3000 PLANK ROAD         FREDERICKSBURG, VA 22407         Patho       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MALTER PRECEDED bY FLIL RECULATORY OR LSC DENTIFYING INFORMATION)       Deficiency actions solutions (EACH DEFICIENCY actions and solutions)       Deficiency actions and solutions (EACH DEFICIENCY actions and solutions)         F 250       Continued From page 28 tasks." This information is taken from the website https://www.nimh.nih.gow/health/publications/schi zophrenia-bookletindex.shtml.       F 250         F 252       SAFE/CLEAN/COMFORTABLE/HOMELIKE EDIV/ROMMENT       F 252         (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space pormis, unless to do so would infinge upon the rights or health and safety of other residents.       F 252         § 433 10(i) Safe environment, The resident has a right to a safe, clean, comfortable, and homelike environment, including burnt timeted to receiving the assessions including turn to intende to represent a supports for daily living safely. The facility must provide-       S The Administrator re-educated the Interdisciplinary Team on submitting work order requisitions as indicated. Resident care equipment to include wheelchairs will be randomly reviewed by the Interdisciplinary Team on will report the audit results monthly to the Quality Assurance Performance Improvement Committee for continued compliance and/or revision.         (i) This includes ensuring that the resident independence and does not pose a safety risk.       EPECE VEED			1 433240	1	STREET ADDRESS, CITY, STATE, ZIP CODE	
FREDERICKSBURG, VA 22407         (X410 TAG       SUMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY OF LSC LIDENT FINAL APPORTATION)       ID PROVEMENT PLAN OF CORRECTION (EACH DEFICIENCY)         F 250       Continued From page 26 tasks." This information is taken from the website https://www.ninh.nih.gov/health/topics/bipolar-dis order/index.shtml.       F 250         (2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.ninh.nih.gov/health/topics/bipolar-dis order/index.shtml.       F 250         F 252 483.10(4) (2)(1)(1)(0) SS=D SAFE/CLEANCOMFORTABLE/HOMELIKE ENVIRONMENT       F 252         (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permix, unless to do swould infringe upon the rights or health and safety of other residents.       F 253         \$433.10(4) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, allowing the resident to use his o her personal belongings to the extent possible.       The Interdisciplinary Team during care keeper rounds weekly times four weeks and the monthly times two months.         (1) This includes ensuring that the resident independence and does not pose a safety risk.       The Interdisciplinary Team will report the audit results monthly to the port independence and does not pose a safety risk.         (ii) The facility shall exercise reasonable care for the protection of the resident to groen the protection of the resident port port for moles       The facility shall exercise reasonable care for the protection of the resident port port for moles<	FREDERICKSBURG HEALTH AND REHAB       FREDERICKSBURG, VA.2207         MAID       SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY ON LISE DEPICIENCIES) (EACH DEFICIENCY ON LISE DEPICIENCY REGULATORY ON LISE DEPICIENCIES) (EACH DEFICIENCY ON LISE DEPICIENCY REGULATORY ON LISE DEPICIENCY REGULATORY ON LISE DEPICIENCY (EACH DEFICIENCY)       F250         F 250       Continued From page 26 tasks." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-booklet/index.shtml.       F250         F 252       A33.10(e)(2)(1)(1)(0)       F252         SS=D SAFE/CLEN/COMFORTABLE/HOMELIKE ENVIRONMENT       F252         (e)(2) The right to retain and use personal possessions, including furnishings, and clothing as space pormis, unless to do so would infringe upon the rights or health and safely of other residents.       F252         (e)(2) The right to retain and use personal postessions, including furnishings, and clothing as space pormis, unless to do so would infringe upon the rights or health and safely of other residents.       S483.10(0) Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment, allowing the resident to use his or ther personal belongings to the extent possible.       The Interdisciplinary Team during care keeper rounds weekly times four weeks and the monthly to the Quality Assurance Performance Improvement Committee for continued compliance and/or revision.         (i) The facil	NAME OF I	PROVIDER OR SUPPLIER		1		
<ul> <li>(A) D (2) Continued From page 26 (2) This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-dis or der/index.shtml.</li> <li>(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-dis or der/index.shtml.</li> <li>(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-bookle/index.shtml.</li> <li>F 252 483.10(e)(2/(i)(1)(i)) (3) Se Septement. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-</li> <li>(i) The includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</li> <li>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss</li> </ul>	<ul> <li>(24) D react interface recent by Full recent of the precedent to precedent of the precedent to precedent to precedent to precedent to precedent to precedent to the precedent to precedent to the precedent to precedent to the precedent to precedent to</li></ul>	FREDER	ICKSBURG HEALTH	AND REHAB			
<ul> <li>(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-dis order/index.shtml.</li> <li>(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-booktet/index.shtml.</li> <li>F 252 433.10(e)(2)(0)(10)(ii)</li> <li>GS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</li> <li>(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.</li> <li>§483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-</li> <li>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident.</li> <li>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss</li> </ul>	<ul> <li>F252 433.10(e)(2)(1)(1)(0)</li> <li>F252 43.10(e)(2)(1)(1)(1)(1)</li> <li>F252 43.10(e)(2)(1)(1)(1)(1)</li> <li>F252 43.10(e)(2)(1)(1)(1)(1)(1)</li> <li>F252 43.10(e)(2)(1)(1)(1)(1)(1)</li> <li>F252 43.10(e)(2)(1)(1)(1)(1)(1)(1)(1)</li> <li>F252 43.10(e)(2)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)</li></ul>	PRÉFIX	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	DBE COMPLETION
<ul> <li>https://www.nimh.nih.gov/health/topics/bipolar-dis order/index.shtml.</li> <li>(2) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-booklet/index.shtml.</li> <li>F 252 483.10(e)(2)(0)(1)(0)(i)</li> <li>SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</li> <li>(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.</li> <li>§483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-</li> <li>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</li> <li>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss</li> </ul>	<ul> <li>https://www.nimh.nih.gov/health/topics/bipolar-disorderthat affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-booklet/index.shtml.</li> <li>F 252 33.10(e)(2)(1)(1)(0)(i)</li> <li>F 252 33.10(e)(2)(1)(1)(0)(i)</li> <li>F 253 33.10(e)(2)(1)(1)(0)(i)</li> <li>F 254 Were replaced on April 27, 2017.</li> <li>C. The Plant Operations Director/ designee will inspect current residents' wheelchairs to ensure armrests are of free from tears.</li> <li>S 3. The Administrator re-educated the Interdisciplinary Team on submitting work order requisitions as indicated.</li> <li>Resident care equipment to include wheelchairs will be randomly reviewed by the Interdisciplinary Team on submitting work order requisitions as indicated.</li> <li>Resident care equipment to include wheelchairs will be randomly reviewed by the Interdisciplinary Team during care keeper rounds weekly times four weeks and then monthly times two months.</li> <li>(i) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</li> </ul>	F 250			F 250	)	
<ul> <li>disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-booklet/index.shtml.</li> <li>F 252 483.10(e)(2)(i)(1)(i)(i)</li> <li>SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</li> <li>(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.</li> <li>S483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-</li> <li>(i) (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</li> <li>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</li> <li>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss</li> <li>F 252 I. Resident #2 wheelchair armrests were replaced on April 27, 2017.</li> <li>2. The Plant Operations Director/ designee will inspect current residents? wheelchairs to ensure armrests are of 6-5-17 free from tears.</li> <li>3. The Administrator re-educated the Interdisciplinary Team on submitting work order requisitions as indicated. Resident care equipment to include wheelchairs will be randomly reviewed by the Interdisciplinary Team will report the audit results monthly to the Quality Assurance Performance Improvement Committee for continued compliance and/or revision.</li> </ul>	<ul> <li>disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schi zophrenia-booklet/index.shtml.</li> <li>F 252 483.10(e)(2)(i)(1)(i)(i)</li> <li>SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</li> <li>(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 resident ts.</li> <li>§ 483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-</li> <li>(i) (1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</li> <li>(ii) The includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</li> <li>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</li> </ul>		https://www.nimh.r	nation is taken from the website nih.gov/health/topics/bipolar-dis			
			disorder that affect and acts." This inf website https://www.nimh.r zophrenia-booklet/ 483.10(e)(2)(i)(1)(i SAFE/CLEAN/COI ENVIRONMENT (e)(2) The right to r possessions, inclu- as space permits, upon the rights or l residents. §483.10(i) Safe en right to a safe, clear environment, inclu- treatment and sup The facility must pr (i)(1) A safe, clean environment, allow her personal belom (i) This includes er receive care and s physical layout of t independence and (ii) The facility shall the protection of th	is how a person thinks, feels, formation is taken from the hih.gov/health/publications/schi index.shtml. )(ii) MFORTABLE/HOMELIKE retain and use personal ding furnishings, and clothing, unless to do so would infringe health and safety of other vironment. The resident has a an, comfortable and homelike ding but not limited to receiving ports for daily living safely. rovide- , comfortable, and homelike <i>r</i> ing the resident to use his or ugings to the extent possible. hsuring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk.	F 252	<ol> <li>Resident #2 wheelchair armine were replaced on April 27, 201</li> <li>The Plant Operations Direct designee will inspect current re- wheelchairs to ensure armrests free from tears.</li> <li>The Administrator re-educat Interdisciplinary Team on subr work order requisitions as india Resident care equipment to ince wheelchairs will be randomly r by the Interdisciplinary Team of care keeper rounds weekly time weeks and then monthly times months.</li> <li>The Interdisciplinary Team of report the audit results monthly Quality Assurance Performanc Improvement Committee for com</li> </ol>	7. or/ esidents' are of 6-5-17 ed the nitting cated. lude reviewed luring es four two will y to the e

VDH/OLC

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROVE	Đ
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495240	B. WING	1		C 04/28/2017	
NAME OF F	PROVIDER OR SUPPLIER		1		EET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			) PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO	N
F 252	by: Based on observat document review a was determined that maintain a clean, c environment for on sample, Resident # The facility staff fail wheelchair armrest The findings includ Resident #2 was at 8/30/16 and readm	NT is not met as evidenced tion, staff interview, facility nd clinical record review, it at the facility staff failed to omfortable, homelike e of 32 residents in the survey 22. led to maintain Resident #2's is in good repair.	F	252			
	limited to: multiple depressive disorder MDS (minimum da status assessment reference date) of being cognitively in Resident #2 as req two or more staff w	sclerosis, diabetes and major r. Resident #2's most recent ta set), a significant change in with an ARD (assessment 1/30/17, coded the resident as tact. Section G coded uiring extensive assistance of with bed mobility and as being on two or more staff with					
	observations of Re conducted. A torn inches long by one	p.m. and 4/27/17 at 8:45 a.m., sident #2's wheelchair were area (approximately four and a half inch wide) was					
	exposed. A torn a	ght armrest; foam padding was ea (approximately two inches wido) was observed on the left					
	armrest; foam pad	wide) was observed on the left ding was exposed. Resident n these observations were			VDH/OLC		

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	IMENT OF HEALTH						F	ORM APPROVED NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPL IDENTIFICATION N	IER/CLIA		TIPLE CONSTRUCT		T	3) DATE SURVEY COMPLETED
		495240		B. WING				C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		1	T	STREET ADDRES	SS, CITY, STATE, ZIP CC	DE	
					3900 PLANK RO	DAD		
FREDER	ICKSBURG HEALTH	AND REHAB			FREDERICKS	BURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC / MUST BE PRECEDED I SC IDENTIFYING INFOR	BY FULL	ID PREFI TAG	(EACH	VIDER'S PLAN OF COR CORRECTIVE ACTION REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION TE DATE
F 252	Continued From pa On 4/27/17 at 8:48 conducted with CN. #1. CNA #1 stated residents more than see if wheelchair re- stated if wheelchair CNAs submit main CNA #1 stated the quick to fix needed staff ever complete wheelchairs for need the housekeeping of every Sunday. Whe had noticed any rep Resident #2's whee CNA #1 was shown stated she didn't re and she would let the the wheelchair need was asked to clarify department or thera responsible for reparameters. CNA #1 They can fix those. Resident #2's whee comfortable and ho wouldn't want to ha On 4/27/17 at 8:59	a.m., an interview A (certified nursing the CNAs work with n other staff so CN epairs are needed. repairs are needed tenance work order maintenance depa repairs. CNA#1 v s any audits to che eded repairs. CNA department cleans en CNA #1 was ask pairs that were nee elchair, she stated so n Resident #2's who call noticing the tor he therapy department was airing or replacing v stated, "I would go " CNA #1 was ask elchair looked clean omelike. CNA #1 s ve it like that."	assistant) th the As normally CNA #1 d then the r requests. rtment is vas asked if eck #1 stated wheelchairs ked if she ded for she had not. eelchair and m armrests nent know CNA #1 tenance is wheelchair to therapy. ed if n, tated, "I	F 2	52			
	observed replacing armrests. OSM (O director of rehabilita wheelchair was per OSM #3 was asked maintenance depar repairing or replacin #3 stated the rehability wheelchair armrest caseload but typica	Resident #2's whe ther staff member) ation [rehab]) state sonally owned by t d if the rehab depar thent was respon- ng wheelchair arm o staff fixes a reside s if the resident is	eelchair #3 (the d the the resident. rtment or sible for rests. OSM ent's on rehab		ECEIVE			
FORM CMS-2	567(02-99) Previous Versions	Obsolete	Event ID:6R5B11		Facility ID: VA0088	If co	intinuation s	sheet Page 29 of 278

		AND HUMAN SERVICES			PRINTED: 05/11/201 FORM APPROVED OMB NO. 0938-039
TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
FREDER	ICKSBURG HEALTH	AND REHAB	1	3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 252	Continued From pa		F 252	2	
	department fixes v	vheelchair armrests.			
	conducted with OS maintenance). OS department fixes v	a.m., an interview was SM #1 (the director of SM #1 stated the maintenance vheelchair armrests if they are			
notified of an issue. OSM #1 sta maintenance department does n audits to ensure wheelchairs are		rtment does not complete any heelchairs are in good repair.	e		
	OSM #1 was aske a maintenance wo #2's wheelchair ha	d to check his records to see if rk order regarding Resident id been submitted.			
	On 4/27/17 at 9:05 conducted with OS housekeeping). C	5 a.m., an interview was SM #2 (the director of SM #2 stated the			
	housekeeping dep wheelchairs at lea OSM #2 stated if h he writes a mainter	ng department inspects and disinfects at least once a week and as needed. ted if he notices a needed repair then naintenance request and or speaks			1
	On 4/27/17 at 9:19	therapy department. 9 a.m., OSM #1 stated he had			
	not received any r requests regarding armrests.	naintenance work order g Resident #2's wheelchair			
	staff member) #1	5 a.m., ASM (administrative (the administrator) and ASM #2	2		
	(the director of nursing) were made aware of the above findings. ASM #1 stated she previously had a CNA complete an audit regarding			RECEIVED	
	was asked when t	that were needed. ASM #1 he audit was completed and as completed approximately		MAY 3 1 2077	
	two months ago. all information reg	ASM #1 was asked to present		VDH/OLC	
	On 4/27/17 at 9:3	7 a.m., ASM #1 presented an			

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		AND HUMAN SERVICES			FORM	: 05/11/2017 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495240	B. WING			28/2017	
NAME OF P	ROVIDER OR SUPPLIER	[	1	STREET ADDRESS, CITY, STATE, ZIP	P CODE		
FREDERI	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2240	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 252	Continued From pa	age 30	F 2	52			
	documented, "Hi Al checked all wheelc Saturday 2/18/2017 you determine if the	to OSM #3 dated 2/20/17 that II, (Name of CNA) CNA hairs with residents in them on 7. (Name of OSM #3), Can e following parts can be y and billed to the facilityLeft Arm rest 12"					
	couldn't find the ac completed. ASM # findings remained a	a.m., ASM #1 stated she tual wheelchair audit that was 1 was made aware the above a concern because Resident nrests were not repaired.					
	The facility document titled, "ENVIRONMENT & PLANT OPERATIONS" documented, "The Administrator must meet with the Maintenance Director and Housekeeping Supervisor to walk through and discuss the condition of the facility on a weekly basis. Maintenance and housekeeping concerns and repair schedules including, but not limited toResident Care Equipment(wheelchairs)"						
F 279 SS=D	No further informat 483.20(d);483.21(b COMPREHENSIV	tion was presented prior to exit. b)(1) DEVELOP E CARE PLANS	F 2	79			
	assessments components in the residence results of the assessments and the assessments of	must maintain all resident oleted within the previous 15 dent's active record and use the ssments to develop, review dent's comprehensive care		RECEIVED			
	483.21						
FORM CMS-25	567(02-99) Previous Version	s Obsolete Event ID:6R5B1	1	Facility ID: VA0088	f continuation sheet	Page 31 of 278	

		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO: 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	θE
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 279	comprehensive pe each resident, con set forth at §483.10 includes measurah to meet a resident' and psychosocial r comprehensive as care plan must des (i) The services tha or maintain the res physical, mental, a required under §48 (ii) Any services th under §483.24, §4 provided due to the under §483.10, inc	e Care Plans st develop and implement a rson-centered care plan for sistent with the resident rights 0(c)(2) and §483.10(c)(3), that ble objectives and timeframes 's medical, nursing, and mental needs that are identified in the sessment. The comprehensive scribe the following - at are to be furnished to attain sident's highest practicable and psychosocial well-being as 33.24, §483.25 or §483.40; and at would otherwise be required 83.25 or §483.40 but are not e resident's exercise of rights cluding the right to refuse	F 27	<ul> <li>F279</li> <li>Resident #8 vision care plan on April 26, 2017 and revised o 2017 after eye doctor visit. Resi- longer a resident of Fredericksb Rehab.</li> <li>Review admission comprehe assessments completed in the la- ensure care plans were develope on CAA summary sheets.</li> <li>Re-education provided to RN 19, 2017 by Vice President of C Reimbursement and Therapy. R educate the interdisciplinary tea designee will review 10% of ad comprehensive assessment trigg are care planned based on care p monthly times three months.</li> <li>The RNAC/designee will rep monthly to the Quality Assuran Improvement Committee to ens compliance and/or revision.</li> </ul>	n April 27, ident #26 is no burg Health and nsive ist 90 days to ed as identified 6-5-17 IAC on May Clinical ENAC to re- turn. RNAC/ mission gered CAA's plan decisions bort audits ce Performance
	rehabilitative servic provide as a result recommendations findings of the PAS rationale in the res (iv)In consultation resident's represe	d services or specialized ces the nursing facility will t of PASARR . If a facility disagrees with the SARR, it must indicate its sident's medical record. with the resident and the ntative (s)-			
	(A) The resident's desired outcomes	goals for admission and		VDH/OLC	
	(B) The resident's future discharge.	preference and potential for Facilities must document			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM	): 05/11/2017 1 APPROVED ). 0938-0391
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495240	B. WING		04	/28/2017
	PROVIDER OR SUPPLIER	AND REHAB	39	REET ADDRESS, CITY, STATE, ZIP CO 100 PLANK ROAD REDERICKSBURG, VA 22407	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	community was as local contact agen entities, for this pu (C) Discharge plan plan, as appropria requirements set f section. This REQUIREME by: Based on staff int review, clinical rec a complaint invest the facility staff fai care plan from the assessment area) set) assessment f	ent's desire to return to the sessed and any referrals to cies and/or other appropriate				
	plan for the trigge on the CAA of Re	ff failed to develop a vision care red care area of visual function sident #8's admission minimum ith an assessment reference 3/17.				
	comprehensive ca area of pressure of 26's admission M	ff failed to develop a are plan for the triggered care ulcers on the CAA of Resident DS (minimum data set) an ARD (assessment reference 6.	R	ECEIVED		
	The findings inclu	ıde:	2/00/00	AAY 31 2017		
	3/25/17 and read that included but	ras admitted to the facility on mitted on 4/6/17 with diagnoses were not limited to: stroke, ness, respiratory failure,	2	/DH/OLC		

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		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB	39	REET ADDRESS, CITY, STATE 00 PLANK ROAD REDERICKSBURG, VA 2	2407
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 279	Continued From pa	ge 33	F 279		
	difficulty swallowing	and high blood pressure.			
	resident as usually self-understood and others. The resider status was coded "u unable to answer a B of the MDS titled, documented, "B 10 adequate light (with appliances)." The n the box indicating the moderately impaire the MDS document Care Area Triggere indicating the area	n ARD of 4/13/17 coded the			
	not evidence docun An interview was co p.m. with LPN (licer When asked who u stated, "Everybody, asked why resident stated, "To address you know if they're	plan initiated on 3/31/17 did nentation of a vision care plan. onducted on 4/26/17 at 1:15 nsed practical nurse) #4. sed the care plans, LPN #4 the nurses, MDS." When s had care plans, LPN #4 their needs. With a care plan a one person assist, how II addressed in the care plan."			
	p.m. with RN (regist coordinator. When comprehensive care stated she did. Whe triggered in the CAA minimum data set (	onducted on 4/26/17 at 4:30 tered nurse) #2, the MDS asked if she developed the e plan from the CAA, RN #2 en asked if vision had A of Resident #8's admission MDS) with an assessment D) of 4/13/17, RN #2 stated it	, , , , , , , , , , , , , , , , , , ,	ECEIVED AN 31 2.4 /DH/OLC	
	567(02-99) Previous Versions			lity ID: VA0088	If continuation sheet Page 34 of 27

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	TMENT OF HEALTH	AND HUMAN SER	VICES VICES	FORM APPROVED OMB NO. 0938-0391					
STATEMEN	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLI IDENTIFICATION NU	ER/CLIA (>		CONSTRUCTION	(X3	) DATE SURVEY COMPLETED C		
		495240	В	WING			04/28/2017		
	PROVIDER OR SUPPLIER			39	REET ADDRESS, CITY, STAT				
			~	L	PROVIDER'S PLAN		(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCII Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT	COMPLETION		
F 279	<ul> <li>plan for vision, RN her vision." When care plans, RN #2 care for our reside nurse you would w resident." When as to complete the MI they used the RAI instrument).</li> <li>On 4/26/17 at 6:30 member) #1, the a director of nursing findings.</li> <li>Review of the facil PREPARATION" of directs the patient" to discharge."</li> <li>No further information According to Funct Williams and Wilk documented, "A w communication to members that help careThe nursing information about and goals. It cont achieving the goa and is used to dire revise and update there are changes with new orders (1) Fundamentals</li> </ul>	to review Resident # #2 stated, "I don't sea asked why the reside stated, "So we know nts. If you were an a vant to know what to sked what resources DS assessment, RN (resident assessment) (resident	ee one for ents had y how to gency do for that she used #2 stated nt trative staff M #2, the of the ARE PLAN plan admission for to exit. Lippincott 7 es as a e team of source of ns, needs, tions for e patient eview, arly, when ents, and tt Williams	F 279					
FORMICMS	& VVIIKINS 2007 LI pages 65-77. 2567(02-99) Previous Versio		Event ID:6R5B11	Fac	ility ID: VA0088	If continuation s	heet Page 35 of 27		
TOTAN CIVIS-	2001 (02 00)1 101000 101010								

	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM	05/11/2017 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED C		
	495240	B. WING	. WING			04/28/2017	
NAME OF PROVIDER OR SUPPLI	ER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
FREDERICKSBURG HEALTH AND REHAB			3900 PLANK ROAD FREDERICKSBURG, VA 22407				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
DREFIX (EACH DEFICIE	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		IX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE	
F 279 Continued From	page 35	F2	279				
comprehensive area of pressure 26's admission M assessment with date) of 7/12/207							
Resident #26 was admitted to the facility on 7/5/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, thrombocytopenia (a condition in which your blood has a lower than normal number of blood cell fragments called platelets [1]), hip fracture, peripheral vascular disease (poor blood circulation to the lower extremities), anemia (low red blood cell count, atrial fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (affecting the lungs).							
Resident #26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/16 coded Resident #26 as scoring a 0 (zero) out of a possible score of 15 on the BIMS (brief interview for mental status), indicating that Resident #26 was severely cognitively impaired with daily decisions about care. Resident #26 was also coded in Section M, Skin Conditions, as having two unhealed pressure ulcers at the time of the assessment, an unstageable* wound with slough and/or eschar* measuring 5.0 cm (centimeters) x 10.0 cm and an unstageable wound with							
suspected deep tis			VI	DH/OLC			
Further review of Resident #27's MDS assessments revealed, in part, an admission assessment with an ARD of 7/12/16. Section V -			¥ §	ner 6 2.) Nacar Frank Yanger			

Facility ID: VA0088

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		AND HUMAN SERVICES			FOR	D: 05/11/201 MAPPROVEI D. 0938-039
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION	(X3) D/	ATE SURVEY MPLETED
		495240	B. WIN	G		C 4/28/2017
NAME OF F	PROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS, CITY	Y, STATE, ZIP CODE	
				3900 PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG	G, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREI TAG	FIX (EACH CORRE G CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From pa	age 36	F	279		
		nent (CAA) Summary of the				
	admission assessr	nent documented that "16.				
	Pressure Ulcer" wa	as checked as a triggered ca	re			
		"A" and also checked under	ſ			
	column "B. Care P	lanning Decision." The d in Section V states, "2. For				
	each triggered Car	e Area, indicate whether a n	ew			
	care plan, care pla	n revision, or continuation of				
	current care plan is	s necessary to address the				
	problem(s) identifie	ed in your assessment of the	1			
	care area. Check	column B if the triggered car	е			**
	area is addressed	in the care plan." Section V, dent #27's MDS was checke	d			
	for pressure ulcer.					
	A review of Reside	nt #27's comprehensive care	Э			
	plan dated 7/5/16 d	lid not reveal any				
		evidence that pressure ulcers	5			
	were care planned	at the time of admission. Resident #27's care plan				
	revealed, in part, th	ne following documentation;				
	"Focus: Pressure	ulcer actual or at risk due to				
		d in bed in bed mobility. Dat	te			
	Initiated: 7/29/2016	δ.				
	On 1/27/17 at 3:55	p.m. an interview was				
	conducted with RN	I (registered nurse) #2, the				
	MDS coordinator.	RN #2 was asked how she				
	determined what w	rould be placed on the care				
		d, "The care plan is determin	iea			
	by the CAA triggen	ed areas, the medical dications taken. New		Party States and State 1 & Car	SPN mm.	
		in interim care plan in the first	st			
	24 hours which is u	used until the comprehensive		and the second second		
	care plan is compl	eted." RN #2 was asked if			1	
		the CAA would always be ca		V/nume.	Pre	
		ated, "Yes and no, it depend ggered. We make that	0	VDH/OL		
	decision." RN #2 v	was shown the care plan for				
	567(02-99) Previous Version		25B11	Facility ID: VA0088	If continuation shee	t Page 37 of 2

Event ID: 6R5B11

Facility ID: VA0088

	MENT OF HEALTH					PRINTED: 05/11/20 FORM APPROV OMB NO. 0938-03
TEMENT		(X1) PROVIDER/S			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		49	5240	B. WING		04/28/2017
	PROVIDER OR SUPPLIER	1		:	STREET ADDRESS, CITY, STAT 3900 PLANK ROAD FREDERICKSBURG, VA	E, ZIP CODE
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L	ATEMENT OF DEFIC Y MUST BE PRECE SC IDENTIFYING II	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE
F 279	Continued From pa Resident #26 and \$ MDS assessment was asked whethe have been care pla the CAA. RN #2 si care planned, I dor On 4/27/17 at 5:20 was conducted wit member) #1, the a director of nursing, director of clinical so owner. ASM #1, A were all made awa policy regarding car requested at this ti	Section V of his with an ARD of r or not pressu anned based of tated, "It should n't know why it p.m. an end o h ASM (admini dministrator, A ASM #3, the i services and A SM #2, ASM # are of the above are plan develo	7/12/16. RN #2 re ulcers should in the results of d have been wasn't." f day meeting strative staff SM #2, the interim regional SM #4, the 3 and ASM #4 e concerned. A	F 279		
	On 4/28/17 at apprinterview was concepted and the practical nurse) #1 #18 was asked to care plan. LPN #1 developing a plan resident's life better meet their needs. and needs in mind the current care."	roximately 9:45 ducted with LPI 8, the MDS co describe the po 8 stated, "The of care is to ma er, guide aides There should	N (licensed ordinator. LPN urpose of the purpose of ake the and nurses to be specific goals	5		
	A review of the fac Preparation" docu "A care plan direct from admission to	mented, in par s the patient's	t, the following; nursing care			
from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment						
	findings, and it em nursing process: a planning, impleme nursing care plan patient, preferably	bodies the cor assessment, di entation, and ev should be writt	nponents of the agnosis, valuation. A en for each		VDH/OLC	
	2567(02-99) Previous Version		Event ID: 6R5E	11 F	acility ID: VA0088	If continuation sheet Page 38 c

					FORM	: 05/11/2017 APPROVED . 0938-0391
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	E SURVEY IPLETED
	495240	B. WING				28/2017
PROVIDER OR SUPPLIER		L				
ICKSBURG HEALTH	AND REHAB					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	×	(EACH CORRECTIVE ACTION SHOU	_D BE	(X5) COMPLETION DATE
Implementation: B data, determine wh	ased on an analysis of the ich nursing diagnoses will	F 2	279			
No further informat	ion was provided prior to the					
website: http://www.npuap.o clinical-resources/r tegories/. Pressure Injury: Unstageable Press full-thickness skin extent of tissue dar be confirmed beca eschar. If slough o 3 or Stage 4 press Stable eschar (i.e. erythema or fluctua limb should not be	org/resources/educational-and- npuap-pressure-ulcer-stagesca sure Injury: Obscured and tissue loss and tissue loss in which the mage within the ulcer cannot use it is obscured by slough or or eschar is removed, a Stage ure injury will be revealed. dry, adherent, intact without ance) on the heel or ischemic softened or removed.			·		
following website: https://www.nhlbi.n cs/thcp 483.10(c)(2)(i-ii,iv,)	hih.gov/health/health-topics/topi v)(3),483.21(b)(2) RIGHT TO	F	280			
483.10						
and implementatio	n of his or her person-centered					
(i) The right to part including the right	icipate in the planning process, to identify individuals or roles to			VDH/OLC		
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER ICKSBURG HEALTH SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa Implementation: B data, determine wh guide your patient of No further informate end of the survey patient of Summary stageable Press full-thickness skin extent of tissue data be confirmed beca eschar. If slough of 3 or Stage 4 press Stable eschar (i.e. erythema or fluctua limb should not be [1] This information following website: https://www.nhlbi.r cs/thcp 483.10 (c)(2) The right to part (i) The right to part	F CORRECTION IDENTIFICATION NUMBER: 495240  PROVIDER OR SUPPLIER ICKSBURG HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 38 Implementation: Based on an analysis of the data, determine which nursing diagnoses will guide your patient care."  No further information was provided prior to the end of the survey process.  *This information was obtained from the following website: http://www.npuap.org/resources/educational-and- clinical-resources/npuap-pressure-ulcer-stagesca tegories/. Pressure Injury: Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. [1] This information was obtained from the following website: https://www.nhlbi.nih.gov/health/health-topics/topi cs/thcp 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process,	RS FOR MEDICARE & MEDICAID SERVICES       (X2) MUL         OF DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLIA       (X2) MUL         IDENTIFICATION NUMBER:       495240       B. WING         PROVIDER OR SUPPLIER       495240       B. WING         SUMMARY STATEMENT OF DEFICIENCIES       ID       PRECEDED BY FULL       REGULATORY OR LSC IDENTIFYING INFORMATION)       PREET         Continued From page 38       F 2         Implementation: Based on an analysis of the data, determine which nursing diagnoses will guide your patient care."       No further information was provided prior to the end of the survey process.         *This information was obtained from the following website:       Nttp://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagesca tegories/.         Pressure Injury:       Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar: If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.         Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.       F2         (1) This information was obtained from the following website:       http://www.npua.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagesca tegories/.         Pressure Injury:       Unstageable Pressure Injury will be revealed.       Stable eschar (i.e. dry, adher	RS FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE ( A. BUILDING_         YROWIDER OR SUPPLIER       495240       B. WING	MENT OF HEALTH AND HUMAN SERVICES SS FOR MEDICARE & MEDICARD SERVICES SS FOR MEDICARE & MEDICARD SERVICES CORRECTOR CONTROL (X) PROVIDERS PROVIDES OF MULTIPLE CONSTRUCTION A BUILDING 495240 B WING BWING CCCSBURG HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCES (EACH OBRICENCE WIST BE PRECODED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 38 F 279 Continued From page 38 F 280 F	MENT OF HEALTH AND HUMAN SERVICES COMBINED SECON MEDICARE & MEDICADI SERVICES OMBINED SECONSECTION MEDICARE & MEDICADI SERVICES OMBINED PCORRECTION 495240 BUVING CON 495240 BUVING CON 495240 BUVING CON SUMMARY STATEMENT OF DEFICIENCIES EXAMPLER SUMMARY STATEMENT OF DEFICIENCIES EXAMPLE STATEMENT OF DEFICIENCIES TO EXAMPLE STATEMENT OF DEFICIENCIES This information was obtained from the following website: https://www.nhibi.nh.govhealth/health-topics/topi CAS/Inc) (C)(2) The right to participate in the development and implementation of his or her person-centered BAS 10 (C)(2) The right to participate in the development and implementation of his or her person-centered BAS 11 EXAMPLE (D) The right to participate in the development and implementation of his or her person-centered BAS 11 EXAMPLE (D) The right to participate in the development and implementation of his or her person-centered BAS 11 EXAMPLE (D) The right to participate in the development and i

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ATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
	ROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE COMPLETE E APPROPRIATE DATE
F 280	request meetings a revisions to the per (ii) The right to part expected goals and amount, frequency other factors relate plan of care. (iv) The right to red included in the plan (v) The right to see right to sign after s of care. (c)(3) The facility s right to participate shall support the re planning process r (i) Facilitate the ind resident represent	blanning process, the right to and the right to request son-centered plan of care. ticipate in establishing the d outcomes of care, the type, , and duration of care, and any ed to the effectiveness of the ceive the services and/or items n of care. The the care plan, including the ignificant changes to the plan hall inform the resident of the in his or her treatment and esident in this right. The must clusion of the resident and/or ative.	F 2	<ul> <li>F280</li> <li>80 <ol> <li>Resident #1 care plan wa</li> <li>26, 2017 to include high risk</li> <li>#8 care plan was revised on Resident #2 care plans were</li> <li>2017. Resident #14 care plans were</li> <li>2017. Resident #14 care plans</li> <li>revised on May 22, 2017.</li> <li>The RNAC/designee will wounds, and urinary catheteensure care plans are current</li> <li>Re-education provided to 2017 by Vice President of C Reimbursement and Theraptore-educate the Interdisciption RNAC/designee will audit of plans of urinary catheters, freesure review and revision times three months.</li> <li>The RNAC/designee will monthly to the Quality Assumption for the state of the compliance and/or revision.</li> </ol> </li> </ul>	k for falls. Resident April 26, 2017. e revised on April 27, an was reviewed and review current falls, er care plans to t. 6-5-1 RNAC May 19, Clinical y. RNAC/designee blinary Team. comprehensive care alls, and wounds to as indicated monthly report audits urance Performance e ensure continued
	(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.			RECEIVED	
	483.21 (b) Comprehensiv	e Care Plans		MAY 31 2017	
	(2) A comprehens	ive care plan must be-		VDH/OLC	
	(i) Developed with the comprehensiv	in 7 days after completion of		dik uludikati on ist ofrem mation and	

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		AND HUMAN SERVICES				FORM	D: 05/11/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		TE SURVEY MPLETED
		495240	B. WING	÷		04	4/28/2017
NAME OF F	PROVIDER OR SUPPLIER	1	1	1	TREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			000 PLANK ROAD REDERICKSBURG, VA 22407		
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F 280	Continued From pa	age 40	F	280			
	(ii) Prepared by an includes but is not	interdisciplinary team, that limited to					
	(A) The attending p	bhysician.					
	(B) A registered nu resident.	rse with responsibility for the					
	(C) A nurse aide with responsibility for the resident.				,		
	(D) A member of fo	ood and nutrition services staff.					
	the resident and the An explanation mu medical record if the and their resident resi	racticable, the participation of e resident's representative(s). st be included in a resident's ne participation of the resident representative is determined the development of the n.					
		ate staff or professionals in rmined by the resident's needs the resident.					
		revised by the interdisciplinary sessment, including both the d quarterly review					
		NT is not met as evidenced			RECEIVED		
	Based on observa document review,	ition, staff interview, facility clinical record review, it was					
	and revise the con	e facility staff failed to review prehensive care plan for four he survey sample, Residents 4,			VDH/OLC		
1							

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	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DA CC	TE SURVEY MPLETED
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JRG HEALTH	AND REHAB					
ACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	×	(EACH CORRECTIVE ACTION SH	HOULD BE	(X5) COMPLETIO DATE
facility staff ehensive ca facility staff ehensive ca er was remo facility staff ehensive ca pment of a p (7/16, and th	failed to review Resident #1's re plan to ensure it included a failed to revise Resident #8's re plan after the urinary ved. failed to revise Resident #2's re plan following the pressure injury on the sacrum e development of pressure	F 2	80			
7. e facility staff ent #14's col kin alteration: 7.	failed to review and revise nprehensive care plan after s were found on 2/3/17 and					
e facility staff rehensive ca	failed to review Resident #1's					
/16 with diag nson's diseas Ity swallowin ion. The mos a quarterly as	noses that included: se (1), movement disorder, g, dementia and urinary					
	R OR SUPPLIER JRG HEALTH SUMMARY ST/ ACH DEFICIENC GULATORY OR L hued From pa e facility staff rehensive cal an of care. e facility staff rehensive cal ter was remo e facility staff rehensive cal pment of a p /7/16, and the son the righ 17. e facility staff ent #14's cor kin alterations 17. ndings incluc e facility staff rehensive cal an of care. lent #1 was a /16 with diag nson's diseas ilty swallowin tion. The mos	495240         R OR SUPPLIER         JRG HEALTH AND REHAB         SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)         nued From page 41         é facility staff failed to review Resident #1's rehensive care plan to ensure it included a an of care.         é facility staff failed to revise Resident #8's rehensive care plan after the urinary ter was removed.         é facility staff failed to revise Resident #2's rehensive care plan following the opment of a pressure injury on the sacrum (7/16, and the development of pressure as on the right heel and left buttock on 17.         e facility staff failed to review and revise ent #14's comprehensive care plan after kin alterations were found on 2/3/17 and 17.         ndings include:         e facility staff failed to review Resident #1's rehensive care plan to ensure it included a an of care.         ent #1 was admitted to the facility on /16 with diagnoses that included: nson's disease (1), movement disorder, alty swallowing, dementia and urinary tion. The most recent MDS (minimum data	A 95240         B. WING         R OR SUPPLIER         JRG HEALTH AND REHAB         SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIL GULATORY OR LSC IDENTIFYING INFORMATION)         PREFIL GULATORY OR LSC IDENTIFYING INFORMATION)         PREFIL Facility staff failed to review Resident #1's rehensive care plan after the urinary tent #14's comprehensive care plan after sin alterations were found on 2/3/17 and 17.         PREFIL	495240       B. WING         R OR SUPPLIER       STRI         JRG HEALTH AND REHAB       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         ACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         GULATORY OR LSC IDENTIFYING INFORMATION)       F280         Hued From page 41       F 280         Pacifity staff failed to review Resident #1's       F 280         Prefersive care plan to ensure it included a       F 280         Pacifity staff failed to revise Resident #8's       F         rehensive care plan after the urinary       F         e facility staff failed to revise Resident #2's       F         rehensive care plan following the       F         opment of a pressure injury on the sacrum       7/16, and the development of pressure         e facility staff failed to review and revise       F         ent #14's comprehensive care plan after       F         in alterations were found on 2/3/17 and       7.         ndings include:       F         e facility staff failed to review Resident #1's         rehensive care plan to ensure it included a         an of care.         ent #1 was admitted to the facility on         /16 with diagnoses that included:         nson's disease (1), movement disorder,	495240     B. WING       R OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP COE 3900 PLANK ROAD       JRG HEALTH AND REHAB     STREET ADDRESS, CITY, STATE, ZIP COE 3900 PLANK ROAD       SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)     D       TAG     PROVIDERS PLAN OF CORR (EACH CORRECTIVE ACTION S)       Preferic Ency Must BE, PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)     F280       TAG     CROSS-REFERENCED TO THE AF DEFICIENCY)       TAG     F280       Tag     CROSS-REFERENCED TO THE AF DEFICIENCY)       TAG     F280	495240     B. WING     04       R OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     3000 PLANK ROAD     FREDERICKSBURG, VA 22407       JRG HEALTH AND REHAB     ID     PROVIDER'S PLAN OF CORRECTION     FREDERICKSBURG, VA 22407       SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       GULATORY OR LSC IDENTIFYING INFORMATION)     ID     PROVIDER'S PLAN OF CORRECTION       Aude From page 41     F 280       a facility staff failed to review Resident #1's rehensive care plan after the urinary ter was removed.     F 280       a facility staff failed to review Resident #2's rehensive care plan after the urinary ter was removed.     F 280       a facility staff failed to review and revise ent #14's comprehensive care plan after the sacrum //7/16, and the development of pressure iso on the right heel and left buttock on 7.     F       a facility staff failed to review and revise ent #14's comprehensive care plan after sin alterations were found on 2/3/17 and 17.     F       a facility staff failed to review Resident #1's rehensive care plan to ensure it included a an of care.     F       a facility staff failed to review Resident #1's rehensive care plan to ensure it included a an of care.     F       a facility staff failed to review Resident #1's rehensive care plan to ensure it included a an of care.     F       a facility staff failed to the facility on 7/16 with diagnoses that included: rson's disease (1), movement disorder, ruy swallowing, dementia and urinary ison. The most recent MDS (minimum data

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TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		ATE SURVEY OMPLETED
		495240	B. WING				4/28/2017
	PROVIDER OR SUPPLIER			3900 P	T ADDRESS, CITY, STATE, ZII LANK ROAD ERICKSBURG, VA 224(		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	CORRECTION ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 280	10/24/16, did not e falls. Review of Resider documented the re further documente Score above 10 re Review of a post fa #1 dated 1/10/17 of self from w/c (whe (interdisciplinary te Recommendations (1/12/17), lay down interview was con- with LPN #4, the re who used the care "Everybody, the nu updated the care p can." When asked updated, LPN #4 s in condition, a fall, to review Residen LPN #4 stated, "H An interview was o p.m. with ASM (ao the director of nur would be updated When asked to re ASM #2 stated, "I plan. It was resolv do that, he's a hus	at #1's care plan initiated on evidence a care plan related to at #1's fall risk dated 2/12/17 esident's fall score as 15. It ad, "TOTAL SCORE (Total epresents HIGH RISK)." all analysis form for Resident documented, "Trying to transfe elchair) to bed. IDT	r D Đ I I				
	was made at that				/DH/OLC		
	Review of the res	olved care plan initiated on			D: VA0088	······	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z	IP CODE
				3900 PLANK ROAD	
FREDER	ICKSBURG HEALTH			FREDERICKSBURG, VA 224	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 280	"RESOLVED: At ris fall with no injury. Ir restorative program ordered." An interview was co a.m. with LPN #11, asked about the ca did not know why s and that the residen On 4/26/17 at 6:30 administrator and A were made aware of Review of the facili PREPARATION" do directs the patient's to discharge. Nurse throughout the pati becomes part of th No further informat According to Funda Williams and Wilkin documented, "A wr communication too members that help careThe nursing information about t and goals. It conta achieving the goals and is used to diret	ed on 4/13/17 documented, k for falls related to:1/10/17 nterventions. Ambulation h. Labs (laboratory) as onducted on 4/27/17 at 11:15 the unit manager. When re plan, LPN #11 stated she he had resolved the care plan ht was a fall risk. p.m. ASM #1, the SM #2, the director of nursing of the findings ty's policy titled, "CARE PLAN bocumented, "A care plan a nursing care from admission es update and revise the plan ent's stay and the document e permanent record." ion was provided prior to exit. amentals of Nursing Lippincott hs 2007 pages 65-77 itten care plan serves as a I among health care team s ensure continuity of care plan is a vital source of he patient's problems, needs, ins detailed instructions for a established for the patient ct careexpect to review,		RECEVED	
	there are changes with new orders"	the care plan regularly, when in condition, treatments, and (1)		VDH/OLC	
	(1) Fundamentals ( 2567(02-99) Previous Version	of Nursing Lippincott Williams	311	Facility ID: VA0088	If continuation sheet Page 44 of 278

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
STATEMENT	S FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY
		495240	B. WING			04	C / <b>28/2017</b>
	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP	CODE	
					00 PLANK ROAD	_	
FREDER	ICKSBURG HEALTH	AND REHAD		FF	EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 280	Continued From page	age 44	F	280			
	& Wilkins 2007 Lip pages 65-77.	pincott Company Philadelphia					
	of the nervous svs	ease is a progressive disorder tem. The disorder affects the brain, especially an area					
	called the substan and movement. Th	tia nigra that controls balance his information was obtained					
	from: https://ghr.nlm.nih e#definition	.gov/condition/parkinson-diseas					
	2. The facility staft comprehensive ca catheter was remo	f failed to revise Resident #8's are plan after the urinary oved.					
	3/25/17 and readr that included but v indigestion weak	admitted to the facility on nitted on 4/6/17 with diagnoses were not limited to: stroke, ness, respiratory failure, ng and high blood pressure.					
	assessment, with resident as usuall self-understood a others. The reside	MDS, an admission an ARD of 4/13/17 coded the by being able to make and sometimes understand ent's brief interview for mental "00" indicating the resident was	5				
	unable to answer	any question correctly. The ed as requiring assistance from					
		vsician's orders dated April 2017	<b>.</b>				
	documented, "Dis tonight in the eve	scontinue foley cath (catheter)			VDH/OLC		
	Review of the Ap record document	ril 2017 treatment administratior ed, "Reinsert foley if no voiding	ו				+ Page 45 of

Event ID:6R5B11

Facility ID: VA0088

If continuation sheet Page 45 of 278

	MENT OF HEALTH							FORM A	05/11/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N	IER/CLIA	, .		NSTRUCTION		(X3) DATE COMP	LETED
		495240		B. WING					, 8/2017
NAME OF I	PROVIDER OR SUPPLIER	L	L			T ADDRESS, CITY, STATE	, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB				PLANK ROAD DERICKSBURG, VA 2	2407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFI TAG		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD	BE	(X5) COMPLETION DATE
F 280	Continued From pa	iqe 45		F 2	280				
	(urinating) in 8 hrs. 04/11/2017." The 4	(hours) Order date							
	Review of the nurse evidence documen needed to be re-ins nurse's notes docu incontinent of urine	tation that the urina serted. Further revie mented that the res	ry catheter w of the						
	Review of the care plan initiated on 3/27/17 documented, "Focus. Alteration in elimination of bowel and bladder related to Diuretic (fluid pill) Use, Indwelling Urinary Catheter. Interventions. foley catheter to straight drainage as ordered."		iination of fluid pill) ventions.						
	An observation of F 4/25/17 at 12:55 p. and on 4/26/17 at 7 was no urinary cath observations.	m., 1:30 p.m. and 4 /:56 a.m. and 1:10	:08 p.m. o.m. There						
	An interview was co p.m. with LPN (lice When asked who us stated, "Everybody asked why resident stated, "To address you know if they're they're eating. It's a When asked who us stated, "We (the nu	nsed practical nurs used the care plans , the nurses, MDS.' ts had care plans, L s their needs. With a one person assis all addressed in the updated the care pla	e) #4. , LPN #4 ' When .PN #4 a care plan t, how care plan."		standingste Standingste	S C M IV M D			
	An interview was c p.m. with RN (regis coordinator. When comprehensive car stated she did. Wh had care plans, RN to care for our resid	stered nurse) #2, th asked if she develore re plan from the CA en asked why the r I #2 stated, "So we	e MDS oped the A, RN #2 esidents know how			AY 31 237 DH/OLC			
FORM CMS-2	567(02-99) Previous Versions		Event ID:6R5B1	1	Facility	ID: VA0088	If continuation	on sheet P	Page 46 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				F	NTED: 05/11/2017 ORM APPROVED 3 NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495240	B. WING	ə			C 04/28/2017
NAMEOFI	PROVIDER OR SUPPLIER		1	STREE	ET ADDRESS, CITY, STATE, 2		
				1	PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB		FRE	DERICKSBURG, VA 224	407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIA	(X5) E COMPLETION TE DATE
F 280	Continued From pa	ige 46	F	280			
	nurse you would wa resident." When as to complete the ME	ant to know what to do for that ked what resource she used OS, RN #2 stated they used the ssment instrument).					
	On 4/26/17 at 6:30 administrator and A were made aware of	SM #2, the director of nursing					
	No further information was obtained prior to exit. 3. The facility staff failed to revise Resident #2's comprehensive care plan following the development of a pressure injury on the sacrum (1) on 12/7/16, and the development of pressure injuries on the right heel and left buttock on 4/19/17.						
	8/30/16 and readm Resident #2's diagonal limited to: multiple depressive disorder MDS (minimum da status assessment reference date) of being cognitively in Resident #2 as req two or more staff we totally dependent of	dmitted to the facility on itted to the facility on 1/23/17. noses included but were not sclerosis, diabetes and major rr. Resident #2's most recent ta set), a significant change in with an ARD (assessment 1/30/17, coded the resident as tact. Section G coded uiring extensive assistance of <i>i</i> th bed mobility and as being on two or more staff with					
	transfers.						
		t #2's clinical record revealed a is form that documented					
	Resident #2 preset injury (2) "across b ulcer (injury) record developed an unst	nted with a stage one pressure uttocks" on 12/7/16. Pressure ds documented Resident #2 ageable pressure injury (2) on el and an unstageable		ŝ	VDH/OLC		
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6R5B	11	Facility	ID: VA0088	If continuation	sheet Page 47 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(	X3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS,	CITY, STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAL		
		TEMENT OF DEFICIENCIES	l ID	PROVID	ER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		RRECTIVE ACTION SHOULD E ERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION ATE DATE
F 280	Continued From pa	age 47	F 2	280		
	pressure injury on	he left buttock on 4/19/17.				
	plan initiated on 1/2 regarding other pre- reveal the care pla above pressure inj On 4/26/17 at 4:40 conducted with LP (the wound care nu- when residents' ca the development o stated care plans a interdisciplinary tea nursing or one of the pressure ulcer is for	p.m., an interview was N (licensed practical nurse) #1 urse). LPN #1 was asked re plans are revised regarding f pressure ulcers. LPN #1 are revised in the weekly am meetings by the director of ne unit managers, when a bund.				
	conducted with AS member) #2 (the d stated she checks	p.m., an interview was M (administrative staff irector of nursing). ASM #2 to ensures orders for wounds ind care plans are updated at meetings.				
	On 4/26/17 at 6:35 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the concern that Resident #2's care plan was not revised following the development of all pressure ulcers.					
	No further informa	tion was presented prior to exit				
	structure that is lovertebrae and that This information w	a shield-shaped bony cated at the base of the lumbar is connected to the pelvis" as obtained from the website: s.gov/ency/imagepages/19464.		VDH/	OLC	
FORM CMS-2	2567(02-99) Previous Version		11	Facility ID: VA0088	If continuation	sheet Page 48 of 278

		AND HUMAN SERVICES			FO	ED: 05/11/2017 RM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	4 (X2) MU	LTIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
		433240	1			04/20/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
	ICKSBURG HEALTH			3900 PLANK ROAD		
FREDER	ICKSDUKG NEALIN	AND REHAD		FREDERICKSBURG,	VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From pa	ige 48	F	280		
	and underlying soft prominence or relat device. The injury of open ulcer and may as a result of intens or pressure in comb tolerance of soft tis may also be affected perfusion, co-morb tissue. Stage 1 Pressure life erythema of intact s Intact skin with a lo erythema, which m pigmented skin. Pre erythema or change or firmness may pre changes do not ince discoloration; these pressure injury Unstageable Press full-thickness skin a Full-thickness skin a Full-thickness skin a Full-thickness skin a Stable eschar (i.e. erythema or fluctua limb should not be Deep Tissue Press non-blanchable deed discoloration Intact or non-intact	s localized damage to the tissue usually over a bon ted to a medical or other can present as intact skin y be painful. The injury oc se and/or prolonged press bination with shear. The sue for pressure and she ed by microclimate, nutritic idities and condition of the njury: Non-blanchable skin calized area of non-blanc ay appear differently in da esence of blanchable es in sensation, temperat ecede visual changes. Co lude purple or maroon e may indicate deep tissue sure Injury: Obscured	y or an curs sure ar on, e soft hable arkly ure, olor e he not gh or age out mic	RECEIVE MAY 31 200 VDH/OL	1977 1977	
FORM CMS-2	persistent non-blan 567(02-99) Previous Versions		); 0:6R5B11	Facility ID: VA0088	If continuation she	eet Page 49 of 278

		AND HUMAN SERVICES			FC	NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 . /	TIPLE CONSTRUCTION	T	DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE	
EDENER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD	-	
FREDER				FREDERICKSBURG, VA 2240		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION E DATE
F 280	revealing a dark we Pain and temperate color changes. Disc differently in darkly results from intense and shear forces a The wound may ev actual extent of tiss without tissue loss. subcutaneous tissu muscle or other un this indicates a full (Unstageable, Stag DTPI to describe v neuropathic, or der information was ob http://www.npuap.oc clinical-resources/r 4. The facility staff Resident #14's cor two skin alterations 3/22/17. Resident #14 was 3/4/13 and readmit that included but w [1], generalized an and behavioral disc and type II diabete MDS (minimum da assessment with a date) of 4/4/17. Re being cognitively in decisions, scoring Interview for Menta was coded as bein and ambulation; ar	n or epidermal separation bund bed or blood filled blister. ure change often precede skin coloration may appear pigmented skin. This injury e and/or prolonged pressure t the bone-muscle interface. rolve rapidly to reveal the sue injury, or may resolve If necrotic tissue, ue, granulation tissue, fascia, derlying structures are visible, thickness pressure injury ge 3 or Stage 4). Do not use		RECEIVED		
	567(02-99) Previous Version		11	Facility ID: VA0088	f continuation sh	neet Page 50 of 278

		AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Y /	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, 2	CIP CODE
	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD	107
FREDER				FREDERICKSBURG, VA 224 PROVIDER'S PLAN OF	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 280	Continued From pa	age 50	F 2	80	
	and bathing.				
	Condition Sheet da following: "Descript site, size, drainage Lower leg, 0.8x 3.0 moderate serous, (	t #14's Non-Decubitus Skin ated 2/3/17 documented the tion (Type of Skin Condition, , odor, color) other: Cellulitis, 0 x 0.1 cm (centimeters) 0 (zero) odor, pink, foam er day." This area was ealed" on 2/20/17.			
	condition sheet dat following: "Date: 3/	t #14's Non-Decubitus Skin ted 3/22/17 documented the '22/17. Site: L (Left calf) Size: e: Light Serous. Odor: 0 (zero)			
	revealed a note tha "Wound Note: Tx ( on Right leg. Wou	ing notes dated 2/6/17 at documented the following: (treatment) in place for wound nd Dr. (doctor) has also been day. RP (responsible party) doctor) aware."			
	revealed a note tha "Wound note: reside 3/22/17, for a wound 11.0 x 3.5 with light 10 % (percent) grad Current treatment	he nursing notes dated 3/23/17 at documented the following: dent was seen by wound Dr. or nd on her left calf, measures it sero-sanguineous exudate. anulation tissue and 90 % skin. is medihoney Mondays, Fridays. RP and MD aware."			
		nt #14's skin care plan dated			
	11/9/16 did not ad	dress the above skin			
	resident has the p	ollowing was documented: "The otential for impaired skin ulcer at risk due to: DX abetes and Anemia, Edema at		VDH/OLC	
FORM CMS-	2567(02-99) Previous Version		311	Facility ID: VA0088	If continuation sheet Page 51 of 27

		AND HUMAN SERVICES					RINTED: 05/11/2017 FORM APPROVED MB NO: 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495240	B. WING	G			C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER			S	REET ADDRESS, CITY, STATE, 2	ZIP CODE	
- CDCDCD				39	000 PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAD		FI	REDERICKSBURG, VA 224	407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD THE APPROPE	BE COMPLETION
F 280	(through) next revie weekly skin inspect initiated on 1/11/17 (This intervention w revised on 1/16/17) a shower, keep are initiated on 5/18/16 Encourage Resider (This intervention w revised on 1/16/17) On 4/26/17 at 12:12 conducted with LPN #3. When asked wf updated, LPN #3 st be updated with an resident's condition new skin areas, LP asked who would u skin area was found nurse who found th LPN #3 stated that the date of when th and location of the she was not familia On 4/26/17 at 1:45 conducted with LPN works with Residen responsible for upd new skin alteration nurse who discover updating the care p care plan would say	kin will remain intact thru ew. Interventions: Conduct tions (This intervention was ), Diabetic foot monitoring vas initiated on 5/18/16 and ), Encourage Resident to take ea clean (This intervention was and revised on 1/16/17), ht to wear proper size shoes vas initiated on 5/18/16 and )." 2 p.m., an interview was N (Licensed Practical Nurse) hen the care plan would be tated that the care plan would y new changes in the . When asked if this included N #3 stated that it did. When pdate the care plan if a new d, LPN #3 stated that the e area would be responsible. the care plan should address e skin alteration was found alteration. LPN #3 stated that r with Resident #14. p.m., an interview was N #4, a nurse who frequently tt #14. When asked who was ating the care plan when a is found, LPN #4 stated the s a skin alteration should be lan. When asked what the y for a new skin area, LPN #4	F	280	RECEIVED		
	stated, "It should have when the area was treatment for the sk	ave the location and date of found." When asked if the in area would also be on the stated, "Yes." When asked			VDH/OLC		
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6R5B1	1	Fac	ility ID: VA0088	If continuation	n sheet Page 52 of 278

		AND HUMAN SERVICES				FO	ED: 05/11/2017 RM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTE		(X3) DATE SURVEY COMPLETED C	
		495240	B. WING				04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		11	STREET AD	DRESS, CITY, STATE,		
	ICKSBURG HEALTH			3900 PLAN			
FREDER	ICKSBURG HEALTH			FREDERI	CKSBURG, VA 22		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN C EACH CORRECTIVE A DSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 280	Continued From pa	age 52	F2	280			
		areas to Resident #14 on , LPN #4 stated, "I would talk e."					
	conducted with LPI LPN #1 stated that she is always gettin When asked who we the care plan when #1 stated, "It is sup LPN #1 stated that ultimately responsi Resident #14's new	p.m., an interview was N #1, the wound care nurse. Resident #14 has cellulitis and ng blisters that pop and heal. was responsible for updating n a new skin area is found, LPN oposed to be a team effort." she wasn't sure if she was ble. LPN #1 stated that w skin areas found on 2/3/17 d have been on the care plan.					
	conducted with AS member) #2, the D When asked if the after a new skin al stated that the care problem area and When asked how b plan to be updated	p.m., an interview was M (administrative staff OON (Director of Nursing). care plan should be updated teration is found, ASM #2 e plan should address the the date that it was found. long it should take for the care I, ASM #2 stated that the care dated the same day or within 24					
	On 4/26/17 at 5:26 p.m., ASM #1, the administrator and ASM #2, the DON, were made aware of the above concerns. No further information was presented prior to exit. ASM #2 stated that the facility uses Lippincott as a				OEIVED		
	Nursing Standard	ot Practice.			Y SI 207		
	Williams and Wilk	amentals of Nursing Lippincott ins 2007 pages 65-77 ritten care plan serves as a		VC	)H/OLC		
FORM CMS-2	2567(02-99) Previous Version	s Obsolete Event ID:6R5B	11	Facility ID: VA	0088	If continuation sh	eet Page 53 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, Z	IP CODE
FREDERICKSBURG HEALTH AND REHAB				3900 PLANK ROAD FREDERICKSBURG, VA 224	07
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 280	Continued From pa	ge 53	F 28	0	
	members that helps careThe nursing of information about th and goals. It conta achieving the goals and is used to direct revise and update t there are changes i with new orders" No further information	I among health care team s ensure continuity of care plan is a vital source of he patient's problems, needs, ins detailed instructions for established for the patient of careexpect to review, he care plan regularly, when in condition, treatments, and ion was presented prior to exit.			
F 281 SS=E	disorder that slows food from the stom This information wa Institutes of Health. https://www.ncbi.nli T0027317/.	m.nih.gov/pubmedhealth/PMH	F 28	1	
	(b)(3) Comprehens	ive Care Plans			
	The services provio as outlined by the c must-	ded or arranged by the facility, comprehensive care plan,			
	(i) Meet profession This REQUIREMEI by:	al standards of quality. NT  is not met as evidenced			
	Based on staff inte	erview, facility document review review, and in the course of a	,		
	complaint investiga	ation, it was determined that ed to follow professional		VDH/OLC	

Facility ID: VA0088

If continuation sheet Page 54 of 278

DEPART	MENT OF HEALTH	HAND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-03
TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
495240		B. WING		C 04/28/2017	
	PROVIDER OR SUPPLIER	<u> </u>	L	STREET ADDRESS, CITY, STATE, ZIP	CODE
	ICKSBURG HEALTH			3900 PLANK ROAD	.7
FREDER				FREDERICKSBURG, VA 2240 PROVIDER'S PLAN OF C	
(X4) ID PREFIX TAG	(EACH DEFICIEN(	ATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	IT A CONTRACTIVE ACTIV	ON SHOULD BE COMPLETE HE APPROPRIATE DATE
			F 2	F281	
F 281 Continued From page 54 standards of practice for seven of 32 residents in the survey sample, Residents #8, #4, #2, #13, #3,		1 2	1. Resident #8 medicatio		
			records were clarified to		
#19 and #26.				route. Resident #4 physi	
				were updated with dialy	
<ol> <li>The facility staff failed to clarify a physician's order for Resident #8's route of medication.</li> </ol>			were transcribed and im		
			Resident #13 remains or		
	2 Posident # 4's	February 2017 and April 2017		Resident #3 orders were	
Physician Order Sheets (POS) were not				Resident #19 is discharg	ged. Resident #26
reconciled at the end of month changeover to reflect Resident # 4's order for Dialysis.				is discharged	
				2. Re-education provide	
	o The feelity of of	f failed to transcribe a		May 19, 2017 by Vice P	
	3. The facility star	for skin prep to Resident #2's		Clinical Reimbursement	
	right heel pressur	e injury on 4/19/17. The order		RNAC/designee to re-ec	iucate the nursing
	was not transcrib	ed until 4/25/17.		staff on professional star Newly hired nursing sta	ff will be educated
	4. The facility sta	ff failed to transcribe a		during orientation.	
	physician's recom 3/26/17 for Resid	mendations into orders on		3. The Director of Nursi	ing/RNAC/
	3/26/17 101 Resid			designee will review phy	ysician orders
	5. The facility stat	f failed to clarify the parameters		three times a week times	
	for administration	of PRN (as needed) pain		then monthly times three	
	medication for Re	esident # 3.		4. The Director of Nursi	-
	6 The facility stat	ff failed to obtain a physician's		designee will report aud	
	order prior to the	administration of Calazime [1]		to the Quality Assurance	
	paste to Residen	t #19's sacral wound.		Improvement committee	
	7	was ordered an antibiotic to trea	t	continued compliance as	nu/or revision.
	<ol> <li>resident #20</li> <li>wound infection</li> </ol>	and the facility staff failed to			
	transcribe the ord	ter onto the MAR (medication		RECENED	
	administration re-	cord). Resident #26 was not		# E Source South Second 18 Second South	
	administered the	medication as ordered.			
	The findings inclu	ude:			
				VDH/OLC	
	1. The facility sta order for Resider	ff failed to clarify a physician's nt #8's route of medication.			If continuation sheet Page 55 c

DEPART		AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE	, ZIP CODE
FRERER	ICKSBURG HEALTH	ΔΝΩ REHΔΒ		3900 PLANK ROAD	2407
FREDER	ICKSBURG HEALTH		l	FREDERICKSBURG, VA 2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 281	Continued From pa	age 55	F 2	81	
	3/25/17 and readm that included but w indigestion, weakn difficulty swallowing The most recent M admission assess coded the resident self-understood an others. The reside status was coded unable to answer a resident was code staff for all activitie was coded as hav Review of the care documented, "Foo risk of nutrition/hyd to) inability to supp dependent on Tub (nothing by mouth Review of the phyd documented, "Lasix Tablet 20 M by mouth one time Senna Tablet (Ser mouth one time a	e plan initiated on 3/25/17 us. Resident is at increased dration imbalance RT (related port own nutrition & hydration, e Feeding. Interventions. NPO )." sician's orders dated April 2017 (G (milligrams) [1] Give 1 tablet e a day Order Date 4/06/2017. nosides) [2] Give 17.2 mg by day.			
	SEROquel Tablet mouth at bedtime.	25 MG [3] Give 1 tablet by		A DECEMBER OF A	
	times a day. Orde	[4] Give 500 mg by mouth two r Date 04/06/17. ) MG [5] Give 1 tablet by mouth		SAN 31 2017	
	two times a day. C Metoprolol Tartrat	Order Date 04/06/2017. e Tablet 25 MG [6] Give 1 tablet es a day. Order Date		VDH/OLC	
FORM CMS-	2567(02-99) Previous Versio	ns Obsolete Event ID: 6R5E	311	Facility ID: VA0088	If continuation sheet Page 56 of 27

DEPAR1	MENT OF HEALTH	AND HUMAN SERVICES				FORM	): 05/11/2017 APPROVED ): 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	KEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DA	(X3) DATE SURVEY COMPLETED C	
		495240	B. WING	;		04	/28/2017
NAME OF I	PROVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			0 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	04/06/2017. All meds medicating cleared by SLP (sp PO (by mouth) medication administration rec "Lasix Tablet 20 M by mouth one time Senna Tablet (Ser mouth one time a SEROquel Tablet mouth at bedtime. Cipro Suspension times a day. Orde Keppra Tablet 500 two times a day. C Metoprolol Tartrate by mouth two time 04/06/2017.	ons via PEG (feeding tube) until beech language pathologist) for eds. Order Date 4/15/17." I 2017 medication ord (MAR) documented, IG (milligrams) [1] Give 1 tablet e a day Order Date 4/06/2017. nosides) [2] Give 17.2 mg by day. 25 MG [3] Give 1 tablet by [4] Give 500 mg by mouth two r Date 04/06/17. 0 MG [5] Give 1 tablet by mouth Order Date 04/06/2017. e Tablet 25 MG [6] Give 1 tablet es a day. Order Date		281			
	cleared by SLP (s PO (by mouth) me medications were mouth until 4/25/1 An interview was	conducted on 4/25/17 at 1:00					
	An interview was conducted on 4/25/17 at 1:00 p.m. with RN (registered nurse) #6. When asked how Resident #8 received her medications, RN #6 stated that the medications were given through the feeding tube. When asked to review the April MAR for Resident #8, RN #6 stated, "Oh						
	wrong," When as	They must have put the order in ked what staff did if there was a					
	question about a	physician's order, RN #6 stated, t they should notify the doctor to					
	clarify it."	· · · · · · · · · · · · · · · · · · ·		1	VDH/OLC		
	An interview was	conducted on 4/25/17 at 1:05					

Event ID:6R5B11

Facility ID: VA0088

If continuation sheet Page 57 of 278

		AND HUMAN SERVICES			FOF	ED: 05/11/2017 RM APPROVED IO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	DATE SURVEY OMPLETED
		495240	B. WING			C )4/28/2017
NAME OF	PROVIDER OR SUPPLIER	1	L	STREET ADDRESS, CITY, ST		
				3900 PLANK ROAD		
FREDER	RICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, V	A 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 281	resident's night nur resident received h stated, "All of her m tube (Peg tube)." W if some of the medi mouth and some th #18 stated, "Then g asked to review the administration reco that there are some be given by mouth." would do if they had LPN #18 stated, "W clarify it." When ask medication adminis "Right patient, right time."	nsed practical nurse) #18, the se. When asked now the er medications, LPN #18 neds should be through her /hen asked what she would do cations were ordered as by give them as ordered." When e April 2017 MAR (medication rd), LPN #18 stated, "I see e meds (medications) written to " When asked what staff d a question about the order, /e need to call the doctor to ked what the five rights of tration were, LPN #18 stated, med, right route and right	F 2	281		
	p.m. with LPN #4. V should do if a reside medications ordere also through the Pet they're not eating yo clarify the order. In you never know." On 4/26/17 at 6:30 member) #1, the ad director of nursing v findings.	onducted on 4/25/17 at 1:15 When asked what a nurse ent with a feeding tube had d to be given by mouth and g tube, LPN #4 stated, "If ou would have to call and nursing you never assume, p.m. ASM (administrative staff lministrator and ASM #2, the vere made aware of the y's policy titled, "Medication d, "The following steps are				
	Orders" documented, "The following steps are initiated to completed documentation and receive the medications: a. Clarify the order. Procedures. A. Elements of the Medication Order 1) Medication orders specify the followinge. Route			VDH/OLC		
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6R5B11		Facility ID: VA0088	If continuation shee	t Page 58 of 278

FORM CMS-2	2567(02-99) Previous Versio	ns Obsolete	Event ID:6R5B	11	Facilit	y ID: VA0088	If continuation s	sheet Page 59 of 278
	Morganella morga Pseudomonas ae Staphylococcus a Staphylococcus e	anii, Citrobacter f ruginosa, methic ureus, methicillir	reundii, sillin-susceptible n-susceptible			/DH/OLC		
	pneumoniae, Ente mirabilis, Proteus	erobacter cloaca vulgaris, Provide	e, Proteus encia stuartii,		5			
	treatment of skin caused by Escher	and skin structur richia coli, Klebsi	e infections ella					
	[4] CIPRO is indic				مىلىرى.	د. کارونی از بر		
	07d461b3							
	gXsI.cfm?setid=c	17aa1e0-8b69-4	c46-8502-9e3e					
	was obtained from https://dailymed.n		ned/fda/fdaDru					
	adjunct to lithium		is information					
	bipolar I disorder,	both as monothe	erapy and as an					
	treatment of mani	c episodes asso	ciated with					
	schizophrenia. Se	roquel is indicate	ed for the acute					
	[3] SEROQUEL is	indicated for the	e treatment of					
	recommended pe obtained from: htt	riods. This inform	nation was lov/Senna htm					
	when used in high	n doses for longe	r than					
	events including c	linically apparent	t liver injury					
	available without p safe and well toler	rated, but can ca	use adverse					
	[2] Senna is a pop	oular herbal laxat	ive that is					
	706bd33							
	gXsI.cfm?setid=ea	adfe464-720b-4d	cd-a0d8-45dba					
	depletion. This inf https://dailymed.nl	ormation was ob	tained from:					
	a profound diuresi	is with water and	electrolyte					
	[1] LASIX® (furose which, if given in e	ernide) is a poter excessive amoun	its, can lead to					
	No further informa	ation was provide	d prior to exit.					
	by nursing with the	e attending physi	cian."					
	age, condition, alle	ergies, or diagnos	sis is verified					
	of administration. appears inappropr	B Any dose or o	order that					
F 281	Continued From p			F 2	281			
		<u></u>						
TAG	REGULATORY OR	LSC IDENTIFYING INF	-UKIMA(IUN)	TAG		DEFICIEN		
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICI	ED BY FULL	PREF		(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE	COMPLETION
				ID	FRE	PROVIDER'S PLAN OF	CORRECTION	(X5)
FREDER	ICKSBURG HEALTH	I AND REHAB				PLANK ROAD DERICKSBURG, VA 224	407	
NAME OF I	PROVIDER OR SUPPLIER	3				ET ADDRESS, CITY, STATE, Z	ZIP CODE	
		495	240	B. WING	ALL ALL OF COMPANY OF COMPANY			04/28/2017
				A. DUILL				С
	OF DEFICIENCIES	(X1) PROVIDER/SU		· · ·			(X3	) DATE SURVEY COMPLETED
	RS FOR MEDICAR							NO. 0938-0391
DEPART	IMENT OF HEALTH	HAND HUMAN S	SERVICES				F	ORM APPROVED
							PRIN	ITED: 05/11/2017

		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
FREDERICKSBURG HEALTH AND REHAB			1	000 PLANK ROAD REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 281	Continued From pa		F 281		
	https://dailymed.nl	ormation was obtained from: m.nih.gov/dailymed/drugInfo.cf -ad9c-4c00-8d50-8ddfd9bd27c			
	<ul> <li>[5] KEPPRA is indit the treatment of: F one month of age Myoclonic seizures and older with juve Primary generalized patients 6 years of generalized epilep obtained from: https://dailymed.nl m?setid=3CA9DF 9AB21</li> <li>[6] Metoprolol such treatment of hyper pressure. Lowerin of fatal and non-fa primarily strokes a information was of https://dailymed.nl</li> </ul>	cated for adjunctive therapy in vartial onset seizures in patients and older with epilepsy (1.1) is in patients 12 years of age enile myoclonic epilepsy (1.2) ed tonic-clonic seizures in fage and older with idiopathic sy (1.3) This information was m.nih.gov/dailymed/drugInfo.cf 05-A506-4EC8-A4FE-320F121 cinate is indicated for the tension, to lower blood g blood pressure lowers the risk tal cardiovascular events, and myocardial infarctions. This batained from: m.nih.gov/dailymed/drugInfo.cf -1b68-4478-1fb7-c1bc9402dee			
	Physician Order S reconciled at the e	February 2017 and April 2017 heets (POS) were not and of month changeover to 4's order for Dialysis.			
	and again on 2/21	admitted to the facility on 2/5/15 /17 with diagnoses that		RECEIVED	
	included but were disease (requiring pressure, dement	not limited to, end stage renal dialysis), anemia, high blood ia. depression			
	pressure, dement gastroesophageal and asthma.	reflux disease, osteoarthritis		VDH/OLC	
1					

Facility ID: VA0088

If continuation sheet Page 60 of 278

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>0. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	IPLE CONSTRUCTION		ATE SURVEY
		495240	B. WING		0	C 4/28/2017
JAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, Z	IP CODE	
	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 224	107	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETIC DATE
F 281	Continued From pa	age 60	F 2	81		
	set) was a quarterl (assessment refere # 4 was coded as h being able to unde was coded as scor the Brief Interview Cognitive Patterns cognitively intact. A review of Reside the signed physicia 2017. The POS fo an order for dialysi During an interview LPN (licensed prace stated that when a for dialysis is on th	st recent MDS (minimum data y assessment with an ARD ence date) of 3/3/17. Resident being understood by others and rstand others. Resident # 4 ing a 14 of a possible 15 on for Mental Status in Section C, , indicating the resident was nt # 4's clinical record revealed an order sheet (POS) for April r April 2017 did not document s treatment. v on 4/26/17 at 11:00 a.m. with ctical nurse) # 4, LPN # 4 resident is admitted the order e admission orders and then it he POS every month	1			
	LPN # 3, LPN # 3 st orders; LPN # 3 st a resident when th admission orders. assistant director of and joined the con RN # 1 agreed tha have a physician of order should be or the current signed not find an order for for February 2017 dialysis. RN # 1 st by Medical records	v on 4/26/17 at 12:40 p.m. with was asked about dialysis ated that the orders come with ey are admitted, on the RN (registered nurse) # 1, the of nurses, was standing nearby versation. Both LPN # 3 and t someone on dialysis should rder. Both agreed that the the POS. RN # 1 reviewed POS for April 2017 and could or dialysis. Review of the POS did document an order for tated that the POS's are printed and the Unit Manager at		RECEIVED		
	turnover. They are	the POS and the POS is also		VUNIULU		

		HAND HUMAN SERVICES				PRINTED: FORM A OMB NO. 0	PPROVE
STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMPL	SURVEY
		495240	B. WING	š		04/28/2017	
NAME OF F	PROVIDER OR SUPPLIEF	ξ		1	EET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			) PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	Continued From p	bage 61	F	281			
	compared to the p	previous POS to make sure all					
	had a "Stop Date'	I on the POS unless the order '. RN # 1 reviewed the					
	telephone orders	to see if there was a change in Ilysis order, and there was not a					
	change. RN # 1 t	hen compared the previous					
	signed POS (Feb	ruary 2017) to see if the dialysis Date", it did not. RN # 1 stated					
	there was no "Sto	p Date" so the order for dialysis					
	should have appe	ared on the April 2017 POS.					
	During the end of	day interview on 4/26/17 at 6:3	C				
	p.m. with ASM (ad	dministrative staff member) # 1, ASM # 2, the director of					
	nurses, and ASM	# 3, interim regional director of					
	clinical services, a request was ma	this concern was revealed and ade for the facility policy.					
		ew on 4/27/17 at 2:20 p.m. with					
	ASM # 3, a pharn	nacy policy was presented.					
		This is all we have." This policy he title of the policy is:	/				
	"Non-Controlled	Medication Order					
	Documentation" ( "F Documentation"	documented the following under on of the Medication Order: 1d					
	Renewed or Reca	apitulated (recapped) Orders (to	)				
	order with limited	ation therapy beyond a previous duration)2. Medication orders	5				
	are recapped on	a monthly basis when the					
	designated nurse	he physician order summary. A reviews the order summary	N		FRARVED		
	before giving it to	the prescriber to sign"					
	No further inform end of the survey	ation was provided prior to the process.			VDH/OLC		
					VUNUVLV		
	3. The facility sta	ff failed to transcribe a for skin prep to Resident #2's					

Facility ID: VA0088

If continuation sheet Page 62 of 278

	IMENT OF HEALTH							RINTED: 05/11/20 FORM APPROV	ED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDI	ID SERVICES ER/SUPPLIER/CLIA CATION NUMBER:	1		CONSTRUCTION	0	VB NO. 0938-03 (X3) DATE SURVEY COMPLETED	91
			495240	B. WING				C 04/28/2017	
NAME OF	PROVIDER OR SUPPLIER	<u>I</u>		L	STR	EET ADDRESS, CITY, STATE,	ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHA	3	:		0 PLANK ROAD EDERICKSBURG, VA 22	407		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRI	ECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OU (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE COMPLETI	ÖN
F 281	Continued From pa	age 62		F	281				
	right heel pressure was not transcribed	injury on 4/							
	Resident #2 was ad 8/30/16 and readm Resident #2's diagr limited to: multiple depressive disorde MDS (minimum da status assessment reference date) of being cognitively in Resident #2 as req two or more staff w totally dependent of transfers.	itted to the noses incluc sclerosis, di r. Resident ta set), a sig with an AR 1/30/17, coo tact. Secti uiring exter rith bed mot	facility on 1/23/17. ded but were not abetes and major #2's most recent gnificant change in D (assessment ded the resident as on G coded usive assistance of bility and as being						
	Review of Residen physician's order d be applied to the re The order was disc	ated 4/6/17 sident's he	els every day shift.						
	Review of Resident #2's pressure ulcer (injury) records revealed the resident developed an unstageable pressure injury (2) on the left lateral heel on 4/19/17 and an unstageable pressure injury on the right medial heel on 4/19/17. (Note: review of the resident's clinical record revealed prevention interventions were previously implemented and the resident's physician deemed pressure injuries were unavoidable.								
	Also, clinical record staff and Resident	d review and	d interviews with			ECENED			
	non-compliant with The wound care ph	turning and hysician's in	l repositioning). itial evaluation of		4				
	the right heel woun 4/19/17 documente deep tissue injuries recommended skir	ed the areas and the wo	s as unstageable ound care physician		1	/DH/OLC			
FORM CMS-2	567(02-99) Previous Versions	s Obsolete	Event ID:6R5B1	1	Facili	ty ID: VA0088	If continuation	on sheet Page 63 of	278

	T OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	LIPLE CO	ONSTRUCTION		NO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	1				COMPLETED
		495240	B. WING				C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER		1		ET ADDRESS, CITY, STATE, ZIP	CODE	
REDER	RICKSBURG HEALTH	AND REHAB			PLANK ROAD DERICKSBURG, VA 22407	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIAT	(X5) COMPLETIC DATE
F 281	Continued From pa	age 63	F 2	81			
	order for skin prep There was no treat right heel. Resider documented skin p resident's left heel 4/19/17 through 4/2 treatment documen from 4/19/17 throu Resident #2's com on 1/23/17 failed to regarding a right he On 4/25/17 at 5:23 staff member) #2 ( LPN (licensed prac care nurse) were a treatment for Resid	prehensive care plan initiated o document information eel pressure injury. p.m., ASM (administrative the director of nursing) and ctical nurse) #1 (the wound sked to provide evidence that dent #2's right heel pressure ented on 4/19/17 when the					
	A physician's order apply skin prep to day shift.	dated 4/25/17 documented, Resident #2's right heel every					
	conducted with LP documented skin p instead of skin pre transcribed the 4/1 documented onto t	5 p.m., an interview was N #1. LPN #1 stated she only prep to Resident #2's left heel p to both heels when she 9/17 physician's order that was he April 2017 TAR. LPN #1 ould verify that nurses applied		Same i se			
	skin prep to both h TAR only documer	eels since the order on the ited to apply skin prep to the					
	prep to the right he	was no directive to apply skin el. LPN #1 stated the nurses omplete treatments when she			/DH/OLC		

		AND HUMAN SERVICES			PRINTED: 05/11/201 FORM APPROVE OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE,	
FREDEF	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22	407
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLÉTIO THE APPROPRIATE DATE DATE
F 281	LPN #1 stated she skin prep to both he was transcribed to made a transcriptio On 4/26/17 at 6:35 administrator), ASM director of clinical s the above findings. On 4/27/17 at 7:43 provide the facility s transcription. ASM the Lippincott manu On 4/27/17 at 12:18 owner) stated there regarding transcript No further informati (1) "SKIN-PREP is a that, upon application protective film to he removal of tapes ar was obtained from th http://www.smith-ne cts/advanced-woun (2) "Pressure Injury A pressure injury is and underlying soft	<ul> <li>a both of Resident #2's heels. meant to document to apply eels on the 4/19/17 order that the April 2017 TAR but she n error.</li> <li>p.m., ASM #1 (the 1 #2 and ASM #3 (the regional ervices) were made aware of a.m., ASM #1 was asked to standard of practice regarding #1 state the facility followed al.</li> <li>B p.m., ASM #5 (the facility was no standard of practice ion in the Lippincott manual. on was presented prior to exit.</li> <li>a liquid film-forming dressing on to intact skin, forms a lp reduce friction during ad films" This information the website: a phew.com/professional/produ d-management/skin-prep/</li> <li>c localized damage to the skin tissue usually over a bony</li> </ul>	F 24	B1	
	device. The injury of an open ulcer and n	ed to a medical or other an present as intact skin or nay be painful. The injury f intense and/or prolonged		MAY 31 2497	
	pressure or pressur	in combination with shear. It tissue for pressure and		VDH/OLC	
RM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:6R5B1	1	Facility ID: VA0088	If continuation sheet Page 65 of 2

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO	. 03/11/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	RE SURVEY
		495240	B. WING				/28/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	ICKSBURG HEALTH	AND REHAB			000 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 281	Continued From pa		F 2	281			
	nutrition, perfusion, of the soft tissue Unstageable Press full-thickness skin a Full-thickness skin extent of tissue dar be confirmed beca eschar. If slough c	and tissue loss in which the mage within the ulcer cannot use it is obscured by slough or or eschar is removed, a Stage					
	3 or Stage 4 press Stable eschar (i.e. erythema or fluctua limb should not be Deep Tissue Press non-blanchable de discoloration	ure injury will be revealed. dry, adherent, intact without ance) on the heel or ischemic softened or removed. sure Injury: Persistent ep red, maroon or purple skin with localized area of					
	persistent non-blar purple discoloration revealing a dark we Pain and temperat color changes. Dis differently in darkly results from intens and shear forces a	nchable deep red, maroon, n or epidermal separation ound bed or blood filled blister. ure change often precede skin coloration may appear pigmented skin. This injury e and/or prolonged pressure at the bone-muscle interface.					
	The wound may ev actual extent of tis without tissue loss subcutaneous tiss muscle or other ur this indicates a full (Unstageable, Sta	volve rapidly to reveal the sue injury, or may resolve . If necrotic tissue, ue, granulation tissue, fascia, iderlying structures are visible, thickness pressure injury ge 3 or Stage 4). Do not use			and the second s		
	neuropathic, or de information was of http://www.npuap.	vascular, traumatic, rmatologic conditions" This otained from the website: org/resources/educational-and- npuap-pressure-injury-stages/			NEW 31 757 VDH/OLC		

Facility ID: VA0088

If continuation sheet Page 66 of 278

FORM CMS-	2567(02-99) Previous Versior	ns Obsolete Event ID: 6R5B	11	Facility	ID: VA0088	If continuation she	eet Page 67 of 278
	nurse) #12 was as palliative care con as recommended After looking throu stated: "I don't se	50 a.m., LPN (licensed practical sked to locate evidence of the sult and psychology evaluation by the physician on 3/26/17. Igh Resident #13's chart, she e anything." When asked what		VD	GEIVED 31 267 H/OLC		
	outside providers i Resident #13 was	cords for consults/visits from revealed no evidence that scheduled for a psychology ative care consult after 3/26/17.		general general general			
	revealed no evider	ent #13's clinical record nce of palliative care consult or tion for Resident #13 after					
	Resident #13 reve signed and dated I "Plan: 1. Continue (management). C	onsult palliative care if (psychology) evaluation for					
	6/5/15 and readmit including, but not li disorder (1), conge schizoaffective diso MDS (minimum da with an assessment	admitted to the facility on ted on 3/31/17 with diagnoses mited to: Diabetes, bipolar estive heart failure, and order (2). On the most recent ita set), a quarterly assessment in reference date of 2/6/17, she ng no cognitive impairment for ions.	t				
	4. The facility staff physician's recomr 3/26/17 for Reside	failed to transcribe a nendations into orders on nt #13.					
F 281	Continued From pa	age 66	F 2	281			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
	ICKSBURG HEALTH	AND REHAB			PLANK ROAD DERICKSBURG, VA 22	2407	
	PROVIDER OR SUPPLIER	495240	B. WING		T ADDRESS, CITY, STATE,		04/28/2017
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		OATE SURVEY COMPLETED
		AND HUMAN SERVICES				FOF OMB N	ED: 05/11/2017 RM APPROVED IO. 0938-0391

		AND HUMAN SERVICES				FORM	). 05/11/2017 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495240	B. WING	G		04	/28/2017
NAME OF	PROVIDER OR SUPPLIER	I	.L	1	REET ADDRESS, CITY, STATE, ZIP C	ODE	
FREDER	ICKSBURG HEALTH	AND REHAB			00 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 67	F	281			
	care consult "as ne be honest, I'm not means if the reside we should do it. It When asked what the recommendation LPN #12 stated: " stated that the reco evaluation should physician order an the consult book. services provider it	ommendation for the palliative eeded" meant, she stated: "To really sure. I'm not sure if it ent needs it, I'm not sure when needs more explanation." needed to be done regarding on for a palliative care consult, it needed to be clarified." She ommendation for a psychology have been transcribed as a d the resident's name placed in She stated a psychology is in the building each week and whose names are in the					
	staff member) #1, director of nursing regional director of informed of this co	p.m., ASM (administrative the administrator, ASM #2, the , and ASM #3, the interim f clinical services, were ncern. Information regarding sional standard for order equested.					
	manager, was ask physician recomm When asked to loc recommendations Resident #13's ch	0 a.m., LPN #11, a unit ed to review the 3/26/17 endations for Resident #13. cate evidence that these were followed, after reviewing art, LPN #11 stated: "I can't e stated the recommendation			RECENTD		
	for the palliative ca	e stated the recommendation are consult should have been					
	clarified, then writt	en as an order and followed by She stated that the					
	recommendation f	or the psychology evaluation written as an order and			VDH/OLC		

Facility ID: VA0088

If continuation sheet Page 68 of 278

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22	2407
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ADADA DEFERRINGED TO	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 281	Continued From p	age 68	F	281	
		ation was provided prior to exit.			
	causes unusual sl levels, and the abitasks." This inform https://www.nimh. order/index.shtml. (2) "Schizophrenia disorder that affect and acts." This in website https://www.nimh. zophrenia-bookle	illness, is a brain disorder that hifts in mood, energy, activity ility to carry out day-to-day mation is taken from the website nih.gov/health/topics/bipolar-dis a is a chronic and severe cts how a person thinks, feels, formation is taken from the .nih.gov/health/publications/schi t/index.shtml. If failed to clarify the parameters of PRN (as needed) pain			
	05/06/14 with diag not limited to: net bladder (1), gastr diabetes mellitus	admitted to the facility on gnoses that included but were uromuscular dysfunction of the oesophageal reflux disease (2), (3), anxiety (4), depression, bipolar (6), hemiplegia (7), (8) and obesity.			
	set), a quarterly a (assessment refe Resident # 3 as s interview for mer - 15, 14 being co decisions. Resid	ost recent MDS (minimum data assessment with an ARD erence date) of 02/21/17, coded scoring a 14 on the brief atal status (BIMS) of a score of 0 gnitively intact for making daily lent # 3 was coded as requiring ance of one staff member for living.		RECEIVED MAY 31 2617 VDH/OLC	
		and Obsolete Event ID: 6R58	11	Facility ID: VA0088	If continuation sheet Page 69 of 278

Facility ID: VA0088

Event ID:6R5B11

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

		AND HUMAN SERVICES			FORM	05/11/2017 APPROVED 0938-0391
STATEMENT	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495240	B. WING	G		C 28/2017
NAME OF I	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STAT	E, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	EIX (EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 281	Continued From pa	age 69	F	281		х.
	The POS (Physicia # 3 dated 01/2017 Tablet (9) 325 MG	an's Order Sheet) For Resident documented, "Acetaminophen (milligram) Give 2 (two) tablets four) hours as needed for pain	5			
	"Ketorolac Trometh Give 10 MG by mo for pain. Order Da	hamine (10) Tablet 10 MG. buth every 6 hours as needed ate: 10/17/2016."				
	(one) tablet by more	(five) MG (milligrams). Give 1 uth every 4 hours as needed vere pain. Order Date:				
	by mouth every 4	12) 50 MG. Give 2 (two) table nours as needed for pain. rder Date: 10/18/2016."	t			
	record) for Reside documented, "Acetaminophen T 2 (two) tablets by r	onic medication administration nt # 3 dated "January 2017 ablet 325 MG (milligram) Give mouth every 4 (four) hours as Order Date: 10/04/2016."				
	MG by mouth ever	hamine Tablet 10 MG. Give 10 ry 6 hours as needed for pain. /2016. D/C (discontinue)	)			
	"Oxycodone (11) 5 (one) tablet by mo	5 (five) MG (milligrams). Give tuth every 4 hours as needed	1			
	for pain use for se 10/18/2016."	vere pain. Order Date:				
	"Tramadol Tablet { mouth every 4 hou	50 MG. Give 2 (two) tablet by urs as needed for pain. rder Date: 10/18/2016."		VDH/OLC		
FORM CMS-2	2567(02-99) Previous Versior	ns Obsolete Event ID: 6R5	B11	Facility ID: VA0088	If continuation sheet	Page 70 of 278

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DEPAR1	MENT OF HEALTH	AND HUMAN SERVIC	ES			PRINTED: 05/ FORM APP OMB NO. 093	PROVED
STATEMENT	RS FOR MEDICARE	& MEDICAID SERVIC	LIA (X2) N		CONSTRUCTION	(X3) DATE SUF COMPLET	RVEY
		495240	B. WI	VG		04/28/2	2017
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIF	CODE	
EDENER	ICKSBURG HEALTH	AND REHAB		1	) PLANK ROAD EDERICKSBURG, VA 2240	17	
					PROVIDER'S PLAN OF (		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATIC	ILL PR	D EFIX AG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE CO HE APPROPRIATE	MPLETION DATE
F 281	Continued From p	age 70		F 281			
	following: Acetaminophen w 2:30 p.m., 01/12/1 9:40 a.m., 01/17/1 a.m., 01/19/17, at a.m., 01/21/17 at a.m., 01/24/17 at a.m., 01/28/17 at and 01/31/17 9:17 Ketorolac was trop on: 01/03/17 at 2: 01/06/17 at 12:33 10/08/17 at 2:57 p on 01/15/17 at 12 Oxycodone was a a.m., 01/02/17 at a.m., 01/06/17 at a.m., 01/06/17 at a.m., 01/20/17 at	methamine was adminis 37 p.m., 01/04/17 at 3:1 a.m., 01/07/17 at 2:04 a o.m., 01/10/17 at 8:46 a. :06 a.m. dministered on 01/01/11 6:09 p.m., 01/05/17 at 4 11:14 a.m., 01/08/17 at 9 9:02 a.m., 01/13/17 at 6 5:01 a.m., 01/19/17 at 5 2:37 a.m., 01/21/17 at 4 3:41 p.m., 01/27/17 at 1 2:31 a.m. and 8:42 p.m. n. ministered on 01/05/17 4:30 p.m., 01/09/17 at 4 12:37 a.m., 01/19/17 at 1 2:37 a.m., 01/19/17 at 1 10:49 a.m., 01/19/17 at 1 10:49 a.m., 01/21/17 at 1 3.m. and 01/31/17 at 3:0 esident # 3 dated "Febru Tablet 325 MG (milligra mouth every 4 (four) ho Order Date: 10/04/2010	03/17 at 7 at 7 at 8:19 28 10:25 56 a.m. etered 7 p.m., a.m., m. and 7 at 1:43 05 8:51 5:01 1:00 12:10 . and on at 5:30 4:01 12:14 11:16 11:59 9 a.m., m., 01 a.m. uary 2017 m) Give purs as		SEIVED V 31 2.47 DH/OLC	If continuation sheet Page	e 71 of 27

		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STAT 3900 PLANK ROAD	
(X4) ID PREFIX TAG	SUMMARY ST/ (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	CROSS-REFERENCED	I OF CORRECTION (X5) ACTION SHOULD BE COMPLETION
F 281	Continued From pa	age 71	F	281	
	(one) tablet by mou for pain use for sev	e) MG (milligrams). Give 1 uth every 4 hours as needed vere pain. Order Date: discontinue) 02/02/2017."			
	mouth every 4 hou	0 MG. Give 2 (two) tablet by rs as needed for pain. der Date: 10/18/2016. D/C			
	following: Acetaminophen wa 9:02 a.m., 02/02/1 p.m., 02/04/17 at 6 a.m., 02/07/17 at 4 02/08/17 at 4:48 p 02/10/17 at 5:09 a 1:06 a.m., 02/14/1 a.m., 02/16/17 at 5 02/18/17 at 4:06 a 4:40 p.m., 02/21/1 p.m. and 02/26/17 Oxycodone was at 12:00 a.m. Tramadol was adm p.m. and 4:08 p.m	Eebruary 2017 revealed the as administered on: 02/01/17 a 7 at 9:12 a.m., 02/03/17 at 4:55 5:22 a.m., 02/06/17 at 1:01 4:10 a.m. and 4:58 p.m., m., 02/09/17 at 4:18 a.m., m. and 4:40 p.m., 02/12/17 at 7 at 5:22 a.m., 02/15/17 at 1:46 5:45 p.m., 02/ 17/17 5:00 p.m., m. and 5:15 p.m., 02/20/17 at 7 at 5:20 p.m., 02/25/17 at 4:29 at 4:25 p.m.; dministered on 02/01/17 at 12:04 . and on02/02/17 at 6:07 a.m. sident # 3 dated "March 2017	7 6 9		
	documented, "Ace (milligram) Give 2	taminophen Tablet 325 MG (two) tablets by mouth every 4 eded for pain. Order Date:		The share and share a second s	ччи
	following: Acetaminophen w	March 2017 revealed the as administered on: 03/02/17 a 7 at 4:46 a.m., 03/06/17 at 3:0	at 8	VDH/OLC	
FORM CMS-2	2567(02-99) Previous Version	ns Obsolete Event ID:6R5	B11	Facility ID: VA0088	If continuation sheet Page 72 of 278

		AND HUMAN SERVICES					FORM	: 05/11/2017 APPROVED . 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DAT COM	E SURVEY IPLETED
		495240	B. WING	G		_		C 28/2017
NAME OF	PROVIDER OR SUPPLIER	I	I		STREET ADDRESS, CITY, STA	TE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB		1	3900 PLANK ROAD FREDERICKSBURG, VA	22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAI (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 281	•	age 72 :21 a.m., 03/14/17 at 12:01	F	28 <sup>-</sup>	1			
	p.m., 03/19/17 at 4 and 4:32 p.m., 03/ p.m., 03/22/17 at 4 03/24/17 at 3:20 a. 4:30 p.m., 03/26/17 a.m. and 11:43 a.m	<ul> <li>121 a.m., 03/20/17 at 6:38 a.m.</li> <li>121/17 at 4:38 a.m. and 1:57</li> <li>138 a.m. and 9:32 a.m.,</li> <li>m. and 4:42 p.m., 03/25 at</li> <li>7 at 4:35 a.m., 03/27/17 at 3:52</li> <li>n., 03/29/17 at 4:57 a.m.,</li> <li>m. and 03/31/17 at 8:27 a.m.</li> </ul>						
	documented, "Ace (milligram) Give 2 (	ident # 3 dated "April 2017 taminophen Tablet 325 MG (two) tablets by mouth every 4 eded for pain. Order Date:						
	following: Acetaminophen wa 4:56 a.m. and 3:42 04/04/17 at 4:28 a. 4:24 a.m. and 8:58 04/07/17 at 4:31 a. 4:00 p.m., 04/09/11 5:09 p.m., 04/10/11 12:39 a.m., 4;47 p. 04/13/17 at 4:18 p. 04/16/17 at 5:14 a. 4:30 p.m., 04/18/11 a.m. and 2:42 p.m.	April 2017 revealed the as administered on: 04/01/17 at p.m., 04/02/17 at 1:33 p.m., m. and 5:11 p.m., 04/05/17 at o a.m., 04/06/17 at 3:29 p.m., m. and 5:00 p.m., 04/08/17 at 7 at 4:50 a.m., 12:40 p.m. an d 7 at 6:51 p.m., 04 11/17 at m., 04/12/17 at 5:00 p.m., m., 04/14/17 at 5:00 p.m., m. and 6:31 p.m., 04/17/17 at 7 at 4:45 p.m., 04/19/17 at 4:27 ., 04/21/17 at 4:55 p.m., m., 04/25/17 at 1:30 p.m. and			and a second of the second			
		20 a.m. an interview was			<b>re</b> ceived			
	12. When asked to	N (licensed practical nurse) # o describe the procedure of						
	LPN # 12 stated, " what type of pain, (	I (as needed) pain medication I would ask where the pain is, determine the level of pain on a , based on the level of pain			VDH/OLC			

Facility ID: VA0088

If continuation sheet Page 73 of 278

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION       (X A. BUILDING         495240       B. WING       B. WING       B. WING         NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         SUMMARY STATEMENT OF DEFICIENCIES         ID       PROVIDER'S PLAN OF CORRECTION         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         ID       PROVIDER'S PLAN OF CORRECTION SHOULD B	3 NO. 0938-0391	OMB NO				MENT OF HEALTH AND H	
NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITY, STATE, ZIP CODE         FREDERICKSBURG HEALTH AND REHAB         SUMMARY STATEMENT OF DEFICIENCIES         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX       REGULATORY OR LSC IDENTIFYING INFORMATION)         F 281       Continued From page 73         would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. When asked how it is determined what PRN pain medication should	3) DATE SURVEY COMPLETED	NSTRUCTION (X3) DA			(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES (X1) PRO	STATEMENT
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         FREDERICKSBURG HEALTH AND REHAB       3900 PLANK ROAD         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX       (EACH CORRECTIVE ACTION SHOULD B)         F 281       Continued From page 73       F 281         would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. When asked how it is determined what PRN pain medication should       F 281	C 04/28/2017	04	G	B. WING	495240		
FREDERICKSBURG HEALTH AND REHAB       FREDERICKSBURG, VA 22407         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)         F 281       Continued From page 73 would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. When asked how it is determined what PRN pain medication should       F 281		T ADDRESS, CITY, STATE, ZIP CODE	STREET AD			PROVIDER OR SUPPLIER	NAME OF F
(X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID       PREFIX       (EACH CORRECTIVE ACTION SHOULD B)         F 281       Continued From page 73       F 281       Continued From page 73       F 281         would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. When asked how it is determined what PRN pain medication should       F 281			1				
(X4) ID       SolumART STATEMENT OF STATEMENT. TAG       F 281         F 281       F 281       F 281       F 281         STATEMENT OF STAT			FREDER			ICKSBURG REALITIAND RE	FREDER
would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. When asked how it is determined what PRN pain medication should	(X5) E COMPLETION ATE DATE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	FIX (E	PREF	MUST BE PRECEDED BY FULL	(FACH DEFICIENCY MUST BE	PRÉFIX
would administer what is prescribed, check it against the physician's order and MAR. I would check the resident 45 minutes to an hour to see if the medication was effective. When asked how it is determined what PRN pain medication should			281	F	ge 73	Continued From page 73	F 281
several pain meds (medications) there needs to be a parameter on the physician's order. If there are no parameters, I would get clarification from the physician before giving the medication." When asked to describe parameters, LPN # 12 stated, "You would give one pain medication for mild pain another pain medication for moderate pain. It would depend on the resident's pain level." After reviewing the eMARs dated January, February, March and April 2017 and physician's orders for Resident # 16's PRN pain medications, LPN # 12 was asked if there was documentation of parameters. LPN # 12 stated, "There are no parameters."				ry, sis, n	n's order and MAR. I would 45 minutes to an hour to see effective. When asked how PRN pain medication should PN # 12 stated, "If there are medications) there needs to the physician's order. If there I would get clarification from e giving the medication." cribe parameters, LPN # 12 give one pain medication for ain medication for moderate ind on the resident's pain ing the eMARs dated Januar d April 2017 and physician's # 16's PRN pain medication of if there was documentation	against the physician's orde check the resident 45 minu the medication was effectiv is determined what PRN pa be administered, LPN # 12 several pain meds (medica be a parameter on the physician be a parameters, I would the physician before giving When asked to describe pa stated, "You would give one mild pain another pain med pain. It would depend on t level." After reviewing the February, March and April orders for Resident # 16's LPN # 12 was asked if the of parameters. LPN # 12 s	
On 04/26/17 at 11:45 a.m. an interview was conducted with RN (registered nurse) # 1, the assistant director of nursing. When asked how it is determined what PRN pain medication should be administered RN # 2 stated, "If there are several pain meds (medications) there needs to be a parameter on the physician's order. If there are no parameters, I would get clarification from the physician before giving the medication." When asked to describe parameters, RN # 1 stated, "You would give one pain medication for mild pain another pain medication for moderate pain. It would depend on the resident's pain level." After reviewing the eMARs dated January, February, March and April 2017 and physician's orders for Resident # 16's PRN pain medications,				r it d	(registered nurse) # 1, the f nursing. When asked how PRN pain medication should	conducted with RN (register assistant director of nursing	
RN # 1 was asked if there was documentation of parameters.       RN # 1 stated, "There are no         FORM CMS-2567(02-99) Previous Versions Obsolete       Event ID: 6R5B11       Facility ID: VA0088       If continuation		KAY 31 201		o re n r s s ns,	(medications) there needs to the physician's order. If ther I would get clarification from e giving the medication." scribe parameters, RN # 1 give one pain medication for wain medication for moderate end on the resident's pain ring the eMARs dated Januar nd April 2017 and physician's t # 16's PRN pain medication	be administered RN # 2 st several pain meds (medica be a parameter on the phy are no parameters, I would the physician before giving When asked to describe p stated, "You would give on mild pain another pain me pain. It would depend on level." After reviewing the February, March and April orders for Resident # 16's	

DEPARTI	IENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
TATEMENT O	FOR MEDICARE	& MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3900 PLANK ROAD	
FREDERIC				FREDERICKSBURG, VA 2 PROVIDER'S PLAN	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE A	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 281	Continued From p	age 74	F:	281	
	narameters." Afte	r reviewing the order for			
	pain and the trama	ded for pain use for severe adol for as needed for moderat	е		
	nain RN#1 was	asked what pain level was vere pain on the one to ten pain			
	scale that is used	to assess a resident's pain. Ri	N		
	# 1 stated, "I don't on the pain scale."	t know what number it would be	9		
	on the pair scale.				
	staff member) #1	25 p.m. ASM (administrative , the administrator and ASM # nursing, were made aware of th	e		
	No further informa	ation was provided prior to exit.			
	References:				
	control due to a b	hich a person lacks bladder rain, spinal cord, or nerve ıformation was obtained from			
	https://medlineplu	us.gov/ency/article/000754.htm			
	the esophagus ar	ents to leak back, or reflux, into nd irritate it. This information m the website: hih.gov/medlineplus/gerd.html.			
	regulate the amo	ase in which the body cannot unt of sugar in the blood. This obtained from the website:			
	https://www.nlm.u 001214.htm.	nih.gov/medlineplus/ency/article	e/		
	website <sup>.</sup>	ormation was obtained from the		VDH/OLC	
	https://www.nlm. 567(02-99) Previous Versi	nih.gov/medlineplus/anxiety.htr		Facility ID: VA0088	If continuation sheet Page 75 of 2

							FOR	D: 05/11/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPL	.IER/CLIA				(X3) D/ CC	ATE SURVEY DMPLETED
	DEPARTMENT OF HEALTH AND HUMAN SERVICES OM CENTERS FOR MEDICARE & MEDICAID SERVICES OM	0	4/28/2017					
		1			3900	PLANK ROAD		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENC	BY FULL	PREFI	x	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO	CORRECTION TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 281		age 75		F 2	281			
	obtained from the https://www.nlm.ni	website:						
	mood, energy, act carry out day-to-da obtained from the https://www.nimh.	ivity levels, and the ay tasks. This inform website: nih.gov/health/topic	ability to mation was					
	Quadriplegia. Par function in part of something goes w pass between you can be complete of both sides of your one area, or it car information was o	alysis is the loss of your body. It happe rrong with the way n ir brain and muscles or partial. It can occ body. It can also oc be widespread. The btained from the we	muscle ns when nessages s. Paralysis ur on one or ccur in just his ebsite:					
	because of sudde the brain. This info website:	n, abnormal electric ormation was obtair	cal activity in ned from the					
	headaches, musc	mild to moderate p le aches, menstrua	I periods,					
	colds and sore the and reactions to v	roats, toothaches, b vaccinations (shots)	ackaches, , and to					
	reduce fever. Ace to relieve the pair	taminophen may al of osteoarthritis (a eakdown of the linin	lso be used rthritis			DH/OLC		
EORM CMS	2567(02-99) Previous Versic	ns Obsolete	Event ID: 6R5B1	11	Facili	ty ID: VA0088	If continuation she	eet Page 76 of 27

		AND HUMAN SERVICES			PRINTED: 05/1 FORM APPE	ROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	Т		OMB NO. 093 (X3) DATE SUR	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION	COMPLETE	
		495240	B. WING	6	04/28/20	017
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STAT	FE, ZIP CODE	
	ICKSBURG HEALTH			3900 PLANK ROAD	22407	
FREDER				FREDERICKSBURG, VA		(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	CIX (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COM	(X5) IPLETION DATE
F 281	Continued From pa	age 76	F	281		
1 201	joints). Acetaminop medications called antipyretics (fever the way the body s body. This informa website: https:	bhen is in a class of analgesics (pain relievers) and reducers). It works by changing senses pain and by cooling the ation was obtained from the s.gov/druginfo/meds/a681004.h	1			
	severe pain and sl than 5 days, for m (long-term) conditi obtained from the	hort-term relief of moderately hould not be used for longer ild pain, or for pain from chronic ons. This information was website: s.gov/druginfo/meds/a693001.h				
	This information w	re moderate to severe pain. /as obtained from the website: s.gov/druginfo/meds/a682132.h	1			
	severe pain. This the website:	ve moderate to moderately information was obtained from s.gov/druginfo/meds/a695011.h				
	order prior to the	f failed to obtain a physician's administration of Calazime [1] #19's sacral wound.				
	Resident #19 was	admitted to the facility on	.t	<b>AE</b> CEVED		
	limited to high blo	noses that included but were no od pressure, failure to thrive,				
	cancer, and anxie most recent MDS	ajor depressive disorder, liver ty disorder. Resident #19's (minimum data set) was an vith an ARD (Assessment		VDH/OLC		
FORM CMS-	2567(02-99) Previous Versio		B11	Facility ID: VA0088	If continuation sheet Page	77 of 278

		AND HUMAN SERVICES			PRINTED: 05/11/20 FORM APPROVE OMB NO. 0938-039	ED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495240	B. WING		04/28/2017	
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CC	DE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIO	N N
F 281	Continued From pa	age 77	F 281	, I		
	Reference Date) of	4/3/17. Resident #19 was				
	the ability to make	derately cognitively impaired in daily decisions scoring 11 out				
	of 15 on the BIMS	(Brief Interview for Mental sident #19 was coded as				
	requiring extensive	assistance with one person				
	physical assist with dressing and limite	transfers, ambulation, d assistance from one staff				
	member with locon	notion on and off the unit.				
	Review of Residen	t #19's hospital notes dated				
	3/27/17 documente Site: Buttocks, Leff	ed the following: "Wound 1 , Wound 1 (one) Type				
	Pressure Ulcer, W	ound Stage 1. Wound 2 Site: ound 2 (two) Type: Pressure				
	Ulcer. Wound Stag					
	Review of the nurs	ing notes revealed the				
	following note date	d 3/27/17 at 10:29 p.m.: ain this shiftResident refused				
	full skin assessme	nt, refused to let this writer				
	remove bandage of	n sacrum, states that there is but the dressing was just				
	placed today. Scat	o on great right toe,				
	blanachable redne scratches and brui	ss on right heel, multiple ses on bilateral arms and legs,				
	tattoos on arms. S	kin tear on right arm 2 cm , abrasion to left arm, applied	,			
	antibiotic ointment	and covered with dry				
	bandage"			DEACHER		
		at #19's Pressure Ulcer Record ealed the following: " Date first		RECEIVED		
	observed: 3/28/17,	Site: Sacrum, Stage: 2 (Two),		MAY 31 267		
	Light Serous, Odo	1 cm (centimeters), Drainage: r: 0 (zero), Current Treatment		VDH/OLC		
	Plan: Barrier Crea	m q (every) shift and PRN (as ort was signed by the wound		್ ಯಾಯಿಗ್ ಸಿ ಕಿಸಿ ∿ದಿಯಿಗೆ ಔಷಣ್ಣಿ ಇದ್ದಿಕೆ		
	care nurse, LPN (I	icensed practical nurse) #1.				

Facility ID: VA0088

If continuation sheet Page 78 of 278

	IMENT OF HEALTH					FORM	0: 05/11/2017 APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SU IDENTIFICATIO	PPLIER/CLIA		PLE CONSTRUCTION		TE SURVEY MPLETED
		4952	240	B. WING		04	/28/2017
NAME OF	PROVIDER OR SUPPLIER	1			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
*					3900 PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB			FREDERICKSBURG, VA	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIE Y MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 281	Continued From pa	age 78		F 28	31		
	Review of Residen that the wound car Resident #19 on 3 documented from Wound Sacrum. W Measurable cm (co Barrier Cream - Q needed)Assessor recommendations shift and PRN, Off Review of Resider orders revealed th was not initiated u wound care physic documented: "App wound every shift integrity." This ord wound care nurse	e physician had /29/17. The follo the visit: "Stage : /ound Size: 1.5 ) entimeters), Dres shift (every) shif nent plan and : Add: House Ba -load wound" ht #19's telephon at an order for C ntil 3/31/17 (two cian visit). The fo oly Calazime pas and PRN (as new der was confirme	visited owing was 2 Pressure ( 0.7 x Not ssing: House t and PRN (as rrier Cream -Q e physician calazime paste days after the ollowing was te to sacral eded) for Skin				
	Review of Resider (treatment adminis the Calazime past 3/31/17 (4 days af after the wound ca	stration record) r e was placed on ter admission ar	evealed that the TAR on id two days				
	On 4/27/17 at 1:00 conducted with LF the wound care nu	N (licensed prac urse. When LPN	ctical nurse) #1, I #1 was asked		and prove the first the		
	what treatment wa	as in place prior t	to the order for		RECEIVED		
	Barrier Cream on "Calazime Cream	is what we used	prior to the		NAM 31 231/ VDH/OLC		
	wound care physic first on 3/28 and the	cian's visit on 3/2	ssing I				
	remember wiping measure and asso told the admitting Calazime Cream	the barrier crear ess the wound. A nurse that he wa	n off him to Apparently he as using the		VDHIOLU		
FORM CMS-	2567(02-99) Previous Versio		Event ID:6R5B	11	Facility ID: VA0088	If continuation shee	t Page 79 of 27

					FORM	D: 05/11/2017 MAPPROVED D: 0938-0391	
STATEMENT	INTERS FOR MEDICARE & MEDICAID SERVI EMENT OF DEFICIENCIES PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM         (X1) PROVIDER OR SUPPLIER         EDERICKSBURG HEALTH AND REHAB         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA         F281 Continued From page 79 continue with that treatment. The wound doctor then agreed with the treatment in when he came in." When asked if an or needed for Calazime cream, LPN #1 stat didn't think we needed an order because barrier cream." When asked how nursin know to apply the barrier cream if it was placed on the TAR until 3/31/17, LPN #41 "He was very adamant about letting us h he needed his cream." When asked wh order for the Calazime cream did not ge the system until 3/31/17, LPN #1 stated, get the order in properly. I probably shou done that sooner." LPN #1 stated that t who admitted Resident #19 was no long employed with the facility.         On 4/27/17 at 3:15 p.m., a copy of the fa standing orders was requested by RN (r nurse) #1, the unit manager. RN #1 stated on't have standing skin orders, every c is medicated needs an order." When as Calazime cream would need a physician RN #1 stated, "Yes, that cream would ne physician's order."         On 4/27/17 at 3:18 p.m., an interview wa conducted ASM (Administrative staff me and ASM #2, the DON (Director of Nurs ASM #2 stated that the facility does not standing orders for wound treatments a there should have been a physician's or the Calazime Cream.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVI COMPLETED		
		495240	B. WING		04	L/28/2017	
NAME OF I	DARTMENT OF HEALTH AND HUMAN SERVICES     FORM       VILERS FOR MEDICARE & MEDICAID SERVICES     OMB NC       WILENS FOR MEDICARE & MEDICAID SERVICES     MULTIPLE CONSTRUCTION       MENT OF CORRECTORS     MILTIPLE CONSTRUCTION       MENT OF CORRECORTS     MILTIPLE CONSTRUCTION       ABULDING     A BULDING       LAN OF CORRECTOR     MILTIPLE CONSTRUCTION       BEERICKSBURG HEALTH AND REHAB     STREET ADDRESS, CITY, STATE, ZIP CODE       DEDENCKSBURG HEALTH AND REHAB     Street ADDRESS, CITY, STATE, ZIP CODE       DID     SUMMARY STATEMENT OF DEFICIENCIES       DID     SUMMARY STATEMENT OF DEFICIENC	,,,,,,,,					
FREDER	ICKSBURG HEALTH	AND REHAB			22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE	
F 281	Continued From p	age 79	F 28	31			
	continue with that if doctor then agreed when he came in." needed for Calazir didn't think we nee barrier cream." Wh know to apply the placed on the TAR "He was very adar he needed his creat order for the Calazi the system until 3/ get the order in pro- done that sooner." who admitted Res employed with the On 4/27/17 at 3:15 standing orders was nurse) #1, the unit don't have standin is medicated need Calazime cream w RN #1 stated, "Yes	reatment. The wound care I with the treatment in place When asked if an order we ne cream, LPN #1 stated, "I ded an order because it is nen asked how nursing would barrier cream if it was not until 3/31/17, LPN #1 stated, nant about letting us know that am." When asked why the cime cream did not get put into 31/17, LPN #1 stated, "I didn't operly. I probably should have LPN #1 stated that the nurse ident #19 was no longer facility. 5 p.m., a copy of the facility's as requested by RN (registered manager. RN #1 stated, "We g skin orders, every cream that is an order." When asked if yould need a physician's order, s, that cream would need a					
	conducted ASM (A and ASM #2, the I ASM #2 stated tha standing orders for there should have	Administrative staff member) #1 DON (Director of Nursing). at the facility does not have or wound treatments and that been a physician's order for	,				
	<ul> <li>continue with that treatment. The wound care doctor then agreed with the treatment in place when he came in." When asked if an order we needed for Calazime cream, LPN #1 stated, "I didn't think we needed an order because it is barrier cream." When asked how nursing would know to apply the barrier cream if it was not placed on the TAR until 3/31/17, LPN #1 stated, "He was very adamant about letting us know that he needed his cream." When asked why the order for the Calazime cream did not get put into the system until 3/31/17, LPN #1 stated, "I didn't get the order in properly. I probably should have done that sooner." LPN #1 stated that the nurse who admitted Resident #19 was no longer employed with the facility.</li> <li>On 4/27/17 at 3:15 p.m., a copy of the facility's standing orders was requested by RN (registered nurse) #1, the unit manager. RN #1 stated, "We don't have standing skin orders, every cream tha is medicated needs an order." When asked if Calazime cream would need a physician's order, RN #1 stated, "Yes, that cream would need a physician's order."</li> <li>On 4/27/17 at 3:18 p.m., an interview was conducted ASM (Administrative staff member) #7 and ASM #2, the DON (Director of Nursing). ASM #2 stated that the facility does not have standing orders for wound treatments and that there should have been a physician's order for the Calazime Cream.</li> <li>On 4/27/17 at 3:18 p.m., ASM #1, the administrator and ASM #2, the DON were made aware of the above concerns. No further information was presented prior to exit.</li> </ul>						
	administrator and aware of the abov	ASM #2, the DON were made e concerns. No further		VDH/OLC			
	2567(02-99) Previous Versio	ns Obsolete Event ID:6R5E	311	Facility ID: VA0088	If continuation shee	t Page 80 of 27	

DEPART		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED C
	MENT OF DEFICIENCIES LAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:         495240       495240         E OF PROVIDER OR SUPPLIER       495240         EDERICKSBURG HEALTH AND REHAB       (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION         281       Continued From page 80         The following information is provided in Basi Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) wa used as a reference for medication administration. A medication order is require you to administer any medication to a patien Once you receive and process a medication place the physician's or health care provider complete order on the appropriate medicatio form, the MAR. The MAR includes the patien name, room, and bed number, as well as the		B. WING			28/2017
NAME OF	PLAN OF CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         495240         ME OF PROVIDER OR SUPPLIER         EDERICKSBURG HEALTH AND REHAB         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         F 281 Continued From page 80 The following information is provided in Basic Nursing, Essentials for Practice, 6th edition (Potter and Perry, 2007, pages 349-360) was used as a reference for medication administration. A medication order is required for you to administer any medication to a patient. Once you receive and process a medication, place the physician's or health care provider's complete order on the appropriate medication form, the MAR. The MAR includes the patient's name, room, and bed number, as well as the names, dosages, frequencies, and routes of			STREET ADDRESS, CITY, STAT	TE, ZIP CODE	
		AND REHAB		3900 PLANK ROAD	22407	
FREDEN				FREDERICKSBURG, VA	N OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETION DATE
F 281	Continued From p	age 80	Fź	281		
	Nursing, Essential (Potter and Perry, used as a reference administration. A n you to administer a	s for Practice, 6th edition 2007, pages 349-360) was ce for medication nedication order is required fo any medication to a patient.	r			
	Once you receive place the physicial complete order on form, the MAR. The name, room, and he names, dosages, the	and process a medication, n's or health care provider's the appropriate medication he MAR includes the patient's bed number, as well as the frequencies, and routes of				
	relief from skin irri in the peri-anal are pain. Active ingre (Percent), Mentho 20%Purpose: Pri information was o Institutes of Health dailymed.nlm.nih. 20160209_1295ct	tations, itching and discomfort ea, for the temporary relief of dients: Calamine 3.5 % I 0.2 %, Zinc Oxide rotectant, Analgesic." This btained by the National h. gov/dailymed/getFile.cfm?setio	d=			
	a wound infection transcribe the ord administration rec	and the facility staff failed to er onto the MAR (medication cord). Resident #26 was not	eat			
	Resident #26 was	admitted to the facility on		a a New Section 2019 Acres and		
	7/5/16 with diagno	oses that included, but were no	ot			
	thrombocytopenia blood has a lower	tia, high blood pressure, a [1] (a condition in which your than normal number of blood lled platelets), hip fracture,		VDH/OLC		
	2567(02-99) Previous Versio		5B11	Facility ID: VA0088	If continuation sheet	Page 81 of 27

		AND HUMAN SERVICES				FORM	: 05/11/2017 APPROVED . 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ´		CONSTRUCTION	CON	E SURVEY MPLETED
		495240	B. WING			1	/28/2017
NAME OF I	PROVIDER OR SUPPLIER		1		REET ADDRESS, CITY, STATE, ZIP CO	DDE	
FREDER	ICKSBURG HEALTH	AND REHAB			00 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 81	F	281			
	peripheral vascula circulation to the lo red blood cell cour	r disease (poor blood ower extremities), anemia (low nt, atrial fibrillation (an abnormal chronic obstructive pulmonary					
	set), a quarterly as (assessment refer Resident #26 as a of 15 on the BIMS status) indicating t cognitively impaire care. Resident #2 Skin Conditions, a pressure ulcers at unstageable woun measuring 5.0 cm	ost recent MDS (minimum data seessment with an ARD ence date) of 10/4/16 coded 0 (zero) out of a possible score (brief interview for mental that Resident #26 was severely ed with daily decisions about 66 was also coded in Section M, is having two unhealed the time of the assessment, an id with slough and/or eschar (centimeters) x 10.0 cm and ound with suspected deep					
	revealed, in part, a 8/17/16 that docur "8/17/16 Bactrim I medication) 1 tab times per day) x 7 was signed by the	ent #26's clinical record a physician's order dated mented, in part, the following; DS (an oral antibiotic (tablet) po (by mouth) BID (two id (for seven days)." The order a physician and hand written as: "faxed & (and) noted					
		ent #26's nurse's notes the following note; "8/17/16			and have been been been been been been		
	1310 (1:10 p.m.) for Bactrim DS 11	Type: General Note: New order tab (tablet) PO (by mouth) BID					
	(twice a day) x (tir heel." The note w nurse, unable to c	nes) 7 day and wound culture to as not electronically signed by a determine the name of the	)		VDH/OLC		
L	nurse.						Bago 82 of 275

Event ID:6R5B11

Facility ID: VA0088

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						FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CON	<b>IPLETED</b>
		495240	B. WING	÷		1	
NAME OF	PROVIDER OR SUPPLIER	Inclusion (L of The Construction of the Constructing the Consend practical nurse) #4. Was asked to review the nursi					
FREDER	ICKSBURG HEALTH	AND REHAB		1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREF	1 1X	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 82	F	281			
	#26 was taking an a dates; 8/18/16 throu days. There was n MAR that evidence	antibiotic on the following ugh 8/26/16, a total of nine o entry on Resident #26's s the administration of Bactrim					
	staff member) #1, t director of nursing, regional director of informed of this con the facility's profess	he administrator, ASM #2, the and ASM #3, the interim clinical services, were neern. Information regarding sional standard for order					
	again requested fro	m ASM (administrative staff					
	conducted with LPN LPN #4 was asked between 8/18/16 ar the nursing staff we given" during this ti the MAR. LPN #4	N (licensed practical nurse) #4. to review the nursing notes and 8/26/16 and to explain why ere documenting "antibiotic me period without an order on reviewed the notes and stated,					
	ME OF PROVIDER OR SUPPLIER EDERICKSBURG HEALTH AND REHAB (4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 281 Continued From page 82 The nursing notes also document that Resident #26 was taking an antibiotic on the following dates; 8/18/16 through 8/26/16, a total of nine days. There was no entry on Resident #26's MAR that evidences the administration of Bactrin during this time period. On 4/26/17 at 6:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the interim regional director of clinical services, were informed of this concern. Information regarding the facility's professional standard for order transcription was requested. A copy of the August pharmacy manifest was again requested from ASM (administrative staff member) #2, the director of nursing on 4/27/16 a 10:15 a.m. On 4/27/17 at 1:35 p.m. an interview was conducted with LPN (licensed practical nurse) #4 LPN #4 was asked to review the nursing notes between 8/18/16 and 8/26/16 and to explain why the nursing staff were documenting "antibiotic given" during this time period without an order or						
	No further informat	ion was provided prior to the			34 34 A.M.		
	OF CORRECTION     IDENTIFICATION NUMBER     A BUILDING     COMPLETED       485240     B. WING     C     04/28/2017       FROVIDEE OR SUPPLIER     SUMMARY STATEMENT OF DEFICIENCIES     STREET ADDRESS, CITY, STATE, ZIP CODE     300 PLANK ROAD       FREDERICK MUST DEFICIENCIES     FREDERICKSBURG, VA 22407     PROVIDERS FLAG FOR SOLUTION     PROVIDERS FLAG FOR SOLUTION     Complete       ICCNTINUED FOR DEFICIENCIES     D     PREVENTION OF DEFICIENCIES     D     PROVIDERS FLAG FOR SOLUTION     Complete       ICCNTINUED FOR DAGE 82     F 281     FEEDER     FEEDER     Complete     Complete     Complete       ICCNTINUED FOR DAGE 82     F 281     F 281     F     F     F     F       ICCNTINUED FOR DAGE 82     F 281     F     F     F     F       ICONTINUED FOR DAGE 82     F 281     F     F     F     F       ICONTINUED FOR DAGE 82     F 281     F     F     F     F       ICONTINUED FOR DAGE 82     F 281     F     F     F     F       ICONTINUED FOR DAGE 82     F 281     F     F     F       ICONTINUED FOR DAGE 82     F     F     F     F       ICONTINUED FOR DAGE 82     F     F     F     F       ICONTINUED FOR DAGE 82     F     F						
	Complaint Deficien	су					
	[1] This information	was obtained from the					

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 83 of 278

		& MEDICAID SERVICES		-1751 F-	CONSTRUCTION	(X3) DATE SI	JRVEY
ATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLE	
		105010	B. WING			04/28	2017
		495240		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
IAME OF F	ROVIDER OR SUPPLIER				00 PLANK ROAD		
REDER	ICKSBURG HEALTH	AND REHAB		FR	REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE S	(X5) OMPLETH DATE
5 004	On-the of From p	000.83	F 2	81			
F 281	Continued From pa	age 00		-			
	following website: https://www.nhlbi.r	hih.gov/health/health-topics/topi					
	cs/thcp			000	F282	Docident	
F 282	483.21(b)(3)(ii) SE	RVICES BY QUALIFIED	F 2	:82	1. Resident #26 is discharged.		
SS=E	PERSONS/PER C	CARE PLAN			#5 care plan updated. Residen	1 #2 18 acidant #1/	1
	(b)(3) Comprehen	sive Care Plans			currently receiving therapy. R	esident #14	ł
	The services prov	ided or arranged by the facility,			care plan updated. Resident #1	5 15	
	as outlined by the	comprehensive care plan,			discharged. Resident #1 meal	dhu	
	must-		ç		consumption will be monitore	a by	
	(1) De provided by	qualified persons in			nurses.	NAC on	
	accordance with e	each resident's written plan of			2. Re-education provided to R May 19, 2017 by Vice Preside	ent of `	6-5-
	bv:	ENT is not met as evidenced			Clinical Reimbursement and RNAC/designee to re-educate	the	
	Based on resider	nt interview, staff interview,			interdisciplinary team on follo	owing the	
	facility document i	review, clinical record review of complaint investigation, it			written plan of care. Newly hi	red nursing	5
	and in the course	hat the facility staff failed to			staff will be educated during of	orientation.	
	follow the written i	plan of care for seven of 32			3. The Director of Nursing/de		
	residents in the su	urvey sample, Resident #26, #5	),		review staff following the wri plan weekly times four weeks		
	#2, #14, #3, #16,				monthly times two months.	and mon	
	1. The facility sta	ff failed to conduct weekly skin			4. The Director of Nursing/de	signee will	
	assessments on I	Resident #26 as required in the			report the audits monthly to the		
	care plan.				Assurance Performance Impre		
	2.a. The facility st	aff failed to attempt			committee to ensure continue		
	non-nharmacolog	ical interventions prior to the	-		compliance and/or revision.		
	administration of	pain medication for Resident #	D.		RECEIVED		
	2.b. The facility st weights per the c	aff failed to obtain Resident #5 omprehensive care plan.	'S				
		ff failed to follow Resident #2's			VDH/OLC		

		AND HUMAN SERV				FORM	: 05/11/2017 APPROVED . 0938-0391	
STATEMENT		(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	R/CLIA (X		IPLE CONSTRUCTION	- (X3) DATE SURVEY COMPLETED C		
		495240	B.	WING		04	/28/2017	
	PROVIDER OR SUPPLIER	AND REHAB			STREET ADDRESS, CITY, ST 3900 PLANK ROAD FREDERICKSBURG, VA			
(X4) ID PREFIX TAG	(FACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 282	Continued From pa			F 2	82			
	care plan for restor	ative nursing service	S.					
	plan of care and at interventions prior	failed to follow Resid tempt non-pharmaco to the administration nedications in April of	logical of PRN					
	5. The facility staff comprehensive ca 3.	failed to follow the re plan for pain for Re	esident #					
C	6 a. The facility staff failed to follow the comprehensive care plan for incontinence care and transfers for Resident # 16.							
	6b. The facility sta comprehensive ca Resident # 16.	6b. The facility staff failed to follow the comprehensive care plan for transfers of Resident # 16.						
	7. The facility staff meal consumption 10/28/16.	failed to monitor Res per the care plan init	ident #1's iated on					
	The findings inclue	le;						
	<ol> <li>The facility staf assessments on F care plan.</li> </ol>	f failed to conduct we Resident #26 as requir	ekly skin ed in the					
	7/5/16 with diagno	admitted to the facilit ses that included, but ia, high blood pressur	were not		And the second of the second o			
	thrombocytopenia blood has a lower	[1] (a condition in wh than normal number	ich your of blood					
	cell fragments called platelets), hip fracture, peripheral vascular disease (poor blood circulation to the lower extremities), anemia (low red blood cell count, atrial fibrillation (an abnormal		emia (low		VDH/OLC			
FORM CMS-	2567(02-99) Previous Versio	ns Obsolete E	vent ID:6R5B11		Facility ID: VA0088	If continuation shee	Page 85 of 278	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	. 03/11/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	CON	E SURVEY MPLETED
		495240	B. WING	i	1	C / <b>28/2017</b>	
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	FREDERICKSBURG HEALTH AND REHAB				0 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			I IX 5	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 282	Continued From pa	ige 85	F	282			
	heart rhythm) and disease (affecting t	chronic obstructive pulmonary he lungs).					
	set), a quarterly as (assessment refere Resident #26 as a of 15 on the BIMS status) indicating th cognitively impaired care. Resident #26 Skin Conditions, as pressure ulcers at unstageable* wour measuring 5.0 cm	st recent MDS (minimum data sessment with an ARD ence date) of 10/4/16 coded 0 (zero) out of a possible score (brief interview for mental nat Resident #26 was severely d with daily decisions about 6 was also coded in Section M, a having two unhealed the time of the assessment, an id with slough and/or eschar* (centimeters) x 10.0 cm and und with suspected deep					
	A review of Resident #26's comprehensive care plan dated 7/5/2016 revealed, in part, the following documentation initiated on 7/29/16 and 8/31/16: "Focus: Pressure ulcer actual due to: Pressure ulcer actual: DTI (deep tissue injury) Left heel. Date Initiated 7/29/2016. Skin assessment to be completed per (name of facility) policy. Date Initiated: 7/29/2016. Conduct weekly skin inspection Date Initiated: 8/31/2016. Revision on: 10/12/2016. Weekly Wound assessment: Date Initiated: 8/31/2016. Revision on: 10/12/2016."						
	revealed, in part, w	Resident #26's clinical record /eekly skin reviews were not			RECEIVED		
	completed betwee 8/2/16; 8/17/16 to 8	n the following dates; 7/5/16 -					
	in part, that beginn	it #26's nursing notes revealed, ing on 7/29/16 Resident #26 ageable DTI (deep tissue			RECEIVED		

Event ID:6R5B11

Facility ID: VA0088

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING	3	C 04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE 3900 PLANK ROAD	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ARAGO DEFERRINGED TO	DF CORRECTION (X5) CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
	Continued From pa		F	282	
	injury) on the left h developed an unst These wounds are	eel and on 8/8/16 Resident #26 ageable DTI on the right heel. not reflected on the following rs; 8/2/16; 8/29/16, 10/6/16 and			
	conducted with LP LPN #4 was asked LPN #4 stated, "To the needs of the re the staff was expe	05 a.m. an interview was N (licensed practical nurse) #4. d the purpose of the care plan. o put in interventions to meet esidents." LPN #4 was asked if cted to provide care based on e plan of care. LPN #4 stated			
	conducted with AS member) #2, the of was asked how of done in the facility the skin assessme #2 was asked wha ASM #2 stated tha	5 p.m. an interview was SM (administrative staff director of nursing. ASM #2 ten skin assessments were ASM #2 stated that per policy ents were done weekly. ASM at a skin assessment entailed. at the nurse should look at the toe and document any new or	1		
	On 4/27/17 at 3:00 p.m. an interview was conducted with RN (registered nurse) #6. RN #6 was asked how often skin assessment should be conducted. RN #6 stated, "Weekly skin assessments are done weekly and are assigned by shift and room. The skin assessments used to be done on the computer, now we do them on				ġ
	paper." On 4/27/17 at 5:2	0 p.m. an end of day meeting			
	was conducted with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim regional director of clinical services and			VDH/OLC	
FORM CMS-	2567(02-99) Previous Versio		B11	Facility ID: VA0088	If continuation sheet Page 87 of 27

		AND HUMAN SERVICES				FOR	D: 05/11/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONST DING			TE SURVEY MPLETED
		495240	B. WING	6		04	4/28/2017
	PROVIDER OR SUPPLIER			STREET AL	DDRESS, CITY, STATE, 2	ZIP CODE	
	ICKSBURG HEALTH			3900 PLA		407	
FREDER				FREDER	ICKSBURG, VA 22		(¥£)
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF EACH CORRECTIVE AC COSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 282	Continued From p	age 87	F	282			
	ASM #4, the owne and ASM #4 were	er. ASM #1, ASM #2, ASM #3 all made aware of the above was requested on following the					
1	No further informa completion of the	ition was provided by survey.					
	Complaint Deficie	ncy					
	[1] This informatio following website: https://www.nhlbi. cs/thcp	i					
	following website: http://www.npuap. clinical-resources. tegories/. Unstageable Pres full-thickness skin Full-thickness skin extent of tissue da be confirmed bec eschar. If slough 3 or Stage 4 pres Stable eschar (i.e erythema or fluctu limb should not be	org/resources/educational-and /npuap-pressure-ulcer-stagesca soure Injury: Obscured a and tissue loss n and tissue loss in which the amage within the ulcer cannot ause it is obscured by slough o or eschar is removed, a Stage sure injury will be revealed. a. dry, adherent, intact without uance) on the heel or ischemic e softened or removed.	а				
	<ul> <li>2.a. The facility staff failed to attempt non-pharmacological interventions prior to the administration of pain medication for Resident #5 per the comprehensive care plan.</li> <li>Resident #5 was admitted to the facility on 4/6/17</li> </ul>				CEVED Vala		
	that included but	on on 4/15/17, with diagnoses were not limited to: lymphedem		Facility ID: \		If continuation she	et Page 88 of 27
FORM CMS-	2567(02-99) Previous Versio	ons Obsolete Event ID: 6R5	DTT	Facility ID.	VA0000	in containdation one	

		AND HUMAN SERVICES					INTED: 05 FORM APF IB NO: 093	PROVED
STATEMENT	TOF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495240	B. WING	€			C 04/28/2	2017
NAME OF	PROVIDER OR SUPPLIER	1		1	REET ADDRESS, CITY, STATE, ZI	P CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			000 PLANK ROAD REDERICKSBURG, VA 2240	07		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD E	BE CO	(X5) MPLETION DATE
F 282	swelling, it occurs seizures, gastric u disease, Parkinso pressure, rheumat	age 88 of lymph in tissues leading to most often in the legs (1)), lcer, anxiety disorder, kidney n's disease, high blood toid arthritis (chronic destructive ized by joint inflammation (2)),		282				
	The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 4/22/17, coded the resident as being moderately impaired to make daily decisions, scoring a 10 on the BIMS (brief interview for mental status) scale of 0-15. The resident was coded as requiring supervision of one staff member for all of her activities of daily living except bathing in which she required total assistance of one staff member.							
	a revision date on "Focus: (Resident and monitoring re- and bilateral lower cellulitis." The "Int "Administer pain r Non-pharmacolog needed) such as l	ve care plan dated, 6/16/16 with 2/2/17, documented in part, #5) needs pain management lated to: Rheumatoid arthritis r extremity lymphedema and erventions" documented in par nedication as ordered. Attemp jical interventions PRN (as but not limited to: relaxation, ry, exercise, music, reposition, I pet therapy."	t,		RECEIVED			
	The physician ord	ers dated, 4/17/17,						
	(used to treat mod	ycodone HCL (hydrochloride) derate to severe pain (3)) Table	t	t				
	20 mg (milligrams 4 hours as neede	s) ; Give 1 tablet by mouth ever d for pain."	YDH/OLC					
	The MAR (medica	ation administration record) for						
L						10 0 0		00 of 27

Facility ID: VA0088

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED
		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING	·	04/28/2017
NAME OF F	PROVIDER OR SUPPLIER	<b>1</b>		STREET ADDRESS. CITY, STA	TE, ZIP CODE
				3900 PLANK ROAD	
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA	22407
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 282	Continued From pa	age 89	F	282	
1 202		inted the resident received			
		occasions since her			
	4/26/17, did not rev non-pharmacologic	e's notes from 4/17/17 throuveal any documentation of cal interventions attempted stration of the Oxycodone.	ugh		
	425/17 at approxim was asked what sta pain. Resident #5 the pain is and ask to ten (ten being th has) and then they if it's time for me to When asked if the a back rub or repose "We are just lucky		5 of e one see as d,		
	An interview was conducted with LPN (licensed practical nurse) #9 on 4/25/17 at 3:36 p.m. LPN #9 was asked what she does when a resident complains of pain. LPN #9 stated, "First you assess the location, type and have the resident rate the pain (on the scale of one to ten), and how long they've had the pain. It depends on the resident's orders we medicate them per the physician orders." When asked if there is anything that is offered before a medication is given, LPN #9 stated, "We offer diversional things, snacks, one to one attention, unless it is true pain then we just give the medication." When asked where the non-pharmacological interventions attempted prior to administering the pain medication is documented, LPN #9 stated, "There is a section on the MAR or in a general			RECEIVED May 31 2017 VDH/OLC	
EODM CMS 2	nurse's note." Whe	en asked the purpose of the		Facility ID: VA0088	If continuation sheet Page 90 of 278

CENTERS FOR MEDICARE & MEDICARD SERVICES	OMB NO. 0938-0391 (X3) DATE SURVEY
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING	COMPLETED
<b>495240</b> B. WING	C 04/28/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
SPREDERICKSBURG HEALTH AND REHAB       3900 PLANK ROAD         FREDERICKSBURG, VA 22407	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOUTAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 282 Continued From page 90 F 282	
care plan, LPN #9 stated, "It's how we are going to provide care to the resident."	
An interview was conducted with RN (registered nurse) #1, the assistant director of nursing, on 4/25/17 at 3:47 p.m. When asked what is expected of the nurses when a resident complains of pain, RN #1 stated, "They assess the pain, ask the resident to rate it on a pain scale, call the doctor for medication." When asked if they offer anything prior to administering the pain medication, RN #1 stated, "We can try repositioning, maybe a referral to the therapy department." When asked where this is documented, RN #1 stated, "It should be documented in the MAR or a progress note." When asked the purpose of the care plan, RN #1 stated, "It's how we provide individualized care to each resident." The administrator, director of nursing and administrative staff member (ASM) #3, the interim regional director of clinical services, were made aware of the above concern on 4/26/17 at 6:37	
p.m. 2.b. The facility staff failed to obtain Resident #5's	
weights per the comprehensive care plan.	
The comprehensive care plan dated, 6/16/16 and revised on 2/2/17, documented in part, "Focus:	
Potential for weight fluctuations as related to hx (history) edema, diuretic use." The "Interventions"	
documented in part, "Weights as ordered."	
The physician order dated, 4/15/17, documented, "Daily weights every day shift for monitoring."	

Facility ID: VA0088

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				MAPPROVED 0. 0938-039
ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495240	B. WING			04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE,	ZIP CODE	
	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22	2407	
(X4) ID PREFIX TAG	(EACH DEEICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 91	F 2	282		
1 202	Review of the MAF	R for April 2017 documented,				
	"Daily Weights eve	ry day shift for monitoring." not documented on 4/18/17,				
	4/20/17, 4/21/17 ar	nd 4/25/17.				
	An interview was c	conducted with LPN #9 on				
	4/25/17 at 3:36 p.n	n. When asked where daily				
	weights should be	documented, LPN #9 stated, R or in the vital signs tab in the				
	computer."					
	4/25/17 at 3.47 p.r	conducted with RN #1 on n. When asked where daily documented, RN #1 stated, "In in the computer "				
	medical record fai	al signs tab in the electronic led to evidence any the missing weights.				
	administrative stat	, director of nursing and ff member (ASM) #3, the interim ff clinical services, were made e concern on 4/26/17 at 6:37	١			
	n m.					
	3. The facility staff care plan for resto	f failed to follow Resident #2's prative nursing services.				
	Resident #2 was	admitted to the facility on				
	Resident #2's dia	nitted to the facility on 1/23/17. gnoses included but were not		Baldon, whereas which is the second second		
	limited to multiple	e sclerosis, diabetes and major				
	MDS (minimum d	er. Resident #2's most recent ata set), a significant change in				
	status assessmer	nt with an ARD (assessment f 1/30/17, coded the resident as				
	reference date) of 1/30/17, coded the resident as being cognitively intact. Section G coded Resident #2 as requiring extensive assistance of			VDH/OLC		
	two or more staff -2567(02-99) Previous Versio	with bed mobility and as being		Facility ID: VA0088	If continuation sh	eet Page 92 of

	F OF HEALTH	AND HUMAN SERVICES				PRINTED: 05/11/201 FORM APPROVED OMB NO: 0938-0391
STATEMENT OF DEF	ICIENCIES	NCIES (X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING			04/28/2017
NAME OF PROVID		AND REHAB		39	REET ADDRESS, CITY, STATE, ZIP CC 000 PLANK ROAD REDERICKSBURG, VA 22407	)DE
(X4) ID PREFIX ( TAG R	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
totall trans prog form The docu thera 1/24 circle func mon Res on 2 reste rang mob (ran part NuS (exe stre day part rails imp bed belt time Res	sfers. Resider ress and could er MDS asses most recent re umentation cou apy screen sig /17 that docur e around the v tional status n itor with nursin ident #2's com /24/17 docum prative nursing ge of motion), pilityGoal: I w ge of motion), pilityGoal: I w ge of motion), pilityGoal: I w ge of motion), cipate in ARC Step (exercise ercise device) ngth for self ca times 6-7 day icipate in bed s, bed control a rove independ . Resident to , slide board, v es 2 and verba	on two or more staff with the #2's current MDS was in d not be compared to the ssment. The habilitation (rehab) mpleted for Resident #2 was a uned by a physical therapist on mented, "Type of screen: (a vord 'Readmit')No change in oted. Will con't (continue) to		282	RECEIVED	
On	4/25/17 at 2:1 iducted with R	1 p.m., an interview was N (registered nurse) #1 (the t coordinator). RN #1 stated in				
the	past, there we	ere designated restorative o full time CNAs (certified s) who provided the programs;			VDH/OLC	

Facility ID: VA0088

If continuation sheet Page 93 of 278

ATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZI	P CODE
REDER	ICKSBURG HEALTH	AND REHAB		00 PLANK ROAD EDERICKSBURG, VA 2240	07
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIO THE APPROPRIATE DATE
F 282	Continued From pa	age 93	F 282		
	program where all provide restorative after care. RN #1 program process of prior to the survey.	y was undergoing an integrated CNAs were being trained to nursing programs during and stated the restorative nursing changed about five to six week RN #1 stated the MDS esponsible for the oversight of			
	conducted with RN responsible for the nursing program). resident declined, collaborate with th create a restorativ RN #2 stated in th meetings were hel CNAs who would n residents' progress RN #2 stated the n restorative notes of to March 2017. R company had take in place. RN #2 stated the facility has a w no longer two full t stated all CNAs an restorative service describe the curre evidence restoratif facility did not curre	I p.m., an interview was N#2 (the MDS coordinator e oversight of the restorative RN #2 stated in the past if a the nursing staff would e rehab department who would e nursing plan for the resident. e past, monthly restorative d with two full time restorative report updates regarding s in the restorative programs. restorative CNAs documented on paper from December 2016 N #2 stated since then, a new en over and a new system was ated as of early to mid-March whole new manual and there are time restorative CNAs. RN #2 re being trained to provide es. RN #2 was asked to nt documentation used to ve programs. RN #2 stated the rently provide restorative sidents because CNAs were	e	RECEIVED	
	being trained to pr	sidents because CNAs were rovide the services. RN #2 was	5		
	needed restorative rehab department	one for residents who currently e services. RN #2 stated the had screened residents who eceiving active restorative	,	VDH/OLC	

	TMENT OF HEALTH						F	NTED: 05/11/2017 ORM APPROVED NO. 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S		1 ' '	TIPLE CONS		(X3	3) DATE SURVEY COMPLETED
		495	5240	B. WING				C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER				STREET	ADDRESS, CITY, STATI	E, ZIP CODE	
	RICKSBURG HEALTH				3900 PL	ANK ROAD		
FREDER	ICKSBURG REALIN	AND KENAD			FREDE	RICKSBURG, VA 2	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIC Y MUST BE PRECEI LSC IDENTIFYING IN	DED BY FULL	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE	(X5) COMPLETION TE DATE
F 282	Continued From pa	age 94		F	282			
	receive restorative		he was care					
	planned to receive	services, RN #	2 stated, "Yes."					
	RN #2 stated Resi	dent #2's care p	olan was not					
	updated. RN #2 w							
	that the rehab dep	antment had eva	orative program					
	Resident #2 when the former restorative program was discontinued.							
	0 405147 -+ 0.51	) – m. on inton	iow was					
	On 4/25/17 at 2:50 conducted with OS	5 p.m., an interv M (other staff r	nember) #3 (the					
	director of rehab) r	egarding the re	storative					
	nursing program.	OSM #3 stated	at that moment					
	she couldn't say a	ny resident was	receiving					
	restorative nursing thought the CNAs	services. OSN	/I #3 stated she					
	of motion and walk	king programs a	and she thought					
	during the previous	s day RN #2 sta	ated she was					
	ready to resume w	alking and rang	ge of motion					
	programs. OSM #	3 stated during	the transition					
	from the former re	storative progra	am to the current					
	program the rehab monitoring the stat	b department na	and during this					
	period, the rehab of	department had	not been					
	notified by nursing	that any reside	nt had					
	presented with a d	ecline. OSM #	3 stated the					
	rehab department	had worked wit	h some					
	residents who wer restorative service	e previously rec	t who was					
	monitoring resider							
	nurses notify the r	ehab departme	nt when					
	residents have a c	hange in status	. OSM #3 was		ting the of			
	asked when the re Resident #2. OSM	hab departmen	it last evaluated			A Sura & W. Sarah Sarah		
	Resident #2. USN Resident #2 was f				St CV			
	department was in	December 201	16 and at that		동안 121 · 동문	,β β ≝ <sub>n</sub> i,Σ≜¢		
	time the resident of	lid not present v	with any change		٧n	HIOLO		
	in functional status	s and could ass	ist with bed		V Incl	i ti "ingi" term "inni"		
	mobility. OSM #3 Resident #2 had b	contirmed no e	valuation of					
			Event ID:6R5B1	1	Facility ID:	VA0088	If continuation s	sheet Page 95 of 27
FORM CMS-	2567(02-99) Previous Versior	is Obsolete	Event ID, 01001		i donity iD.			

		AND HUMAN SERVICES				FORM	D: 05/11/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SUF COMPLET	
		495240	B. WING			04	L/28/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			00 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)					
F 282	Continued From pa	age 95	F	282			
	department since f program. OSM #3 need for a screen not evaluated the r On 4/25/17 at 3:20	he transition of the restorative stated no one had relayed the so the rehab department had resident since the transition. p.m., RN #2 stated she talked					
	to the director of rehab and no evaluation was completed for Resident #2 during the transition of the restorative program. RN #2 was asked to provide all of Resident #2's restorative documentation.						
	Resident #2's rest Restorative notes and bed mobility s Resident #2 on 2/2 3/3/17, 3/6/17, 3/7. No further restorat restorative service dates or an evalua determine the resi	p.m., RN #2 presented brative documentation. documented range of motion services were offered to 27/17, 2/28/17, 3/1/17, 3/2/17, /17, 3/8/17, 3/9/17 and 3/10/17. ive documentation to evidence s were provided any other tion was completed to dent could be removed from gram was presented.					
	On 4/26/17 at 6:35 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional director of clinical services) were made aware of the above findings.						
	No further informa	tion was presented prior to exit			portas persona de la companya		
	4. For Resident #1	4, facility staff failed to follow	1				
	the plan of care and attempt non-pharmacological interventions prior to the administration of PRN (as needed) pain medications in April of 2017.				VDH/OLC		
	Resident #14 was	admitted to the facility on					

Facility ID: VA0088

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С 495240 B. WING 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 282 Continued From page 96 F 282 3/4/13 and readmitted on 7/5/15 with diagnoses that included but were not limited to gastroparesis [1], generalized anxiety disorder, history of mental and behavioral disorders, high blood pressure, and type two diabetes. Resident #14's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #14 was coded as being cognitively intact in the ability to make daily decisions, scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded as being independent with transfers, and ambulation; and independent with supervision only with dressing, eating, toileting, and bathing. Review of Resident #14's most recent POS (Physician Order Sheet) documented the following orders: "Percocet Tablet [2] 10-325 MG (milligrams) (Oxycodone- Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain." This order was initiated on 8/4/16. "Tylenol Tablet [3] 325 mg (milligrams) (Acetaminophen) Give 2 tablets by mouth every 6 hours as needed for Pain related to OTHER CHRONIC PAIN." This order was initiated on 12/3/15. Review of Resident #14's April 2017 MAR (Medication Administration Record) documented RECEVED that Resident #14 received Percocet 10-325 mg on the following dates and times: MAY 31 267 4/1/17 at 4:19 a.m., 11:19 a.m., 4:21 p.m. VDH/OLC 4/2/17 at 1:01 a.m., 4:42 p.m. 4/3/17 at 1:40 p.m., 6:55 p.m. 11:45 p.m. 4/4/17 at 4:10 a.m., 12:05 p.m., 3:50 p.m. 4/5/17 at 12:18 a.m., 4:20 a.m., 10:59 p.m., and

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

Event ID:6R5B11

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PRINTED: 05/11/2017

STATEMENT OF DEFICIENCIES       INCOMPERSUPPLER       INCOMPETENCIES       INCOMPETENCE       INCOMPETENCE         AMD DUAN OF CORRECTION       495240       INVIDUE       STREET ADDRESS. CITY. STATE. 2P CODE         MAME OF PROVIDER OR SUPPLER       STREET ADDRESS. CITY. STATE. 2P CODE       300 PLANK ROAD       FREDERICKSBURG HEALTH AND REHAB       STREET ADDRESS. CITY. STATE. 2P CODE         IMPL       CAMPANY STREEMENT OF DEFICIENCES       STREET ADDRESS. CITY. STATE. 2P CODE       300 PLANK ROAD         F282       Continued From page 97       F282       CONSTREET OF THE PERSION OF PROVIDER OF AND OF CONSTRETON OF THE ADDRESS. CITY. STATE. 2P CODE       DEFICIENCY         F282       Continued From page 97       F282       F282       CONSTREET OF THE ADDRESS. CITY. STATE. 2P CODE       DEFICIENCY         F1282       Continued From page 97       F282       F282       DEFICIENCY       DEFICIENCY       DEFICIENCY         F1284       Continued From page 97       F282       F282       F282       DEFICIENCY       DEFICIENCY <td< th=""><th></th><th></th><th>AND HUMAN SERVICES</th><th></th><th></th><th>PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391</th></td<>			AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391
495240     BLWING     04/28/20       NAME OF PROVIDER OR SUPPLIER     300 PLANK ROAD     300 PLANK ROAD       FREDERICKSBURG HEALTH AND REHAB     SUMMARY STATEMENT OF DEFICENCIES     300 PLANK ROAD       PREDERICKSBURG HEALTH AND REHAB     FREDERICKSBURG, VA 22407     FREDERICKSBURG, VA 22407       PHOTEN     CANTO DEFICENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     FREDERICKSBURG, VA 22407     CONSTRUCTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG     FREDERICKSBURG, VA 22407       F 282     Continued From page 97     F 282     Construct TAG     F 282       300 7 p.m., 4/07/17 at 1:33 a.m., 708 a.m., 11:05 p.m., 5:10 p.m., 4/07/17 at 1:20 a.m., 11:36 a.m., 3:2 p.m., 4/17/17 at 1:20 a.m., 11:36 a.m., 3:3 p.m., 4/17/17 at 1:20 a.m., 11:36 a.m., 3:3 p.m., 4/17/17 at 1:20 a.m., 11:36 a.m., 3:3 p.m., 4/17/17 at 1:20 a.m., and 4:15 p.m., 4/17/17 at 1:20 a.m., and 5:15 a.m., 11:34 a.m., 4/17/17 at 1:20 a.m., and 5:15 a.m., 11:34 a.m., 4/19/17 at 1:20 a.m., and 4:24 p.m., 4/12/17 at 2:20 a.m., and 4:24 p.m., 4/22/17 at 1:05 a.m., and 3:05 p.m., 4/22/17 at 1:20 a.m., and 3:05 p.m., 4/22/17 at 1:20 a.m., and 3:25 p.m., 4/22/17 at 1:20 a.m., and 4:24 p.m., 4/22/17 at 1:20 a.m., and 3:25 p.m., 4/22/17 at 1:20 a.m., and 3:26 p.m., 4/22/17 at 1:20 a.m., and 3:26 p.m., 4/22/17 at 1:20 a.m., and 3:26 p.m., 4/22/17 at 1:20 a.m., and 4:24 p.m., 4/22/17 at 1:20 a.m., and 3:25 p.m., 4/22/17 at 1:20 a.m., and 5:5 p.m., 4/22/17 at 1:20 a.m., and 5:5 p.m., 4/22/17 at 1:20 a.m., and 3:50 p.m., 4/22/17 at 1:20 a.m., and 3:50 p.m., 4/22/17 at 1:20 a.m., and 3:50	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 · · /		(X3) DATE SURVEY COMPLETED
NME: OF PROVIDER OR SUPPLIER       STREET ADDRESS. CITY. STATE. ZIP CODE         STREET ADDRESS. CITY. STATE. ZIP CODE       300 PLANK ROAD         PREFEX       TECHNOLOGUESS. CITY. STATE. ZIP CODE         PREFEX       TECHNOLOGUESS. CITY. STATE. ZIP CODE         PAGE       TECHNOLOGUESS. CITY. STATE. ZIP CODE         PREFEX       TECHNOLOGUESS. CITY. STATE. ZIP CODE         TAG       TECHNOLOGUESS. CITY. STATE. ZIP CODE         PREFEX       TECHNOLOGUESS. CITY. STATE. ZIP CODE         TAG       TECHNOLOGUESS. CITY. STATE. ZIP CODE         TECHNOLOGUESS. CITY. STATE. ZIP CODE       TECHNOLOGUESS. CITY. STATE. ZIP CODE         TAG       TECHNOLOGUESS. CITY. S			495240	B. WING	3	04/28/2017
FREDERICKSBURG HEALTH AND REHAB       PROVIDERS OF HEALTH AND REHAB       IDEPERICKSBURG, VA 22407       PROVIDERS PLANDE CORRECTION       DEPERICKSBURG, VA 22407       PROVIDERS PLANDE CORRECTION       PREVENTION FOR STATEMENT OF DEPICIENCES       PREVENTION       RECOMPTINE INFORMATION       PREVENTION FOR STATEMENT OF DEPICIENCES       PREVENTION FOR STATEMENT OF DEPICIENCES       PREVENTION FOR STATEMENT OF DEPICIENCES       CARRECT STATEMENT OF DEPICIENCE       PREVENTION STATEMENT OF DEPICIENCE OF STATEMENT OF DEPICIENCE ACCORRECTION       Addition of Statement of DEPICIENCE ACCORRECT TO THE APPROPRIATE OF DEPICIENCE ACCORRECT TO THE APPROPRIATE OF DEPICIENCE ACCORRECT TO THE APPROPRIATE OF DEPICIENCE ACCORRECT OF STATEMENT OF DEPICIENCE ACC	NAME OF I	PROVIDER OR SUPPLIER		<u></u>		
PREEX TAG         (EACH CORRECTIVE ACTION STOLE PRECED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION)         PREEX TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         COMM           F 282         Continued From page 97 307 p.m., 4/6/17 at 12:43 a.m., 11:01 a.m., 3:14 p.m., 4/7/17 at 1:33 a.m., 7:08 a.m., 1:05 p.m., 4/8/17 at 9:02 a.m., 11:30 a.m., 3:05 p.m., 4/9/17 at 1:29 a.m., 11:20 p.m., 4:15 p.m., 4/10/17 at 1:29 a.m., 11:20 p.m., 4:15 p.m., 4/10/17 at 1:29 a.m., 11:30 a.m., 3:32 p.m., 4/11/17 at 1:27 a.m., 5:15 a.m., 11:34 a.m., 4/16/17 at 12:27 a.m., 5:15 a.m., 11:34 a.m., 4/16/17 at 12:20 a.m., 4:54 a.m., 4:20 p.m., 5:39 p.m., 4/16/17 at 12:07 a.m., 4:07 a.m., 11:54 a.m., 4:00 p.m., and 10:45 p.m., 4/19/17 at 12:07 a.m., 4:07 a.m., 11:54 a.m., 4:00 p.m., and 10:45 p.m., 4/25/17 at 12:06 a.m., 4/25/17 at 12:06 a.m., 4/26/17 at 12:05 a.m., 4/26/17 at 12:05 a.m., 4/26/17 at 12:45 a.m., 4:46 a.m.         RECEIVED MY 31 L // VDH/OLC	FREDER	ICKSBURG HEALTH	AND REHAB			2407
3:07 p.m.,         4/6/17 at 12:43 a.m., 11:01 a.m., 3:14 p.m.,         4/6/17 at 12:03 a.m., 11:08 a.m., 1:05 p.m.,         4/9/17 at 4:02 a.m., 11:18 a.m., 5:05 p.m.,         4/9/17 at 4:02 a.m., 11:00 a.m., 3:32 p.m.,         4/10/17 at 1:29 a.m., 11:00 a.m., 3:32 p.m.,         4/11/17 at 12:29 a.m., 11:30 a.m., 3:32 p.m.,         4/11/17 at 12:29 a.m., 11:30 a.m., 3:32 p.m.,         4/12/17 at 12:15 a.m., 11:09 a.m., a:32 p.m.,         4/12/17 at 12:07 a.m., 2:19 p.m.,         4/12/17 at 12:00 a.m., 2:19 p.m.,         4/15/17 at 12:00 a.m., 4:15 a.m., 11:34 a.m.,         4/15/17 at 12:22 a.m., 4:54 a.m., 12:30 p.m., 5:39 p.m.,         9.m.,         4/17/17 at 5:11 a.m., 11:46 a.m., 4:20 p.m., 11:43 p.m.,         4/18/17 at 12:07 a.m., 4:07 a.m., 11:54 a.m., 4:00 p.m., and 10:45 p.m.,         4/18/17 at 12:00 a.m., and 4:24 p.m.,         4/20/17 at 10:04 a.m., and 4:24 p.m.,         4/22/17 at 12:05 a.m.,         4/22/17 at 12:05 a.m.,         4/22/17 at 12:04 a.m., and 3:56 p.m.,         4/22/17 at 12:04 a.m.,         4/22/17 at 12:05 a.m.,         4/21/17 at 3:32 p.m.,         4/21/17 at 3:29 p.m.,         4/16/17	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE A) CROSS-REFERENCED TO	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE DATE
4/6/17 at 12:43 a.m., 11:01 a.m., 3:14 p.m.,         4/7/17 at 1:33 a.m., 7:08 a.m., 1:05 p.m., 6:10         p.m.         4/8/17 at 9:02 a.m., 11:18 a.m., 5:05 p.m.,         4/9/17 at 4:19 a.m., 12:10 p.m., 4:15 p.m.,         4/10/17 at 1:29 a.m., 11:30 a.m., 3:32 p.m.,         4/11/17 at 1:27 a.m., 11:30 a.m., a:32 p.m.,         4/11/17 at 1:29 a.m., 11:30 a.m., a:32 p.m.,         4/11/17 at 1:27 a.m., 109 a.m., a:04 4:10 p.m.,         4/13/17 at 7:30 a.m., 2:19 p.m.,         4/16/17 at 1:2:07 a.m., 5:15 a.m., 11:34 a.m.,         4/16/17 at 1:2:02 a.m., 4:54 a.m., 12:30 p.m., 5:39         p.m.,         4/18/17 at 5:12 a.m., and 9:15 a.m.,         4/19/17 at 1:2:07 a.m., 4:07 a.m., 11:54 a.m., 4:00         p.m.,         4/18/17 at 2:03 a.m.,         4/22/17 at 1:04 a.m., and 4:24 p.m.,         4/22/17 at 1:04 a.m., and 3:55 p.m.,         4/22/17 at 1:04 a.m., and 3:25 p.m.,         4/22/17 at 1:2:05 a.m.,         4/26/17 at 1:2:05 a.m.,         4/2/17 at 2:20 p.m.,         4/16/17 at 3:29 p.m.,         4/16/17 at 3:29 p.m.,         4/16/17 at 3:29 p.m.,	F 282	Continued From pa	ge 97	F:	282	
non-pharmacological interventions were attempted prior to the administration of PRN		4/6/17 at 12:43 a.m 4/7/17 at 1:33 a.m., p.m. 4/8/17 at 9:02 a.m., 4/9/17 at 4:19 a.m., 4/10/17 at 1:29 a.m 4/11/17 at 12:47 a.m 4/12/17 at 12:15 a.m 4/12/17 at 12:15 a.m 4/13/17 at 7:30 a.m 4/14/17 at 12:27 a.m 4/15/17 at 12:00 a.m 4/16/17 at 12:22 a.m 4/16/17 at 12:22 a.m 4/18/17 at 5:12 a.m 4/18/17 at 5:12 a.m 4/19/17 at 5:12 a.m 4/20/17 at 10:04 a.m 4/20/17 at 10:04 a.m 4/23/17 at 2:30 a.m. 4/26/17 at 12:05 a.m 4/26/17 at 12:05 a.m 4/26/17 at 12:45 a.m Review of Resident documented that Re 325 mg on the follow 4/2/17 at 4:33 a.m., 4/12/17 at 2:24 p.m. 4/16/17 at 3:29 p.m. 4/17/17 at 1:35 p.m.	7:08 a.m., 1:05 p.m., 5:10 11:18 a.m., 5:05 p.m., 12:10 p.m., 4:15 p.m., , 11:30 a.m., 3:32 p.m., n., 12:34 p.m., 4:45 p.m., n., 11:09 a.m., and 4:10 p.m., , 2:19 p.m., n., 5:15 a.m., 11:34 a.m., n., 4:15 a.m., 5:15 p.m., n., 4:54 a.m., 12:30 p.m., 5:39 , 11:46 a.m., 4:20 p.m., 11:43 , and 9:15 a.m., n., 4:07 a.m., 11:54 a.m., 4.00 , n., and 4:24 p.m., , and 12:23 p.m., , and 3:56 p.m., n., t. 4:46 a.m. ##14's April 2017 MAR esident #14 received Tylenol ving dates and times:		···· /* Vager	
reicocet and Tylenol.		non-pharmacologica	al interventions were e administration of PRN			

Facility ID: VA0088

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	IMENT OF HEALTH						RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/S					(X3) DATE SURVEY COMPLETED
		49	5240	B. WING			C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	<b>.</b>
FREDER	ICKSBURG HEALTH	AND REHAB			3900 PLANK ROAD		
					FREDERICKSBUR		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFI TAG	X (EACH CORR	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 282	Continued From pa Review of Resident 11/09/16 document Management and m Chronic Pain, Multip fracture, Radius frac S/P (status post) Me Has diagnoses of se depressionIntervent decline in function m reviewIntervention preferred non-pharm strategies as neede On 4/26/17 at 1:25 p conducted with Res stated that nursing s interventions prior to medications. Resid requests pain medic the pill. On 4/26/17 at 1:45 p conducted with LPN a nurse who administ medication, LPN #4 that time, and see if attention. I try to tak see if that works." V non-pharmacologica administering every stated, "No. Some p LPN #4 stated that se non-pharmacologica administering pain m	#14's Pain ca ed the followin nonitoring relation of right and le cture, Ulnar Stotor Vehicle Ac- evere entions: Will no elated to pain ns:Implement nacological pain d." p.m., an intervident #14. Re staff did not atto padministering ent #14 stated cation, nursing p.m., an intervident atto cate of a prin stated, "I ask I can distract when asked if al interventions prin pain medi eople will ask she won't alwa al interventions nedications for	g: Needs Pain ted to: History of ft sided rib cyloid fracture, ccident in 2012. At experience a through next at the patient's ain relief iew was sident #14 tempt other g pain I that when she will give her iew was ctical nurse) #4, et on some of ed the process pain the pain level at or divert their of the pain and she attempts s before cation, LPN #4 for their pill." ys attempt s prior to r residents who			DEFICIENCY)	
	requests pain medic documents non-pha attempted prior to th	rmacological i e administrati	nterventions on of pain		VDH/OLC		
FORM CMS-25	67(02-99) Previous Versions (	Obsolete	Event ID:6R5B11		Facility ID: VA0088	If continuation	sheet Page 99 of 278

		AND HUMAN SERVICES					RINTED: 05/11/2017 FORM APPROVED MB NO: 0938-0391
1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	STRUCTION		(X3) DATE SURVEY COMPLETED C
		495240	B. WING				04/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE,	ZIP CODE	
FREDER	CICKSBURG HEALTH	AND REHAB			ANK ROAD RICKSBURG, VA 22	2407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE COMPLETION
F 282	Continued From pa	ge 99	F2	282			
	stated, "I should. I c non-pharmacologic attempted if the res instructions to do se don't think the care LPN #4 was shown When asked if her #4 stated, "No." On 4/16/17 at 5:00 staff member) #1, th the DON (Director c of the above concer facility uses Lippinc The following quota Nursing Procedures nursing care plan se planning assignmer reports, conferring w members of the hea	ne does attempt al interventions, LPN #4 don't." When asked if al interventions should be ident's care plan documents b, LPN #4 stated, "Yes, but I plan usually addresses that." Resident #14's care plan. care plan was followed, LPN p.m., ASM (administrative ne administrator and ASM #2, of Nursing) were made aware rns. ASM #2 stated that the ott as a standard of practice. tion is found in Lippincott's a 6th edition (p. 128): "A erves as a database for nts, giving change of shifts with the doctor or other alth care team, planning nd documenting patient					
	Williams and Wilkin documented, "A writ communication tool members that helps careThe nursing c information about th and goals. It contain	ten care plan serves as a among health care team ensure continuity of are plan is a vital source of e patient's problems, needs, ns detailed instructions for established for the patient	Anna	RECE MAY 3 VDH			
	No further information	on was presented prior to exit.		VUM	and the second		

Facility ID: VA0088

If continuation sheet Page 100 of 278

	TMENT OF HEALTH							RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES		R/SUPPLIER/CLIA ATION NUMBER:			ONSTRUCTION		(X3) DATE SURVEY COMPLETED
		4	95240	B. WING			~~~~~~	Č 04/28/2017
NAME OF	PROVIDER OR SUPPLIER	<b>.</b>		<b>I</b>	STRE	ET ADDRESS, CITY,	STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB				PLANK ROAD DERICKSBURG,	VA 22407	
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTIC TIVE ACTION SHOULI CED TO THE APPROF EFICIENCY)	DBE COMPLETION
F 282	Continued From pa	ge 100		F 2	282			
	5. The facility staff t comprehensive car 3.							
	Resident # 3 was a 05/06/14 with diagn not limited to: neuro bladder (1), gastroe diabetes mellitus (3 hypertension (5), bi seizure disorder (8)	oses that inc omuscular dy sophageal re ), anxiety (4) polar (6), her	luded but were sfunction of the eflux disease (2), , depression, niplegia (7),					
	Resident # 3's mos set), a quarterly ass (assessment refere Resident # 3 as sco interview for mental - 15, 14 being cogn decisions. Residen extensive assistance activities of daily livit	essment with nce date) of pring a 14 on status (BIMS itively intact f t # 3 was coo e of one staff	n an ARD 02/21/17, coded the brief 6) of a score of 0 or making daily ded as requiring					
	The POS (Physician # 3 dated 01/2017 c "Acetaminophen Ta Give 2 (two) tablets as needed for pain.	locumented, blet (9) 325 N by mouth ev	/IG (milligram) ery 4 (four) hours					
	"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016."							
	"Oxycodone (11) 5 ( (one) tablet by mout	h every 4 ho	urs as needed					
	for pain use for severe pain. Order Date: 10/18/2016."				ji ji	and the second		
	"Tramadol Tablet (1)	2) 50 MG. G	ive 2 (two) tablet		VDF	4/010		
ORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 6R5B1	1	Facility ID	D: VA0088	If continuation	sheet Page 101 of 278

If continuation sheet Page 101 of 278

TATEMEN	OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS		(X3)	NO. 0938-03 DATE SURVEY COMPLETED
		495240	B. WING				C 04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB		3900 PLA	ADDRESS, CITY, STATE ANK ROAD RICKSBURG, VA 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN ( (EACH CORRECTIVE A ROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE
F 282	Continued From pa	ige 101	F 2	82			
		ours as needed for pain. der Date: 10/18/2016."					
	record) for Residen documented, "Aceta (milligram) Give 2 (f	nic medication administration t # 3 dated "January 2017 aminophen Tablet (9) 325 MG two) tablets by mouth every 4 ded for pain. Order Date:					
	(one) tablet by mout	(five) MG (milligrams). Give 1 th every 4 hours as needed ere pain. Order Date:					
	mouth every 4 hours	) MG. Give 2 (two) tablet by s as needed for pain. ler Date: 10/18/2016."					
	following: Acetaminophen was 2:30 p.m., 01/12/17 9:40 a.m., 01/17/17	anuary 2017 revealed the s administered on: 01/03/17 at at 11:31 a.m., 01/15/17 at at 8:47 a.m., 01/18/17 at 8:21 34 a.m., 01/20/17 at 8:19					
		35 a.m., 01/23/17 at 8:28 :44 a.m., 01/25/17 at 10:25		REC			
	and 01/31/17 9:17 a				Paradolika 1979 - J. 1970 - J. 1976 - J.		
	Ketorolac was tromethamine was administered on: 01/03/17 at 2:37 p.m., 01/04/17 at 3:17 p.m., 01/06/17 at 12:33 a.m., 01/07/17 at 2:04 a.m., 10/08/17 at 2:57 p.m., 01/10/17 at 8:46 a.m. and on 01/15/17 at 12:06 a.m.						
RM CMS-256	7(02-99) Previous Versions (	Dbsolete Event ID: 6R5B1	1	Facility ID: VA	10088	If continuation shee	Page 102 of 2

CENTE	RS FOR MEDICAR	HAND HUMAN SERVICES					APPROVE 0938-039
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	CON	E SURVEY IPLETED
		495240	B. WING				C 28/2017
NAME OF	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
FREDEF	RICKSBURG HEALTH	AND REHAB			0 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 102	F 2	82			
		dministered on 01/01/17 at 1:43					
		6:09 p.m., 01/05/17 at 4:05 11:14 a.m., 01/08/17 at 8:51					
	a.m., 01/11/17 at 9	0:02 a.m., 01/13/17 at 6:15					
	,	5:01 a.m., 01/19/17 at 5:01					
		2:37 a.m., 01/21/17 at 4:00 3:41 p.m., 01/27/17 at 12:10					
		2:31 a.m. and 8:42 p.m. and on					
	01/30/17 1:12 a.m.						
		ninistered on 01/05/17 at 5:30 H:30 p.m., 01/09/17 at 4:01					
		2:37 a.m., 01/17/17 at 12:14					
	p.m., 01/18/17 at 1	1:38 a.m., 01/19/17 at 11:16					
	÷	0:49 a.m., 01/21/17 at 11:59					
		:05 p.m., 01/24 at 4:09 a.m., m., 01/26/17 at 5:43 a.m.,					
		m. and 01/31/17 at 3:01 a.m.					
		ident # 3 dated "February 2017					
	documented,	ablet 325 MG (milligram) Give					
		nouth every 4 (four) hours as					
		Order Date: 10/04/2016."					
	"Oxycodone 5 (five	e) MG (milligrams). Give 1					
	(one) tablet by mou	th every 4 hours as needed					
		/ere pain. Order Date: discontinue) 02/02/2017."					
	"Tramadol Tablet 5	0 MG. Give 2 (two) tablet by					
	mouth every 4 hou	rs as needed for pain.					
	Moderate pain. Or 02/02/2017."	der Date: 10/18/2016. D/C			a kinada tadi Sasa S. Y. Kun Bugat		
	ULIULILUII.						
		ebruary 2017 revealed the					
	following:	as administered on: 02/01/17 at			VDH/OLC		
		7 at 9:12 a.m., 02/03/17 at 4:57					
		:22 a.m., 02/06/17 at 1:01					

Facility ID: VA0088

		E & MEDICAID SERVICES			221127211271211	T	NO. 0938-03
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED
		495240	B. WING				C 04/28/2017
NAME OF P	ROVIDER OR SUPPLIER	1			REET ADDRESS, CITY, STATE, ZIP COI	I DE	04/20/2017
FREDERI	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC E DATE
F 282	Continued From pa	age 103	F 2	82			
		:10 a.m. and 4:58 p.m.,					
		m., 02/09/17 at 4:18 a.m., m. and 4:40 p.m., 02/12/17 at					
	1:06 a.m., 02/14/17	′ at 5:22 a.m., 02/15/17 at 1:46	i				
		:45 p.m., 02/ 17/17 5:00 p.m., m. and 5:15 p.m., 02/20/17 at					
	4:40 p.m., 02/21/17	at 5:20 p.m., 02/25/17 at 4:29					
	o.m. and 02/26/17 a						
	12:00 a.m.	ministered on 02/01/17 at					
		inistered on 02/01/17 at 12:04 and on02/02/17 at 6:07 a.m.					
	documented, "Aceta milligram) Give 2 (f	he eMAR for Resident # 3 dated "March 2017 ocumented, "Acetaminophen Tablet 325 MG nilligram) Give 2 (two) tablets by mouth every 4 our) hours as needed for pain. Order Date: 0/04/2016."					
	The eMAR dated M ollowing:	arch 2017 revealed the					
	Acetaminophen was 3:47 p.m., 03/04/17 a.m., 03/10/17 at 4: b.m., 03/19/17 at 4: and 4:32 p.m., 03/2 b.m., 03/22/17 at 4: 03/24/17 at 3:20 a.m. 1:30 p.m., 03/26/17 a.m. and 11:43 a.m.	s administered on: 03/02/17 at at 4:46 a.m., 03/06/17 at 3:08 21 a.m., 03/14/17 at 12:01 50 p.m., 03/20/17 at 6:38 a.m. 21/17 at 4:38 a.m. and 1:57 38 a.m. and 9:32 a.m., n. and 4:42 p.m., 03/25 at at 4:35 a.m., 03/27/17 at 3:52 , 03/29/17 at 4:57 a.m.,					
		n. and 03/31/17 at 8:27 a.m.			AECENEO		
		dent # 3 dated "April 2017 aminophen Tablet 325 MG					
(	milligram) Give 2 (t	wo) tablets by mouth every 4					
	four) hours as neec 0/04/2016."	ed for pain. Order Date:			VDH/OLC		

Facility ID: VA0088

If continuation sheet Page 104 of 278

		AND HUMAN SERVICES			P	RINTED: 05/11/2017 FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 . /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING	; 		C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	ICKSBURG HEALTH	AND REHAB		390	00 PLANK ROAD	
				FR	EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	4:56 a.m. and 3:42 04/04/17 at 4:28 a.r 4:24 a.m. and 8:58 04/07/17 at 4:31 a.r 4:00 p.m., 04/09/17 5:09 p.m., 04/10/17 12:39 a.m., 4;47 p.r 04/13/17 at 4:18 p.n 04/16/17 at 5:14 a.n 4:30 p.m., 04/18/17 a.m. and 2:42 p.m., 04/24/17 at 3:34 p.n 04/26 at 4:59 a.m. The "Progress Note 01/01/2017 through and failed to evidence non-pharmacologica administration of acc ketorolac tromethan The care plan for Re documented, "Focus (diagnoses) of CVA stroke) with left hem Pain, Syndrome, and she experiences mor makes it hard for he her daily activities. If pain medication/Pair monitoring. Date In "Interventions" it door	s administered on: 04/01/17 at p.m., 04/02/17 at 1:33 p.m., n. and 5:11 p.m., 04/05/17 at a.m., 04/06/17 at 3:29 p.m., n. and 5:00 p.m., 04/08/17 at at 4:50 a.m., 12:40 p.m. an d at 6:51 p.m., 04 11/17 at n., 04/12/17 at 5:00 p.m., n. and 6:31 p.m., 04/17/17 at at 4:45 p.m., 04/19/17 at 4:27 04/21/17 at 4:55 p.m., n., 04/25/17 at 1:30 p.m. and s" for Resident # 3 dated 04/24/2017 were reviewed ce documentation of al interventions prior to the etaminophen, oxycodone, nine and tramadol. esident # 3 dated 07/12/16 s: Resident has a Dx (cerebral vascular accident - iparesis, paralysis, Chronic d Backache. Reports that derate to severe pain, which r to sleep at night, and limits Receives PRN (as needed) n management and itiated: 07/12/2016." Under	F	282		
	Date Initiated: 07/12				VDH/OLC	
	On 04/26/17 at 11:20	) a.m. an interview was				

Event ID:6R5B11

Facility ID: VA0088

		HAND HUMAN SERVICES			FORM	D: 05/11/20 APPROVI D. 0938-03	
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		495240	B. WING		04	C /28/2017	
NAME OF I	PROVIDER OR SUPPLIE	R	{\$	STREET ADDRESS, CITY, STATE, Z		20/2011	
FREDER	ICKSBURG HEALT		3	900 PLANK ROAD			
TREDER			F	REDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETH DATE	
F 282	Continued From p	bage 105	F 282				
		PN (licensed practical nurse) #	1 202				
		to describe the procedure of			,		
		N (as needed) pain medication					
	LPN # 12 stated,						
		ical interventions like ing down the lights or television					
		pain medication." When asked					
	how often the non	-pharmacological interventions					
		ed, LPN # 12 stated, "It's every					
		the medication." After					
		Rs dated January, February, 017 and the progress notes					
		rough 04/24/17 for Resident #					
	3, LPN # 12 was a						
		non-pharmacological					
		npted prior to the administration					
		cation. LPN # 12 stated, "There wasn't documented it wasn't					
		ed to describe the purpose of					
		# 12 stated, "It provides an					
		we should provide. If it's on					
		eds to be followed." After					
		e plan for Resident # 3's pain, ed if the care plan was followed					
		logical interventions. LPN # 12					
		n't followed for pain."					
		45 a.m. an interview was					
		(registered nurse) # 1, the					
		of nursing. When asked to					
	describe the procedure of administering PRN pain medication RN # 1 stated, "Check the MAR to determine when the last pain med (medication						
	was given, attemp	t non-pharmacological		a a construction of the second se			
		/ time, if not working call		and an and a second			
		tment of pain regimen, on the eMAR. Reassess the		VDH/OLC			
		ately 30 to 45 minutes after		n sai s ti na sai sai			
		ion to determine if it was					

		AND HUMAN SERVICES					FORM	: 05/11/2017
STATEMENT	CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	U	(X3) DAT CON	. 0938-0391 E SURVEY MPLETED
		495240	B. WING					C / <b>28/2017</b>
NAME OF F	PROVIDER OR SUPPLIER	L	L	STREE	TADDRESS, CITY, STA	TE, ZIP CODE	1 0	
FREDER	ICKSBURG HEALTH	AND REHAB			LANK ROAD ERICKSBURG, VA	22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 106 ewing the MARs dated	F 28	82				
	January, February, progress notes date for Resident # 3, RI documentation of n interventions attem of PRN pain medica wasn't done." Whe purpose of the care provide a plan of ca provide staff that is to meet the residen families of the resid reviewing the care p RN # 1 was asked i for non-pharmacolo stated, "No, it's not On 04/27/17 at 3:25	March and April 2017 and the ed 01/01/17 through 04/24/17 N # 1 was asked if there was on-pharmacological pted prior to the administration ation. RN # 1 stated, "No, it n asked to describe the plan, RN # 1 stated, "To ire for the resident. A guide to not familiar with the resident t's needs and informing ent's current status." After plan for Resident # 3's pain, f the care plan was followed gical interventions. RN # 1						
	No further informati	on was provided prior to exit.						
	control due to a bra condition. This info the website:	ch a person lacks bladder in, spinal cord, or nerve rmation was obtained from gov/ency/article/000754.htm.		erry part	a <sup>gen</sup> a, 1924 û 1. y 1894 man.			
	2 Stomach contact	s to leak back, or reflux, into		Josef Jaco Karri				
		irritate it. This information						
		.gov/medlineplus/gerd.html.		VD	H/010			
		e in which the body cannot t of sugar in the blood. This	<b></b>		··· • ••• • • •			

Facility ID: VA0088

If continuation sheet Page 107 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 05/11/2017 MAPPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /		E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495240	B. WING	S		0	C 4/28/2017
NAME OF F	PROVIDER OR SUPPLIER		1	s	TREET ADDRESS, CITY, STATE, ZIP COI	······	
FREDER	ICKSBURG HEALTH	AND REHAB			900 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 107	F:	282			
		ained from the website: .gov/medlineplus/ency/article/					
	website:	nation was obtained from the .gov/medlineplus/anxiety.html					
	obtained from the w	ure. This information was /ebsite: .gov/medlineplus/highbloodpr					
	mood, energy, activ carry out day-to-day obtained from the w	hat causes unusual shifts in ity levels, and the ability to / tasks. This information was /ebsite: h.gov/health/topics/bipolar-dis					
	Quadriplegia. Para function in part of yo something goes wro pass between your can be complete or both sides of your b one area, or it can b	iplegia, Palsy, Paraplegia, lysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just be widespread. This ained from the website:			layanga gayan ini ini susa u s. a Juntu kandu		
	https://medlineplus.	gov/paralysis.html.					
	because of sudden,	rain problem. They happen abnormal electrical activity in			$ \begin{array}{cccc} - 1 & -1 & -1 & -1 \\ - 1 & -1 & -1 & -1$		
	the brain. This inform website:	mation was obtained from the			VDH/OLC		

Facility ID: VA0088

If continuation sheet Page 108 of 278

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)	NO. 0938-0391 DATE SURVEY COMPLETED C
AND DEAN OF CORRECTION	COMPLETED C
<b>495240</b> B. WING	04/28/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	04/20/2017
FREDERICKSBURG HEALTH AND REHAB	
FREDERICKSBURG, VA 22407	
(X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION E DATE
F 282 Continued From page 108 F 282	
9. Used to relieve mild to moderate pain from	
headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches,	
and reactions to vaccinations (shots), and to	
reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis	
caused by the breakdown of the lining of the	
joints). Acetaminophen is in a class of	
medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing	
the way the body senses pain and by cooling the	
body. This information was obtained from the website: https:	ć
https://medlineplus.gov/druginfo/meds/a681004.h tml.	
10. Used for the short-term relief of moderately severe pain and should not be used for longer than 5 days, for mild pain, or for pain from chronic (long-term) conditions. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693001.h tml.	
(11) Used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.h tml.	
(12) Used to relieve moderate to moderately	
severe pain. This information was obtained from	
the website: https://medlineplus.gov/druginfo/meds/a695011.ht	
ml.	
6a. The facility staff failed to follow the	

Event ID: 6R5B11

Facility ID: VA0088

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		AND HUMAN SERVICES			F	RINTED: 05/11/2017 FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		С	MB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	(X3) DATE SURVEY COMPLETED		
		495240	B. WING	minanakitamin		C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		4	ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	ICKSBURG HEALTH			39	00 PLANK ROAD	
TREDER				FF	REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 282	Continued From pa	ge 109	F2	282		
	comprehensive care Resident # 16.	e plan for incontinence care of				
	11/23/13 with a read diagnoses that inclu- dementia (1), hyper (3), gastroesophage Parkinson's disease Resident # 16's mos set), a quarterly ass (assessment refere Resident # 16 as so interview for mental - 15, three being set for making daily ded coded as requiring e staff member for ac On 04/24/17 at appr Resident # 16's hus	st recent MDS (minimum data dessment with an ARD nce date) of 03/21/17, coded coring a three on the brief status (BIMS) of a score of 0 verely impaired of cognition cisions. Resident # 16 was extensive assistance of one tivities of daily living. roximately 12:30 p.m. band requested to speak with 5/17 at approximately 8:30				
	interview was condu- husband. Resident concerns regarding Resident # 16 (spou- day arriving at appro- feeds Resident # 16 leaves at 1:30 p.m.	a.m. a conversation and acted with Resident # 16's # 16's husband stated he had incontinence care for use). He stated he visits every eximately 7:30 to 8:00 a.m., her breakfast and lunch and He stated he has found his ad soaked when he comes in			REORVED Addates VDH/OLC	
	conducted of CNA (	o.m. an observation was certified nursing assistant) # 6 ce care to Resident # 16.			VUTICALO	

Facility ID: VA0088

If continuation sheet Page 110 of 278

		AND HUMAN SERVICES				FOR	D: 05/11/201 MAPPROVEI D. 0938-039
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495240	B. WING	-		04	l/28/2017
NAME OF	PROVIDER OR SUPPLIER		1	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			) PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 110	F 2	282			
		lying in bed and was soaked					
		ith urine. When asked when					
		last changed CNA # 6 stated, her until now." CNA # 6					
	further stated that t	he resident's husband had					
		ay have changed Resident #					
		e else change her. When resident who is incontinent					
		, CNA # 6 stated, "They should					
	be checked every h	nour and a half to two hours."					
	On 4/25/17 at 2.40	p.m. an interview was					
		A # 6 in the presence of ASM					
		f member) # 2, the director of					
		ted if she was assigned to A # 6 stated, "Yes." When					
		he procedure for incontinence					
	care, CNA # 6 state	ed, "Go in and check the					1
		hours. Introduce yourself, tell					
		ou are about to do and When asked when the last					
	time was that she h	ad provided Resident # 16	:				
		are, CNA # 6 stated, "After					
		e lunch about 9:30 (a.m.). I ower. I rechecked back					
	0	ven and asked the husband if					
		eded to be changed." When					
		ally checked Resident # 16 to quired incontinence care, CNA					
		ked the husband." When					
		art of the process, CNA # 6					
		asked if she had physically #16 between 9:30 a.m. and		Band Server	RCEIVED		
		stated "No." When asked if			o a car an a second of a		
	she followed the two	o hour check procedure for			MAY 31 2017		
		# 6 stated, "No. It's what I			VDH/OLC		
	two hour check for i	ed." When asked about the incontinence care described 2 stated CNA # 6 was correct			VUTIVLV		

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If continuation sheet Page 111 of 278

		AND HUMAN SERVICES				FORM APPROVE
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1			<u>OMB NO. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		1	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	
	FREDERICKSBURG HEALTH AND REHAB				3900 PLANK ROAD	
				F	FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 282	Continued From page	ge 111	F 2	282	2	
	and that it should be	-				
	documented, "Focu functioning deficit re impairment, Mobility 16) has dx (diagnos and Dementia." Un documented, "Requ toileting and or inco 03/22/2017." On 4/27/17 at 9:40 a conducted with CNA					
	stated, "Continence when I check them a are wet when I chec the care plan for Re	is when the resident is dry and incontinence is when they ked them." After reviewing sident # 16's incontinence asked if she followed the care				
	conducted with LPN 11, unit manager. V continent and incont "Continent is someo urine and respond to have to go. Incontin not have the ability t have the sensation t After informing LPN 6 not providing timel reviewing the care p incontinence care, L care plan was follow The care plan should	a.m. an interview was I (licensed practical nurse) # Vhen asked to describe tinence LPN # 11 stated, one who is able to hold their to the sensation of when they hence is someone who does to hold their urine and/or don't to know when they are wet." #11 of the incident of CNA # Iy incontinence care and alan for Resident # 16's .PN # 11 was asked if the yed. LPN # 6 stated, "No. d have been followed." When			RECEIVED	
		e purpose of the care plan, s a road map, guide that tells				

Facility ID: VA0088

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		AND HUMAN SERVICES					RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT OF DEFICIEN AND PLAN OF CORRECTI	ICIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495240	B. WING	;			C 04/28/2017
NAME OF PROVIDER OF	SUPPLIER	1	1	1	STREET ADDRESS, CITY, STATE, ZI	P CODE	
FREDERICKSBURG	HEALTH	AND REHAB		1	3900 PLANK ROAD FREDERICKSBURG, VA 2240	)7	
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD HE APPROPI	BE COMPLETION
On 04/27. staff mem 2, the dire above find No further Reference (1) A loss diseases. judgment obtained t https://me (2) High b obtained t https://ww essure.htm (3) A chro regulate tt informatio https://ww 001214.htm (4) Stoma the esoph was obtained	o take can (17 at 3:28 (17 at	The of the resident." 5 p.m. ASM (administrative the administrator and ASM # irsing, were made aware of the ion was provided prior to exit. unction that occurs with certain memory, thinking, language, avior. This information was vebsite: gov/ency/article/000739.htm. sure. This information was	F 2	282			
informatio	n was obt w.nlm.nih	nent disorder. This ained from the website: .gov/medlineplus/parkinsonsdi			VDH/OLC		

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Facility ID: VA0088

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		HAND HUMAN SERVICES			PRINTED: 05/11/201 FORM APPROVED
STATEMEN	RS FOR MEDICAR	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER		39	REET ADDRESS, CITY, STATE, ZIP CO 00 PLANK ROAD REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION A CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 282	Continued From pa	age 113	F 282		
		ff failed to follow the re plan for transfers of			
	tracking sheets for 22, 2017 through M Under "Intervention Transferring." Of 1 two-person transfe	activities of daily living) Resident # 16 dated March March 31, 2017 was reviewed. n / Task" it documented, "ADL 2 opportunities to implement a rr, Resident # 16 was coded as using one-person two times.			
	tracking sheets for 2017 through April Under "Interventior Transferring." Of 5 two-person transfe	activities of daily living) Resident # 16 dated April 01, 26, 2017 was reviewed. n / Task" it documented, "ADL 50 opportunities to implement a r, Resident # 16 was coded as using one-person 28 times.			
	documented, "Focu functioning deficit r impairment, Mobilit 16) has dx (diagno and Dementia." Ur documented, "Req	Resident # 16 dated 05/09/16 us: I have a physical elated to: Self-care ty impairments. (Resident # ses) of Parkinson's Disease nder "Interventions" it uires staff assistance with Mechanical Lift and 2 (two)			
	conducted with CN to transfer Residen	0 a.m. an interview was A # 6 regarding the procedure t # 16. When asked what any people are needed to		and the second s	
	transfer Resident # do it myself. She (I	16, CNA # 6 stated, "I usually Resident # 16) holds my			
	she obtains the info	nsfer her.' When asked where prmation regarding how to 16, CNA # 6 stated, "It's on			

Event ID:6R5B11

Facility ID: VA0088

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DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES					D: 05/11/2017
		& MEDICAID SERVICES					M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495240	B. WING	÷		0,	C 4/28/2017
NAME OF I	PROVIDER OR SUPPLIER	<b>.</b>	.1	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	ICKSBURG HEALTH			3	900 PLANK ROAD		
				F	REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	-	F:	282			
		times I refer to it sometimes I en showed this surveyor the					
		ith a print date of 03/16/17.					
	The Kardex docum	ented, "Transferring: 2 (two)					
		e Kardex with the print date of by ASM # 2, director of					
		ed, "Transferring: 2 (two)					
		the sit to stand lift." When					
		e Kardex for Resident # 16 f 4/26/17, CNA # 6 stated, "I					
	don't have that one,	, this is the only one I have."					
		receives a new kardex each d, "This is the only one I have."					
	conducted with LPN 11, unit manager. W purpose of the care road map, guide that the resident." After sheets dated 03/22/ 11 was asked if Res transferred using a (Name of Mechanic plan, LPN # 11 state	a.m. an interview was I (licensed practical nurse) # When asked to describe the plan, LPN # 11 stated, "It's a at tells you how to take care of reviewing the ADL tracking (17 through 04/26/17, LPN # sident # 16 was being two-person assist and a al Lift) according to the care ed, "I can't say if it's being he care plan should be					
	staff member) # 1, t	p.m. ASM (administrative he administrator and ASM # rsing, were made aware of the		0			
	No further information	on was provided prior to exit.		1000 C	New Yest Control VIII and State		
		ailed to monitor Resident #1's per the care plan initiated on					
	10/28/16.	F		V	04/01.0		

Event ID:6R5B11

Facility ID: VA0088

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CENTE	RS FOR MEDICARI	E & MEDICAID SERVICES	1		OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			N. DOILD		С
		495240	B. WING		04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 282	Continued From pa	age 115	F 2	82	
	10/22/16 with diag Parkinson's diseas	dmitted to the facility on noses that included: e (1), movement disorder, g, dementia and urinary			
	The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date of 4/18/17 coded the resident as having scored an 11 out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired cognitively. The resident was coded as requiring assistance for all activities of daily living. The resident was coded as requiring extensive assistance of one staff member for eating.				
	10/28/16 documen Food/Beverage Inta tremors, SOB (sho hx (history) of famil against dietary con- resident noncompli consistency restrict time when mouth s Requires extra time mouth) intake. Inter assistance to eat. M	lent's care plan initiated on nted, "Focus. Inadequate Oral ake due to: Parkinson's, rtness of breath), Altered Diet. y bringing in outside foods sistency (sic) restrictions, ant (sic) with dietary tions, resident has periods of pasms and will not open, to eat, hx of variable PO (by rventions. Allow extra time and Monitor meal consumption. dered, Weights as ordered."	9 <sup>0</sup> *	The same super states to be a second	
		ent's ADL (activities of daily rch 2017 documented that			
		consumption for 30 out of 93			
				IDH(OLC)	
		ent's ADL sheet for April eal consumption for 16 out of locumented			

Facility ID: VA0088

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		AND HUMAN SERVICES			PRINTED: 05/11/201 FORM APPROVE OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER	<b></b>	1	STREET ADDRESS. CITY, STATE, ZIP (	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIO
F 282	Continued From pa	age 116	F 2	82	
	3/7/17 documented dropped from 189.6	lent's weights from 10/22/16 to I that Resident #1 weight had 6 pounds to 169.6 pounds, a oximately 11 percent.			
	a.m. with CNA (cert When asked to revi explain what the bla meant, CNA #19 sta in." When asked wh food a resident con- we can track what t weight." When aske accurately track Re	onducted on 4/28/17 at 8:50 tified nursing assistant) #19. iew the ADL sheets and to ank spaces beside the meals ated, "They weren't charted ny staff charted the amount of sumed, CNA #19 stated, "So hey eat in case they lose ed if it was possible to sident #1's food consumption, ot with the blank space."			
	a.m. with ASM (adm the director of nursi monitors resident's stated, "It would be reviewed the March for Resident #1. Wh considered sufficient stated, "The kiosk m might be in the char	onducted on 4/28/17 at 9:25 ninistrative staff member) #2, ng. When asked how staff food consumption, ASM #2 in his ADLs." ASM #2 and April 2017 ADL sheets nen asked if that was nt for monitoring, ASM #2 night have been down and it t." A request was made at this entation evidencing Resident ion.			
	No further documen exit.	tation was provided prior to		RECEIVED	
		y's policy titled "Restorative ence documentation regarding		VDH/OLC	

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Facility ID: VA0088

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	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY
	FCORRECTION	DENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		405340	B. WING		C
allogent of the last street streets		495240		STREET ADDRESS, CITY, STATE, ZIP COD	04/28/2017
AME OF F	PROVIDER OR SUPPLIER		1	3900 PLANK ROAD	~ <b>L</b>
REDER	ICKSBURG HEALTH	AND REHAB	1	FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC
F 282	Continued From pa	age 117	F 282	2	
F 309 SS=E	the nervous system regions of the brain substantia nigra that movement. This inth https://ghr.nlm.nih.g e#definition 483.24, 483.25(k)(I FOR HIGHEST WB 483.24 Quality of Int Quality of life is a fu applies to all care a residents. Each re facility must provide services to attain o practicable physical well-being, consiste comprehensive ass 483.25 Quality of c Quality of care is a applies to all treatm facility residents. B assessment of a re	fe undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest il, mental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure	5 F 309	<ul> <li>F309</li> <li>Resident #7 orders updat</li> <li>#26 is discharged. Resident</li> <li>plan updated. Resident #3 i</li> <li>Resident #1 care plan updat</li> <li>#5 care plan updated.</li> <li>2. The Director of Nursing/</li> <li>re-educate nursing staff on care to maintain the highest</li> <li>3. The Director of Nursing/</li> <li>randomly audit quality of care</li> <li>antibiotic therapy, pain mar</li> <li>vital signs, weights and dial</li> <li>times a week times four we</li> <li>monthly times four months.</li> </ul>	t #14 care s discharged. ed. Resident /designee will providing t well-being. 6-5-17 /designee will are; hagement, lysis three eks and then
	accordance with pr practice, the compr care plan, and the i but not limited to th (k) Pain Manageme The facility must er provided to residen consistent with prot			4. The Director of Nursing/ report the audits results more Quality Assurance Performs Improvement committee to continued compliance and/compliance	nthly to the ance ensure

Facility ID VA0088

Event ID:6R5B11

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

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CENTERS FOR MEDICARE	AND HUMAN SERVICES				RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
	495240	B. WING			C 04/28/2017
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, C	ITY, STATE, ZIP CODE	UHLUILUII
FREDERICKSBURG HEALTH A	ND REHAB		3900 PLANK ROAD FREDERICKSBU	RG VA 22407	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDE X (EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION
F 309 Continued From pag	e 118	FS	809		
services, consistent of practice, the comp care plan, and the re preferences. This REQUIREMENT by: Based on staff interv facility document revi and in the course of of was determined that maintain the highest well-being for five of sample, Resident #7, 1. The facility staff fa ordered daily weights 2. The facility staff fa antibiotic medication #26 after receiving ar administered for seve 3. The facility staff fai non-pharmacological administration of PRN medication for Reside 5a. The facility staff fai non-pharmacological administration of PRN medication for Reside	<ul> <li>a dialysis receive such with professional standards orchensive person-centered sidents' goals and</li> <li>T is not met as evidenced</li> <li>view, resident interview, iew, clinical record review complaint investigation, it the facility staff failed to level of practicable</li> <li>32 residents in the survey #26 #14, #3 and #5</li> <li>alled to obtain physician</li> <li>for Resident #7 as ordered.</li> <li>alled to administer an (Bactrim DS) to Resident or der for Bactrim DS to be en days.</li> <li>led to attempt interventions prior to the N (as needed) pain nt #14 in April of 2017.</li> <li>led to implement interventions prior to the N (as needed) pain ent # 3.</li> <li>ailed to offer</li> </ul>		RECEN VDH/O	n inst	

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	IMENT OF HEALTH							RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA	1 '		CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		49524	40	B. WING				C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			4	STR	EET ADDRESS, CITY, STAT	E, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB				) PLANK ROAD EDERICKSBURG, VA 2	22407	
	SUMMARY STA	TEMENT OF DEFICIEN		ID		PROVIDER'S PLAN		<b>1</b> (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDEI SC IDENTIFYING INFC	D BY FULL	PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE COMPLETION
F 309	Continued From pa	ae 119		F 3	309			
	medication for Res	•						
	5b. The facility staff per the physician or							
	5c. The facility staff ordered by the phys							
	The findings include	Э;						
	1. The facility staff on Resident #7 as o 3/30/17.							
	Resident #7 was ac 8/16/16 with a read diagnoses that inclu severe peripheral va flow to the lower ex pressure, coronary impacting the vesse obstructive pulmona lungs), dementia, bi amputations of the t	mission on 3/26/1 uded, but were no ascular disease ( tremities), high bl artery disease (a els of the heart), o ary disease (affec polar disorder an	7 with t limited to; poor blood ood disease chronic cting the d					
	Resident #7's most set) a five day asse (assessment refere documented that Re possible 15 on the E status), indicating th moderately cognitive regarding daily living A review of Residen in part, a physician of documented the foll	ssment with an A nce date) of 4/15, esident #7 scored BIMS (brief intervi nat Resident #7 w ely impaired with g. t #7's clinical reco order dated 3/21/	RD /17 I 10 of a iew of mental ras decisions ord revealed, 17 that		į	RECEIVED		
ORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 6R5B11		Facility	ID: VA0088	If continuation s	sheet Page 120 of 278

		AND HUMAN SERVICES					FORM	05/11/2017 APPROVED 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		495240	B. WING				04/2	) 28/2017
NAME OF I	PROVIDER OR SUPPLIER	L	4	STR	EET ADDRESS, CITY, STATE, Z	P CODE	1 0 1/2	
FREDER	ICKSBURG HEALTH	AND REHAB			) PLANK ROAD DERICKSBURG, VA 224	07		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	CORRECTION	) BE	(X5) COMPLETION DATE
F 309	Continued From pa	ae 120	F	309				
	evening shift for Mc Method: Verbal. O Date: 3/21/17 Start were signed and da	onitoring. Communication rder Status: Active: Order Date: 3/22/17." The orders ted by the physician on no discontinue date on the		09				
	Further review of Resident #7's clinical record revealed, in part, a facility document titled "Weights and Vitals Summary" listing all the weights obtained on Resident #7 since 3/22/17. The following dates did not have a corresponding weight; 3/24/17; 3/25/17; 3/26/17; 3/30/17; 3/31/17; 4/3/17; 4/5/17; 4/6/17; 4/7/17; 4/8/17; 4/13/17; 4/16/17;							
	plan dated 4/8/17 re documentation; "Fo food/beverage intak nutrition/hydration ri hx (history) IV (intra dementia, HTN (hig (chronic obstructive dependence for ADI including meals. Re significant wt (weigh 4/2/2017. Interventi	at #7's comprehensive care evealed, in part, the following cus: Potential for inadequate a and increased sk due to presence of ulcers, venous) abx (antibiotics), h blood pressure), COPD pulmonary disease), total Ls (activities of daily living), esident has hx (history) of nt) loss. Date Initiated: ions: Weights per facility ated: 2/28/17. Revision on:						
	member) #2, the dir there were any resid weights. ASM #2 st daily weights, they u restorative aides bu and we have one aid	b.m. ASM (administrative staff ector of nursing, was asked if dents who were on daily ated, "I am not aware of any used to be done by the t I now manage the weights de who does all my weights			RECEIVED			
	for me."				a ser a si but les but			

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 121 of 278

		AND HUMAN SERVICES				FORM APPROVED //B NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	[`` '	TIPLE CONSTRUCTION	T	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NG	-	COMPLETED C
		495240	B. WING		04/28/2017	
NAME OF F	PROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
FREDERICKSBURG HEALTH AND REHAB				3900 PLANK ROAD FREDERICKSBURG, VA	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIV CROSS-REFERENCEI	N OF CORRECTION E ACTION SHOULD I D TO THE APPROPR CIENCY)	BE COMPLETION
F 309	Continued From pa	ge 121	F 3	09		
	conducted with CN/ #7. CNA #7 was as CNA #7 stated, "I de done (with weights) was asked how she weight schedules for stated, "(Name of th me a list each week (pounds) difference re-weight." CNA #7 Resident #7 was to "I just did his yester CNA #7 was asked daily weights. CNA aware of. I weigh th given to me." CNA pocket that had all t weights for the wee Resident #7's name	p.m. an interview was A (certified nursing assistant) sked to describe her role. o weights weekly and when I work on the floor." CNA #7 e was made aware of the or each resident. CNA #7 ne director of nursing) gives and if there is a 5 lbs in weight then I have to do a ' was asked how often be weighed. CNA #7 stated, day, he gets done weekly." if he was supposed to get #7 stated, "Not that I am ne residents based on the list #7 pulled out a list from her the residents requiring weekly k of 4/23/17 to 4/29/17. e was half way down the list at on 4/25/17 he was				·
	day meeting was he administrator, ASM ASM #3 the regiona ASM #1, ASM #2 ar that Resident #7 ha had not been consis	#2, the director of nursing and al director of clinical services. nd ASM #3 were made aware d a daily weight ordered and stently weighed on a daily requested at this time that	adance.	andong generation of the state of the stat		
	conducted with ASM	a.m. an interview was 1 #2, the director of nursing.				
	ensuring that weight	to describe the process for ts were obtained as ordered. hen they are admitted to us		VDH/OLC		

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 122 of 278

		AND HUMAN SERVICES				FO	ED: 05/11/2017 RM APPROVED NO: 0938-0391	
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) [	DATE SURVEY	
		495240	B. WING	i		C 04/28/2017		
NAME OF F	PROVIDER OR SUPPLIER		4	ST	REET ADDRESS, CITY, STATE, ZIP COL			
FREDER	ICKSBURG HEALTH	AND REHAB		1	00 PLANK ROAD			
					REDERICKSBURG, VA 22407	FOTION	(N-7-4	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ige 122	F:	309				
	they automatically g When Resident #7 nurse failed to ente days and so the M4 record) did not reflect transcription. ASM responsible for ens were completed as the nurses were. A review of Resident the following entry; shift for Monitoring. Date 4/19/17." The on all dates except 4/13/17 and 4/16/1 No further informat end of the survey p 2. The facility staff antibiotic medicatio #26 after receiving administered for se Resident #26 was a	get daily weights for two days. came in on admission the r a stop date after the first two AR (medication administration ect that. So it was an error on #2 was asked who was uring that the daily weights ordered. ASM #2 stated that ht #7's MAR revealed, in part, "Daily weight. every evening Order date 3/21/2017. D/C e nurses had entered weights for 4/5/17; 4/6/17; 4/7/17; 7. ion was provided prior to the rocess. failed to administer an n (Bactrim DS) to Resident an order for Bactrim DS to be ven days.						
	7/5/16 with diagnos limited to, dementia thrombocytopenia ( blood has a lower ti cell fragments calle peripheral vascular circulation to the low red blood cell count heart rhythm) and c disease (affecting t	es that included, but were not a, high blood pressure, a condition in which your han normal number of blood d platelets [1]), hip fracture, disease (poor blood wer extremities), anemia (low t, atrial fibrillation (an abnormal chronic obstructive pulmonary he lungs).			RECENSED NORMAN VDH/OLC			
1	Resident #26's mos	st recent MDS (minimum data						

Event ID:6R5B11

Facility ID: VA0088

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		AND HUMAN SERVICES					RINTED: 05 FORM AP MB NO. 09	PROVED
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CON	STRUCTION	0	(X3) DATE SU COMPLE	JRVEY
		495240	B. WING				C 04/28/	2017
NAME OF I	PROVIDER OR SUPPLIER		I	STREET	ADDRESS, CITY, STATE	, ZIP CODE	047207	
FREDER	ICKSBURG HEALTH				ANK ROAD			
				FREDE	RICKSBURG, VA 2	2407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD O THE APPROPF	BE CO	(X5) DMPLETION DATE
F 309	set), a quarterly ass (assessment refere Resident #26 as a 0 of 15 on the BIMS ( status) indicating th cognitively impaired care. Resident #26 Skin Conditions, as pressure ulcers at t unstageable wound measuring 5.0 cm ( an unstageable wound tissue injury. A review of Resider revealed, in part, a 8/17/16 that docum "8/17/16 Bactrim DS medication) 1 tab (t times per day) x 7d was signed by the p	sessment with an ARD ince date) of 10/4/16 coded 0 (zero) out of a possible score brief interview for mental at Resident #26 was severely I with daily decisions about 5 was also coded in Section M, having two unhealed he time of the assessment, an with slough and/or eschar centimeters) x 10.0 cm and und with suspected deep at #26's clinical record physician's order dated ented, in part, the following;	F	309	· · ·			
	revealed, in part, the 1310 (1:10 p.m.) Ty for Bactrim DS 1 tal (twice a day) x (time heel." The note was	at #26's nurse's notes e following note; "8/17/16 pe: General Note: New order tablet) PO (by mouth) BID es) 7 day and wound culture to not electronically signed by the name of the		Boyed Careto i	ur sur si jina jur			
	<b></b>			gang gaus ( Suro 1)				
	#26 is taking an ant	lso document that Resident ibiotic on the following dates; 6/16, a total of nine days.						
		on Resident #26's MAR that histration of Bactrim during		VD	HIOLC			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:6R5B11		Facility ID:	VA0088	If continuation	sheet Page	124 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 05/11/2017 FORM APPROVED MB NO: 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		<b></b>	STREET ADDRESS, CITY,	STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD		
				FREDERICKSBURG,	VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPR EFICIENCY)	BE COMPLETION
F 309	Continued From pa	ge 124	F:	309		
	conducted with ASM #2, the director of n interim regional dire #1, ASM #2 and AS above concern. At requested to evider medication was adr beginning on 8/18/1 made for a copy of manifest for the mo A copy of the Augus again requested fro member) #2, the dir 10:15 a.m. On 4/27/17 at 1:35 conducted with LPN LPN #4 was asked between 8/18/16 ar the nursing staff wa given" during this tir the MAR. LPN #4 r "I don't know why th	st pharmacy manifest was m ASM (administrative staff rector of nursing on 4/27/16 at p.m. an interview was I (licensed practical nurse) #4 to review the nursing notes ad 8/26/16 and to explain why s documenting "antibiotic me period without an order on reviewed the notes and stated ney would document that can't remember what was				
	No further informati end of the survey pr	on was provided prior to the rocess.				
	Complaint Deficience	су		and the second se		
	following website:	was obtained from the h.gov/health/health-topics/top		VDH/OLC		
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:6R5B	11	Facility ID: VA0088	If continuation s	sheet Page 125 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 05/11/2017 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ATE SURVEY	
		495240	B. WING			C 04/28/2017		
NAME OF I	PROVIDER OR SUPPLIER		.1		EET ADDRESS, CITY, STATE, ZIP COD			
FREDER	ICKSBURG HEALTH	AND REHAB			0 PLANK ROAD EDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 309	Continued From pa	ge 125	F	309				
	administration of PI	ailed to attempt al interventions prior to the RN (as needed) pain lent #14 in April of 2017.						
	Resident #14 was admitted to the facility on 3/4/13 and readmitted on 7/5/15 with diagnoses that included but were not limited to gastroparesis [1], generalized anxiety disorder, history of mental and behavioral disorders, high blood pressure, and type two diabetes. Resident #14's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Resident #14 was coded as being cognitively intact in the ability to make daily decisions, scoring 15 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #14 was coded as being independent with transfers, and ambulation; and independent with supervision only with dressing, eating, toileting, and bathing.							
	(Physician Order Sh following orders: "Pa (milligrams) (Oxyco tablet by mouth eve	#14's most recent POS neet) documented the ercocet Tablet [2] 10-325 MG done- Acetaminophen) Give 1 ry 4 hours as needed for as initiated on 8/4/16.						
	"Tylenol Tablet [3] 3			Vendipeu				
	(Acetaminophen) Give 2 tablets by mouth every 6 hours as needed for Pain related to OTHER							
	CHRONIC PAIN." This order was initiated on 12/3/15.				VDH/OLC			
		#14's April 2017 MAR stration Record) documented			A DU/AFA			

Facility ID: VA0088

If continuation sheet Page 126 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 05/11/2017 MAPPROVED D. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495240	B. WING			0	C 4/28/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 900 PLANK ROAD		
FREDERICKSBURG HEALTH AND REHAB           (X4) ID           SUMMARY STATEMENT OF DEFICIENCIES           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FU					REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY		ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	on the following dat 4/1/17 at 4:19 a.m., 4/2/17 at 1:01 a.m., 4/3/17 at 1:40 p.m., 4/4/17 at 4:10 a.m., 4/5/17 at 12:18 a.m 3:07 p.m., 4/6/17 at 12:43 a.m 4/7/17 at 12:43 a.m, 4/7/17 at 12:43 a.m, 4/8/17 at 9:02 a.m., 4/9/17 at 4:19 a.m., 4/10/17 at 12:29 a.m 4/11/17 at 12:47 a.m 4/12/17 at 12:15 a.m 4/12/17 at 12:15 a.m 4/13/17 at 7:30 a.m 4/14/17 at 12:27 a.m 4/15/17 at 12:20 a.m 4/16/17 at 12:22 a.m 4/17/17 at 5:11 a.m. p.m., 4/18/17 at 5:12 a.m 4/19/17 at 12:07 a.m 4/20/17 at 10:04 a.m 4/23/17 at 2:30 a.m 4/26/17 at 12:05 a.m 4/26/17 at 12:45 a.m Review of Resident documented that Resident	<ul> <li>acceived Percocet 10-325 mg es and times:</li> <li>11:19 a.m., 4:21 p.m.,</li> <li>4:42 p.m.,</li> <li>6:55 p.m. 11:45 p.m.,</li> <li>12:05 p.m., 3:50 p.m.,</li> <li>12:05 p.m., 10:59 p.m., and</li> <li>., 4:20 a.m., 10:59 p.m., and</li> <li>., 11:01 a.m., 3:14 p.m.,</li> <li>7:08 a.m., 1:05 p.m., 5:10</li> <li>11:18 a.m., 5:05 p.m.,</li> <li>12:10 p.m., 4:15 p.m.,</li> <li>., 11:30 a.m., 3:32 p.m.,</li> <li>n., 12:34 p.m., 4:45 p.m.,</li> <li>n., 11:09 a.m., and 4:10 p.m.,</li> <li>., 2:19 p.m.,</li> <li>n., 5:15 a.m., 11:34 a.m.,</li> <li>n., 4:15 a.m., 5:15 p.m.,</li> <li>n., 4:54 a.m., 12:30 p.m., 5:39</li> <li>, 11:46 a.m., 4:20 p.m., 11:43</li> <li>and 9:15 a.m.,</li> <li>n., and 4:24 p.m.,</li> <li>and 12:23 p.m.,</li> <li>and 3:56 p.m.,</li> </ul>	F	309			
	4/2/17 at 4:33 a.m., 4/12/17 at 2:24 p.m.	1			VDH/OLC		

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 127 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES					RINTED: 05/11/2 FORM APPROV MB NO: 0938-03	/ED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING				C 04/28/2017	
NAME OF F	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, 2	IP CODE	<u> </u>	
FREDER	ICKSBURG HEALTH	AND REHAB			900 PLANK ROAD REDERICKSBURG, VA 224	407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	FION SHOULD	BE COMPLET	ION
F 309	Continued From pa	ge 127	F3	309				
	4/16/17 at 3:29 p.m 4/17/17 at 1:35 p.m	••						
	non-pharmacologic	Id not be found that evidenced al interventions were he administration of PRN ol.						
	11/09/16 document Management and r Chronic Pain, Multi fracture, Radius fra S/P (status post) M Has diagnoses of s depressionInterve decline in function r reviewInterventio	entions: Will not experience a related to pain through next ns:Implement the patient's macological pain relief						
	conducted with Res stated that nursing interventions prior t medications. Resid	p.m., an interview was sident #14. Resident #14 staff did not attempt other o administering pain dent #14 stated that when she cation, nursing will give her						
	conducted with LPN	p.m., an interview was V (licensed practical nurse) #4, istered Percocet on some of			and the second s			
	the occasions in Approcess staff follow	oril. When asked about the sprior to the administration of						
	pain level at that tin divert their attention the pain and see if	on, LPN #4 stated, "I ask the ne, and see if I can distract or n. I try to take their mind off that works." When asked if harmacological interventions			VDH/OLC			

Facility ID: VA0088

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		AND HUMAN SERVICES				1	FORM APPROVED
[		& MEDICAID SERVICES	r				B NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS		()	X3) DATE SURVEY COMPLETED
ANDIENC		A. BUILDI	ING			С	
		495240	B. WING				04/28/2017
	PROVIDER OR SUPPLIER		I	STREET	ADDRESS, CITY, STATE, ZIP CO	DE	04/20/2011
				3900 PL/	ANK ROAD		
FREDER	FREDERICKSBURG HEALTH AND REHAB         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES			FREDE	RICKSBURG, VA 22407		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORF		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION S ROSS-REFERENCED TO THE A		DATE
TAG	ALCOLATORT ON L		140	U	DEFICIENCY)		
F 309	Continued From pa	ge 128	F 3	09			
	before administerin	g every prn pain medication,					
		. Some people will ask for					
	•	ked if she documents					
		al interventions attempted tration of pain medication					
		mpt non-pharmacological					
	interventions, LPN a	#4 stated, "I should. I don't."					
		pharmacological interventions					
		d if the resident's care plan ions to do so, LPN #4 stated,					
		ik the care plan usually					
		PN #4 was shown Resident					
		hen asked if her (Resident					
		s followed, LPN #4 stated,					
	"No."						
	On 4/26/17 at 4:30	p.m., an interview was					
	conducted with LPN						
		cet on some of the occasions					
	•	ed the process prior to ain medication, LPN #1 stated					
		is should be attempted to					
		o administering pain					
		#1 stated, "(Name of Resident					
	, ,	e did other interventions					
		ain medications. She will cologicals." When asked if it					
	•	at Resident #14 refused					
		al interventions anywhere in					
		.PN #1 stated, "It's so routine I					
	didn't document."						
	On 4/26/17 at 5:00 (	p.m., ASM (administrative		RECE	EIVED		
	staff member) #1, th	ne administrator and ASM #2,		LANV S	* 11/147		
		of Nursing) were made aware		MAT 5			
	of the above concer	ns.		VDH	/OLC		
				v 64/18/			
	The facility policy titl	led, "Pain Assessment"					

Event ID:6R5B11

Facility ID: VA0088

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

PRINTED: 05/11/2017

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF F	ROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STAT	
FOFOFO				3900 PLANK ROAD	
FREDER	ICKSBURG HEALTH			FREDERICKSBURG, VA	22407
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLÉTION TO THE APPROPRIATE DATE DATE
F 309	Continued From pa	-	F	309	
	record will be maint Medication Adminis completed when the	the following: "4. A Pain flow ained with the resident's tration Record. This is to be e resident has identified they the following: a. Date and time			
	Precipitating/aggrav	ype of pain d. intensity e. vating f. ned/medication g. intensity of on h. Side effects I. Initials"			
	No further informati	on was provided prior to exit.			
		al interventions prior to the RN (as needed) pain			
	05/06/14 with diagn not limited to: neuro bladder (1), gastroe diabetes mellitus (3	dmitted to the facility on oses that included but were omuscular dysfunction of the esophageal reflux disease (2), ), anxiety (4), depression, polar (6), hemiplegia (7), and obesity.			
	set), a quarterly ass (assessment refere Resident # 3 as sco interview for mental - 15, 14 being cogn	t recent MDS (minimum data sessment with an ARD nce date) of 02/21/17, coded oring a 14 on the brief status (BIMS) of a score of 0 itively intact for making daily		RECEIVED	
		t # 3 was coded as requiring e of one staff member for			
	activities of daily livi	ng.		MAY 3 1 2017	
	# 3 dated 01/2017 d	n's Order Sheet) For Resident documented, "Acetaminophen milligram) Give 2 (two) tablets		VDH/OLC	
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6R5B1	1	Facility ID: VA0088	If continuation sheet Page 130 of 278

STATEMENT OF DEFICIENCES       (X) PROVIDERSUPPLIENCIAL       (X) DATE SURVEY         AND FLON OF CORRECTION       (X) PROVIDERSUPPLIENCIAL       (X) DATE SURVEY         AND OF CORRECTION       495240       X         NAME OF PROVIDER OR SUPPLIEN       495240       STREET ADDRESS OTV. STATE JP CODE         FREDERICKSBURG HEALTH AND REHAB       STREET ADDRESS OTV. STATE JP CODE       04/28/2017         FREDERICKSBURG HEALTH AND REHAB       STREET ADDRESS OTV. STATE JP CODE       04/28/2017         FREDERICKSBURG HEALTH AND REHAB       STREET ADDRESS OTV. STATE JP CODE       04/28/2017         F309       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MALSE DEFICIENCIES)       PREPARTING (MA 22407       COMPLETION (EACH DEFICIENCY MALSE DEFICIENCIES)         F309       Continued From page 130       F 309       PREPARTING OF DEFICIENCIES)       F 309         Conder to an. Order Date: 10/17/2016."       Tramadol Tablet (12) 50 MG. Give 2 (two) tablet       F 309       F 309         "Tramadol Tablet (12) 50 MG. Give 2 (two) tablet       Draw of the aster 10/18/2016."       F 309       F 309         "Tramadol Tablet (12) 50 MG. Give 2 (two) tablet       Draw of the aster 10/18/2016."       F 309       F 309         "Tramadol Tablet (12) 50 MG. Give 2 (two) tablet       Draw of the aster 10/18/2016."       F 309         "Tramadol Tablet (12) 50 MG. Give 2 (two) tablet <th></th> <th></th> <th>AND HUMAN SERVICES &amp; MEDICAID SERVICES</th> <th></th> <th></th> <th></th> <th>FORM APPROV MB NO. 0938-03</th> <th>ED</th>			AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROV MB NO. 0938-03	ED
495240     B. WING     04/28/2017       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY. STATE. 2IP CODE       FREDERICKSBURG HEALTH AND REHAB       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROVIDER'S CITY. STATE. 2IP CODE       Dynamic     B. WING     Deficiencies       (X4.)D TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROVIDER'S CITY. STATE. 2IP CODE     Deficiency     <	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FREDERICKSBURG HEALTH AND REHAB     300 PLANK ROAD FREDERICKSBURG, VA 22407       Image: Continued From page 130 by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."     Providers PLANOF CORRECTIVE (EACH ORTREFICE ACTION SHOLD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY)     Content of the APPROPRIATE DEFICIENCY)       F 309     Continued From page 130 by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."     F 309       "Xetorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain use for severe pain. Order Date: 10/18/2016."     F 309       "Tram adol Tablet (12) S0 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."     F 309       The eMAR (electronic medication administration record) for Resident # 3 dated 'January 2017 documented, is 2 (two) tablets by mouth every 6 hours as needed for pain. Order Date: 10/04/2016."     F       "Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain use for severe pain. Order Date: 10/18/2016."     F       "The eMAR (electronic medication administration record) for Resident # 3 dated 'January 2017 documented, is 2 (two) tablets by mouth every 6 hours as needed for pain. Order Date: 10/04/2016."     F       "Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/04/2016."     F       "Xeotaminophen Tablet (by 325 MG (milligram)) Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/04/2016."     F       "Oxycocdone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 6 hours as			495240	B. WING				
FREDERICKSBURG, HEALTH AND REHAB       FREDERICKSBURG, VA 22407         (x) ID PROTEX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ASTREMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROTEX TAG       PROVIDENCITO SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (x) D DATE         F 309       Continued From page 130 by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."       F 309         "Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 4 hours as needed for pain. Order Date: 10/17/2016."       F 309         "Tramadol Tablet (12) 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Order Date: 10/18/2016."       F Tramadol Tablet (12) 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."         The eMAR (electronic medication administration record) for Resident # 3 dated "January 2017 documented, "Acetaminophen Tablet (9) 325 MG (milligram) Give 10 MG by mouth every 4 hours as needed for pain. Order Date: 10/04/2016."         "Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 4 hours as needed for pain. Order Date: 10/04/2016."         "Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 4 hours as needed for pain. Order Date: 10/04/2016."         "Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 4 hours as needed for pain. Order Date: 10/17/2016. D/C (discontinue) 01/17/2017."         "Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016." </td <td>NAME OF F</td> <td>PROVIDER OR SUPPLIER</td> <td></td> <td></td> <td>ST</td> <td>REET ADDRESS, CITY, STATE, ZIP CODE</td> <td></td> <td></td>	NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
Prediation (EACH DEFICIENCY MIST BE PRÉCEDED BY FULL       PRÉTX       TAG       IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE       COMPLETION DEFICIENCY         F 309       Continued From page 130       F 309         by mouth every 4 (four) hours as needed for pain.       Order Date: 10/04/2016."       F 309         "Ketorolac Tromethamine (10) Tablet 10 MG.       Give 10 MG by mouth every 6 hours as needed for pain.       Order Date: 10/07/2016."         "Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain.       Give 2 (two) tablet by mouth every 4 hours as needed for pain.         Moderate pain.       Order Date: 10/18/2016."       "Tramadol Tablet (12) 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain.       Moderate pain.         Moderate pain.       Order Date: 10/18/2016."       The eMAR (electronic medication administration record) for Resident # 3 dated "January 2017 documented.       "Acetaminophen Tablet (0) 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain.       Order Date: 10/04/2016."         "Ketorolac Tromethamine (10) Tablet 10 MG.       Give 10 MG by mouth every 6 hours as needed for pain.       Give 10 MG by mouth every 4 hours as needed for pain.         Grocented       Give 10 MG by mouth every 4 hours as needed for pain.       Order Date: 10/04/2016."       The eMAR (electronic medication administration record) for Resident # 3 dated "January 2017 documented.       "Acetaminophen Tablet (0) Tablet 10 MG.	FREDER	ICKSBURG HEALTH	AND REHAB					
<ul> <li>by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."</li> <li>"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 6 hours as needed for pain. Order Date: 10/17/2016."</li> <li>"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."</li> <li>"Tramadol Tablet (12) 50 MG. Give 2 (two) tablet by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016."</li> <li>The eMAR (electronic medication administration record) for Resident # 3 dated "January 2017 documented, "Acetaminophen Tablet (9) 325 MG (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016."</li> <li>"Ketorolac Tromethamine (10) Tablet 10 MG. Give 10 MG by mouth every 4 hours as needed for pain. Order Date: 10/17/2016. D/C (discontinue) 01/17/2017."</li> <li>"Oxycodone (11) 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed for pain use for severe pain. Order Date: 10/18/2016."</li> </ul>	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	BE COMPLÉTIO	ON
by mouth every 4 hours as needed for pain. Moderate pain. Order Date: 10/18/2016." The eMAR dated January 2017 revealed the MAY 31 2017 VDH/OLC	F 309	by mouth every 4 (fe Order Date: 10/04/2 "Ketorolac Trometh Give 10 MG by mou for pain. Order Dat "Oxycodone (11) 5 fe (one) tablet by mou for pain use for seve 10/18/2016." "Tramadol Tablet (1 by mouth every 4 he Moderate pain. Order The eMAR (electron record) for Residen documented, "Acetaminophen Ta Give 2 (two) tablets as needed for pain. "Ketorolac Trometh Give 10 MG by mou for pain. Order Dat (discontinue) 01/17/ "Oxycodone (11) 5 fe (one) tablet by mou for pain use for seve 10/18/2016." "Tramadol Tablet (1 by mouth every 4 he Moderate pain. Order	our) hours as needed for pain. 2016." amine (10) Tablet 10 MG. uth every 6 hours as needed e: 10/17/2016." (five) MG (milligrams). Give 1 th every 4 hours as needed ere pain. Order Date: 2) 50 MG. Give 2 (two) tablet ours as needed for pain. der Date: 10/18/2016." hic medication administration t # 3 dated "January 2017 blet (9) 325 MG (milligram) by mouth every 4 (four) hours Order Date: 10/04/2016." amine (10) Tablet 10 MG. uth every 6 hours as needed e: 10/17/2016. D/C /2017." (five) MG (milligrams). Give 1 th every 4 hours as needed ere pain. Order Date: 2) 50 MG. Give 2 (two) tablet ours as needed for pain. der Date: 10/18/2016."	F3		IAY 3 1 2017		

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Facility ID: VA0088

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495240 **B** WING 04/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 Continued From page 131 F 309 Acetaminophen was administered on: 01/03/17 at 2:30 p.m., 01/12/17 at 11:31 a.m., 01/15/17 at 9:40 a.m., 01/17/17 at 8:47 a.m., 01/18/17 at 8:21 a.m., 01/19/17, at 8:34 a.m., 01/20/17 at 8:19 a.m., 01/21/17 at 8:35 a.m., 01/23/17 at 8:28 a.m., 01/24/17 at 11:44 a.m., 01/25/17 at 10:25 a.m., 01/28/17 at 8:57 a.m. 01/29/17 at 8:56 a.m. and 01/31/17 9:17 a.m.. Ketorolac was tromethamine was administered on: 01/03/17 at 2:37 p.m., 01/04/17 at 3:17 p.m.. 01/06/17 at 12:33 a.m., 01/07/17 at 2:04 a.m., 10/08/17 at 2:57 p.m., 01/10/17 at 8:46 a.m. and on 01/15/17 at 12:06 a.m. Oxycodone was administered on 01/01/17 at 1:43 a.m., 01/02/17 at 6:09 p.m., 01/05/17 at 4:05 a.m., 01/06/17 at 11:14 a.m., 01/08/17 at 8:51 a.m., 01/11/17 at 9:02 a.m., 01/13/17 at 6:15 a.m., 01/16/17 at 5:01 a.m., 01/19/17 at 5:01 a.m., 01/20/17 at 2:37 a.m., 01/21/17 at 4:00 a.m., 01/26/17 at 3:41 p.m., 01/27/17 at 12:10 a.m., 01/29/17 at 2:31 a.m. and 8:42 p.m. and on 01/30/17 1:12 a.m. Tramadol was administered on 01/05/17 at 5:30 a.m., 01/06/17 at 4:30 p.m., 01/09/17 at 4:01 a.m., 01/16/17 at 12:37 a.m., 01/17/17 at 12:14 p.m., 01/18/17 at 11:38 a.m., 01/19/17 at 11:16 a.m., 01/20/17 at 10:49 a.m., 01/21/17 at 11:59 a.m., 01/23/17 at 1:05 p.m., 01/24 at 4:09 a.m., 01/25/17 at 3:09 a.m., 01/26/17 at 5:43 a.m., 01/27/17 at 1:06 p.m. and 01/31/17 at 3:01 a.m. RECEIVED The eMAR for Resident #3 dated "February 2017 documented, "Acetaminophen Tablet 325 MG MAY 3 1 2017 VDH/OLC (milligram) Give 2 (two) tablets by mouth every 4 (four) hours as needed for pain. Order Date: 10/04/2016." "Oxycodone 5 (five) MG (milligrams). Give 1 (one) tablet by mouth every 4 hours as needed

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

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								FORM AF	PROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/S			IPLE CONSTRU		0	(X3) DATE S COMPLI	URVEY
		49	5240	B. WING				C 04/28	/2017
NAME OF F	PROVIDER OR SUPPLIER	L			STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			3900 PLANK	ROAD	22407		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	(EA	ROVIDER'S PLAN CH CORRECTIVE S-REFERENCED DEFICII	ACTION SHOULD	BE C	(X5) OMPLETION DATE
F 309	Continued From par for pain use for sev 10/18/2016. D/C (c "Tramadol Tablet 50 mouth every 4 hour Moderate pain. Ore 02/02/2017." The eMAR dated For following: Acetaminophen wa 9:02 a.m., 02/02/17 p.m., 02/04/17 at 6: a.m., 02/04/17 at 6: a.m., 02/07/17 at 4: 02/08/17 at 4:48 p.r 02/10/17 at 5:09 a.r 1:06 a.m., 02/14/17 a.m., 02/16/17 at 5: 02/18/17 at 4:06 a.r 4:40 p.m., 02/21/17 p.m. and 02/26/17 a Oxycodone was add 12:00 a.m. Tramadol was adm p.m. and 4:08 p.m. The eMAR for Resi documented, "Aceta (milligram) Give 2 (f (four) hours as need	ere pain. Orde liscontinue) 02. 0 MG. Give 2 ( s as needed for der Date: 10/18 ebruary 2017 re s administered at 9:12 a.m., 02 22 a.m., 02/06 10 a.m. and 4: m., 02/09/17 at m. and 4:40 p.r at 5:22 a.m., 02 45 p.m., 02/ 17 m. and 5:15 p.r at 5:20 p.m., 02 at 4:25 p.m.; ministered on 02 and on02/02/1 dent # 3 dated aminophen Tab two) tablets by	/02/2017." (two) tablet by or pain. B/2016. D/C evealed the on: 02/01/17 at 02/03/17 at 4:57 /17 at 1:01 58 p.m., 4:18 a.m., n., 02/12/17 at 02/15/17 at 1:46 7/17 5:00 p.m., n., 02/20/17 at 02/25/17 at 4:29 02/01/17 at 12:04 7 at 6:07 a.m. "March 2017 olet 325 MG mouth every 4	F 3(	)9				
	The eMAR dated M following: Acetaminophen wa: 3:47 p.m., 03/04/17 a.m., 03/10/17 at 4: p.m., 03/19/17 at 4: and 4:32 p.m., 03/2	s administered at 4:46 a.m., 0 21 a.m., 03/14/ 50 p.m., 03/20/	on: 03/02/17 at )3/06/17 at 3:08 /17 at 12:01 /17 at 6:38 a.m.			EIVED 1 2017 /OLC			
FORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID:6R5B11		Facility ID: VA008	38	If continuation	sheet Page	133 of 278

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DEPART	FORM APPROVED				
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	r	C	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING	j	04/28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		DBE COMPLETION
F 309	03/24/17 at 3:20 a.r 4:30 p.m., $03/26/17$ a.m. and 11:43 a.m. 03/30/17 at 4:50 a.r The eMAR for Resid documented, "Aceta (milligram) Give 2 (t (four) hours as need 10/04/2016." The eMAR dated Ap following: Acetaminophen was 4:56 a.m. and 3:42 p 04/04/17 at 4:28 a.n 4:24 a.m. and 8:58 a 04/07/17 at 4:31 a.n 4:00 p.m., $04/09/17$ 5:09 p.m., $04/10/17$ 12:39 a.m., 4;47 p.n 04/13/17 at 4:18 p.n 04/16/17 at 5:14 a.n 4:30 p.m., $04/18/17$ a.m. and 2:42 p.m., 04/24/17 at 3:34 p.n 04/26 at 4:59 a.m. The "Progress Note: 01/01/2017 through and failed to evidend non-pharmacologica administration of ace ketorolac trometham	38 a.m. and 9:32 a.m., n. and 4:42 p.m., 03/25 at at 4:35 a.m., 03/27/17 at 3:52 ., 03/29/17 at 4:57 a.m., n. and 03/31/17 at 8:27 a.m. dent # 3 dated "April 2017 aminophen Tablet 325 MG wo) tablets by mouth every 4 ded for pain. Order Date: oril 2017 revealed the s administered on: 04/01/17 at p.m., 04/02/17 at 1:33 p.m., n. and 5:11 p.m., 04/05/17 at a.m., 04/06/17 at 3:29 p.m., n. and 5:00 p.m., 04/08/17 at at 4:50 a.m., 12:40 p.m. an d at 6:51 p.m., 04 11/17 at n., 04/12/17 at 5:00 p.m., n. and 6:31 p.m., 04/17/17 at at 4:45 p.m., 04/19/17 at 4:27 04/21/17 at 5:00 p.m., n. and 6:31 p.m., 04/17/17 at at 4:45 p.m., 04/19/17 at 4:27 04/21/17 at 4:55 p.m., n., 04/25/17 at 1:30 p.m. and s" for Resident # 3 dated 04/24/2017 were reviewed be documentation of al interventions prior to the etaminophen, oxycodone, nine and tramadol. esident # 3 dated 07/12/16 s: Resident has a Dx	F3	RECEIVED MAY 31 2017 VDH/OLC	
	documented, "Focus			ANHIOPC	

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		AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLETION
F 309	stroke) with left hen Pain, Syndrome, an she experiences mo makes it hard for he her daily activities. pain medication/Pai monitoring. Date In "Interventions" it do non-pharmacologic: Date Initiated: 07/12 On 04/26/17 at 11:2 conducted with LPN 12. When asked to administering PRN LPN # 12 stated, "I what type of pain, d scale one to ten, ba administer what is p the physician's order the resident 45 minu- medication was effer non-pharmacologica repositioning, turnin prior to giving the pa how often the non-p should be attempted time before giving th reviewing the MARs March and April 201 dated 01/01/17 thro 3, LPN # 12 was as documentation of no interventions attempt of PRN pain medica isn't anything. If it w done."	hiparesis, paralysis, Chronic di Backache. Reports that oderate to severe pain, which er to sleep at night, and limits Receives PRN (as needed) in management and hitlated: 07/12/2016." Under cumented, "Provide al interventions as needed. 2/2016." 0 a.m. an interview was I (licensed practical nurse) # describe the procedure of (as needed) pain medication, would ask where the pain is, etermine the level of pain on a ised on the level of pain sective. I would check utes to an hour to see if the ective. I would try al interventions like g down the lights or television ain medication." When asked obarmacological interventions d, LPN # 12 stated, "It's every ne medication." After a dated January, February, 7 and the progress notes ugh 04/24/17 for Resident # ked if there was	F 3	RECEIVED MAY 3 1 2017 VDH/OLC	

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Facility ID: VA0088

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		AND HUMAN SERVICE			F	NTED: 05/11/2017 ORM APPROVED
		& MEDICAID SERVICE	1		T	3 NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER	<b>L</b>		STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
rororo				3900 PLANK ROAD		
FREDER	ICKSBURG HEALTH			FREDERICKSBUR	G, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREF ) TAG	X (EACH CORR	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	
F 309	Continued From pa	ge 135	F:	309		
	assistant director of describe the proceed pain medication, RI assessment, location nonverbal cues, use being most severe. when the last pain re attempt non-pharm time, if not working of pain regimen, do Reassess the resid minutes after giving if it was effective. A dated January, Feb and the progress no 04/24/17 for Reside there was document interventions attemption	(registered nurse) # 1, th f nursing. When asked to dure of administering PRI N # 1 stated, "Do a pain on, intensity, observe e pain scale one to ten, te Check the MAR to deter med (medication) was giv acological interventions e call physician for adjustm cument all of it on the eM ent approxImately 30 to 4 the medication to detern ofter reviewing the MARs ruary, March and April 20 bites dated 01/01/17 throu- ent # 3, RN # 1 was asked tation of non-pharmacolo bited prior to the administra- ation. RN # 1 stated, "No	o N en rmine ren, every hent IAR. 55 nine 117 Igh d if ogical ration			
	staff member) # 1, 1	5 p.m. ASM (administrativ he administrator and ASI rsing, were made aware	VI #			
	No further informati	on was provided prior to	exit.			
	References:					
	control due to a bra condition. This info the website:	ch a person lacks bladder in, spinal cord, or nerve rmation was obtained fro gov/ency/article/000754.h	m	RECEIVED MAY 3 1 2017		
		s to leak back, or reflux, i irritate it. This informatio		VDH/OLC		
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID	:6R5B11	Facility ID: VA0088	If continuation she	eet Page 136 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES					RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495240	B. WING				C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP C	ODE	
FREDER	ICKSBURG HEALTH	AND REHAB			) PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE COMPLÉTION
F 309	<ol> <li>A chronic disease regulate the amoun information was obt https://www.nlm.nih 001214.htm.</li> <li>Fear. This inform website: https://www.nlm.nih. #summary.</li> <li>High blood presse obtained from the w https://www.nlm.nih. essure.html.</li> <li>A brain disorder th mood, energy, activit carry out day-to-day obtained from the w https://www.nim.nih.</li> <li>A brain disorder th mood, energy, activit carry out day-to-day obtained from the w https://www.nimh.nil order/index.shtml.</li> <li>Also called: Hemi Quadriplegia. Paral function in part of yo something goes wro pass between your to can be complete or both sides of your bo one area, or it can b</li> </ol>	the website: .gov/medlineplus/gerd.html. e in which the body cannot t of sugar in the blood. This ained from the website: .gov/medlineplus/ency/article/ nation was obtained from the .gov/medlineplus/anxiety.html ure. This information was rebsite: .gov/medlineplus/highbloodpr hat causes unusual shifts in ity levels, and the ability to tasks. This information was ebsite: h.gov/health/topics/bipolar-dis plegia, Palsy, Paraplegia, ysis is the loss of muscle bour body. It happens when ong with the way messages prain and muscles. Paralysis partial. It can occur on one or body. It can also occur in just e widespread. This ained from the website:	F :	N			
		ain problem. They happen abnormal electrical activity in			9997		

Event ID:6R5B11

Facility ID: VA0088

If continuation sheet Page 137 of 278

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 Continued From page 137 F 309 the brain. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/seizures.ht ml. 9. Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.h tml. 10. Used for the short-term relief of moderately severe pain and should not be used for longer than 5 days, for mild pain, or for pain from chronic (long-term) conditions. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693001.h tml. (11) Used to relieve moderate to severe pain. This information was obtained from the website: RECEIVED https://medlineplus.gov/druginfo/meds/a682132.h MAY 3 1 2017 tml. (12) Used to relieve moderate to moderately /DH/OLC severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695011.ht ml.

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

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Facility ID: VA0088

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DEPART		APPROVED					
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		(	<u>DMB NC</u>	). 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>I</b> ' '		LE CONSTRUCTION		TE SURVEY MPLETED
		495240	B. WING	í		04	/28/2017
NAME OF I	PROVIDER OR SUPPLIER	<b>L</b>		5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 .	
FREDER	ICKSBURG HEALTH	AND REHAB			3900 PLANK ROAD		
				F	FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 138	F 3	309			
	administering pain r	al interventions prior to medication and failed to follow t on the effectiveness of the					
	Resident #5 was admitted to the facility on 4/6/17, with a readmission on 4/15/17, with diagnoses that included but were not limited to: lymphedema (an accumulation of lymph in tissues leading to swelling, it occurs most often in the legs (1)), seizures, gastric ulcer, anxiety disorder, kidney disease, Parkinson's disease, high blood pressure, rheumatoid arthritis (chronic destructive disease characterized by joint inflammation (2)), and heart failure.						
	assessment, a Med with an assessment coded the resident a to make daily decisi BIMS (brief interview 0-15. The resident w supervision of one s activities of daily livit	DS (minimum data set) licare five day assessment, t reference date of 4/22/17, as being moderately impaired ions, scoring a 10 on the w for mental status) scale of was coded as requiring staff member for all of her ng except bathing in which ssistance of one staff					
	(narcotic used to tre (3)) Tablet 20 mg (m mouth every 4 hours	rs dated, 4/17/17, odone HCL (hydrochloride) eat moderate to severe pain hilligrams); Give 1 tablet by s as needed for pain." on administration record) for			RECEIVED MAY 3 1 2017 VDH/OLC		
		nted the resident received ollowing dates and times:					

Event ID: 6R5B11

Facility ID: VA0088

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		AND HUMAN SERVICES				FOF	RM APPROVED
				7101		T	IO. 0938-0391 DATE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		OMPLETED
			A. DOILD				С
		495240	B. WING			c	4/28/2017
NAME OF F	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	i	
EDENED	CKSBURG HEALTH			39	900 PLANK ROAD		
FREDERI	CK3BUKG HEALIN	AND REHAD		F	REDERICKSBURG, VA 22407		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT		(X5) COMPLETION
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
F 309	Continued From pa	-	F 3	309			
	4/17/17 at 3:50 p.m						
	4/18/17 at 8:37 a.m	., 9:55 a.m., 4:05 p.m. and					
	8:39 p.m.	., 9.00 a.m., 4.00 p.m. and					
		., 4:39 p.m. and 10:40 p.m.					
	4/21/17 at 8:48 a.m	•					
	4/22/17 at 10:01 a.r 4/23/17 at 8:03 a.m						
	4/24/17 at 6:29 a.m	•					
	4/25/17 at 8:17 a.m						
		locumented the following: ., documented, "Effective."				,	
		., documented, "Effective."					
	4/19/17 at 6:57 a.m	., 1:12 p.m., 7:16 p.m. and					
	9:26 p.m., documer						
	4/20/17 at 11:56 a.n "Effective."	n., 10:39 p.m., documented,					
		., documented, "Effective."					
		., documented, "Effective."					
		the documentation for the					
		ation of the Oxycodone. no documentation of the					
		Oxycodone administered at					
	4:45 p.m.	-					
		no documentation of the					
	10:01 a.m.	Oxycodone administered at					
	4/23/17 at 12:25 p.n	n. and 2:00 p.m.,					
	documented, "Effect						
	•	documented, "Effective."	Í	Ör			
	"Effective."	6:59 p.m., documented,		1 V C	ECEIVED		
				M	Y S A		
		's notes from 4/17/17 through					
		eal any documentation of	0,000	VĽ	)H/OLC		
		al interventions attempted ration of the Oxycodone.					

Facility ID: VA0088

If continuation sheet Page 140 of 278

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495240			C 04/28/2017
NAME OF	PROVIDER OR SUPPLIEF	λ		STREET ADDRESS, CITY, STATE, ZIP	P CODE
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2240	)7
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETI HE APPROPRIATE DATE
F 309	Continued From p	age 140	F 30	09	
		ve care plan dated, 6/16/16 with			
		7, documented in part, "Focus:			
		ds pain management and to: Rheumatoid arthritis and			
		emity lymphedema and			
		erventions" documented in part			
		nedication as ordered. Attempt			
		ical interventions PRN (as out not limited to: relaxation,			
		ry, exercise, music, reposition,			
	back rub, rest and	pet therapy."			
	425/17 at approximates approximate approximates approxima	conducted with Resident #5 on mately 4:10 p.m. Resident #5 taff do when she complains of stated, "They ask me where k me to rate it on a scale of one ne worse pain a person ever go check the computer to see o have it (pain medication)."			
	When asked if the a back rub or repo "We are just lucky	nurse offers anything such as ositioning, Resident #5 stated, to get the pills." When asked i	f		
		back and asks if the pain			
		fective, Resident #5 stated, ome back." This was verified by			
		mmate who has a BIMS of 15.			
	practical nurse) #9	conducted with LPN (licensed o on 4/25/17 at 3:36 p.m. LPN at she does when a resident			
		LPN #9 stated, "First you	100	The second second	
	assess the locatio	n, type and have the resident		ecented	
		ne scale of one to ten), and how ne pain. It depends on the	/		
		ve medicate them per the			
	physician orders." anything that is off	When asked if there is ered before a medication is	V	DH/OLG	
	given, LPN #9 sta	ted, "We offer diversional			

		AND HUMAN SERVICES				FORM APPRO	VED
[		& MEDICAID SERVICES	r			MB NO. 0938-0	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			(X3) DATE SURVEY COMPLETED	Ŷ
		495240	B, WING	S		04/28/201	7
NAME OF F	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB		[ `	900 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	TION
	true pain then we ju asked where the no interventions attemp pain medication is of "There is a section of nurse's note." Where care plan, LPN #9 s to provide care to the An interview was con nurse) #1, the assis 4/25/17 at 3:47 p.m expected of the nurse complains of pain, F the pain, ask the rest scale, call the docto asked if they offer a the pain medication repositioning, maybe department." When documented in the F When asked the put stated, "It's how we each resident." The administrator, d administrative staff of regional director of of	to one attention, unless it is st give the medication." When in-pharmacological oted prior to administering the locumented, LPN #9 stated, on the MAR or in a general n asked the purpose of the tated, "It's how we are going he resident." Inducted with RN (registered tant director of nursing, on . When asked what is ses when a resident RN #1 stated, "They assess sident to rate it on a pain r for medication." When nything prior to administering , RN #1 stated, "We can try e a referral to the therapy asked where this is stated, "It should be MAR or a progress note." rpose of the care plan, RN #1 provide individualized care to lirector of nursing and member (ASM) #3, the interim clinical services, were made	F3	309			
	aware of the above p.m.	concern on 4/26/17 at 6:37			CEVED .		
	No further information	on was provided prior to exit.			MAY 3 2017		
				١	/DH/OLG		
		failed to obtain daily weights ders for Resident #5.					

Facility ID: VA0088

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		AND HUMAN SERVICES & MEDICAID SERVICES				INTED: 05/11/2017 FORM APPROVED IB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	T	X3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATI	E, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD B	
F 309	Continued From pa	ge 142	F 30	99		
		r dated, 4/15/17, documented, y day shift for monitoring."				
	"Daily Weights ever	for April 2017 documented, y day shift for monitoring." ot documented on 4/18/17, d 4/25/17.				
		tal signs tab in the electronic d to document the missing				
	revised on 2/2/17, o Potential for weight (history) edema, diu	e care plan dated, 6/16/16 and locumented in part, "Focus: fluctuations as related to hx irretic use." The "Interventions" , "Weights as ordered."				
	4/25/17 at 3:36 p.m weights should be c	onducted with LPN #9 on . When asked where daily locumented, LPN #9 stated, or in the vital signs tab in the				
	4/25/17 at 3:47 p.m	onducted with RN #1 on . When asked where daily locumented, RN #1 stated, "In the computer."				
	documented in part of the facility shall b	Weighing the Resident" , "At a minimum, all residents e weighed upon admission ordered otherwise by the		RECEIVED		
	physician or as dire			MAY 3 1 2017		
	committee."			VDH/OLC		
		f Nursing" 6th edition, 2005; d Anne Griffin Perry; Mosby,				

Facility ID: VA0088

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	IMENT OF HEALTH						INTED: 05/11/2017 FORM APPROVED <b>1B NO</b> . 0938-0391		
STATEMENT		(X1) PROVIDER/S			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		49	5240	B. WING			C 04/28/2017		
NAME OF	PROVIDER OR SUPPLIER	L	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	STREET ADDRESS, CIT	Y, STATE, ZIP CODE			
FREDER	ICKSBURG HEALTH	AND REHAB			3900 PLANK ROAD	C VA 22407			
		TEMENT OF DEFI			FREDERICKSBUR	S, VA 22407	(X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	MUST BE PRECE	DED BY FULL	ID PREF TAG	X (EACH CORR	ECTIVE ACTION SHOULD E ENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 309	Continued From pa	ae 143		FS	309				
	Inc; Page 419. "Th directing medical tr obligated to follow p	e physician is eatment. Nurs physician's ord	ses are ers unless they						
	believe the orders a clients."	are in error or v	would narm						
	The administrator, administrative staff regional director of aware of the above p.m.	member (ASM clinical service	1) #3, the interimes, were made						
	No further informat	ion was provid	ed prior to exit.						
	5c. The facility staff ordered by the phys #5.								
	The physician orde "Take vital signs ev		7, documented,						
	The MAR for April 2 signs every shift." T documented for the	he vital signs	were not						
	The comprehensive revised on 2/2/17, or Resident at risk for cardiac status r/t (re	locumented in alterations in r elated to) short	part, "Focus: espiratory or ness of breath						
	and CHF (congestin "Interventions" docu	umented in par	t, "Observe and		RECEIVE				
	document vital sign pattern, rate, rhythr muscles."				MAY 3 1 2017 VDH/OLO	•			
	An interview was co 4/25/17 at 3:36 p.m					9			
FORM CMS-2	567(02-99) Previous Versions	Obsolete	Event ID: 6R5B11		Facility ID: VA0088	If continuation s	heet Page 144 of 278		

		AND HUMAN SERVICES				FOR	D: 05/11/2017 MAPPROVED O. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		495240	B. WING	i		0	C 4/28/2017
NAME OF I	PROVIDER OR SUPPLIER	L	L	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			PLANK ROAD DERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 144	F	309			
	physician, LPN #9 s	ted when ordered by the stated, "If the doctor ordered uld be on the MAR."					
	assistant director of p.m. When asked v documented when #1 stated, "They sh signs tab in the con should obtain the vi	onducted with RN #1, the f nursing, on 4/25/17 at 3:47 where vital signs are ordered by the physician, RN ould be in the weight/vital nputer." When asked why we tal signs, RN #1 stated, "First, er and second they are g something."					
	electronic record di vital signs for the da	signs tab section of the d not reveal any documented ay shift on 4/25/17. The ot document the vital signs for					
	in part, "Policy: Vita the Vital Signs Flow of computer progra Record the following resident condition: of	Vital Signs Flow" documented I signs may be recorded on V Sheet this may be in (name m) electronic documentation. g items as indicated by date, time, B/P (blood ture, pulse, respirations and aturation)."					
	administrative staff regional director of	director of nursing and member (ASM) #3, the interim clinical services, were made concern on 4/26/17 at 6:37			ECEIVED		
	No further informati	on was provided prior to exit.		V	DH/OLC		
	(1) Barron's Diction	ary of Medical Terms for the					

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Facility ID: VA0088

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	05/11/2017
FORM.	APPROVED
ON AD NO	0020 0201

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0920-0291
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	PLETED
AND PLAN Ö	F CORRECTION		A, BUILDI	ING	c	
		495240	B. WING		1	8/2017
	PROVIDER OR SUPPLIER		Ī	STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			3900 PLANK ROAD			
FREDER	ICKSBURG HEALTH	ANU KEMAD		FREDERICKSBURG, VA 22407		151P3
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 309	Chapman, page 34	er, 5th edition, Rothenberg and 5.	F 3	309		
F 311 SS=D	<ul> <li>(2) Barron's Diction Non-Medical Read Chapman, page 51</li> <li>(3) This information following website: https://www.ncbi.nl T0001326/ 483.24(a)(1) TREA IMPROVE/MAINTA</li> <li>(a)(1) A resident is treatment and serv or her ability to car living, including the of this section. This REQUIREME by: Based on staff inte and clinical record the facility staff fail nursing services for survey sample, Real</li> </ul>	hary of Medical Terms for the er, 5th edition, Rothenberg and 1. In was obtained from the m.nih.gov/pubmedhealth/PMH TMENT/SERVICES TO AIN ADLS given the appropriate rices to maintain or improve his ry out the activities of daily ose specified in paragraph (b) NT is not met as evidenced erview, facility document review review, it was determined that ed to implement restorative or one of 32 residents in the		<ul> <li>F311</li> <li>Resident #2 was evaluated and receiving physical therapy and oc services. Resident #2 care plan is</li> <li>Current residents with restorati care plan were re-evaluated by the Residents identified as no change referred to restorative nursing services. The RNAC/designee will re-ed licensed staff on implementing reservices and evaluating prior to di The RNAC/designee will random restorative program to ensure imp and discontinuance of restorative monthly times three months.</li> </ul>	cupational current. ye nursing rapy. were vices. icate torative scharge. y audit the lementatio services	6-5-17
	nursing services p failed to evaluate F discontinuing the s	er Resident #2's care plan and Resident #2 prior to services.		4. The RNAC/designee will repor results monthly to the Quality Ass Performance Improvement comm continued compliance and/or revis	urance ttee for	
	The findings inclue	le:				
	8/30/16 and readm Resident #2's diag limited to: multiple depressive disorde	idmitted to the facility on hitted to the facility on 1/23/17. Inoses included but were not sclerosis, diabetes and major er. Resident #2's most recent ata set), a significant change in		RECEIVED MAY 3.1 2017 VDH/OLC		

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Facility ID: VA0088

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		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES DF CORRECTION	E & MEDICAID SERVICES           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:	1 . /	LTIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATI 3900 PLANK ROAD FREDERICKSBURG, VA	E, ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 311	reference date) of being cognitively in Resident #2 as req two or more staff w totally dependent of transfers. Residen progress and could former MDS asses The most recent red documentation con- therapy screen sign 1/24/17 that docum circle around the w functional status no monitor with nursin Resident #2's comp on 2/24/17 docume restorative nursing range of motion) participate in AROM NuStep (exercise do (exercise device) to strength for self-ca- day times 6-7 days participate in bed m rails, bed control ar- improve independe- bed. Resident to p belt, slide board, wi times 2 and verbal Resident to be see days a week"	with an ARD (assessment 1/30/17, coded the resident as ttact. Section G coded with bed mobility and as being in two or more staff with t #2's current MDS was in a not be compared to the sment. The for Resident #2 was a need by a physical therapist on nented, "Type of screen: (a ford 'Readmit')No change in oted. Will con't (continue) to g"	F :	311 RECEIVED MAY 31 2017 VDH/OLC	

Event ID:6R5B11

Facility ID: VA0088

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID COMPLETION (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 311 Continued From page 147 F 311 conducted with RN (registered nurse) #1 (the staff development coordinator). RN #1 stated in the past, there were designated restorative programs with two full time CNAs (certified nursing assistants) who provided the programs; however the facility was undergoing an integrated program where all CNAs were being trained to provide restorative nursing programs during and after care. RN #1 stated the restorative nursing program process changed about five to six weeks prior to the survey. RN #1 stated the MDS department was responsible for the oversight of the program. On 4/25/17 at 2:14 p.m., an interview was conducted with RN #2 (the MDS coordinator responsible for the oversight of the restorative nursing program). RN #2 stated in the past if a resident declined, the nursing staff would collaborate with the rehab department who would create a restorative nursing plan for the resident. RN #2 stated in the past, monthly restorative meetings were held with two full time restorative CNAs who would report updates regarding residents' progress in the restorative programs. RN #2 stated the restorative CNAs documented restorative notes on paper from December 2016 to March 2017. RN #2 stated since then, a new company had taken over and a new system was in place. RN #2 stated as of early to mid-March the facility has a whole new manual and there are no longer two full time restorative CNAs. RN #2 stated all CNAs are being trained to provide RECEIVED restorative services. RN #2 was asked to describe the current documentation used to MAY 3 1 2017 evidence restorative programs. RN #2 stated the facility did not currently provide restorative VDH/OLC services to any residents because CNAs were being trained to provide the services. RN #2 was

Facility ID: VA0088

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		AND HUMAN SERVICES				PRINTED: 05/11/2 FORM APPROV OMB NO. 0938-0	VE
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	٢
		495240	B. WING			04/28/2017	7
NAME OF I	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			PLANK ROAD DERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET	TION
F 311	Continued From pa	age 148	F	311			
		one for residents who currently					
		services. RN #2 stated the nad screened residents who					
	were previously rec	ceiving active restorative					
		ked if a resident should					
		services if he/she was care services, RN #2 stated, "Yes."					
		dent #2's care plan was not					
		as asked to provide evidence					
		artment had evaluated the former restorative program					
	was discontinued.	and former rooterative program					
		p.m., an interview was					
		M (other staff member) #3 (the egarding the restorative					
		DSM #3 stated at that moment					
	she couldn't say an	y resident was receiving					
		services. OSM #3 stated she vere currently trained on range					
		ing programs and she thought					
	during the previous	day RN #2 stated she was					
		alking and range of motion 3 stated during the transition					
		storative program to the current					
		department had been					
		us of residents and during this epartment had not been					
		that any resident had					
	presented with a de	ecline. OSM #3 stated the					
		nad worked with some		0m	CEIVED		
	restorative services	. When asked who was		RE	JEIVEL		
	-	s, OSM #3 stated CNAs and hab department when			31.2017		
		ange in status. OSM #3 was					
	asked when the reh	ab department last evaluated		VU	H/OLC		
		#3 stated the last time rehab					

Event ID: 6R5B11

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If continuation sheet Page 149 of 278

CENTE	RS FOR MEDICAR	RE & MEDICAID SERVICES	-			MAPPROVI D. 0938-03
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · /	PLE CONSTRUCTION		TE SURVEY
		495240	B. WING		04	C /28/2017
NAME OF	PROVIDER OR SUPPLIER	R	1	STREET ADDRESS, CITY, STATE, Z		
FREDER	RICKSBURG HEALTH	HAND REHAB		3900 PLANK ROAD	07	
			I	FREDERICKSBURG, VA 224		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE	(X5) COMPLETIC DATE
F 311	Continued From p	bage 149	F 31	1		
		December 2016 and at that				
		did not present with any change				
		s and could assist with bed confirmed no evaluation of				
		been completed by the rehab				
		the transition of the restorative				
		3 stated no one had relayed the so the rehab department had				
		resident since the transition.				
		0 p.m., an interview was				
		PN (licensed practical nurse) #2 us of Resident #2's ADL (activity				
		hen asked if Resident #2 had				
	•	ADL decline LPN #2 stated she				
		I she thought the resident was diverse of the stated the				
		heel himself down the hall but				
		hat. LPN #2 stated a lot of				
		refused to get up in the #2 further stated Resident #2				
	used to assist mor	re with turning. When asked				
		ne if an ADL decline is noticed,				
		/e let the doctor know." When #2 was referred to rehab for an				
	ADL decline, LPN	#2 stated she didn't know.				
		) p.m., RN #2 stated she talked				
		ehab and no evaluation was sident #2 during the transition of				
		gram. RN #2 was asked to				
	provide all of Resi	dent #2's restorative				
	documentation.			RECEIVED		
		) p.m., RN #2 presented orative documentation.				
		documented range of motion		VDH/OLC		
		services were offered to 27/17, 2/28/17, 3/1/17, 3/2/17,		Y U LI V LV V		
	· · · · · · · · · · · · · · · · · · ·	, , <u> , ,</u> ,				

		AND HUMAN SERVICES				FOR	D: 05/11/2017 MAPPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	STRUCTION	(X3) DA	NTE SURVEY
		495240	B. WING			04	C 4/28/2017
NAME OF	PROVIDER OR SUPPLIER	<b>.</b>		STREET	ADDRESS, CITY, STATE, ZIP CODE		
FREDER	CKSBURG HEALTH	AND REHAB			ANK ROAD RICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	3/3/17, 3/6/17, 3/7/ No further restorative restorative services dates or an evaluat determine the resid the restorative prog On 4/26/17 at 6:35 staff member) #1 (t (the director of nurs director of clinical s the above findings. The facility docume Program" documen restorative intervent Nursing Assistants, licensed nurse. A C should be training in good written and or responsibility and se carrying out residen interventions, it is th on a daily basis, doo completed, the time interventions, and to summary of each re status/goal achieved and the resident's re treatmentEvidenc licensed nurse mus medical record" No further information 483.24(a)(2) ADL C DEPENDENT RESI	17, 3/8/17, 3/9/17 and 3/10/17. ve documentation to evidence a were provided any other ion was completed to ent could be removed from gram was presented. p.m., ASM (administrative he administrator), ASM #2 sing) and ASM #3 (the regional ervices) were made aware of ant titled, "Restorative Nursing ted, "Implementation of tions is provided by Certified under the supervision of a CNA providing restorative care in rehabilitation, demonstrate al communication skills, ensitivity. In addition to the responsibility of the CNA to, cument the specific tasks is it takes to deliver the to document weekly a esident's progress, functional ment, assistive devices used e of periodic evaluation by the t be present in the resident's on was presented prior to exit. ARE PROVIDED FOR	F 3	311			

Facility ID: VA0088

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	05/11/2017
FORM	APPROVED
OMB NO	0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY
		495240	B. WING			28/2017
NAME OF PROVIDER OR SUPPLIER		AND REHAB		STREET ADDRESS, CITY, STA 3900 PLANK ROAD FREDERICKSBURG, VA	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE DENCY)	(X5) COMPLETION DATE
F 312	services to maintai personal and oral h This REQUIREME by: Based on observa interview, and clinic determined that the assistance for one sample, (Resident requiring extensive (activities of daily li The facility staff fai eating to Resident 4/26/17. The findings includ Resident #1 was a 10/22/16 with diagr Parkinson's diseas	ving receives the necessary n good nutrition, grooming, and hygiene. NT is not met as evidenced tion, family interview, staff cal record review, it was e facility staff failed to provide of 32 residents in the survey #1) who was coded as assistance of staff for ADLs ving). led to provide assistance with #1 during the lunch meal on	F	nursing staff on pr for dependent resi 3. The Director of will randomly obs requiring extensiv ensure residents re support with eatin weeks and then me months. 4. The Director of will report the aud the Quality Assura Improvement com	ignee will re-educate oviding ADL care dents. Nursing/designee erve residents e assistance to eceive appropriate g weekly times four onthly times four Nursing/designee it results monthly to unce Performance	6-5-17
	quarterly assessme reference date) of having an 11 out of interview for menta was moderately im resident was coded activities of daily liv as requiring extens member for eating.			RECEIVE MAY 3 1 2017 VDH/OLC		
	10/28/16 documen 67(02-99) Previous Versions	lent's care plan initiated on ted, "Focus. Inadequate Oral		Facility ID: VA0088	If continuation sheet Pa	ge 152 of 21

		AND HUMAN SERVICES				FO	ED: 05/11/201 RM APPROVE NO: 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3)	DATE SURVEY COMPLETED
		495240	B. WING	è			C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER			Τ	STREET ADDRESS, CITY, STATE, ZIP C		0.120/2011
FREDER	ICKSBURG HEALTH	AND REHAB			3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 312	Continued From pa	ge 152	F:	31:	2		
	9	ke due to: Parkinson's,					
		tness of breath), Altered Diet.					
	•	y bringing in outside foods sitency (sic) restrictions,					
	resident nocomplia	nt (sic) with dietary					
		ions, resident has periods of					
		pasms and will not open, to eat, hx of variable PO (by					
	mouth) intake. Inter	ventions. Allow extra time					
		at. Monitor meal consumption. dered, Weights as ordered."					
	4/26/17 at 1:50 p.m the edge of the bed bedside table. Resid and he was drooling to get food onto the food was pureed an asked if he was hun "yes." When asked eat, Resident #1 sho asked if his food wa "yes." At that time C assistant) #7 entere "This (the residents since lunch time." W was served, CNA #7 #7 took the resident pantry and returned placed the tray on the that she had reheated	made of Resident #1 on . The resident was sitting on with his lunch tray on the dent #1's hands were shaking g. The resident was attempting spoon without success. The d the plate was full. When ogry, Resident #1 nodded if anyone had tried to help him bok his head "no." When s cold, Resident #1 nodded NA (certified nursing d the room. CNA #7 stated, lunch tray) has been here /hen asked what time lunch 7 stated, "Around noon." CNA 's tray, was observed entering to Resident #1's room, he over bed table and stated, ed the food. CNA #7 then yout assisting Resident #1.			RECEIVED		
	conducted with CNA When asked how sta to be fed, CNA #9 st	o.m. an interview was #9, the resident's aide. aff knew if a resident needed ated, "We have a Kardex." dent #1 needed assistance			MAY 3 1 2017 VDH/OLC		

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		AND HUMAN SERVICES			PRINTED: 05/11/20 FORM APPROVE OMB NO. 0938-039
STATEMENT OF D	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495240	B. WING		- C 04/28/2017
NAME OF PROVI	DER OR SUPPLIER			STREET ADDRESS, CITY, STA	
FREDERICKS	BURG HEALTH	AND REHAB		3900 PLANK ROAD	20407
				FREDERICKSBURG, VA	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLETIC TO THE APPROPRIATE DATE IENCY)
F 312 Cor	tinued From pa	age 153	F3	12	
Kar see #9 s was if sh eati had stat Res finis #9 a was #9 r roor On obse was able mou cont thre from	dex." When as how residents stated, "Every ti asked to obse the thought he con ng, CNA #9 sta attempted to fee ed she had not. ident's room ar h his lunch. Re attempted to fee unable to oper emoved the tra n. The food on 4/27/17 at 12:50 erved in the Bis served his tray to spoon his for th. He attempted ainer five sepal e sips of juice. In the staff until 1:30 roximately 50 p	ted, "I didn't check the ked how often she checked to were to eat their meals, CNA me I go past I check." CNA #9 rve Resident #1. When asked buld use assistance with ted, "Yes." When asked if she bed the resident, CNA #9 CNA #9 went into the nd asked him if he would like to sident #1 nodded "yes." CNA ed the resident but the residen the is mouth at that time. CNA y and exited Resident #1's the tray had not been eaten. O p.m., Resident #1was tro during lunch. The resident at 1:05 p.m. Resident #1 was bod from the tray into his ed to drink from the juice rate times and was able to get He was not offered assistance p.m. He consumed ercent of his meal but less his juice and no water.	o t s		
docı (cub	umented, "2 cal	2017 physician's orders (calorie) Supplement 240cc three times a dayOrder		RECEIVEI	
		2017 MAR (medication		MAY 3 1 207	
Sup and docu cc a	olement 240cc PM snack two t umented that th nd 240 cc's of t	rd) documented, "2 cal three times a day. Offer AM times a day." It was e resident drank between 75 he 2 cal supplement three t the snack was offered twice		VDH/OLC	
RM CMS-2567(02-9	99) Previous Versions	Obsolete Event ID: 6R5B	11	Facility ID: VA0088	If continuation sheet Page 154 of 2

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	FORM APPROV OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG	COMPLETED
		495240	B. WING _		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER		-1	STREET ADDRESS, CITY, STATE, ZIF	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2240	)7
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 312	Continued From pa a day."	age 154	F 31	12	
	March 2016 failed t the resident had co meals. For 33 out o documented, "0,1" was independent in set up assistance o sheet for March 20	ent's ADL meal sheet for to evidence the amount of food insumed for 30 out of 93 of the 63 meals it was indicating that the resident if feeding self and was provided only. Further review of the ADL 16 documented that the led assistance of one staff			
	2016 failed to evide resident consumed For 43 out of the 81 that the resident wa only from staff. For documented that th assistance from one	#1's ADL meal sheet for April ence the amount of food the for 26 meals out of 81 meals. meals it was documented is provided set up assistance 64 out of the 81 meals it was e resident was provided e staff member to eat. One y how much assistance the			
	p.m. documented, " more, unable to talk	e's note dated 3/16/17 at 1:30 Resident has been freezing a eat, gets shakes, the event inutes and has happened x		RECEIVED	
	p.m. documented, "	's note dated 3/22/17 at 1:34 consult neurologist for pisodes r/t (related to) n as possible."		MAY 3 1 2017 VDH/OLC	
	p.m. documented, "l returned call Recom	's note dated 3/27/17 at 10:57 Dr. (doctor) [neurologist] mend Long acting aFreezing when trying to eat,		'. 400000, 60 2010, 40000, 50009, 60004,	

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PRINTED: 05/11/2017 FORM APPROVED OMB NO 0938-0391

DEPARTMENT	OF HEALTH AI	ND HUMAN	SERVICES
	MEDICARE &	MEDICAID	SERVICES

CENIE	RS FOR MEDICAR	E & MEDICAID SERVICES	T		UMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 3900 PLANK ROAD FREDERICKSBURG, VA 22407	DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR	SHOULD BE COMPLETIN
F 312	<ul> <li><sup>5</sup> 312 Continued From page 155 give meds. Diet incorrect in mar (mediation administration record) per (name of speech therapist) should be thickened liquids and soft mechanical. I did not change."</li> <li>Review of the speech therapy note dated 3/29/17 documented, "Patient is consuming approximately 60% of his mechanical soft textured sides and pureed meats. His consumption is greater when dining in room as he reports significant distraction associated with table mates. PATIENT HAS BEEN EXHIBITING DAILY EPISODES OF FACIAL RIGIDITY; JAW CLINCHING (sic); AND UPPER EXTREMITY TREMORS RESULTING IN POOR - FAIR PO INTAKE WITH THERAPEUTIC MEALS PLACING HIM AT CONTINUED RISK FOR WEIGHT LOSS."</li> </ul>		F 3	12	
		nt #1's Kardex did not evidence garding assisting the resident			
	4/27/17 at 10:00 a were, the resident When asked if he resident stated, "N asked if he was hu times I can't eat. I Resident stated th he can't eat during	conducted with Resident #1 on .m. When asked how his meals stated the food was cold. received help with eating, the lot always." Resident #1 was ungry, he stated, "Yes. Many have to go without food." at his jaw would freeze up and those times. When asked if he		RECEIVED	
		after his jaw was no longer 1 stated they (staff) sometimes			
	a.m. with LPN #11	conducted on 4/27/16 at 11:05 , the unit manager. When preakfast Resident #1 ate, LPN		VDH/OLC	

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

Facility ID: VA0088

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DEPART	IMENT OF HEALTH	٢	FORM APPROVED			
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	<b>r</b>		0	MB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
						с
		495240	B. WING			04/28/2017
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB			0 PLANK ROAD EDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 312	and one-half puddir asked what the plar nutritional requirem educated the wife o want it." When aske food when he was a should be his nurse food but I'm not her An interview was co p.m. with LPN (licer resident's nurse. Wi which residents nee eating, LPN #4 state When asked which assistance, LPN #4 being Resident #1. V was able to feed him not freezing up he c his breakfast yester usually eats in the B shaking so much we room." On 4/27/17 at 6:30 p administrator, ASM ASM #3, the interim services and ASM # aware of the finding	bites but I just gave him two higs a minute ago." When h was to meet Resident #1's ents, LPN #11 stated, "I've n a feeding tube but she didn't ed if Resident #1 was offered able to eat, LPN #11 stated, "It s. I'm always offering him e 24 hours a day." anducted on 4/27/17 at 1:25 her asked how staff knew eded assistance with being ed, "Speech therapy tells us." of her residents needed named three residents, one When asked if Resident #1 nself, LPN #4 stated, "If he's an feed himself. He ate all of day." LPN #4 stated, "He bistro but today he was the had his meal sent to his b.m. ASM #1, the #2, the director of nursing, regional director of clinical 5, the owner were made s. The group was asked if	F 3	312		
	they knew that the resident complained of being hungry, the group was not aware of that. An interview was conducted on 4/28/17 at 9:25 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked how staff			attitistado	ECEIVED MAY 3 1 2017 IDH/OLG	
	stated, "It would be i	6 food consumption, ASM #2 in his ADLs." ASM #2 and April 2017 ADL sheets		*	; & i ii & in V	

Facility ID: VA0088

If continuation sheet Page 157 of 278

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/11/2017 FORM APPROVED OMB NO: 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:		G	C 04/28/2017		
NAME OF PROVIDER OR SUPPLIER         FREDERICKSBURG HEALTH AND REHAB         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)		AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE			
TAG	Continued From pa for Resident #1. W considered sufficie "The kiosk might h in the chart." A reg	age 157 hen asked if that was nt monitoring, ASM #2 stated, ave been down and it might be uest was made for any	F 31	DEFICIENCY)			
F 314 SS=G	consumption was No further informa 483.25(b)(1) TRE/ PREVENT/HEAL I (b) Skin Integrity - (1) Pressure ulcer comprehensive as facility must ensur (i) A resident recei professional stand pressure ulcers ar ulcers unless the demonstrates that (ii) A resident with necessary treatmo- professional stand healing, prevent in from developing. This REQUIREMI by: Based on observ interview, facility of review and in the investigation, it was staff failed to prov- and services to pr-	tion was provided prior to exit. ATMENT/SVCS TO PRESSURE SORES s. Based on the sessment of a resident, the	f.	<ul> <li>F314</li> <li>1. Resident #26 is discharged. Reside wound care physician recommendation implemented, soft boot to right heel, while in bed. Resident #2 has wo orders in place. Resident #19 is disch 2. The Director of Nursing and nursin completed a skin sweep on current re April 27, 2017. One resident was iden risk, treatment initiated, and care plan RNAC re-educated the wound RN on wound prevention program. The wou will re-educate licensed nurses and no nurses as part of orientation.</li> <li>3. The Director of Nursing/designee w randomly audit pressure ulcers using pressure ulcer tool; identifying Brade weekly skin checks, treatment, wound documentation, pain evaluation, care updates, and preventative measures w times four weeks, then twice a month monthly times one month.</li> <li>4. The Director or Nursing/designee w the audit results monthly to the Quali Assurance Performance Improvemen continued compliance and/or revision</li> </ul>	and float ound arged. ig staff sidents on atified at 6-5-17 a updated. the and RN ewly hired will the QAPI a scores, d plan teekly , and then will report		

Event ID: 6R5B1 RECEIVED

MAY 3 1 2017 VDH/OLC

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

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		AND HUMAN SERVICES				FORM	D: 05/11/2017 MAPPROVED D: 0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SU COMPLE	
		495240	B. WING			04	C /28/2017
NAME OF	PROVIDER OR SUPPLIER		<b>.</b>	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	CKSBURG HEALTH	AND REHAB			0 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	Continued From pa #7, #2, #19 and #1		F:	314			
	implement intervent the development of 7/29/16 Resident #2 facility staff as havir on his left heel. The weekly skin assess sheets until 8/8/16. and wound evaluati completed did not d measurements or a being assessed and to determine if the v improving. On 8/16 documented that th purulent drainage, E ordered by the phys administered for set failed to transcribe t MAR (medication ac failed to administer Resident #26 was n until 8/29/16 followin culture that was doo infection. During th 9/16/16 facility docu worsening, odorous Stage IV* ulcer dese podiatrist as "open t Resident #26's left H diagnosed with oste the bone), resulting 1 b. The facility stat implement intervent	locument complete description of the wound d failed to monitor the wound wound was declining or /16 the facility staff e left heel wound opened with Bactrim (an oral antibiotic) was sician on 8/17/16 to be ven days. The facility staff the order for Bactrim onto the dministration record) and the medication as ordered. Not administered an antibiotic ng the results of a wound cumented as positive for an e time period 7/29/16 - imentation evidenced a wound culminating into a cribed on 9/16/16 by a to bone and Achilles tendon." meel wound was subsequently comyelitis [6] (an infection of					

Facility ID: VA0088

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	IMENT OF HEALTH							RINTED: 05/11/201 FORM APPROVE MB NO: 0938-039	
STATEMENT		(X1) PROVIDER/S				NSTRUCTION	0	(X3) DATE SURVEY COMPLETED	
		495	5240	B. WING			~	C 04/28/2017	
NAME OF	PROVIDER OR SUPPLIER			-	STREE	TADDRESS, CITY, STA	TE, ZIP CODE		
EDENED	ICKSBURG HEALTH				3900 F	LANK ROAD			
	ICKSBURG NEALTH				FRED	ERICKSBURG, VA	22407		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	BE COMPLETION	
F 314	Continued From pa	ige 159		F 3	314				
	from developing an to the right heel. The monitor and revise continuous basis ar of the treatments in	he facility staff treatments to th nd to assess the	also failed to ne wound on a						
	2. The facility staff failed to implement measures to promote healing of a suspected deep tissue injury for Resident #7 on admission which declined to an unstageable wound on Resident #7's heel. The facility staff also failed to initiate and implement interventions recommended by the facility wound care physician for a period of 13 days. The facility staff also failed to float the residents heels. Resident #7's heels were observed directly on the mattress during the survey.								
	3.a. Resident #2 de the right calf on 3/9/ implement treatmer 3/17/17.	17. The facility	/ staff failed to						
	3.b. The facility staff wound care physicia treatment of Reside injury from 3/15/17 t	an's recommen nt #2's sacral (	dations for 1) pressure						
	3.c. Resident #2 dev the right heel on 4/1 to implement treatm	9/17. The facil	ity staff failed		R	ECEIVED			
	4. For Resident #19 maintain infection co dressing change an	ontrol practices d promote heal	during a ing of an			MAY 3 1 2007			
	unstageable [1] saci	ral pressure wo	ound [2].		V	DH/OFC			
	5. The facility staff fa	ailed to assess	and						
ORM CMS-25	67(02-99) Previous Versions (	Obsolete	Event ID: 6R5B11	· · · · · · · · · · · · · · · · · · ·	Facility ID:	VA0088	If continuation s	heet Page 160 of 27	

		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED
STATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB	3	TREET ADDRESS, CITY, STATE 900 PLANK ROAD FREDERICKSBURG, VA 2	E, ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLÉTION TO THE APPROPRIATE DATE
F 314	from her admission	Resident #13's pressure injury o on 4/5/17 until 4/12/17, when he wound specialist.	F 314		
	implement interven the development of 7/29/16 Resident # facility staff as havi on his left heel. The weekly skin assess sheets until 8/8/16. and wound evaluat completed did not of measurements or a being assessed an to determine if the improving. On 8/16 documented that the purulent drainage, ordered by the physi administered for se failed to transcribe MAR (medication a failed to administer Resident #26 was n until 8/29/16 followi	ff failed to initiate and tions on admission to prevent f a pressure ulcer and on 26 was documented by the ng a DTI* (deep tissue injury) e facility staff failed to initiate ments and wound evaluation The weekly skin assessments ion sheets that were document complete a description of the wound d failed to monitor the wound wound was declining or 5/16 the facility staff he left heel wound opened with Bactrim (an oral antibiotic) was sician on 8/17/16 to be even days. The facility staff the order for Bactrim onto the idministration record) and the medication as ordered. not administered an antibiotic ing the results of a wound cumented as positive for an		RECEIVED	

Facility ID: VA0088

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING С 495240 **B** WING 04/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG TAG DEFICIENCY) F 314 Continued From page 161 F 314 diagnosed with osteomyelitis [6] (an infection of the bone), resulting in harm. Resident #26 was admitted to the facility on 7/5/16 with diagnoses that included, but were not limited to, dementia, high blood pressure, thrombocytopenia [1] (a condition in which your blood has a lower than normal number of blood cell fragments called platelets) hip fracture, peripheral vascular disease (poor blood circulation to the lower extremities,[\*Note the resident was evaluated in the facility and found to have good blood flow to bilateral lower extremities. See the physician note dated 7/27/16]), anemia (low red blood cell count), atrial fibrillation (an abnormal heart rhythm) and chronic obstructive pulmonary disease (affecting the lungs). Resident #26's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/4/16 coded Resident #26 as a 0 (zero) out of a possible score of 15 on the BIMS (brief interview for mental status) indicating that Resident #26 was severely cognitively impaired with daily decisions about care. The resident was also assessed as requiring extensive to total assist from at least one staff person for transfers, dressing, eating, toileting, hygiene and bathing. Resident #26 was also coded in Section M, Skin Conditions, as RECEIVED having two unhealed pressure ulcers at the time of the assessment, an unstageable\* wound with MAY 3 1 2017 VDH/OLC slough and/or eschar measuring 5.0 cm (centimeters) x 10.0 cm and an unstageable wound with suspected deep tissue injury. Resident #26's admission MDS with an ARD of

7/12/16 coded Resident #26 as being at risk of

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Event ID: 6R5B11

Facility ID: VA0088

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PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391

DEPARTMENT	OF HEALTH AND	) HUMAN SERVICE	S
CENTERS FOR	MEDICARE & M	EDICAID SERVICES	3

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		Ĺ	OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (         IDENTIFICATION NUMBER:       A. BUILDING       (		(X3) DATE SURVEY COMPLETED C			
		495240	B. WING		04/28/2017		
NAME OF F	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE			
FREDER	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD			
				FREDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 314	Continued From pa	ge 162	F 3	14			
	or acquired existing Care Area Assessm admission assessm Pressure Ulcer" wa column "A" and alse Care Planning Deci provided in Section triggered Care Area plan, care plan revi care plan is necess identified in your as Check column B if t addressed in the ca	e ulcers with no admitted with g pressure ulcers. Section V - nent (CAA) Summary of the nent documented that "16. s a triggered care area under o checked under column "B. ision." The instruction V states, "2. For each a, indicate whether a new care sion, or continuation of current ary to address the problem(s) sessment of the care area. the triggered care area is are plan." Section V, Column s MDS was checked for					
	revealed, in part, a "Clinical Health Sta (3:40 p.m.), the box checked. Under the Conditions" a diagra arrow drawn, pointii hand written beside There were no othe documented. Under Scale (9) for Predic	nt #26's clinical record facility document titled tus" dated 7/5/16 at 1540 & titled "Admission" was e section titled "Section B Skin am of the human body had an ng to the back left hip and the arrow was "38 staples." er wounds/skin conditions er the section titled "Braden ting Pressure Sore Risk a cumented, indicating					
	on 7/5/16 was revie care plan for skin o	prehensive care plan dated wed and did not include a r potential for pressure. On		RECEIVED MAY 3 1 2017			
	plan included the fo "Focus: Pressure u ulcer actual: DTI (de	o the comprehensive care illowing documentation; ilcer actual due to: Pressure eep tissue injury) Left heel. 2016. Interventions: Assist		VDH/OLC			

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		AND HUMAN SERVICES					RINTED: 05/11/2017 FORM APPROVED MB NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495240	B. WING	6			C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		L	STRI	EET ADDRESS, CITY, STAT	E, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB			DERICKSBURG, VA	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD	BE COMPLETION
F 314	Continued From pa	ge 163	F	314			
	Initiated 7/29/2016. Bilateral calf support						
	8/8/2016. Revision skin inspection Date	neels. Date Initiated: on 8/8/2016. Conduct weekly e Initiated: 8/31/2016.			ø		
	assessment: Date on: 10/12/2016." Di	2016. Weekly Wound Initiated: 8/31/2016. Revision etary to implement prostat to					
	8/3/2016. Extended Heel elevator device 8/3/2016. Revision assessment to be of facility) policy. Date	ompleted per (name of Initiated: 7/29/2016.					
	Treatments as orde 07/29/2016."	red Date Initiated:					
	TAR (treatment adm reveal any intervent	nt #26's physician orders and ninistration record) did not ions for prevention of n the time of admission on					
	documented, in par + (two plus) edema	d 7/27/16 at 2:07 a.m. t, "LLE (left lower extremity) 2 (swelling) noted and elevated arm to touch, site observed					
	part, "Venous Dopp	ated 7/27/16 documented, in ler (ultrasound) to Left Lower n (morning) on 7/27/16."			ECEIVED		
		t dated 7/27/16 documented, g findings; "Clinical indication:					
	Leg edema and rule	e out Deep Vein Thrombosis There is no intraluminal (within			/DH/OLC		

Facility ID: VA0088

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		AND HUMAN SERVICES			PRINTED: 05 FORM API OMB NO. 09	PROVE		
STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	(X3) DATE SURVEY COMPLETED		
		495240	B. WING	•	C 04/28/:	2017		
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE,				
FREDER	ICKSBURG HEALTH	AND REHAB		00 PLANK ROAD REDERICKSBURG, VA 22	2407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE CC	(X5) MPLETION DATE		
F 314	Continued From pa	age 164	F 314					
	manifestation of de vessels. The right patent. Impression ultrasound. No DV documentation on the status of the le A nurse's note date part, "Left heel mu Skin prep q (every therapy) to eval (every t	ed 7/29/16 documented, in shy with moderate bleeding. ) shift. Rehab (rehabilitation valuate) for boots or pressure RP (responsible party) and MD ware of the new area." iical record revealed, in part, a dated 7/26/16 at 11:00 a.m. umentation on the assessment						
	weekly skin assess sheet was complet	ce in the clinical record that a sment or a wound evaluation ed when the SDTI (suspected was identified on Resident						
	dated 8/1/16 docur was working towar patient did not prog progress reporting was (sic) making s onset of left heel u (weight bearing) ad	rapy) Therapist Progress note mented, in part, "Pt (patient) ds his functional goals and the gress as anticipated during this period. This is likely due to ome progress until recent leer impacting standing/ WB ctivities. During assessment rity and pain, pt. exhibited	्रे. २ २७२	ECEIVED AY 3 1 2017 DH/OLC				
	F67(02,00) Provious Version		1 Easi	ity ID: VA0088	If continuation sheet Page	165 of 1		

Facility ID: VA0088

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	TMENT OF HEALTH RS FOR MEDICARE							FORM APPR MB NO: 0938-	OVE
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVI COMPLETED	ΕY	
		4	95240	B. WING				-	17
NAME OF	PROVIDER OR SUPPLIER			1	STREET	ADDRESS, CITY, ST	COMPLETED C 04/28/2017 SS, CITY, STATE, ZIP CODE		
FREDER	RICKSBURG HEALTH	AND REHAB				ANK ROAD RICKSBURG, VA	A 22407		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFI) TAG		(EACH CORRECTIN ROSS-REFERENCE	/E ACTION SHOULD D TO THE APPROPI	BE COMPL	LETION
F 314	Continued From partendency to slide heresist positioning partendency to slide here was no documental staff conducted a wastaged the wound of Resident #26's left Review of Resident in part the following - 8/3/16 "Float heels refuses. Every shift - 8/4/16 "Bilateral herevery shift for Wour - 8/4/16 "Prostat Martin part the following - 8/4/16 "House Sup DTI left heel 90cc (contendenced to the slident deversion of the slider of the slid	eels on bed in erformed by P ical record rev dated 8/2/16 a mentation on by skin concer d 8/3/16 docu th blackened tion to evidend ound evaluati or obtained me heel wound. #26's clinical physician ord s. Document for Preventati eels up device nd Healing." ax (a whey bas day for DTI le cubic centime name of sup hat the physic	T. realed, in part, a at 11:22 a.m. the weekly skin ns. mented, in part, area." There be that the facility on assessment, easurements of record revealed lers; if patient ive." when in bed, sed liquid eft heel 30 ml e times a day for ters) plement)." dated 8/1/16 - cian orders on	F 3	14				
	8/4/16 were initiated heels was not docur however the nurse's		ing initiated,			EIVED			
	device.	atod officer by	a pillow of a			1 207			
	A physician progres documented, in part Receiving treatment	, "Open area	L (left) heel.		VDH	/OLC			
ORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID:6R5B11		Facility ID: \	/A0088	If continuation	sheet Page 166	of 278

		AND HUMAN SERVICES				FOR	D: 05/11/2017 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495240	B. WING			04	C I/28/2017
NAME OF	PROVIDER OR SUPPLIER		4	SI	REET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			00 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 166	F:	314			
	Float heel. Nut (nu (wound) MD (medic	tritional) support. Wnd cal doctor) consult."					
		d 8/6/16 at 13:58 (1:58 p.m.) t, "Blister area to left heel absorbing."					
		d 8/6/16 at 19:13 (7:13 p.m.) t, "Blister is intact/closed."					
	part, the following; ' room for skin prep a heels. Strong odor from left heel. Area approx. 0.5 x 0.5 wi asked to look at wo recommendation to	d 8/16/16 documented, in To resident (Resident #26) application to bilaterally (sic) noted when sock removed a open to left inner heel th purulent drainage. Therapy und for possible (sic) with apply calcium alginate [7] to nt. MD (medical doctor) and rty) made aware."					
	the following docum by nursing that an a had opened and wa and had purulent dr assessed wound is debridement to rem promote healing. N the medial aspect of measuring 25 cm (c	d 8/16/16 revealed, in part, inentation; "It was noted earlier rea of the Pt's left heel wound s covered with necrotic tissue ainage. Therefore PT has starting selective sharp ove necrotic tissue and ecrotic tissue is present on f the left heel wound centimeters) 2 (squared) in overed in 100% necrotic			RECEIVED		
	in part, "Clean left h alginate to open are every day shift." A r	dated 8/16/16 documented, eel daily, apply calcium as and then apply dressing eview of Resident #26's TAR ion of this order starting on		que	MAY 3 1 2017 VDH/OLC		

Event ID: 6R5B11

Facility ID: VA0088

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	to rortime bior	E & MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
AME OF	PROVIDER OR SUPPLIER	₹	1	STREET ADDRESS, CITY, STATE, ZIF	
REDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2240	17
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 314	Continued From p	bage 167	F 3	14	
	8/17/16 and disco A weekly skin revi 8/17/16 document Left heel. Wound There was no doc	ntinued on 8/31/16. ew completed by nursing on ted, in part, the following; "Site: s followed by wound nurse." cumentation describing the age and no measurements of			
	<ul> <li>A physician order dated 8/17/16 documented, in part, "8/17/16 Bactrim DS [2] (an oral antibiotic) 1 tab (tablet) PO (by mouth) BID (two times per day) x 7d (for seven days."</li> <li>A review of Resident #26's nursing notes revealed documentation stating that Resident #26 was taking an antibiotic from 8/18/16 to 8/26/16, a total of nine days.</li> </ul>				
	any documented e transcribed the ord evidence that Bac Resident #26 for s physician beginnin August pharmacy ASM (administrativ director of nursing end of day meeting This was not provi survey process.	ent #26's MAR failed to reveal evidence that the facility staff der onto the MAR and did not trim DS was administered to seven days as ordered by the og on 8/18/16. A copy of the manifest was requested from ve staff member) #2, the on 4/26/17 at 6:10 p.m. at the g, and on 4/27/16 at 10:15 a.m. ded prior by the end of the			
A review of Resident #26's clinical record revealed a wound culture with a collection date of 8/18/16. The final report of the culture dated 8/23/16 documented, in part, "HEAVY MIXED FLORA CULTURE [3]. CONTAMINATION		culture with a collection date of report of the culture dated		RECEIVED	
			MAY 3 1 2017		
	SUGGEST REPER below the report w	AT CULTURE." Hand written		VDH/OLG	

Facility ID: VA0088

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	RS FOR MEDICARI	E & MEDICAID SERVICES	(X2) MUL	TIPLE CONSTRUC	TION	OMB NO. ( (X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER:				COMP	LETED
		495240	B. WING			C 04/2	8/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRE 3900 PLANK R	ESS, CITY, STATE, ZIP COD	E	
FREDER	ICKSBURG HEALTH	AND REHAB			SBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	DVIDER'S PLAN OF CORRE I CORRECTIVE ACTION SH REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE
F 314	Continued From pa	age 168	F 3	14			
	A physician order of	dated 8/24/16 instructed the					
	facility staff to repe	at the wound culture. The					
	2	led to administer the Bactrim to een 8/17/16 and 8/24/16.	)				
	A physical therapy	note dated 8/24/16 revealed, ir	1				
		selective debridement using					
		and gauze to left heel wound -viable blade escar (sic) tissue.					
		addressed by nursing."					
		n assessment (one of three ident #26's left heel) dated					
	8/24/16 documente	ed, in part, "Wound Evaluation					
		no entry). Width (in cm) 3.2 ero). Current preventative					
		ssure redistribution mattress.					
		cushion. Heel boots." The					
		o document a description of stage of the wound and					
	measurements of t	he wound.					
		d culture was done as ordered left heel wound. On 8/28/16 a					
		oratory documented, in part,					
		. Organism 1 (one) - Heavy ive rods."[8] Hand written at					
		aboratory report was the					
		n oral antibiotic) 500 mg					
		D x 5 (for five) days Lrg (large) gram (-) (negative) rods." A					
	review of the clinica	al record revealed, in part, a					
		ed and signed by the physician cumented; "Cipro Tablet 500		RECEI	VED		
	MG Give 500 mg b	y mouth every morning at BACTERIAL INFECTION,					
		il 9/3/2016. May give am dose		VDH/Q			
		d 8/26/16 documented, in sident #26) left the facility for		ANUIA	76U		

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		& MEDICAID SERVICES	- <u>r</u>		OMB NO. 093		
	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUF COMPLET		
		495240	B. WING		04/28/2017		
NAME OF	PROVIDER OR SUPPLIER	<b>L</b> . (1997)		TREET ADDRESS, CITY, STATE, ZI	P CODE		
FREDER	ICKSBURG HEALTH	AND REHAB		900 PLANK ROAD REDERICKSBURG, VA 2240	)7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COM HE APPROPRIATE	(X5) MPLETIC DATE	
F 314	Continued From pa	ge 169	F 314				
	his wound appointr	nent." The facility staff failed imentation from the wound					
	part; "Left heel 8/15 (date 6.0 x 11.0 (cm tissue injury)." Rev revealed the facility evaluation assessm heel between 8/24/ continuous monitor A nurse's note date part, "Continues to odor and drainage." the wound, no wour measurements for A wound evaluation documented, in par cm) 00 (zero). Wid warm to touch Skin Temperature warm skin prep q (every) Ordered: 7/29/16."	d 8/29/16 documented, in monitored (sic) for excessive ' There was no description of nd stage and no					
	part, "(L) heel ulcer	ted 9/7/16 documented, in " There was no cribing the wound bed, the					
		or the measurements of the		ECEIVED			
	A physical therapy r documented, in par	note dated 9/13/16 t, "Pt (patient) has left heel	V	AY 3 1 2017			
wound unstageable w (with) total surface area of 50 cm 2 (squared) w depth 0 (zero) cm w minimal thin watery purple exudate (discharge), foul odor		V	DH/OLC				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С 495240 **B** WING 04/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 170 F 314 95% necrotic, 5 % slough." On 9/14/16 Resident #26 was seen by a physician at the wound care clinic. The physician orders details from the wound care clinic documented instructions for cleaning and management of Resident #26's wound. A hand written physician order dated 9/14/16, signed by the wound care clinic physician and noted by the facility physician documented, in part, the following: "Change dressing daily s/p (following) clean with normal saline. Santyl (an ointment used to treat infected wounds) to wound bed. Slightly moistened gauze. Kerlix/light coban or ace wrap. Continue to float heel and keep weight off at all times turning pt q (every) 2 hours. Increase protein. X-Ray of (L) heel." A review of Resident #26's 9/1/16 - 9/31/16 TAR revealed that the facility staff failed to administer the ordered dressing to Resident #26's left heel between 9/20/16 and 9/26/16. On these dates the facility staff documented that the dressing on Resident #26's left heel was as follows; "Cleanse left heel ulcer with 0.125% Dakin's then apply moist-dry dressing with gauze soaked in 0.125% Dakin's Soln. Wrap with kerlix and light coban or ace wrap. Change qd (every day) and prn (as needed). Order date 9/19/16." There was no documentation in the clinical record regarding this order. RECEIVED Further review of the clinical record did not MAY 3 ( 2017 provide evidence that the facility staff were turning Resident #26 every two hours. VDH/OLC Further review of the clinical record did not provide evidence that the facility staff had increased the amount of protein in his food.

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		AND HUMAN SERVICES		FORM APPROVEI OMB NO. 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATI	E, ZIP CODE
FREDER	ICKSBURG HEALTH	AND REHAB	1		22407
			L	EDERICKSBURG, VA	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 314	Continued From pa	age 171	F 314		
	documented, in pa (a pressure injury). consult. Started C reviewed. MRI (Ma Continue clindamy 9/8/16 to be admin A wound evaluation documented, in pa 0 Staging: Suspect (in cm) 4. Addition DTI." The docume location of the wou assessment such a A radiology report documented, in pa Heel 2V (two views comparison study change at posterio for osteomyelitis. sensitive imaging written at the botto	ss note dated 9/15/16 rt; "L heel wound. Decubitus Float heels, wound care ipro (an oral antibiotic). X-ray agnetic resonance imaging). cin (an oral antibiotic ordered istered for 14 days)." n assessment dated 9/15/16 rt, the following; "Depth (in cm) cted Deep Tissue Injury. Width hal notes: Intact deep purple entation did not state the und described in the as left or right heel. for Resident #26 dated 9/15/16 irt, the following; "Examination: s) Left. Results: No is available. Mild erosive or calcaneus (sic) is concerning Conclusion: Consider more evaluation with MRI (magnetic g) as clinically directed." Hand om of the report is as follows; ilt podiatry." Signed and dated irian on 9/15/16			
	through 9/30/16 re administered Augr days starting 9/21/	ent #26's MAR dated 9/1/16 evealed that Resident #26 was nentin (an oral antibiotic) for 10 /16 and ending on 9/30/16. ed 9/23/16 documented, in	R	ECEIVED	
	part: "Wound has	strong smell, when entering the			
	room you can sme is wrapped.	ell the odor even when the foot	V	DH/OLC	
		ed 10/4/16 documented, in	w.	1999 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	567(02-99) Previous Version		11 Faci	ity ID: VA0088	If continuation sheet Page 172 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С 04/28/2017 **B** WING 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 172 part; "Wound assessment. The left heel ulcer remains an unstageable pressure ulcer at 5.5 cm x 11 cm x unable to measure due to necrosis. 70% thick adherent necrotic and 30% granulation tissue is present on wound bed. Moderate serous exudate is noted with foul odor. Surrounding skin is macerated (the softening and breaking down of tissue in response to an infection)." A wound culture collected on 10/4/16 and resulted on 10/8/16 documented, "Heavy growth Proteus Mirabilis [4] (a gram negative bacilla)." A physician's verbal order dated 10/4/16 documented, in part, "PICC [5] (peripherally inserted central catheter- a long, thin, hollow tube placed into a vein above the bed of the elbow) line placement for infusion of ABT (antibiotic) therapy/infusion IV therapy. One time only until 10/4/16." A review of Resident #26's clinical record revealed, in part, a consent titled "Peripherally Inserted Central Catheter (PICC)" signed by Resident #26's RP on 10/4/16 that documented, in part, "I consent to the placement/insertion of a PICC with catheter tip location at the superior vena cava level .... " RECEIVED A report from an Infectious Disease consultant NA ST 201 dated 10/6/16 documented, in part, "History of Present Illness: Apparently PICC line was attempted at the NH (nursing home) but patient VDH/OLM (Resident #26) was too combative to place a line. Discussion/Summary. Patient (Resident #26) has a large left heel necrotic decubitus ulcer with osteomyelitis of the calcaneous (heel bone). This ulcer needs surgical debridement. I recommend

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	T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
				NG	C	
		495240	B. WING		04/28/2017	
NAME OF	PROVIDER OR SUPPLIEF	<b></b> ζ		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
FREDEF	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407		
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F 314	Continued From p	age 173	F 3	14		
	he will likely need After PICC line pla meropenem (an IV	atrist. Will order a PICC which to have it placed at the hospital. ace, will empirically start / [intravenous] antibiotic) 1 gm ery 12 hours). Plan at least 6 otics."				
	part, "Spoke with I and haven't resent radiology) for picc like to think about obtain (sic) picc ar the wound to the r stating (sic) I need you know on Thurs apt (appointment). up with (name of I	note dated 10/7/16 documented, in ke with RP regarding picc placement 't resent (sic) to IR (interventional for picc placement. Per RP she would k about it, I explained the benefits of ) picc and what it could do regarding to the res (resident) left foot. RP c) I need to think about it and I will let on Thursday after the resident podiatry ntment). I also advise (sic) RP to follow ame of Infectious Disease physician) rding the picc placement."				
	did not reveal that hospital and did not	Resident #26's clinical record a PICC line was placed at the ot reveal that Resident #26 was biotic between 10/1/16 and				
	notes did not revea regarding Residen or regarding an alt	nt #26's physician progress al any further discussion t #26's refusal of the PICC line ernate antibiotic. cal record revealed, in part, the		RECEIVED		
		n Resident #26's podiatrist llcer on the left side is open to				
		tendon exposed and no		MAY 3 1 2017 VDH/OLC		
	part, the following;	dated 10/13/16 documented, in "(L) heel decub (decubitus) aneous poor healing; potential		77 and 6 af and in (1)		

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	TMENT OF HEALTH			FORM APPF OMB NO. 0938					
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	/SUPPLIER/CLIA TION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C			
		4	95240	B. WING				04/28/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
	RICKSBURG HEALTH					0 PLANK ROAD			
TREDEN					FR	EDERICKSBURG, VA 2	2407		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPP	BE COMPLETION	
F 314	Continued From pa of acute infection; ( (osteomyelitis). Re knee amputation)." A nurse's note date part, the following; ' entered the residen administer medicat diaphoretic (sweaty name resident and Assessment: resid closed resident did nurse administered did open his eyes h disoriented resident were as follows 102 rate), 16 (respiration 92% (oxygen satura transferred at 8:45 a hospital). On 4/27/17 at 12:35 conducted with OSI therapy director. O remembered Resid the PT daily notes. initial evaluation on	<ul> <li>+) chronic ost commend; (L Signed by ph d 10/17/16 do "Situation: W its (sic) room ion resident a d) and not resp skin was warr ent lying in be not respond to the sternum i owever he ap ts skin warm to 2.4 (temperatures), 138/104 ( ation). Reside am via stretch 5 p.m. an inter M (other staff SM #3 was as ent #27. OSM OSM #3 state</li> </ul>	) AKA (left above hysician. becumented, in hen nurse at 08:20 am to ppeared slightly bonding to his m to touch. ed with eyes o name alone rub and resident peared to touch vitals ure), 98 (heart (blood pressure), ent was her to (name of twiew was member) #3, the sked if she <i>I</i> #3 obtained ed, "We did the	F 3	314		· · · · · · · · · · · · · · · · · · ·		
	was variable secondary to impaired cognition. He had surgery on his hip with anesthesia and was struggling to recover. He was having heel pain that was impairing his progression. We did start diathermy [8] (therapeutic treatment most commonly prescribed for muscle and joint					RECEIVED			
	commonly prescribed for muscle and joint conditions. It uses a high-frequency electric current to stimulate heat generation within body								
	tissue) and ultra sou the pain. We starte really was not helpfu pain with weight bea	d diathermy o ul, especially v	on 8/2/16 and it with addressing			VDH/OLC			
FORM CMS-25	67(02-99) Previous Versions	Obsolete	Event ID: 6R5B11		Facilit	y ID: VA0088	If continuation	sheet Page 175 of 278	

PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391 RUCTION (X3) DATE SURVEY COMPLETED C

## (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 175 F 314 asked by nursing to address the wound around 8/16/16 and we did some sharp debridement. He (Resident #27) continued to decline and we ended therapy on 9/30/16. On 9/13/16 the wound was huge, with a total surface area of 50 cm squared. It was totally covered in necrotic tissue. There was a definite foul odor." On 4/27/17 at 1:35 p.m. an interview was conducted with LPN (licensed practical) #4, a floor nurse. LPN #4 was asked what documentation she completed for a new admission. LPN #4 stated that she would complete the admission package. LPN #4 was asked if that included a skin assessment. LPN #4 stated, "I do a head to toe assessment and document anything found. We do weekly skin assessments which used to be on the computer and now they are handwritten." LPN #4 was asked if she remembered Resident #26. LPN #4 stated that she did, "he had a mushy heel, I saw it at that time, and we had a wound nurse so I told her to look at it." LPN #4 further stated, "I don't think it was opened, they moved him, his heels were elevated and he was moved to another unit." LPN #4 was asked if she remembered any interventions or treatments. LPN #4 stated, "I remember that the heel opened up, it had a foul odor and was full of infection." LPN #4 was asked to look at the documentation regarding the Bactrim order. LPN #4 was asked why the RECEIVED nursing staff would document the antibiotic as being given between 8/18/16 and 8/26/16 on the MAY 3 1 2017 nurse's notes but not on the MAR. LPN #4 stated, "I am not sure what happened there it VDH/OLC should have been on the MAR."

On 4/27/17 at 2:10 p.m. an interview was

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С 495240 B. WING 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 176 F 314 conducted with RN (registered nurse) #1, the staff development coordinator and assistant director of nursing. RN #1 was asked whether or not a care plan should have been in place when Resident #26 was admitted to address potential skin breakdown. RN #1 stated, "The care plan should have been initiated on 7/5/17, admission, and interventions should have been put into place at that time to address his (Resident #26's) risk to develop a pressure ulcer." RN #1 was asked to explain when wound tracking would be initiated, RN #1 stated, "Wound tracking begins once a wound is identified. For this resident (Resident #26) as soon as the wound on the heel was identified a wound tracking sheet should have been done." RN #1 was asked if she had any documentation to present regarding a care plan prior to the wound or any documentation evidencing ongoing measurements and monitoring of Resident #26's left heel wound. RN #1 stated she did not. On 4/27/17 at 2:55 p.m. an interview was conducted with LPN #9. Resident #26's admission nurse. LPN #9 was asked to describe her process on admission. LPN #9 stated, "I do a complete skin assessment, head to toe, color, turgor and the Braden scale." LPN #9 was asked if she remembered Resident #26. LPN #9 stated that she was very familiar with the resident, but if she was busy she may have passed certain parts RECEIVED of the assessment on to another nurse. LPN #9 was unable to recall the circumstances of MAY 3 1 2007 Resident #26's admission process. LPN #9 was asked if she was familiar with the Braden scale VDH/OLC and if so what did a score of 14 indicate. LPN #9 stated, "A score of 14 would mean at risk for developing a pressure ulcer." LPN #9 was asked Facility ID: VA0088 If continuation sheet Page 177 of 278 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6R5B11

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 177 F 314 if a Braden score of 14 would trigger for preventative measures to be put into place. LPN #9 stated, "Yes, turn and reposition would be one thing we could do." LPN #9 was asked if she would put that on the care plan. LPN #9 stated, "We (the nurses) sometimes do the care plan, generally it is the unit manager." On 4/27/17 at 3:00 p.m. an interview was conducted with RN #6, a floor nurse. RN #6 was asked how often weekly skin assessments were done. RN #6 stated, "They are done by shift and by room. Back then (last year) we did them on the computer." RN #6 was asked if she remembered Resident #26. RN #6 stated, "He was moved to my side and I remember a really bad wound on his heel." RN #6 was asked whether she remembered anything in particular about the wound / management of the wound. RN #6 stated, "We had so many different wound nurses back then. I remember it got really smelly but other than that I don't really know the details." RN #6 was asked what she would do if she saw a Braden Scale of 14. RN #6 stated, "We should start care planning for preventative measures. It really depends on their mobility. We would implement interventions if the resident was shown to be at risk." RN #6 further stated, "Skin integrity is definitely something that should be addressed. The care plan is definitely important." RECEIVED On 4/27/17 at 3:55 p.m. an interview was conducted with RN #2, the MDS coordinator. RN #2 was asked to describe when a care plan would MAY 3 1 200 be initiated. RN #2 stated, "On admission we have an interim care plan, this has to be done in VDH/OLC the first 24 hours. Then we use the CAAs (care area assessments), medical diagnoses and medications to develop a comprehensive care

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facility staff failed to evidence Bactrim was administered to Resident #26 as ordered when

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		AND HUMAN SERVICES & MEDICAID SERVICES				F	NTED: 05/11/2017 FORM APPROVED B NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′				(3) DATE SURVEY COMPLETED
		495240	B. WING	6			C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		.L	5	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
	ICKSBURG HEALTH				3900 PLANK ROAD		
FREDERICKSBURG HEALTH AND REHAB					REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI	
F 314	Continued From pa	ge 179	F:	314			
	found on 8/16/16. <sup></sup> administer the orde left heel between 9/ were informed of th documented evider monitoring including of Resident #26's le subsequently declin wound with osteom On 4/28/17 at 8:45 conducted with ASM ASM #2 was asked weekly wound flow of the wound on the the wound was four evaluation sheet sh the wound nurse at that the first wound 8/8/16, one week af identified on Reside further stated, "I have	om the left heel wound was The facility staff failed to red dressing to Resident #26's 20/16 and 9/26/16. They e concern there was no ace of ongoing assessments, g staging and measurements at heel DTI which led to a stage IV pressure yelitis, resulting in harm. a.m. an interview was M #2, the director of nursing. to review Resident #26's sheets to explain the timeline eleft heel. ASM #2 stated that ad on 7/29 and a wound ould have been completed by that time. ASM #2 agreed evaluation sheet was dated ter the wound had been ant #26's left heel. ASM #2 ye no other documentation to und was properly assessed or					
	Guideline: Skin Inte following documents systemic approach skin. To decrease p identifying those res developing interven residents will be ass skin breakdown with quarterly and as nee condition. (Name o	ity policy titled "Clinical grity" revealed, in part, the ation: Purpose: To provide a and monitoring process for pressure ulcer formation by idents who are at risk and tions. General Policy: All sessed/ observed for risk of nin 24 hours of admission - cessitated by change in f facility) develops a routine to h wounds or at risk on a			RECEIVED MAY 3.1 2017 VDH/OLC		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С 495240 B. WING 04/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 180 F 314 weekly basis. Documentation and Care Interventions for Skin Integrity: If identified risk present the interventions will be documented in the Immediate Plan of Care or Comprehensive Care Plan. Documentation of Weekly Skin Assessments/Observations: The nursing order for weekly observations will be entered on all residents and print out on the Treatment Administration Record. Licensed nurse to document weekly on all wounds using the "Wound Evaluation Flow Sheet." Determine care plans consistently implemented, evaluated and revised based on the needs of the resident. Continuous Quality Management: Tracking and analysis of pressure ulcers is done at least monthly through the Quality Assurance Committee. Identification of trends and / or problems associated with resident care that would impact skin integrity is discussed along with interventions for improvement. Monitoring Compliance: The flowing elements are in place to demonstrate satisfactory compliance with guideline: Wound Evaluation Flow Sheet is being used. DNS (director of nursing services) or designee evaluates wounds on a weekly basis. Physical observation reflects all care plan interventions are implemented and in place. No further information was provided by the facility by completion of the survey process RECEIVED **Complaint Deficiency** MAY 31 2017 (\*) This information was obtained from the VDH/OLC following website source: Pressure Ulcer Staging Revised by NPUAP. Copyright 2007. National Pressure Ulcer Advisory Panel. 8/3/2009 <http://www.npuap.org.pr2.htm>.

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		AND HUMAN SERVICES				05/11/2017 PPROVED
STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		495240	B. WING	6	C 04/2	8/2017
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY,		
FREDER	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG,	VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	EX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	http://www.npuap.o clinical-resources/n tegories/. Pressure injury: A pressure injury is and/or underlying s prominence or related device. The injury c open ulcer and may as a result of intens or pressure in combi- tolerance of soft tiss may also be affected perfusion, co-morbi- tissue. Stage 1 Pressure In- erythema of intact s Intact skin with a loc non-blancheable erythem temperature, or firm changes. Color cha- maroon discoloratio tissue pressure inju Stage 2 Pressure In- loss with exposed d Partial-thickness los dermis. The wound moist, and may also	International and a provide a series of skin of the sk	- a 1	314 RECEIVE		
	visible and deeper t Granulation tissue,	d blister. Adipose (fat) is not issues are not visible. slough and eschar are not ries commonly result from		MAY 3 1 2017 VDH/OLC		
	adverse microclima	te and shear in the skin over r in the heel. This stage				
DRM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6R5B	11	Facility ID: VA0088	If continuation sheet Page	e 182 of 278

Facility ID: VA0088

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		AND HUMAN SERVICES & MEDICAID SERVICES					INTED: 05/11/201. FORM APPROVED IB NO. 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(	X3) DATE SURVEY COMPLETED
		495240	B. WING	š			C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CO	DE	
FREDER	ICKSBURG HEALTH	AND REHAB			0 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E	(X5) BE COMPLETION ATE DATE
F 314	Continued From pa	ige 182	F	314			
	should not be used associated skin dat incontinence associ intertriginous derma	to describe moisture mage (MASD) including iated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds					
	Full-thickness loss is visible in the ulce epibole (rolled wou Slough and/or esch of tissue damage v areas of significant wounds. Undermin Fascia, muscle, ter and/or bone are no	njury: Full-thickness skin loss of skin, in which adipose (fat) er and granulation tissue and nd edges) are often present. har may be visible. The depth aries by anatomical location; adiposity can develop deep hing and tunneling may occur. hdon, ligament, cartilage it exposed. If slough or eschar at of tissue loss this is an sure Injury.					
	tissue loss Full-thickness skin or directly palpable ligament, cartilage and/or eschar may edges), underminir Depth varies by an	njury: Full-thickness skin and and tissue loss with exposed fascia, muscle, tendon, or bone in the ulcer. Slough be visible. Epibole (rolled ng and/or tunneling often occur. atomical location. If slough or ne extent of tissue loss this is essure Injury.					
	Unstageable Press	sure Injury: Obscured			RECEIVED		
		and tissue loss in which the					
	be confirmed beca eschar. If slough o 3 or Stage 4 press	mage within the ulcer cannot use it is obscured by slough or or eschar is removed, a Stage ure injury will be revealed. dry, adherent, intact without			VDH/OLC		

Facility ID: VA0088

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		AND HUMAN SERVICES			FORM	: 05/11/201 APPROVE . 0938-039	
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT CON	E SURVEY	
		495240	B. WING			C 04/28/2017	
NAME OF I	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STA			
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD			
	·			FREDERICKSBURG, VA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE	
F 314	Continued From pa	age 183	F 3	314			
	erythema or fluctua	ance) on the heel or ischemic softened or removed.					
	References:						
	following website: https://www.nhlbi.n cs/thcp [2] This information following website; https://www.ncbi.nli T0012241/?report= [3] This information following website: http://www.bpac.org unds.aspx [4] This information following website; http://emedicine.me verview	n was obtained from the g.nz/BT/2013/June/infected-wo was obtained from the edscape.com/article/226434-o					
	following website; http://www.macmilla port/treating/chemo emotherapy/picc-lir [6] This information following website; http://www.mayoclir eomyelitis/basics/de	was obtained from the an.org.uk/information-and-sup therapy/being-treated-with-ch ies.html was obtained from the hic.org/diseases-conditions/ost efinition/con-20025518 was obtained from the		4000 4000 00 4000 00 40 40 40 40 40 <sup>61</sup> %			
		ource.com/product-category/dr		RECEIVED			
		was obtained from the					
	https://www.cdc.gov -bacteria.html	//hai/organisms/gram-negative was obtained from the		VDH/OLC			
	[9] THIS INFORMATION 67(02-99) Previous Versions			Facility ID: VA0088	If continuation sheet Pa	104 -60	

Event ID: 6R5B11

Facility ID: VA0088

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TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY		
			A. BUILDING	3	(			
		495240	B. WING			8/2017		
NAME OF I	PROVIDER OR SUPPLIEF	R		STREET ADDRESS, CITY, STATE, ZIP <b>3900 PLANK ROAD</b>	PCODE			
FREDER	ICKSBURG HEALTH	I AND REHAB		FREDERICKSBURG, VA 2240	)7			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 314	Continued From p	age 184	F 314	ł				
	following website; https://www.in.gov	/isdh/files/Braden_Scale.pdf						
	implement interver to develop a care from developing a to the right heel. T monitor and revise	aff failed to initiate and ntions on admission and failed plan to prevent Resident #26 n unstageable pressure injury The facility staff also failed to e treatments to the wound on a and to assess the effectiveness n place.	I					
	See above for admission and MDS information.							
	revealed, in part, a "Clinical Health Sta (3:40 p.m.) the box checked. Under th Conditions" there i with an arrow poin hand written besid There were no oth documented. Und Scale (1) for Predi	ent #26's clinical record a facility document titled atus" dated 7/5/16 at 1540 k titled "Admission" was ne section titled "Section B Ski s a picture of the human body ting to the back left hip and e the arrow is "38 staples." er wounds/skin conditions fer the section titled "Braden cting Pressure Sore Risk a umented, indicating moderate						
		mprehensive care plan dated ewed and did not include a		RECEIVED				
	care plan for skin o 7/29/16 a revision	or potential for pressure. On to the comprehensive care		MAG 3 F 2017				
	"Focus: Pressure ulcer actual: DTI ( Date Initiated 7/29	ollowing documentation; ulcer actual due to: Pressure deep tissue injury) Left heel. /2016. Interventions: Assist epositioning as needed. Date		VDH/OLC				
	67(02-99) Previous Version			acility ID: VA0088 If co	ontinuation sheet Pag	0 195 of 2		

		AND HUMAN SERVICES				FORM APPROVED
r		& MEDICAID SERVICES	(X2) MUI	TIPLE CONSTRUCTION	0	VB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	l` í	DING	-	COMPLETED
						С
		495240	B. WING			04/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST. 3900 PLANK ROAD	ATE, ZIP CODE	
FREDE	RICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA	A 22407	
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F 314	Bilateral calf suppo wheelchair to float f 8/8/2016. Conduct Initiated: 8/31/2016 Date Initiated: 8/31/ completed per (nam Initiated: 7/29/2016 Initiated: 07/29/2019 A review of Resider administration record 8/31/16 revealed, in "Apply skin prep to Every shift for susp D/C (discontinue) d A nurse's note dated "Right lateral heel n black area to the ba and firm when palpa Edges defined. 1.8 no further documen stage. Further review of Re did not reveal any w sheets related to a w A weekly skin review in part, the following Description: Area is ankle. Wound care documentation rega wound bed, wound s the wound on the rig A weekly skin review in part; "Site: Right	Revision on: 8/9/2016. rt device while up in neels. Date Initiated: weekly skin inspection Date . Weekly Wound assessment: /2016. Skin assessment to be ne of facility) policy. Date . Treatments as ordered Date 6." nt #26's TAR (treatment rd) dated 8/1/16 through n part, the following order; bilateral heels every shift. ected DTI." Order date 8/3/16 ate 8/31/16. d 8/8/16 documented, in part, oted to have a hardened ase of the lateral ankle. Rough ated. No drainage at present. x 4.0 cm in size." There was tation regarding the wound esident #26's clinical record weekly wound evaluation wound on the right heel.		RECEIVED		
FORM CMS-25	567(02-99) Previous Versions		1	Facility ID: VA0088	If continuation	sheet Page 186 of 278

PRINTED: 05/11/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5)(X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 186 F 314 documentation regarding a description of the wound bed, staging or measurements of the right lower heel/ankle. A nurse's note dated 8/24/16 documented, in part; "Treatment continues to right lateral heel. Area continues to be course and firm in texture with surrounding darkened tissue. No drainage or odor to sire (sic)." A nutrition monthly wound note dated 8/26/16 documented, in part; "Right lateral heel DTI 8/15 (date) 3.0 x 3.2; 8/22 (date) 2.0 X 3.0." Further review of Resident #26's TAR revealed the following entry "8/31/16 - 10/17/16 Apply skin prep to DTI (deep tissue injury) on right heel q (every) day." This was signed off on the TAR (treatment administration record) every day 8/31/16 - 10/17/16. A nurse's note dated 9/6/16 documented, in part, "SDTI (suspected deep tissue injury) noted to R (right) heel." There was no further documentation regarding measurement or description of the wound bed. A nurse's note dated 10/4/16 documented, in part; "Wound assessment; Resident's (Resident #26) right heel DTI is stable. It remains an intact deep purple DTI at 2.5 cm (centimeters) x 4 cm x RECENCE 0 (zero)." A nurse's note dated 10/11/16 documented, in part; "Apply skin prep to DTI on right heel q VDH/OLC (every) day."

A podiatrist consult note dated 10/13/16

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Event ID:6R5B11

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) D/	<u>O. 0938-039</u> ATE SURVEY DMPLETED
NU PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	NG	C	
		495240	B. WING		0	4/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FREDEF	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 314	Continued From pa	age 187	F 3	14		
		rt; "The right lateral heel has a ) ulceration open to dermis upon arrival."				
	A Nurse's note dated 10/13/16 documented, in part: "Wound note: Upon return from (name of care provider) appt (appointment), resident presents with an open area to his right heel (2 x 2.5 x 0.2). Intact skin of DTI is now dislodged to expose underlying granulation and necrotic tissue on wound bed. Scant exudate is noted. surrounding skin is dry and intact. No signs of pain noted to the area by the resident." This author was no longer employed at the facility. There were no facility physician progress notes regarding the pressure injury on the right heel. There were no wound evaluation sheets documented in the clinical record in regards to					
	conducted with LPI a floor nurse. LPN documentation she admission. LPN #4 complete the admis asked if that includ #4 stated, "I do a h document anything assessments which and now they are h asked if she remen stated that she did, at that time, we have to look at it." LPN a	p.m. an interview was N (licensed practical nurse) #4, #4 was asked what completed for a new 4 stated that she would ssion package. LPN #4 was ed a skin assessment. LPN ead to toe assessment and found. We do weekly skin n used to be on the computer handwritten." LPN #4 was nbered Resident #26. LPN #4 "he had a mushy heel, I saw it d a wound nurse so I told her #4 further stated, "I don't think y moved him, his heels were		RECEIVED MAY 3 1 2017 VDH/OLC		

Event ID: 6R5B11

Facility ID: VA0088

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		& MEDICAID SERVICES	Locaren		OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495240	B. WING		04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	er ad
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE ( EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLET
F 314	Continued From pa	age 188	F 3	14	
		e remembered any information heel. LPN #4 stated that she			
	conducted with RN development coord nursing. RN #1 wa plan should have b #26 was admitted t breakdown. RN #1 have been initiated interventions should that time to address develop a pressure explain when woun RN #1 stated, "Wou wound is identified. #26) as soon as the identified a wound t been done." RN #1 documentation to p prior to the wound of documentation evic measurements and	p.m. an interview was (registered nurse) #1, the staff linator and assistant director of is asked whether or not a care een in place when Resident o address potential skin stated, "The care plan should on 7/5/17, admission, and d have been put into place at s his (Resident #26's) risk to ulcer." RN #1 was asked to d tracking wound be initiated, und tracking begins once a For this resident (Resident e wound on the heel was tracking sheet should have I was asked if she had any resent regarding a care plan on the right heel or any lencing ongoing I monitoring of Resident #26's RN #1 stated she did not.			
	conducted with LPN admission nurse. L her process on adm she completes a co was asked if that in stated that it did. Ll complete skin asse turgor and the Brad if she remembered that she was very fa	p.m. an interview was N #9, Resident #26's .PN #9 was asked to describe hission. LPN #9 stated that omplete assessment. LPN #9 cluded the skin. LPN #9 PN #9 further stated, "I do a ssment, head to toe, color, len scale." LPN #9 was asked Resident #26. LPN #9 stated amiliar with the resident, but if nay have passed certain parts		RECEIVED	

Event ID:6R5B11

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		HAND HUMAN SERVICES			PRINTED: 05/11/201 FORM APPROVE
STATEMENT		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP (	
FREDER	ICKSBURG HEALTH	AND REHAB		00 PLANK ROAD REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 314	Continued From pa	age 189	F 314		
		on to another nurse. LPN #9			
		all the circumstances of mission process. LPN #9 was			
		amiliar with the Braden scale			
		a score of 14 indicate. LPN #9			
		14 would mean at risk for sure ulcer." LPN #9 was asked	f		
		of 14 would trigger for			
		ures to be put into place. LPN			
		rn and reposition would be one 'LPN #9 was asked if she			
	would put that on t	he care plan. LPN #9 stated,			(
	"We (the nurses) s generally it is the u	ometimes do the care plan,			
	generally it is the u	mit manager.			
		p.m. an interview was			
		I #6, a floor nurse. RN #6 was eekly skin assessments were			
		d, "They are done by shift and			
		n (last year) we did them on			
		I #6 was asked if she dent #26. RN #6 stated, "He			
		side and I remember a really			
		heel." RN #6 was asked			
		mbered anything in particular management of the wound.			
		had so many different wound			
		I remember his wound got			
	5 5	her than that I don't really know 3 was asked what she would	1		
	do if she saw a Bra	aden Scale of 14. RN #6			
	-	start care planning for		ECEIVED	
		ures. It really depends on their d implement interventions if the		ist a i mart	
		•			
		n to be at risk." RN #6 further ity is definitely something that	.*		

Facility ID: VA0088

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495240 B. WING 04/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 190 F 314 On 4/27/17 at 3:55 p.m. an interview was conducted with RN #2, the MDS coordinator. RN #2 was asked to describe when a care plan would be initiated. RN #2 stated, "On admission we have an interim care plan, this has to be done in the first 24 hours. Then we use the CAAs (care area assessments), medical diagnoses and medications to develop a comprehensive care plan in 7 - 14 days." RN #2 was asked who was responsible for the interim care plan. RN #2 stated that the nurse on duty at the time of the admission should do it. RN #2 was asked what was included on an interim care plan. RN #2 stated, "The core areas; falls, pain, skin, anticoagulants, psychotropic drugs. Anything pertinent to needing immediate care for example diabetes, IV (intravenous) lines, that type of thing." RN #2 was asked whether or not a Braden score of 14 would trigger the need for a care plan for the potential for skin break down. RN #2 stated that it would. RN #2 was asked if she could explain why a care plan was not put in place for Resident #26 on admission with a Braden score of 14. RN #2 stated that she did not know but asked for the opportunity to research the question. RN #2 was asked to present any information that she had evidencing that a preventative pressure ulcer care plan was initiated when Resident #26 was admitted. On 4/27/17 at 5:20 p.m. an end of day meeting RECEIVED was held with ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the interim director of clinical services and ASM #5, an NAY OF 265 owner. The above area of concerns was discussed. DH/OLC The facility staff was informed that no interventions were implemented on Resident

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 191 F 314 #26's admission; no care plan was put in place and no wound evaluation assessments were completed from the date of admission on 7/5/16 until after Resident #26 was found to have an avoidable DTI (deep tissue injury) on his right heel on 8/8/16. The staff was informed of the concern that there was no documented evidence of ongoing assessments and monitoring. including staging and measurements of Resident #26's worsening right heel DTI. On 4/28/17 at 8:45 a.m. an interview was conducted with ASM #2, the director of nursing. ASM #2 was asked to review Resident #26's weekly wound flow sheets to explain the timeline of the wound on the right heel. ASM #2 stated that the right heel wound was not documented and a separate wound evaluation sheet should have been implemented and completed by the wound nurse at the time that it was discovered. ASM #2 further stated, "I have no other documentation to support that this wound was properly assessed or monitored." No further information was provided prior to the end of the survey process. **Complaint Deficiency** 2. The facility staff failed to implement measures to promote healing of a suspected deep tissue RECEIVED injury for Resident #7 on admission which declined to an unstageable wound on Resident Way 11 220 #7's heel. The facility staff also failed to initiate and implement interventions recommended by VDH/OLC the facility wound care physician for a period of 13 days. The facility staff also failed to float the FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6R5B11 Facility ID: VA0088 If continuation sheet Page 192 of 278

		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	- <b>T</b>		OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
FREDER	ICKSBURG HEALTH	AND REHAB	3		
	OUN BALLON OTA		l	REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 314	Continued From pa	ge 192	F 314		
		sident #7's heels were n the mattress during the			
	8/16/16 with a read diagnoses that incluse severe peripheral v flow to the lower ex was evaluated in th good blood flow to l See physician note pressure, coronary impacting the vesse obstructive pulmona lungs), dementia, b	dmitted to the facility on mission on 3/26/17 with uded, but were not limited to; ascular disease (poor blood tremities [*Note the resident e hospital and found to have bilateral lower extremities. dated 4/9/17]), high blood artery disease (a disease els of the heart), chronic ary disease (affecting the ipolar disorder and toes on the right foot.			
	(minimum data set) assessment with an date) of 4/2/17 docu scored 10 out of a p interview of mental Resident #7 was me with decisions regar M, Skin Conditions, as being at risk for o and as having 2 (tw eschar, present on a 3rd toe of the right f	recent comprehensive MDS a significant change ARD (assessment reference umented that Resident #7 possible 15 on the BIMS (brief status), indicating that oderately cognitively impaired rding daily living. In Section Resident #7 was documented developing pressure ulcers o) unstageable * - slough / admission [*the 2nd toe and oot] and an unstageable ulcer ssue injury* at the time of		RECEIVED	
	dannoolon.				
		t #7's clinical record revealed,			
	Collection Form" that information; "Date of	itled, "Admission-Data at documented the following f Admission 3/26/17. Time: kin: Skin Conditions:		VDH/OLC	

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 193 of 278

		AND HUMAN SERVI				RINTED: 05/11/2017 FORM APPROVED MB NO: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495240	B. WING	-		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY	, STATE, ZIP CODE	
	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD		
		• • • • • • • • • • • • • • • • • • • •		FREDERICKSBURG,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		IX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION
F 314	Continued From pa	ige 193	F	314		
	Pressure reduction (checked), Bed (ch (checked). Other: 1	ge 1 - IV*). Skin Trea (checked), For Chair ecked), Turning/Repo Heels offloading. *Righ areas - Right heel * S	sitioning nt Heel			
	and areas on R Toe	e. Risk for Pressure Ul n Score Tool) 17 (15-1	cers -			
	plan revealed, in pa documentation; "Fo potential for impaire ulcers due to: Occa incontinence, decre (peripheral vascula areas on right heel. Interventions: Enco and repositioning a 6/14/2016. Revisio pressure reduction/ Initiated: 3/31/2017 Date Initiated: 3/3	ocus: The resident has a skin integrity/pressu asional (sic) bladder ease (sic) mobility, PVI r disease), actual press Date Initiated: 3/17/2 ourage and assist with s needed. Date Initiat n on: 1/16/2017. Pro relieving mattress. Da 7. Treatments as orde 1/2017. Skin assessm iving Center Policy. D	s ure Sure 016. turning ed; vide ate red. nent to			
	assessment record assessment record did not reveal any d being applied to Re	nt #7's MAR (medication) and TAR (treatment) dated 3/1/2017 - 3/3 locumentation of treation sident #7's right foot, for r floating heals to allevent ent #7's heels.	1/2017 ments urning	RECEIVED		
	notes revealed, in p - 3/29/2017. "Unsta	nt #7's wound care spe part, the following note ageable (Due to Necro cused Wound Exam.	s: sis) of	MAY 3 1 2017 VDH/OLC		
FORM CMS-25	67(02-99) Previous Versions	Obsolete Eve	nt ID:6R5B11	Facility ID: VA0088	If continuation	sheet Page 194 of 278

STATURALINI OF DEPICENCIES AND PLAN OF CORRECTION       (M) DENTIFICATION NUMBER:       (A BULDING			AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 05/11/2017 MAPPROVED D. 0938-0391
495240     B WING     04/28/2017       NAME OF PROVIDER OR SUPPLER     STREET ADDRESS, CITY, STATE, ZP CODE     3000 PLANK ROAD       FREDERICKSBURG HEALTH AND REHAB     STREET ADDRESS, CITY, STATE, ZP CODE     3000 PLANK ROAD       (MILD)     SUMMARY STATEMENT OF DEFICIENCIES     PLANK ROAD     FREDERICKSBURG, VA 22407       (MILD)     SUMMARY STATEMENT OF DEFICIENCIES     PLANK ROAD     FREDERICKSBURG, VA 22407       (MILD)     SUMMARY STATEMENT OF DEFICIENCIES     PLANK ROAD     FREDERICKSBURG, VA 22407       (MILD)     SUMMARY STATEMENT OF DEFICIENCIES     PLANK ROAD     FREDERICKSBURG, VA 22407       (MILD)     SUMMARY STATEMENT OF DEFICIENCIES     PLANK ROAD     FREDERICKSBURG, VA 22407       (MILD)     FAST     PLANK ROAD     FREDERICKSBURG, VA 22407       (Quality): Pressure, MDS 3.0 Stage:     PLANK ROAD     PREVENTION     OWNERST PLANK ROAD       (Ineight) X W (widh) X D (depth)): 3.5 x 4.6 x Not     Measurable cm. Surface Area:     F 314       (Ineight) X W (widh) X D (depth)): 3.5 x 4.6 x Not     Measurable cm. Surface Area:     F 314       Desing: Betadine - Twice Daily.     Recommendation:     Cort       Recommendations: Unstageable (Due to Necrosis) of the Right HeI-Initial Evaluation:     - 412/17 Unstageable (Meerosis). Duration: > (greater than) 1 days (sic). Objective: Healing.       3.0 Stage: Unstageable (Meerosis. Duration: > (greater than) 1 days	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· '			(X3) DA	ATE SURVEY DMPLETED
FREDERICKSBURG HEALTH AND REHAB     3900 PLANK ROAD FREDERICKSBURG, VA 22407       PHETIX TAG     SUMMARY STATEMENT OF DEFICIENCES (EACH CORRECTIVE ACTION FOR SHOULD BE RECULTORY OR USCIDENTFYING INFORMATION)     ID PREFIX TAG     D PREFIX (EACH CORRECTIVE ACTION FOR SHOULD BE (EACH CORRECTIVE ACTION FOR SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE DEFICENCY)     D D D D D D D D D D D D D D D D D D D			495240	B. WING			04	
FREDERICKSBURG, VA 22407         (Mi)D TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEDED BY FULL PRETTIX       ID (EACH DEFICIENCY MUST BE ARRECEDED TO THE APPROPRIATE DEFICIENCY)       CMIPTICE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 314       Continued From page 194       F 314         (quality): Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration: > (greater than) 1 days (sic). Objective: Healing, Wound Size (L (length) X W (width) X D (depth)]: 3.5 x 4.6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adherent Black Necrotic Tissue (Eschar): 100%. Additional Information: Dr1, hard, stable eschar. Dressing: Betadine - Twice Daily. Recommendations: Unstageable (Due to Necrosis) of the Right Heel - Initial Evaluation: -Add: Betadine - Twice Daily. Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration. > (greater than) 1 days (sic). Objective: Healing. Wound Size (L (length) X W (width) X D (depth))); 3.5 x 4.6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adhreent Black Necrotic Tissue (Eschar): 100%. Wound Progress: No Change. Dressing; Betadine - Twice Daily. Recommendation: Float Heels is Bed. Off-Load Wound. Reposition per facility protocol." Signed by ASM #4.         A review of Resident #7's physician orders revealed, in part, the following verbal orders signed by Resident #7's melical dorders revealed, in part, the following verbal orders signed by Resident #7's melical dorders       FILL	NAME OF F	PROVIDER OR SUPPLIER	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		STRE	ET ADDRESS, CITY, STATE, ZIP COD	E	
<ul> <li>PRETRY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>F 314 Continued From page 194 (quality): Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration: &gt; (greater than) 1 days (sic). Objective: Healing. Wound Size (L (length) XW (width) XD (depth)): 3.5 x 4.6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adherent Black Necroit Tissue (Eschar): 100%. Additional Information: Dry, hard, stable eschar. Dressing: Betadine - Twice Daily. Recommendation: Off-Load Wound. Reason for No Debridement: Non-infected heel necrosis. Assessment and Plan of Care Recommendation: Off-Load Wound Care physician ASM (administrative staff member) #4.</li> <li>-4/12/17 Unstageable (Due to Necrosis) of the Right Heel. Etiology (quality): Pressure. MDS 3.0 Stage: Unstageable (Due to Necrosis) of the Right Heel. Etiology (quality): Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration: &gt; (greater than) 1 days (sic). Objective: Healing, Wound Size (L (length) XW (width) XD (depth))); 3.5 x 4 6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adherent Black Necrotic Tissue (Eschar): 100%. Wound Progress: No Change. Dressing: Betadine - Twice Daily. Recommendation: Float Heels in Bed, Off-Load Wound, Reposition per facility protocol." Signed by ASM #4.</li> <li>Areview of Resident #7's physician orders revealed, in part, the following verbal orders signed by Resident #7's medical docts: "Order</li> </ul>	FREDER	ICKSBURG HEALTH	AND REHAB					
<ul> <li>(quality): Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration &gt; (greater than) 1 days (sic). Objective: Healing. Wound Size (L (length) X W (width) X D (depth)): 3.5 x 4.6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adherent Black Necrotic Tissue (Eschar): 100%. Additional Information: Dry, hard, stable eschar. Dressing: Betadine-Twice Daily. Recommendation: Off-Load Wound. Reason for No Debridement: Non-infected heel necrosis. Assessment and Plan of Care Recommendations: Unstageable (Due to Necrosis) of the Right Heel - Initial Evaluation: -Add: Betadine - Twice Daily - Recommendation: Off-load wound." Signed by the wound care physician ASM (administrative staff member) #4.</li> <li>-4/12/17 Unstageable (Due to Necrosis) of the Right Heel. Etiology (quality): Pressure. MDS 3.0 Stage: Unstageable Necrosis. Duration: &gt; (greater than) 1 days (sic). Objective: Healing. Wound Size (L (length) X W (width) X D (depth)): 3.5 x 4.6 x Not Measurable cm. Surface Area: 16.10 cm 2(squared). Exudate: None. Thick Adherent Black Necrotic Tissue (Eschar): 100%. Wound Progress: No Change. Dressing: Betadine - Twice Daily x Recommendation: Float Heels in Bed, Off-Load Wound, Reposition per facility protoci." Signed by ASM #4.</li> <li>A review of Resident #77s physician orders revealed, in part, the following verbal orders signed by Resident #77s medical doctor: "Order</li> </ul>	PREFIX	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	IOULD BE	COMPLETION
Date: 4/13/2017 09:43 (a.m.) Communication Method: Verbal. Apply betadine to right foot, 2nd and 3rd toes BID every morning and at bedtime for wound care." There were no further orders	F 314	(quality): Pressure. Unstageable Necro 1 days (sic). Objec (length) X W (width Measurable cm. Su 2(squared). Exuda Black Necrotic Tiss Additional Informati Dressing: Betadine Recommendation: No Debridement: N Assessment and Pl Recommendations: Necrosis) of the Rig -Add: Betadine - Tw Off-load wound." S physician ASM (adm - 4/12/17 Unstageal Right Heel. Etiolog 3.0 Stage: Unstage (greater than) 1 day Wound Size (L (leng 3.5 x 4.6 x Not Mea 16.10 cm 2(squared Adherent Black Nec Wound Progress: N Betadine - Twice Da Heels in Bed, Off-Lo facility protocol." Sig A review of Resident revealed, in part, the signed by Resident Date: 4/13/2017 09 Method: Verbal. Ag and 3rd toes BID ev	MDS 3.0 Stage: sis. Duration: > (greater than) tive: Healing. Wound Size (L ) X D (depth)): 3.5 x 4.6 x Not urface Area: 16.10 cm te: None. Thick Adherent ue (Eschar): 100%. on: Dry, hard, stable eschar. - Twice Daily. Off-Load Wound. Reason for Ion-infected heel necrosis. an of Care Unstageable (Due to ght Heel - Initial Evaluation: vice Daily - Recommendation: igned by the wound care ninistrative staff member) #4. ble (Due to Necrosis) of the gy (quality): Pressure. MDS eable Necrosis. Duration: > rs (sic). Objective: Healing. gth) X W (width) X D (depth)): surable cm. Surface Area: d). Exudate: None. Thick crotic Tissue (Eschar): 100%. lo Change. Dressing: aily. Recommendation: Float bad Wound, Reposition per gned by ASM #4. at #7's physician orders #7's medical doctor: "Order :43 (a.m.) Communication bply betadine to right foot, 2nd rery morning and at bedtime	F				

Facility ID: VA0088

		& MEDICAID SERVICES	(X2) MULT	FIPLE CONSTRUCTION	OMB NO. 0 (X3) DATE S	
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG	COMPL	
					С	
		495240	B. WING		04/28	3/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETIC DATE
F 314	Continued From pa	ge 195	F 3	14		
	On 4/25/17 at 8:40 a.m. Resident #7 was observed sitting up in his bed with his breakfast tray in front of him eating his breakfast. A specialty air mattress was observed in place with the power on. Resident #7's feet were observed flat on the mattress and were not elevated.					
	observed lying on h observed wearing " feet; there were no devices observed o space. A pillow was #7's feet to offload l	p.m. Resident #7 was is bed. Resident #7 was grippy" socks on his bilateral other types of heel protector in his bed or around his living is not observed under Resident his heels and his feet were a mattress and not elevated.				
	observed lying in his (certified nursing as Resident #7's room CNA #1 was asked observed. CNA #1 look at his feet and pulled the lower par Resident #7's feet a was observed at the flat and Resident #7 the pillow to float the	a.m. Resident #7 was s bed on his right side. CNA sistant) #1 was observed in attending to his roommate. if Resident #7's feet could be asked Resident #7 if we could he agreed. CNA #1 then t of the blanket up to reveal and their position. A pillow e bottom of the bed, but it was 7's feet were not propped on e resident's heels. Resident lirect contact with the bed and				
	and pushing agains	served stretching his legs out t the wooden foot board of the eel. There were no protective		RECEIVED		
	devices observed o	n Resident #7's heels and				
	bed to protect Resid surface of the foot b whether or not Resi	e observed on the foot of his dent #7's heels from the hard board. CNA #1 was asked dent #7 had protective		VDH/OLG		
	uevices in place to p	protect his heels. CNA #1				

Facility ID: VA0088

If continuation sheet Page 196 of 278

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

PRINTED: 05/11/2017 FORM APPROVED

				NO. 0000 0001
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	405240			С
	495240	B. WING		04/28/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
FREDERICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
	TEMENT OF DEFICIENCIES	ID	· PROVIDER'S PLAN OF CORRECTIO	)N (X5)
	MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOULI	
TAG REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE DATE

F 314

## F 314 Continued From page 196

stated that she thought that he had a heel lifter under his feet to enable his "feet to dangle." CNA #1 was asked whether or not there was a heel lifter under Resident #7's feet. CNA #1 stated she did not notice one but did see that there was a pillow which could be used in the same way. CNA #1 was asked whether or not Resident #7's feet were elevated and without pressure on his heels. CNA #1 stated they were not. CNA #1 further stated, "He (Resident #7) moves his feet and pushes up against the footboard, I don't think that there is anything else in place for him." CNA #1 was asked if she was aware that Resident #7 had a pressure sore on his right heel. CNA #1 stated, "Just on his toes, he had surgery to remove some toes and had some areas on his toes."

An interview was continued with CNA #1 at the nurse's station. CNA #1 was asked how she would be made aware of any special instructions or devices for residents that she cared for. CNA #1 stated that she would refer to the kardex (a medical information system used by nursing staff as a way to communicate important information on their patients). CNA #1 was asked if she had a kardex on her person at that time. CNA #1 stated that she did not and asked if she could retrieve the kardex. CNA #1 went to the nurse's station and attempted to locate a kardex for Resident #7. CNA #1 was unable to find the kardex. CNA #1 asked another staff member seated at the nurse's station and was directed to a book that contained individual "kardex" sheets for each resident. Resident #7's kardex sheet did not contain any information regarding pressure ulcers or that his heels were to be off-loaded while in bed. CNA #1 stated, "The kardex does not say anything about the pressure ulcer on his

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

RECEIVED

VDH/OLC

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING _		04/28/2017
NAME OF F	ROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE,	ZIP CODE
FREDER	ICKSBURG HEALTI	H AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22	2407
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETIC DITHE APPROPRIATE DATE
F 314	Continued From p	bage 197	F 31	4	
		know that unless someone ie. I would not know that his oated."			
	at the nurse's stat in part, the followi my right foot for a (sic) nurse." Ther	ent #7's kardex found in a book tion dated 4/3/17 documented, ng information; "Please monitor ny discolor (sic) and notified re were no other updated erence book used by nursing			
	observed with LPI care physician. R wheelchair with dr foot. ASM #4 exp completed his ass #1, would be reap dressing. A clean Resident #7's bed right foot on top of observed to be bla aspect of Residen donned gloves an black eschar and stable and that the aspect of the treat dry and hard, prot allowing the new s stated that withour wound would be a	45 a.m. wound care was N #1 and ASM #4, the wound Resident #7 was seated in his ressings removed from the right plained that he had just sessment and the nurse, LPN oplying the betadine and a chuck was placed on top of d and Resident #7 placed his f the chuck. The wound on was ack and located on the lateral at #7's right heel. ASM #4 d pressed the center of the stated that the wound was e betadine was an important tment as it kept the wound area ecting the skin beneath and skin to repair. ASM #4 further t the eschar on the surface the a stage 3 or stage 4 and subject		RECEIVED	
	the treatments on	#1 was asked who was doing Resident #7's heel when she LPN #1 stated that the nurses dent were responsible for doing			

Event ID: 6R5B11

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	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
F 314	member) #4 (the v	M (administrative staff vound care physician). ASM #4	F 3	14	
	wound care recom he couldn't speak in the building. AS				
	recommendations have to be "okayed" by the attending primary care physician but in general, the treatment he recommends is what he thinks will be implemented.				
	conducted with LP #1, the wound nurs was put into place, prevent the suspect documented on Re declining. LPN #1 place for skin prep asked where the o where it was being completed. LPN # the order, I may ha can do skin prep tr	<ul> <li>p.m. an interview was</li> <li>N (licensed practical nurse)</li> <li>se. LPN #1 was asked what</li> <li>at the time of admission, to cted deep tissue injury</li> <li>esident #7's heel from</li> <li>stated "We had a treatment in</li> <li>on 3/27/17." LPN #1 was</li> <li>rder was for the skin prep and</li> <li>gigned off as being</li> <li>stated, "I don't know about</li> <li>ave missed it, I did it though, we</li> <li>reatments without an order, the</li> <li>t also." LPN #1 was asked to</li> </ul>			
	provide evidence t applied. LPN #1 ft doctor saw him (R recommendations heel and to off load	hat skin prep was being urther stated, "The wound esident #7) and gave for betadine application to the d the heel wound." LPN #1 was ecommendations were not put			
	into place until 4/13 waiting on an okay	3/17. LPN #1 stated, "I was from the vascular surgeon.		RECEIVED	
	area be kept clean	urgeon) had requested that the and dry." When asked why it			
		get approval from the vascular		VDH/OLC	

Facility ID: VA0088

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С 495240 **B** WING 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)ID (X4) ID EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 199 F 314 On 4/26/17 at 3:45 p.m. an interview was conducted with LPN #17, a floor nurse who had completed Resident #7's admission package and assessment on 3/26/17. LPN #17 was asked to describe what she remembered seeing on Resident #7's right heel when he was admitted to the facility on 3/26/17. LPN #17 reviewed her admission package and assessment, and stated: "I remember he (Resident #7) was admitted late that day, around 8:30 p.m. His skin looked pretty good except for the heel. It was on the outer aspect of his right heel, it was about the size of a guarter, very small. It was darkened like a bruise, I felt it and it was intact and not boggy. I remember it being firm." When asked why she documented the area as "black" LPN #17 stated that she just felt that it was dark, like a bruise. LPN #17 was asked if she contacted the physician to obtain a treatment order. LPN #17 stated, "I don't think that I did. I would have let the next shift know. I did not put any treatments in place because the heel was intact." LPN #17 was asked what she should do when she found an area of concern on the skin. LPN #17 stated. "We are instructed to refer to an RN, but I didn't because there was no RN around. I think I off loaded his heels by rolling up a pillow. I did not write it anywhere. We had been doing that for him, he could move his feet so it really was only beneficial when he was asleep." LPN #17 was RECENCO asked if she updated the care plan to reflect the area on Resident #7's heel. LPN #17 stated, "No, MAY 3.1 2017 I probably just got busy." VDH/OLC On 4/26/17 at 6:10 p.m., ASM (administrative staff member) #2 (the director of nursing) and ASM #3 (the regional director of clinical services)

Facility ID: VA0088

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PLE CONSTRUCTION (X3) DATE SURVEY COMPLETED C
04/28/2017
STREET ADDRESS, CITY, STATE, ZIP CODE
3900 PLANK ROAD FREDERICKSBURG, VA 22407
PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETI CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
4
RECEIVED MAR 31 287 VDH/OLC

Event ID:6R5B11

Facility ID: VA0088

		AND HUMAN SERVICES				FOR	D: 05/11/201 MAPPROVEI D. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DA	TE SURVEY
		495240	B. WING			0,	C 4/28/2017
	PROVIDER OR SUPPLIER	AND REHAB	1	3900	ET ADDRESS, CITY, STATE, ZIP CODE PLANK ROAD DERICKSBURG, VA 22407	0	+/20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	units do this each w ASM #2 was asked made a recommend to be implemented. done on the same of hours later." ASM # was meant by "off lo "It means keep the are a "heels up" dev mattress, we can us resident frequently, podus boots to keep #2 was made aware made by the wound	n checks, the nursing on the	F3	14			
	Prevention and Trea Index" revealed, in p documentation; "PR at risk for skin break Residents identified have interventions in (Suggested Interven changes ii. Weekly s condition of mattress Moisturize skin with ambulation and mob and support devices wrinkly free ix. Prot for elbows and heels Program: a. Identify Branden (sic) Scale. interventions for resi	ty policy titled "Wound atment Program Section part, the following EVENTION: Identify residents adown - Braden Scale. at risk for skin breakdown will hitiated on the Plan of Care tions): i. Monitor for clinical skin checks iii. Assess is iv. Keep clean and dry v. lotion vi. Encourage illity vii. Position with pillows viii. Keep linen dry and ect skin. 5. Provide padding a. 6. Apply skin barrier. Skin v residents at risk utilizing b. Implement Plan of Care dents identified at risk for Resident(s) with wounds will			XEN/ED 31207 1/OLC		

Facility ID: VA0088

If continuation sheet Page 202 of 278

STATEMENT C	S FOR MEDICARE	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		495240	B. WING		С
	OVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	04/28/2017
FREDERIC	KSBURG HEALTH		1	3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIC
	Continued From pa	-	F 314		
d	ave appropriate tre leterioration or no o veeks, the treatment	eatment. If there is change in a wound within 2 nt will be changed.			
w # d o d	vas held with ASM 2, the director of n irector of clinical se wner. The above a iscussed and no fu	p.m. an end of day meeting #1, the administrator, ASM ursing, ASM #3, the interim ervices and ASM #5, an area of concerns was urther information was e end of the survey process.			
w ht cl te Pl A ar pr de op as or to m	ebsite; ttp://www.npuap.or inical-resources/np gories/. ressure Injury: pressure injury is I nd/or underlying so cominence or relate evice. The injury ca ben ulcer and may is a result of intense pressure in combi lerance of soft tissu ay also be affected	as obtained from the following g/resources/educational-and- ouap-pressure-ulcer-stagesca ocalized damage to the skin ft tissue usually over a bony ed to a medical or other in present as intact skin or an be painful. The injury occurs e and/or prolonged pressure nation with shear. The ue for pressure and shear l by microclimate, nutrition, ities and condition of the soft			
ful Fu ex be es	tent of tissue dama confirmed becaus char. If slough or e	d tissue loss nd tissue loss in which the age within the ulcer cannot e it is obscured by slough or eschar is removed, a Stage			
3 (	or Stage 4 pressure	e injury will be revealed.	V	DH/OLC	

Event ID:6R5B11

Facility ID: VA0088

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TATEMENT (	S FUR MEDICARE					M APPROVE 0. 0938-039
ND PLAN OF	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495240	B. WING		- 0	4/28/2017
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STA	TE, ZIP CODE	
FREDERI	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA	22407	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIC DATE
	erythema or fluctua	ge 203 dry, adherent, intact without nce) on the heel or ischemic softened or removed.	F 3'	14		
	the right calf on 3/9	veloped a pressure injury on /17. The facility staff failed to ht for the pressure injury until				
	8/30/16 and readmi Resident #2's diagn limited to: multiple s depressive disorder MDS (minimum dat status assessment reference date) of 1 being cognitively int Resident #2 as requ two or more staff wi totally dependent or transfers. Section	Imitted to the facility on tted to the facility on 1/23/17. toses included but were not aclerosis, diabetes and major . Resident #2's most recent a set), a significant change in with an ARD (assessment /30/17, coded the resident as act. Section G coded uiring extensive assistance of th bed mobility and as being in two or more staff with M documented Resident #2 unstageable pressure injuries mission.				
	pressure sore (injur	en scale for predicting y) risk dated 8/30/16 sident was at risk for pressure				
	records revealed the unstageable pressu	#2's pressure ulcer (injury) e resident developed an re injury on the right calf on w of the resident's clinical				
	record revealed pre	vention interventions were				
	physician deemed p	nted and the resident's pressure injuries was clinical record review and		NAY 31 207 VDH/OLC		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (FACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 204 F 314 interviews with staff and Resident #2 revealed the resident was non-compliant with turning and repositioning). Further review of Resident #2's clinical record (including March 2017 physician's orders, March 2017 physician's notes and the March 2017 TAR [treatment administration record]) revealed treatment was not implemented for the right calf pressure injury until 3/17/17 when Santyl (2) and a foam dressing every day was ordered by the physician. (Note: further review of the pressure ulcer record revealed the pressure injury did not decline from 3/9/17 through 3/17/17). Resident #2's comprehensive care plan initiated on 1/23/17 documented, "Pressure ulcer actual and at risk due to ... DTI (deep tissue injury)/unstageable to right calf...Interventions: wound MD (medical doctor) as ordered. Date Initiated 03/17/2017..." On 4/26/17 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the wound care nurse). LPN #1 was made aware of the above findings. LPN #1 stated during the time period of 3/9/17 through 3/17/17 staff offloaded (positioned to relieve pressure) Resident #2 and applied skin prep (3) to the resident's right calf pressure injury. LPN #1 stated the resident favors his right side because of right leg pain. LPN #1 confirmed there was no documentation that treatment was provided to RECENSED Resident #2's right calf pressure injury from 3/9/17 until 3/17/17. LPN #1 was asked how often skin prep should have been applied to the 127 31 237 resident's right calf. LPN #1 stated although the wound care physician did not follow the resident VDH/OLC at that time, the protocol was to apply skin prep every day. LPN #1 confirmed she provided

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Facility ID: VA0088

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 205 F 314 wound care Monday through Friday each week except for the days she was "pulled" to work as a floor nurse. LPN #1 stated the nurse providing care to Resident #2 was responsible for wound care when she (LPN #1) didn't provide wound care. LPN #1 was asked how she could evidence wound care was provided to Resident #2 on the days she didn't provide wound care since there was no physician's orders documented on the TAR. LPN #1 stated the two CNAs (certified nursing assistants) who care for Resident #2 are good CNAs so she could tell this surveyor that they offloaded the resident's right calf although she didn't witness them do so. LPN #1 stated she could not tell this surveyor that other nurses applied skin prep to the resident's right calf. On 4/26/17 at 4:52 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated when nurses identify a new wound and LPN #1 is not available then the nurses call the physician to get a treatment order. ASM #2 stated if LPN #1 is available then she looks at the wound to determine if it is a pressure ulcer or a non-pressure wound and obtains an order to treat the wound. ASM #2 stated LPN #1 observes residents' pressure ulcers each day except for weekends and when LPN #1 is "pulled to the medication cart." ASM #2 was asked how staff ensures treatments are initiated. ASM #2 stated the manager's print out order listings then staff ensures the treatments are implemented and the responsible party is notified. On 4/26/17 at 6:35 p.m., ASM #1 (the administrator), ASM #2 and ASM #3 (the regional VDH/OLC director of clinical services) were made aware of the above findings. Facility ID: VA0088 If continuation sheet Page 206 of 278 Event ID: 6R5B11 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 F 314 Continued From page 206 No further information was presented prior to exit. (1) "Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue... Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin RECEVED color changes. Discoloration may appear differently in darkly pigmented skin. This injury NAT 31 207 results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. VDH/OLC The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve

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Event ID: 6R5B11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 207 without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible. this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions..." This information was obtained from the website: http://www.npuap.org/resources/educational-andclinical-resources/npuap-pressure-injury-stages/ (2) Santyl is an ointment that removes dead tissue from wounds to aid in wound healing. This information was obtained from the website: http://www.santyl.com/ (3) "SKIN-PREP is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films ... " This information was obtained from the website: http://www.smith-nephew.com/professional/produ cts/advanced-wound-management/skin-prep/ 3.b. The facility staff failed to implement the wound care physician's recommendations for treatment of Resident #2's sacral (1) pressure injury from 3/15/17 through 4/25/17. Resident #2 was readmitted to the facility on RECEIVED 1/23/17. Review of Resident #2's pressure ulcer (injury) records revealed the resident presented NA 31 hel with an unstageable pressure injury (2) on the sacrum on 1/23/17. A physician's order dated 1/24/17 documented an order for Santyl (3) to be VDH/OLC applied to the sacrum once daily. The former wound care physician's initial evaluation of Resident #2's sacral pressure injury dated

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PRINTED: 05/11/2017 FORM APPROVED OMB NO 0938-0391

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

CLIVIC	NO FUN MEDICARE	A MEDICAID SERVICES			UNB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C
		495240	B. WING	·	04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CC 3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF COR IX (EACH CORRECTIVE ACTION S	SHOULD BE COMPLETION
F 314	pressure wound (4) once daily. Review 2017 and March 20 administration reco applied to Resident per the wound care until 3/3/17 when th documented to disc alginate (5) with foa order dated 3/3/17 of alginate and a foam Resident #2's March alginate with foam w sacral pressure inju 3/15/17 per the wou recommendations. A wound care physic documented to disc continue foam and a alginate (6) once da note dated 3/22/17 of foam, Santyl and ca wound care physicia documented to cont calcium alginate ond dated 3/31/17 documented to cont	d the area as a stage four and recommended Santyl of Resident #2's February 17 TARs (treatment rds) revealed Santyl was #2's sacral pressure injury physician's recommendations e wound care physician's note continue Santyl and add silver im once daily. A physician's documented an order for silver dressing daily. Review of h 2017 TAR revealed silver vas applied to Resident #2's ry from 3/3/17 through and care physician's cian's note dated 3/15/17 ontinue silver alginate, add Santyl and calcium ily. A wound care physician's documented to continue lcium alginate once daily. A an's note dated 3/29/17 inue foam, Santyl and ce daily. A physician's order mented an order for calcium dressing once daily. The	F	314	
	revealed the facility alginate and foam to pressure injury from although the wound foam, Santyl and ca which time the order	#2's March 2017 TAR staff continued to apply silver Resident #2's sacral 3/15/17 until 3/31/17 care physician recommended lcium alginate until 3/31/17 at was changed to calcium dressing once daily. A		RECEIVED MAY 31 207 VDH/OLC	

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Event ID:6R5B11

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		AND HUMAN SERVICES					FORM APPROVED
Procession and and and and and and and and and an		& MEDICAID SERVICES	1				1B NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '				X3) DATE SURVEY COMPLETED C
		495240	B. WING				04/28/2017
	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CC	DDE	
				3900	PLANK ROAD		
FREDER	ICKSBURG HEALTH			FRE	DERICKSBURG, VA 22407		
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F 314	Continued From pa	age 209	F 3	14		,	
	documented to cor calcium alginate or physician's note da	ian's note dated 4/5/17 ntinue foam, Santyl and nce daily. A wound care ated 4/19/17 documented to ntyl and calcium alginate once					
	cleanse the sacral alginate and a foar failed to document recommended in tl 4/5/17 and 4/19/17 (Note: further revie	w of wound care physician					
	from 3/15/17 throu						
	physician's notes in A nurse practitioner documented, "Sac practitioner's note "healing wound RL nurse practitioner discussion regardi recommendations recommendations	should not be followed. There ' nurse practitioner's notes in					
	on 1/23/17 docum and at risk due to:	prehensive care plan initiated ented, "Pressure ulcer actual Pressure Ulcer Present to					
		tions: Treatments as ordered. al doctor) as ordered"					
	On 4/26/17 at 1:25 conducted with AS	5 p.m., an interview was SM (administrative staff		Constraint, Constr	DH/OLC		

Event ID:6R5B11

Facility ID: VA0088

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039 (X3) DATE SURVEY	
ATEMENT D PLAN O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		C	
		495240	B. WING		04/28/2017	
AME OF F	PROVIDER OR SUPPLIER	*		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
REDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIC	
F 314	Continued From pa	age 210	F3	314		
1 011		ound care physician). ASM #4				
	was asked if it was	possible for Resident #2 to				
		Instageable pressure injuries. resident had so many				
	co-morbidities, was	s exceeding thin, was				
	non-compliant with	treatment and had poor				
	intake; ASM #4 sta	ited these factor drastically of the resident developing				
	unstageable press	ure injuries. ASM #4 was				
	asked the process	for staff following his wound				
	care recommendat	tions. ASM #4 stated he				
	the building. ASM	he policies and procedures in #4 stated his				
	recommendations	have to be "Okayed" by the				
	attending primary of	care physician but in general,				
	the treatment he re will be implemente	ecommends is what he thinks				
	will be implemente	u.				
	On 4/26/17 at 1:45	p.m. LPN #1 was observed				
	providing wound c	are to Resident #2. Foam, a alginate was applied to the				
	resident's sacral p					
	On 4/26/17 at 4:05	p.m., an interview was				
	LPN #1 was asked	N #1 (the wound care nurse). I why the wound physician's				
	recommendations	were not followed regarding				
	Resident #2's sacr	al pressure injury. LPN #1 was				
		had held a discussion with the nor nurse practitioner				
	regarding the wou	nd recommendations. LPN #1				
	stated she didn't re	ecall a discussion with the		and the second		
	attending physicia	n or the nurse practitioner.		RECEIVED		
	LPN #1 was asked	d if the wound care physician's should have been followed.		4 ないくま 200 夏 ガンペードラ		
	LPN #1 stated she	e didn't remember what the		RAY 3 207		
	wound looked like	and if there was any drainage. d if she typically follows the		VDH/OLC		
	I DI UN LING A AND A ALLAN			5 5 5 8 <sup></sup> 5 7 8 <i>F 5</i> 8 4		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С **B** WING 04/28/2017 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 211 stated, "Yes." On 4/26/17 at 4:52 p.m., an interview was conducted with ASM #2 (the director of nursing) regarding the facility process for following the wound care physician's recommendations. ASM #2 stated when the wound care physician gives a recommendation, the wound care nurse is supposed to write the recommendation as an order on the order form and have the order approved by the attending physician. ASM #2 stated the wound nurse "dropped the ball" if the wound physician gave a recommendation and the recommendation was not implemented. ASM #2 stated recommendations from the wound physician are usually implemented the same day the recommendations are given or within 24 hours. ASM #2 stated she checks to ensures orders for wounds are implemented and care plans are updated at the weekly wound meetings. ASM #2 stated she wasn't saying she didn't miss "stuff" but there was a process and all pressure injuries are discussed in the weekly wound meetings. ASM #2 stated she has a wound round sheet that documents the wounds and treatments. ASM #2 stated the information documented on her wound round sheets is obtained from the wound care nurse's documentation and the wound physician's notes. On 4/26/17 at 6:10 p.m., ASM #2 and ASM #3 RECEIVED (the regional director of clinical services) stated the facility did not have a policy for following the wound physician's recommendations. RAY 31 2.7 On 4/26/17 at 6:35 p.m., ASM #1 (the VDH/OLC administrator), ASM #2 and ASM #3 (the regional director of clinical services) were made aware of the concern that the facility staff were not If continuation sheet Page 212 of 278 Facility ID: VA0088 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 6R5B11

		AND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER	1	ST ST	REET ADDRESS, CITY, STATE, ZIP	CODE
FREDER	ICKSBURG HEALTH	AND REHAB	1	000 PLANK ROAD REDERICKSBURG, VA 22407	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIC E APPROPRIATE DATE
F 314	Continued From pa	age 212	F 314		
	following the woun recommendations.	d physician's			
	No further informat	tion was presented prior to exit.			
	vertebrae and that This information wa https://medlineplus htm	ated at the base of the lumbar is connected to the pelvis" as obtained from the website: gov/ency/imagepages/19464.			
	and underlying soft prominence or rela- device. The injury an open ulcer and occurs as a result pressure or pressur The tolerance of so shear may also be nutrition, perfusion of the soft tissue Unstageable Press full-thickness skin Full-thickness skin extent of tissue da be confirmed beca eschar. If slough of 3 or Stage 4 press Stable eschar (i.e. erythema or fluctua	s localized damage to the skin t tissue usually over a bony ited to a medical or other can present as intact skin or may be painful. The injury of intense and/or prolonged ire in combination with shear. off tissue for pressure and affected by microclimate, , co-morbidities and condition sure Injury: Obscured and tissue loss and tissue loss and tissue loss in which the mage within the ulcer cannot use it is obscured by slough or or eschar is removed, a Stage ure injury will be revealed. dry, adherent, intact without ance) on the heel or ischemic			
	Deep Tissue Press non-blanchable de	softened or removed. sure Injury: Persistent ep red, maroon or purple			
	discoloration				

	TOF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION		ATE SURVEY
		495240	B. WING				C 4/28/2017
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIF	, CODE	
REDER	RICKSBURG HEALTH	AND REHAB			PLANK ROAD DERICKSBURG, VA 2240	17	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 314	Continued From p	age 213	F 3	314			
	purple discoloratio	n or epidermal separation					
	revealing a dark w	ound bed or blood filled blister.					
		ture change often precede skin					
	differently in darkly	scoloration may appear y pigmented skin. This injury					
		se and/or prolonged pressure					
	and shear forces a	at the bone-muscle interface.					
		volve rapidly to reveal the					
	actual extent of tis without tissue loss	sue injury, or may resolve					
		ue, granulation tissue, fascia,					
	muscle or other ur	nderlying structures are visible,					
	this indicates a ful	I thickness pressure injury					
		ge 3 or Stage 4). Do not use					
		vascular, traumatic,					
	information was of	rmatologic conditions" This btained from the website:					
		org/resources/educational-and	-				
	clinical-resources/	npuap-pressure-injury-stages/					
	(3) Santyl is an oir	ntment that removes dead					
	tissue from wound	is to aid in wound healing. This	S				
		btained from the website:					
	http://www.santyl.o						
		sure Injury: Full-thickness skin					
	and tissue loss	and ticque loss with expected					
		and tissue loss with exposed e fascia, muscle, tendon,					
		or bone in the ulcer. Slough					
	and/or eschar may	y be visible. Epibole (rolled					
	edges), undermini	ng and/or tunneling often occu	r.				
	Depth varies by a	natomical location. If slough or					
		he extent of tissue loss this is ressure Injury." This					
		btained from the website:					
			_				
	http://www.nbuab.	org/resources/educational-and			H/OLC		

CENTERS FOR MEDICARE & MEDICAID SERVICESTATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO	(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:	A. BUILD	ING		С
		495240	B. WING			04/28/2017
AME OF PROVIDER OR SUPPLIER					ET ADDRESS, CITY, STATE, ZIP CODE	
REDER	ICKSBURG HEALTH	AND REHAB			PLANK ROAD DERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 314	Continued From p	age 214	F	314		
	(5) Silver alginate is a wound dressing. This					
	information was of	otained from the website: Im.nih.gov/pmc/articles/PMC4	4			
	information was of	te is a wound dressing. This otained from the website: Im.nih.gov/pubmed/2610818				
	the right heel on 4	eveloped a pressure injury on /19/17. The facility staff failed ment until 4/25/17 (six (6)				
	order to offload Re every shift. Resid (treatment admini	r dated 1/23/17 documented a esident #2's heels while in bed ent #2's April 2017 TAR stration record) documented th ere offloaded each shift during	е			
	physician's order of be applied to the r	nt #2's clinical record revealed dated 4/6/17 for skin prep (1) to resident's heels every day shift continued on 4/19/17.	C			
	records revealed t unstageable press heel on 4/19/17 a	nt #2's pressure ulcer (injury) the resident developed an sure injury (2) on the left latera nd an unstageable pressure				
	injury on the right medial heel on 4/19/17. (Note: review of the resident's clinical record revealed prevention interventions were previously implemented and the resident's physician					
	deemed pressure clinical record rev Resident #2 revea	injuries was unavoidable. Als iew and interviews with staff ar aled the resident was	o, nd	VC.	)+/()LC	
	non-compliant wit	h turning and repositioning).	B11	Facility	ID: VA0088 If continua	tion sheet Page 215 of

Event ID:6R5B11

Facility ID: VA0088

FORM CMS-2	2567(02-99) Previous Versio	ns Obsolete	Event ID: 6R5B1	1	Facility	y ID: VA0088	If continuation she	et Page 216 of 278
	On 4/26/17 at 4:05 p.m., an interview was conducted with LPN #1. LPN #1 stated she only documented skin prep to Resident #2's left heel instead of skin prep to both heels when she transcribed the 4/19/17 physician's order that was documented on the April 2017 TAR. LPN #1 was				ख प्र ि व	ECENED Mat237 DH/OLC		
	A physician's order dated 4/25/17 documented to apply skin prep to Resident #2's right heel every day shift.							
	staff member) #2 LPN (licensed pracare nurse) were treatment for Res injury was implem wound was identif		sing) and e wound ridence that pressure rhen the					
	on 1/23/17 failed t	nprehensive care pl to document information neel pressure injury	ation					
	prep was applied day each day from There was no skir	il 2017 TAR docume to the resident's left 1 4/19/17 through 4/ 1 prep treatment do 1 ight heel from 4/19/	heel once a /25/17. cumented					
	the right heel wound and left heel wound dated 4/19/17 documented the areas as unstageable deep tissue injuries and the wound care physician recommended skin prep to each heel every shift. A physician's order dated 4/19/17 documented an order for skin prep to the left heel every day shift. There was no treatment order for Resident #2's right heel.							
F 314	Continued From p The wound care p	hysician's initial eva	luation of	F:	314			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEDED LSC IDENTIFYING INFOR	BY FULL	ID PREF TAG		(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	ICKSBURG HEALTH					PLANK ROAD DERICKSBURG, VA	22407	
	PROVIDER OR SUPPLIER	495240	)	B. WING		ET ADDRESS, CITY, ST/		04/28/2017
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LIER/CLIA			DNSTRUCTION		(X3) DATE SURVEY COMPLETED C	
	MENT OF HEALTH						FOF	ED: 05/11/2017 RM APPROVED IO: 0938-0391

		AND HUMAN SERVICES				I	NTED: 05/11/2017 FORM APPROVED
T		& MEDICAID SERVICES	1			1	B NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCT			(3) DATE SURVEY COMPLETED
			A. BUILD	ING			С
		495240	B. WING				04/28/2017
	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP COL	 DE	04,20,2011
I NAME OF I	No NDER OR OUT EIER			3900 PLANK R	ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKS	SBURG, VA 22407		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		OVIDER'S PLAN OF CORR		(X5) F COMPLETION
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		H CORRECTIVE ACTION S REFERENCED TO THE AF		
140		·····,			DEFICIENCY)		
F 314	Continued From pa	age 216	F 3	514			
	asked if she could	verify that nurses applied skin					
	prep to both heels s	since the order on the TAR					
		o apply skin prep to the left					
		no directive to apply skin prep					
		PN #1 stated the nurses follow te treatments when she isn't at					
		ould not confirm skin prep was					
		Resident #2's heels. LPN #1					
		o document to apply skin prep					
		e 4/19/17 order that was					
		opril 2017 TAR but she made a					
	transcription error.				·		
	On 4/26/17 at 6:35	p.m., ASM #1 (the					
	administrator), ASM	A #2 and ASM #3 (the regional					
	director of clinical s	ervices) were made aware of					
	the above findings.						
	No further informati	ion was presented prior to exit.					
		- linuid film forming dropping					
		a liquid film-forming dressing on to intact skin, forms a					
		elp reduce friction during					
		nd films" This information					
	was obtained from						
		ephew.com/professional/produ					
	cts/advanced-woun	id-management/skin-prep/					
	(2) "Pressure Injury	ŗ.					
		s localized damage to the skin					
		tissue usually over a bony					
	prominence or relat	ted to a medical or other					
		can present as intact skin or		T Can Set Ten S	t to how the t		
		may be painful. The injury					
		of intense and/or prolonged re in combination with shear.			Carlos States		
		oft tissue for pressure and		VDH/(	and a second		
	shear may also be a	affected by microclimate,		V 1/1 1/ \	ad bar had		
	nutrition, perfusion,	co-morbidities and condition					
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 6R5B	11	Facility ID: VA0088	If contin	nuation sl	neet Page 217 of 278

		AND HUMAN SERVICES					FORM	: 05/11/2017 APPROVED . 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	ISTRUCTION		Сом	E SURVEY IPLETED
		495240	B. WING			16.497	1	28/2017
NAME OF I	PROVIDER OR SUPPLIER		1	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			LANK ROAD ERICKSBURG, VA	22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVI CROSS-REFERENCED		BE	(X5) COMPLETION DATE
F 314	full-thickness skin a Full-thickness skin a Event of tissue dar be confirmed becar eschar. If slough of 3 or Stage 4 press Stable eschar (i.e. erythema or fluctua limb should not be Deep Tissue Press non-blanchable der discoloration Intact or non-intact persistent non-blar purple discoloration revealing a dark we Pain and temperat color changes. Dis differently in darkly results from intens and shear forces a The wound may eva actual extent of tiss without tissue loss subcutaneous tiss muscle or other un this indicates a full (Unstageable, Stag DTPI to describe v neuropathic, or der information was of http://www.npuap.of	sure Injury: Obscured and tissue loss and tissue loss in which the mage within the ulcer cannot use it is obscured by slough or or eschar is removed, a Stage ure injury will be revealed. dry, adherent, intact without ance) on the heel or ischemic softened or removed. sure Injury: Persistent ep red, maroon or purple skin with localized area of nchable deep red, maroon, n or epidermal separation ound bed or blood filled blister. ure change often precede skin coloration may appear pigmented skin. This injury e and/or prolonged pressure t the bone-muscle interface. volve rapidly to reveal the sue injury, or may resolve . If necrotic tissue, ue, granulation tissue, fascia, iderlying structures are visible, thickness pressure injury ge 3 or Stage 4). Do not use						
	(3) Santyl is an oin tissue from wound	tment that removes dead s to aid in wound healing. This btained from the website:	6	VDH/				

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 218 of 278

		AND HUMAN SERVICES			FOR	D: 05/11/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		495240	B. WING	·	0	C 4/28/2017
NAME OF I	PROVIDER OR SUPPLIER	1	I	STREET ADDRESS, CITY,		
	•			3900 PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG,	VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From pa	age 218	F	314		
	http://www.santyl.c	om/				
	maintain infection of dressing change to infection of an unst wound [2]. Resident #19 was a 3/27/17 with diagno limited to high bloo hallucinations, maje cancer, and anxiety most recent MDS ( admission MDS with Reference Date) of coded as being mo the ability to make of 15 on the BIMS of Status) exam. Res requiring extensive physical assist with dressing and limite	9, facility staff failed to control practices during a promote healing and prever ageable [1] sacral pressure admitted to the facility on oses that included but were r d pressure, failure to thrive, or depressive disorder, liver y disorder. Resident #19's minimum data set) was an th an ARD (Assessment 4/3/17. Resident #19 was derately cognitively impaired daily decisions scoring 11 ou (Brief Interview for Mental sident #19 was coded as assistance with one person transfers, ambulation, d assistance from one staff notion on and off the unit.	not d in ut			
	care evaluation by dated 4/26/17 docu "Unstageable (Due 0.4 cm x 0.2 cm. W Dressing: Santyl [3] dressing- once dail Review of Resident (Physician Order S current order: "San (gram) (Collagenas every day shift for W	t #19's most recent wound the wound care physician imented the following: to necrosis): Wound Size: 1 /ound progress: Improved. ] -Once daily, dry protective y." t #19's most recent POS heet) revealed the following tyl Ointment 250 UNIT/GM se) Apply to Sacrum topically Wound Care Cleanse wound apply santyl ointment and a	/	RECEVED DV3124/ VDH/OLC	1	
FORM CMS-25	667(02-99) Previous Versions			Facility ID: VA0088	If continuation sheet I	Page 219 of 278

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM A	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	SURVEY LETED
		495240	B. WING			1	8/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB			900 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa foam dressing."	ge 219	F 3	314	·		
	care was conducted #6. RN #6 walked out a package of ga placed them on top then pulled out San medication into a m cup on top of the tre observed washing h the treatment suppl Next, RN #6 took h stack of gauze out of	er bare hands and pulled a of the package and placed the					
	underneath the stat flat touching the sur RN #6 then placed scrub pocket and ca medicine cup of Sa #6 walked into Resi the procedure and v	treatment cart. Nothing was ck of gauze. The gauze was fface of the treatment cart. the stack of gauze in her arried the saline bullets and ntyl with her bare hands. RN ident #19's room, explained walked out of his room. RN alking back to the treatment					
	gauze from the scru of a foam dressing gathered supplies a #19's room. The su Resident #19's bed were still on the tab down, and a drape then observed place bedside table witho	served taking the stack of ub pocket and placing it on top package. RN #6 then again and walked to Resident upplies were placed on top of side table while his belongings le. The table was not wiped was not used. RN #6 was ing the stack of gauze on the ut a drape underneath the was flat against the bedside			RECEIVED		

Event ID:6R5B11

Facility ID: VA0088

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	C	
		495240	B. WING		04/28/2017	
ME OF	PROVIDER OR SUPPLIEF	२	<u> </u>	STREET ADDRESS, CITY, STATE, Z	IP CODE	
	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD		
				FREDERICKSBURG, VA 224		
X4) ID REFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
F 314	Continued From p	bage 220	F 31	4		
		r hands, donned gloves and				
		ing off Resident #19's sacral took gauze from the top of the				
	stack and wiped o	off Resident #19's wound. She				
		removing her gloves or washing cleaning the wound.				
	ner nanus prior to	cleaning the would.				
		ound was a tiny open area with				
		around the wound was nchable skin. RN #6 measured				
		$2 \times 0$ cm (centimeters). RN #6				
		und from one side of the				
		nchable skin to the other side. ged her gloves and cleaned the				
	wound with norma	al saline from the saline bullets.				
	She was not obse she changed her	rved to wash her hands when				
	she changed her g	gioves.				
		some gauze from the top of the				
		he wound dry. RN #6 placed nd and then covered the wound				
	with a foam dress	ing. RN #6 then threw away the				
		that was not used during the ast few pieces of gauze that				
		the bedside table were not				
	used during the dr	ressing change. RN #6 was				
	then observed wa	shing her hands.				
		proximately 4:15 p.m., an				
		ducted with RN #6. When				
		I identify anything that she might ntly during the dressing change,		anna gant ware an a coma mare		
	RN #6 stated, "We	ell I usually use a drape				
		upplies but I don't have a drape upply is locked. Or I will use a				
	napkin." When as	sked if it is good practice to put		ersoni di territori		
	gauze pads direct	ly on the treatment cart surface		VDH/OLC		
		s bedside table surface, RN #6 ver use the bottom of the gauze				
				Facility ID: VA0088	If continuation sheet Page 221 of	

DEPART	MENT OF HEALT	H AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED
CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-0391 (X3) DATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	C
		495240	B. WING		04/28/2017
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STAT	E, ZIP CODE
	ICKSBURG HEALT			3900 PLANK ROAD	22407
FREDER	ICKSBURG HEALI			FREDERICKSBURG, VA	
(X4) ID PREFIX TAG	(FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREF TAG	CROSS-REFERENCED	ACTION SHOULD BE COMPLETION
F 314	Continued From	bage 221	F:	314	
1 514		e it on top of a package like I d	id		
	earlier when I put	the gauze on the foam			
	package," When	asked if it was ever ok to place	Э		
	gauze pads in a s	scrub pocket, RN #6 stated, "No	0		
	that would be kind	d of gross. I don't ever put gauz	ze		
	in my pocket. I ar	n very big about what touches en RN #6 was informed of the			
	the wound. Whe	rvations, RN #6 stated, "That			
	wasn't gauze Th	at was a piece of paper the			
	hospice nurse ha	nded me. I never put gauze in			
	my pocket."				
	conducted with L	23 p.m., an interview was PN (licensed practical nurse) #	:1,		
	the wound care n	nurse. When asked the proces	S		
	of maintaining inf	ection control during a dressing	g	-	
	change, LPN #1	stated that she would wash her			
	hands before she	e gathered supplies, gather ce them into a Ziploc bags, and			
	supplies and plac	re in individual packages. LPN			
	#1 stated that sh	e would use the Ziploc bags as	а		
	clean surface to	put her supplies on. When			
	asked if it was ev	ver ok to place treatment			
	supplies directly	on the resident's bedside table	,		
	LPN #1 stated, "I	No. It is never ok. You don't kno	JW		
	what is on the tal	ble." When asked if it was ok f to be placed on the bedside	0i		
	a stack of gauze	plans to throw away the bottor	n		
	stack after a dres	ssing change, LPN #1 stated,			
	"Well that is not	good practice at all and it is			
	wasteful." Wher	h asked if it was ever ok to plac	е		
	treatment items	in her scrub pocket, LPN #1			
	stated, "No. That	t is never ok. The supplies are	ce.	a a fann Neddawe (C. V. Constant)	
	not clean anymo	re. That's the reason why I plac ags." LPN #1 stated that she			
	would wash her	hands right before she provide	s	North Contraction	
	the treatment. L	PN #1 stated that she would al	SO	VDH/OLC	
	change her glove	es and wash her hands after sh	ne	A MULLY	
	takes the dirty dr	ressing off the resident. LPN #*	1		
ORM CMS-	2567(02-99) Previous Vers	ions Obsolete Event ID:6F	R5B11	Facility ID: VA0088	If continuation sheet Page 222 of 2

		AND HUMAN SERVICES					RINTED: 05/11/2017 FORM APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			T	IB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495240	B. WING	š			C 04/28/2017
	PROVIDER OR SUPPLIER		<b>I</b>	5	STREET ADDRESS, CITY, STATE,	ZIP CODE	
					3900 PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB			REDERICKSBURG, VA 22	407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD I	BE COMPLETION
F 314	Continued From pa	ae 222	F	314			
		ng my gloves off, I am washing	·				
	On 4/27/17 at 4:30	p.m., ASM (administrative he administrator was made concerns.					
	Dressing Changes, following: "Purpose changing of dressin and prevent infection hands 2. Explain pr you are going to do can hear you. 3. Por comfortable. 4. Esti will be needed and 5. Open the dressing protective pads und wound is located. 7 for soiled dressings Put on clean gloves tape 3. Remove of time and place in g stick to the wound, ease removal. 5. R gloves. 6. Wash yo Open sterile supplie and leave each dre package. 2. Put or dipped in normal sa edges using small of the wound to the wound separately. across wound. 6. P gauze. 7. Throw aw	titled, "General Rules for " documents in part, the : Proper cleaning and proper ing on a wound can aid healing on. What to do: 1. Wash your ocedure to the patient what even if you do not think they osition patient so they are imate what dressing supplies place on a clean work area. Ing materials. 6. Place der the body part where the . Place garbage bag nearby 5. To remove old dressings: 1. 5 (not sterile). 2. Loosen all old dressings. One layer at a arbage bag. 4. If dressings moisten with normal saline to emove and throw away old ur hands. To clean the wound: es by peeling apart the edges ssing inside the open a sterile gloves. 3. Using swabs aline, clean along the wound circular motions from one end other. 4. Clean each side of 5. Do not scrub back and forth at the area dry with sterile vay cleaning materials.			RECEIVED Carasta/		
	Dress the wound: A dressing as instruct	vay cleaning materials. After the wound is dry, apply ted by the nurse or a medical te dressing in place."			VDH/OLC		

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 223 of 278

and a second	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:			COMPLETED
		105240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER	495240		TREET ADDRESS, CITY, STATE, ZIF	
			3	900 PLANK ROAD	
REDER	ICKSBURG HEALTH	AND REHAB	F	REDERICKSBURG, VA 2240	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLETE HE APPROPRIATE DATE
F 314	Continued From p	age 223	F 314		
	loss in which the b slough (yellow, tar	ressure-Full thickness tissue base of the ulcer is covered by a, gray, green or brown) and/or a or black) in the wound bed.			
	the skin over a bol blade, elbow, hip, from prolonged pro- from being confine in elderly and imm ulcers may be pre- position, early amb skin lubricants and called bedsores. F Dictionary of Medi	er is an inflammation or sore on ny prominence (e.g., shoulder buttocks, or heel), resulting essure on the area, usually ed to bed. Most frequently seen obilized persons, decubitus vented by frequently change of bulation, cleanliness, and use of d a water or air mattress. Also Pressure sores. Barron's cal Terms for the Non Medical el A. Rothenberg, M.D. and tan. Page 155.			
	active enzymatic t removes necrotic microscopic level. bed of microscopi granulation to proc	tment is an FDA-approved herapy that continuously tissue from wounds at the This works to free the wound c cellular debris, allowing ceed and epithelialization to w.santyl.com/about>)			
	appropriately treat	ff failed to assess and Resident #30's pressure injury n on 4/5/17 until 4/12/17, when		and the second s	
	she was seen by t	he wound specialist.			
	4/5/17 with diagno history of a stroke	admitted to the facility on ses including, but not limited to with paralysis, left leg disease, diabetes and major		VDH/OLC	

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С 04/28/2017 B. WING 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 224 depression. On the most recent MDS (minimum data set), an admission assessment with an assessment reference date of 4/12/17, Resident #30 was coded as being moderately impaired for making daily decisions. She was coded as having one unstageable pressure ulcer on admission to the facility. On 4/27/17 at 8:20 a.m., observation was made of Resident #30's pressure ulcer. The wound measured 0.3 X 0.1 X 0.1 cms (centimeters), and had a pink wound bed. The wound had no drainage. A review of Resident #30's progress notes revealed the following: - 4/5/17 at 4:10 p.m. by LPN (licensed practical nurse) #1, the wound nurse: "Wound Note: Resident was assessed by wound nurse. Resident had dressing on sacrum. Nurse removed dressing to reveal a wound measuring 5 X 0.5 X 0.2 with light serous exudate (drainage). Awaiting an RN to stage wound. Resident has an old amputation scar on the left leg. Dry skin noted behind left ear. Some moisture noted in the skin of right hand and between the fingers of the right hand. Resident is currently resting in bed, bed in lowest position and call light within reach." - 4/14/17 at 6:10 p.m. by LPN #1: "Wound Note: Resident was seen by wound Dr. (doctor) on 4/12/17 for sacral wound measuring 0.5 X 0.3 X 0.2. No exudate, 40% necrotic tissue, 60% granulation tissue. Current tx (treatment) is Santyl (3) and foam dressing daily." San Britan A review of Resident #30's discharge notes from VDH/OLC the outside hospital dated 4/4/17 revealed, in part, the following:

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		AND HUMAN SERVICES			FOR	D: 05/11/20 MAPPROV D. 0938-03
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY
		495240	B. WING		04	C 4/28/2017
NAME OF PF	ROVIDER OR SUPPLIER	A	1	STREET ADDRESS, CITY, S	TATE, ZIP CODE	
FREDERIC	KSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, V	A 22407	
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F 314	Continued From pa	uge 225	F 3	14		
	•	ary dated 4/5/17, containing	гJ	14		
		raph: "Coccygeal wound -				
-	This has been eval	uated and managed per				
		gular basis. Wound has d intertriginous moisture/shear				
		d appears unchanged and has				
l	been treated with s	aline, cover with Mepilex				
	(foam dressing) an more frequently if s	d change every 3 days or				
		: "Bacitracin-Polymyxin B				
(	Ointrnent (4) Apply	500 g (grams) topically 2				
		mazole 1% cream For surgica				
	creases two times	sequela. Apply to groin daily."				
	signed by the physi part, the following: topically two times of sacral region, sta 1% Apply to groin t related to pressure stage 2." A review administration reco	nt #30's orders dated 4/5/17, cian on 4/9/17 revealed, in "Polysporin Ointment Apply a day related to pressure ulcer age 3 (6)Clotrimazole Cream opically two times a day ulcer of the sacral region, of the TARs (treatment rds) for Resident #30 revealed its were administered as				
     	Resident #30 datec following: "Resider pressure ulcer and			RECEIVED		
(	On 4/26/17 at 4:50	p.m., ASM (administrative				
i	interviewed about t	he director of nursing, was ne process for assessing newly admitted residents.		VDH/OLC		
•	7(02-99) Previous Versions	-	4	Facility ID: VA0088	If continuation sheet	Daga 226 of

Event ID:6R5B11

Facility ID: VA0088

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PRINTED: 05/11/2017 FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING С B. WING 04/28/2017 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 226 She stated that if the wound nurse does an initial assessment, an RN (registered nurse) follows up on that assessment within 48 hours for the purposes of staging the wound. She stated LPN #1 implements a treatment for the wound even before an RN assessment of the wound. When asked where LPN #1 gets information for the proper treatment for the pressure injury, ASM #2 stated: "She gets that from the admitting orders or from our physician." At this time, ASM #2 was made aware of concerns regarding Resident #30's admission orders for wound care. On 4/26/17 at 4:55 p.m., LPN #1 was interviewed regarding the treatment for Resident #30's sacral pressure injury implemented at the time of admission. LPN #1 stated: "An RN was not with me when I went in to see it the first time. I can't remember who followed up to assess it." At this point. LPN #1 needed to leave for the day. She stated she would review the admission orders and meet again with the surveyor in the morning on 4/27/17. On 4/27/17 at 11:20 a.m., LPN #1 was again interviewed. She was shown the above-referenced discharge information from the outside hospital. When she read the paragraph about the "coccygeal wound," LPN #1 stated: "I do not remember ever seeing this. I did not know this was in there." When informed that the RECEIVED discharge information was in the front of Resident #30's chart, LPN #1 stated: "I didn't ever see it." She stated the outside hospital discharge

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information did not indicate a stage for the pressure injury. She stated when she assessed

the wound on 4/5/17; it was unstageable due to the presence of slough. She stated she thought ASM #2 had gone with her to stage it, but could

Event ID: 6R5B11

Facility ID: VA0088

495240     B. WING     04/28/2017       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS. CITY. STATE. 2P CODE     STREET ADDRESS. CITY. STATE. 2P CODE       PREDERICKSBURG HEALTH AND REHAB     STREET ADDRESS. CITY. STATE. 2P CODE     STREET ADDRESS. CITY. STATE. 2P CODE       OM, ID TAS     SUMMARY STATE. MENT OF DEPREEDED BIT. IFACH DEPROEMVENT MIST BE PREEDED BIT. TAS     IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
Sumary startment of DEFICIENCIES (FREDERICKSBURG HEATH AND REHAB     3900 PLANK ROAD PREDEXICKSBURG, VA 22407       Sumary startment of DEFICIENCIES (FREDERICKSBURG, VA 22407       TAG       Sumary startment of DEFICIENCIES (FREDERICKSBURG, VA 22407       F 314 Continued From page 227 not find any information about this in the clinical record. She stated she could not remember any conversations about the wound with either ASM #2 or with LPN (ticensed practical nurse) #11, the unit manager. When asked to review the discharge medication orders for Polyspoini and for Clottmazole, LPN #1 stated: "It looks like they (Polysporn and Clottmiazole) were for something else. I didn't realize that they weren't for the pressure ulcer." When asked what the foam dressing. But I need to check and get back to you."     F 314       On 4/27/17 at 11:30 a.m., LPN #11 was interviewed. She stated the same reatment as the outside hospital had been providing should have been ordered for the readent (saline and foam dressing). When asked if she could not. She stated the process for wound assessment begins with the amitting charge nurse. She stated if a resident has a pressure injury, the admitting nurse assesses the pressure injury, the admitting nurse informs the wound hurse. The wound nurse assesses the pressure injury, the admitting nurse assesses the pressure injury within 24 hours of admission. This is followed by an RN assessment and staging within the next 24 hours. She stated the wound nurse is responsible for obtaining treatment orders for the wound LPN #11 stated: "I never looked at [Resident #30]. didn't know she even had a wound nullifight		495240	B. WING		
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Facility ID: VA0088

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	IMENT OF HEALTH							FORM A	05/11/2017 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SU IDENTIFICATIO	PPLIER/CLIA	1 ' '		ONSTRUCTION		(X3) DATE COMP	LETED
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NAME OF I	PROVIDER OR SUPPLIER				STRE	ET ADDRESS, CITY, STA	TE, ZIP CODE		
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F 314	Continued From pa	age 228		F	314				
	<ul> <li>(1) "Bipolar disorder manic-depressive causes unusual shilevels, and the abilitasks." This inform https://www.nimh.r order/index.shtml.</li> <li>(2) "Schizophrenia disorder that affect and acts." This infine website https://www.nimh.r zophrenia-booklet/</li> <li>(3) Santyl - "Collag sterile enzymatic d contains 250 collag petrolatum USP. T derived from the fee histolyticum. It pos digest collagen in r information is take https://dailymed.nli</li> </ul>	illness, is a brain ifts in mood, ene ity to carry out d nation is taken fr nh.gov/health/top is a chronic and s how a person ormation is take nh.gov/health/pu index.shtml. enase Santyl® ( ebriding ointmer genase units per he enzyme colla ermentation by C sesses the uniqu necrotic tissue." n from the webs m.nih.gov/dailym	disorder that ergy, activity ay-to-day om the website bics/bipolar-dis severe thinks, feels, n from the blications/schi Dintment is a t which gram of white genase is lostridium ue ability to This ite						
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FORM CMS-2	567(02-99) Previous Version	s Obsolete	Event ID: 6R5B	11	Facility	ID: VA0088	If continuation	n sheet Pag	ge 229 of 278

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С 04/28/2017 B. WING 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 F 314 Continued From page 229 foot, jock itch, and body ringworm. It can also be used to prevent oral thrush in certain patients." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682753.h tml (6) Stage 3 - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. This information was obtained from the website http://www.npuap.org/resources/educational-andclinical-resources/npuap-pressure-ulcer-stagesca tegories/. F 328 F 328 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE F328 1. Resident #13 and Resident #8 nebulizer mask SS=D FOR SPECIAL NEEDS and equipment were put in protective storage. (b)(2) Foot care. To ensure that residents receive 2. Current residents with nebulizer masks and 6-5-17 equipment were placed in proper storage. proper treatment and care to maintain mobility and good foot health, the facility must: 3. The Director of Nursing/designee will reeducate nursing staff on proper treatment care (i) Provide foot care and treatment, in accordance for special needs and proper storage of nebulizer with professional standards of practice, including equipment. The Director of Nursing/designee to prevent complications from the resident's will randomly audit residents with nebulizer equipment to ensure proper storage three times a medical condition(s) and week times four weeks and then monthly times (ii) If necessary, assist the resident in making two months. appointments with a qualified person, and 4. The Director of Nursing/designee will report arranging for transportation to and from such the audit results monthly to the Quality Assurance Performance Improvement appointments committee for continued compliance and/or (f) Colostomy, ureterostomy, or ileostomy care. revision. The facility must ensure that residents who RECEIVED require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the NA 31 1.55

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				OMB NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
	495240	B. WING		04/28/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
FREDERICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETIN E APPROPRIATE DATE
F 328 Continued From pa	age 230	F 32	8	
	rson-centered care plan, and			
receives the appro to prevent comp including but not lin diarrhea, vomiting, abnormalities, and (h) Parenteral Fluid administered consistandards of practi physician orders, th person-centered ca goals and preferen (i) Respiratory care and tracheal suction that a resident who including tracheost suctioning, is provi professional stand comprehensive pe residents' goals an	are plan, and the resident's			
resident who has a and assistance, co standards of practi person-centered c and preferences, t prosthetic device. This REQUIREME by: Based on observa	e facility must ensure that a a prosthesis is provided care onsistent with professional ice, the comprehensive are plan, the residents' goals o wear and be able to use the ENT is not met as evidenced ation, resident interview, staff		RECEIVED	
interview, facility d record review, it w	ocument review and clinical as determined that the facility			continuation sheet Page 231 o

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 231 of 278

		AND HUMAN SERVICES					FORM APPROVED MB NO. 0938-0391
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C
		495240	B. WING	i			04/28/2017
NAME OF	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE	, ZIP CODE	
FREDER	CKSBURG HEALTH	AND REHAB		-	900 PLANK ROAD REDERICKSBURG, VA 2	2407	
	SUMMA DV ST	ATEMENT OF DEFICIENCIES	ID	<b>V</b> (X5)			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPF	BE COMPLETION
F 328	Continued From pa	age 231	F	328			
	staff failed to provid	de proper treatment and					
		atory care for two of 32					
	Residents in the sur Resident #13.	vey sample, Resident #8 and					
	nebulizer mask in a #8's nebuizer mask	failed to store Resident #8's a sannitary manner. Resident < was observed uncovered lastic bag on seprate					
	ocassions during th						
	nebulizer equipmer Resident #13's neb	failed to store Resident #13's nt in a protective cover. oulizer equipment was rotected on top of, and in edside table.					
	The findings includ	e:					
	<ol> <li>Resident #8 was admitted to the facility on 3/25/17 and readmitted on 4/6/17 with diagnoses that included but were not limited to: stroke, indigestion, weakness, respiratory failure, difficulty swallowing and high blood pressure.</li> <li>The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 4/13/17 coded the resident as usually being able to make self-understood and sometimes understand others. The resident's brief interview for mental status was coded "00" indicating the resident was</li> </ol>						
	unable to answer a	ny questions correctly. The das requiring assistance from			and the second s		
	staff for all activities						
	2/25/17 at 12:55 p.	s made of Resident #8 on m. The resident was getting bed into the wheelchair. The			VDH/OLC		
L		Objective Event (D: 6859					sheet Page 232 of 278

Facility ID: VA0088

If continuation sheet Page 232 of 278

*************************************					OMB NO. 0938-03
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495240	B. WING		04/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
FREDER	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLET
F 328	Continued From pa	age 232	F 3	28	
	nebulizer mask wa plastic bag on the	as observed sitting on top of a bedside table.			
	2/25/17 at 1:30 p.n wheelchair. The ne	s made of Resident #8 on n. The resident was up in the ebulizer bag was observed plastic bag on the bedside			
	2/25/17 at 4:08 p.n	s made of Resident #8 on n. The resident was up in the ebulizer mask was observed e plastic bag.			
	not evidence docu	plan initiated on 3/23/17 did mentation regarding proper dents nebulizer mask.			
	documented, "Iprat	sician's orders for April 2017 tropium-Albuterol Solution (1) ams)/3ML (milliliters) 1 vial 6 hours"			
	administration reco "Ipratropium-Albute (milligrams)/3ML (r every 6 hours" T	erol Solution (1) 0.5-2.5 MG nilliliters) 1 vial inhale orally			
	a.m. with RN (regis	An interview was conducted on 4/26/17 at 8:07 a.m. with RN (registered nurse) #6, the resident's nurse. When asked what process the staff follows		RECEIVED	
		eatment is completed, RN #6			
		nebulizer mask) in the bag."		the state of the s	
	RN #6, she stated,	"I gave her it (the nebulizer noon. I don't remember that, I		MAY 3 1 2017 VDH/OLC	

Facility ID: VA0088

If continuation sheet Page 233 of 278

CENTE		HAND HUMAN SERVICES			FORM APPROVI OMB NO. 0938-03
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	and the second
FREDE	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
F 328	Continued From pa	age 233	F 3	28	
	asked if the reside mask off and placi #6 stated, "No." W	lizer mask) in a bag." When nt was capable of taking the ng it on the bedside table, RN hen asked why staff put the a plastic bag, RN #6 stated, on control."			
	p.m. with LPN #4. followed after a nel completed, LPN #4 (nebulizer mask) or	onducted on 4/26/17 at 1:15 When asked the process staff pulizer treatment was stated, "You wash it ut. Take it apart, dry it and put in asked why staff did this, avoid infection."			
	a.m. with LPN #11, asked the process treatment, LPN #11	onducted on 4/27/17 at 11:07 the unit manager. When staff followed after a nebulizer stated, "After it's done take it with warm water. Air dry it g."			
	member) #1, the ac	p.m. ASM (administrative staff Iministrator and ASM #2, the were made aware of the			
	ADMINISTRATION	y's policy titled "OXYGEN " did not evidence any arding the care of the nebulizer			
	No further informati	on was provided prior to exit.	R	ECEIVED	
		f Nursing" 7th edition, 2009: Id Anne Griffin Perry: Mosby,	200 190		
	Inc; Page 648. "Box 34-2 Sites for and Cause of Health Care-Associated Infections under Respiratory Tract Contaminated respiratory		V	DH/OLC	

Event ID:6R5B11

Facility ID: VA0088

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		AND HUMAN SERVICES			FOR	D: 05/11/201 MAPPROVE D. 0938-039
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495240	B. WING			C I/28/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 3900 PLANK ROAD FREDERICKSBURG, V	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETIO DATE
F 328	of the ß2-adrenerg sulfate, and the an ipratropium bromic obtained from:	tion Solution is a combination gic bronchodilator, albuterol ticholinergic bronchodilator, de. This information was m.nih.gov/dailymed/archives/fd	F 3	328		
	nebulizer equipme Resident #13 was	f failed to store Resident #13's nt in a protective cover. admitted to the facility on				
	including, but not li disorder (1), conge schizoaffective dis MDS (minimum da with an assessmer	tted on 3/31/17 with diagnoses imited to: Diabetes, bipolar estive heart failure, and order (2). On the most recent ata set), a quarterly assessment int reference date of 2/6/17, she ing no cognitive impairment for ions.				
	room was observe observations, Resi mouthpiece were of top of, and in conta 4/25/17 at 12:00 no	ates and times, Resident #13's d. At each of these ident #13's nebulizer tubing and observed lying unprotected on act with, her bedside table: oon and 3:40 p.m.; 4/26/17 at 00 noon; 4/27/17 at 10:32 a.m.		RECEIVED MAY 3 1 2017 VDH/OLC		
	A review of Reside	nt #13's physician's orders				

Event ID: 6R5B11

Facility ID: VA0088

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	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	DNSTRUCTION		NO. 0938-03
ND PLAN (	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING			COMPLETED
		495240	B. WING				C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER	1	1	STRE	ET ADDRESS, CITY, STATE, ZIP CC	DE	
FREDER	ICKSBURG HEALTH	AND REHAB			PLANK ROAD DERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC E DATE
F 328	Continued From p	age 235	F 3	28			
	"DuoNeb Solution (milligrams per thr	ving order written 2/9/17: (3) 0.5 - 2.5 MG/3ML ee milliliters). 1 applicatorful at bedtime for SOB (shortness					
	administration reco	ent #13's MARs (medication ords) revealed that she had cation as ordered in February, 017.					
	asked if she ever t equipment betwee	50 p.m., Resident #13 was ouched the nebulizer an administrations of the stated that she did not.					
	nurse) #12 was as mouthpieces shou administrations. S should be stored in When asked why, equipment] does n control thing." LPN surveyor to Reside shown Resident #1 When asked if the	B2 a.m., LPN (licensed practical ked how nebulizer tubing and ld be stored between the stated this equipment in plastic bags with drawstrings. LPN #12 stated: "So [the not get dirty. It's an infection N #12 accompanied the ent #13's bedside and was 13's nebulizer equipment. equipment was properly aid it was not. LPN #12 stated: a bag to store it in."					
		5 a.m., ASM (administrative the director of nursing was ncern.		ŝ	RECEIVED		
	No further informat (1) "Bipolar disorde	tion was provided prior to exit.			KAY Q I MAY		
	manic-depressive i	illness, is a brain disorder that ifts in mood, energy, activity			/DH/OLC		

Event ID: 6R5B11

Facility ID: VA0088

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	RS FOR MEDICARI	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP	04/28/2017
	RICKSBURG HEALTH			3900 PLANK ROAD FREDERICKSBURG, VA 2240	17
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLET HE APPROPRIATE DATE
F 328	Continued From pa	age 236	F 3	28	
	tasks." This inform	ity to carry out day-to-day nation is taken from the website nih.gov/health/topics/bipolar-dis			
	disorder that affect and acts." This inf website	is a chronic and severe s how a person thinks, feels, ormation is taken from the ih.gov/health/publications/schi index.shtml.			
F 329	is used to prevent to chest tightness, an chronic obstructive group of diseases to airways) such as cl the air passages th emphysema (dama lungs). Albuterol ar used by people who controlled by a sing Albuterol and ipratr medications called ipratropium combin opening the air pass breathing easier." the website https://medlineplus tml. 483.45(d)(e)(1)-(2)	on of albuterol and ipratropium wheezing, difficulty breathing, d coughing in people with pulmonary disease (COPD; a that affect the lungs and monic bronchitis (swelling of at lead to the lungs) and age to the air sacs in the d ipratropium combination is ose symptoms have not been gle inhaled medication. opium are in a class of bronchodilators. Albuterol and tation works by relaxing and sages to the lungs to make This information is taken from .gov/druginfo/meds/a601063.h DRUG REGIMEN IS FREE	F 32	20	IVED
SS=D	Each resident's dru	SARY DRUGS sary Drugs-General. g regimen must be free from . An unnecessary drug is any	·	MAY 3 VDH/	

If continuation sheet Page 237 of 278

	OF DEFICIENCIES	E & MEDICAID SERVICES	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ID PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	1		COMPLETED
		495240	B. WING		C 04/28/2017
AME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP	
REDER	ICKSBURG HEALTH	AND REHAB	1	900 PLANK ROAD REDERICKSBURG, VA 2240	7
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE COMPLETION E APPROPRIATE DATE
r 000		007	F 329	F329	
F 329	Continued From p	age 237	F 329	1. Resident #14 was inte	erviewed and
	(1) In excessive d	ose (including duplicate drug		care plan updated. 2. Current residents on p	osychotropic 6-5-17
	therapy); or			drugs will be reviewed f	
	(2) For excessive	duration; or		reductions. 3. The Director of Nursi	ng/designee will
	(3) Without adequ	ate monitoring; or		re-educate nursing staff	
	(4) Without adequ	ate indications for its use; or		medications. The Direct designee will randomly a	or of Nursing/
Ň	(5) In the presence	e of adverse consequences		on psychotropic to ensur	
	which indicate the discontinued; or	dose should be reduced or		dose reductions and beha interventions are identifi	ed as indicated
	(6) Any combination paragraphs (d)(1)	ons of the reasons stated in through (5) of this section.		weekly times four weeks monthly times two mont 4. The Director of Nursi	hs. ng/designee will
	483.45(e) Psycho Based on a comp resident, the facili	tropic Drugs. rehensive assessment of a ty must ensure that		report the audit results m Quality Assurance Perfo Improvement committee compliance and/or revisi	rmance for continued
	(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;				
	oradual dose redu	o use psychotropic drugs receive actions, and behavioral ass clinically contraindicated, in	)		
	an effort to discon	itinue these drugs; ENT is not met as evidenced		RECEIVED	
	bv:				
	Based on resident interview, staff interview, clinical record review and facility document review, it was determined that facility staff failed to ensure the drug regimen for one of 32			VDH/OLC	
		ns Obsolete Event ID: 6R5B		icility ID: VA0088	continuation sheet Page 238 of 2

		AND HUMAN SERVICES	FORM APPR OMB NO. 0938					
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	IPLE CONSTRUCTION		ATE SURVEY OMPLETED		
		495240	B. WING		04/28/2017			
NAME OF F	ROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIF	CODE			
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2240	7			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 329	Continued From pa	age 238	F 3	29				
		rvey sample, (Resident #14), ecessary medications.						
	administration of p (antianxiety medica several occasions	cal interventions prior to the rn (as needed) Ativan ation [1]) to Resident #14 on in the month of April 2017.						
	The findings includ	le:						
	Resident #14 was admitted to the facility o 3/4/13 and readmitted on 7/5/15 with diagree that included but were not limited to: gastroparesis [2], generalized anxiety dison history of mental and behavioral disorders, blood pressure, and type two diabetes. Ref #14's most recent MDS (minimum data set a quarterly assessment with an ARD (assessment reference date) of 4/4/17. Ref #14 was coded as being cognitively intact if ability to make daily decisions, scoring 15 of 15 on the BIMS (Brief Interview for Mental exam. Resident #14 was coded as being independent with transfers, and ambulation independent with supervision only for dress eating, toileting, and bathing.							
	(Physician Order S following order: "A (milligrams) (Loraz every 6 hours as n from 7 pm to 7 am (Nurse Practitioner	at #14's most recent POS Sheet) documented the tivan Tablet 0.5 MG zepam) Give 0.5 mg by mouth eeded for anxiety. Do not give per Psych (psychiatric) NP r)." at #14's April 2017 MAR		RECEIVED MAY 3 1 2017 VDH/OLC				
	(Medication Admin	istration Record) revealed that ived prn Ativan on the following						

Facility ID: VA0088

If continuation sheet Page 239 of 278

			HAND HUMAN SERVICES	• • •		FORM APPE OMB NO. 0938	
495240     B. WING     04/28/2017       AME: OF PROVIDER OR SUPPLER     STREET ADDRESS. CITY, STATE 2/P CODE     3000 PLANK ROAD       PREDERICKSBURG HEALTH AND REHAB     STREET ADDRESS. CITY, STATE 2/P CODE     3000 PLANK ROAD       MAIL OF PROVIDER OF AUALTH AND REHAB     STREET ADDRESS. CITY, STATE 2/P CODE     3000 PLANK ROAD       MAIL OF CONSIDERING WAST BE PRECEDED STULL     PREDERICKSBURG, VA 22407     PROVIDER OF ADDRESS PLANK ROAD     PREDERICKSBURG, VA 22407       TAG     EXAMPLEY YANDS IS PRECEDED STULL     PREDERICKSBURG, VA 22407     PREDERICKSBURG, VA 22407     PREDERICKSBURG, VA 22407       TAG     EXAMPLEY YANDS IS PRECEDED STULL     PREDERICKSBURG, VA 22407     PREDERICKSBURG, VA 22407     PREDERICKSBURG, VA 22407       F 329     Continued From page 239     F 329     F 329     F 329       Gates and times:     "4/1/17 at 8.316 a.m., and 4.47 p.m., 4/4/17 at 8.33 a.m., and 4.05 p.m., 4/4/17 at 8.34 a.m., and 6.15 p.m., 4/10/17 at 8.13 a.m., and 3.25 p.m., 4/10/17 at 8.34 a.m., and 4.25 p.m., 4/12/17 at 8.34 a.m., and 4.25 p.m., 4/12/17 at 8.34 a.m., and 4.25 p.m., 4/12/17 at 8.34 a.m., and 4.26 p.m., 4/12/17 at 8.34 a.m., and 4.26 p.m., 4/22/17 at 8.42 a.m., and 5.00 p.m., 4/22/17 at 8.42 a.m., and 4.26 p.m., 4/22/17 at 8.42 a.m., and 5.00 p.m., 4/22/17 at 8.42 a.m., and 5.00 p.m., 4/22/17 at 8.42 a.m.,						COMPLETE	
300 PLANK ROAD PREDERICKSBURG HEALTH AND REHAB     300 PLANK ROAD PREDERICKSBURG, VA 22407     j.so.       0x110 NRT1X AG     SUMMARY STATEMENT OF DEFICIENCIES (EACH BERGENCY MIST BE PRECEDED BY FUL REGULATORY OR ISC IDENTIFYING INFORMATION)     D PREFX IAG     PROVERSITY AND CORRECTION (EACH BERGENCY MIST BE PRECEDED BY FUL REGULATORY OR ISC IDENTIFYING INFORMATION)     D PREFX IAG     PROVERSITY AND CORRECTION (EACH BERGENCY DI THE APPROPRIME DEFICIENCY)     J.so.       F 329     Continued From page 239 dates and times:     F 329     F 329     F 329       * 4/1/17 at 8:16 a.m., and 6:35 p.m. 4/2/17 at 8:16 a.m., and 6:55 p.m. 4/10/17 at 8:16 a.m., and 6:55 p.m. 4/10/17 at 8:16 a.m., and 6:55 p.m. 4/10/17 at 8:16 a.m., and 6:55 p.m. 4/12/17 at 8:56 a.m., and 4:30 p.m. 4/12/17 at 8:68 a.m., and 4:30 p.m. 4/12/17 at 8:43 a.m. 4/12/17 at 8:42 a.m., and 4:25 p.m. 4/22/17 at 8:42 a.m., and 5:00 p.m. 4/22/17 at 8:42 a.m. 4/22/17 at 7:49 p.m. <sup>3</sup> RECEIVED MICL       Notes on the April 2017 MAR and April 2017 nursing notes failed to reveal that non-pharmacological interventions were attempted prior to the administration of prn Altivan.     RECEIVED MICL       On 4/26/17 at 1:25 p.m., an interview was conducted with Resident #14. stated that facility staff did not attempt other interventions prior to administration of prn Altivan.     RECEIVED			495240	B. WING			017
REDERICKSBURG, VA 22407         XX1 D       SUMMARY STATEMENT OF DEFICIENCIES. REGULATORY OR LSC IDENTIFYING INFORMATION)       D       PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCIES MUST BE RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D       PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCIES) (EACH DEFICIES) (EACH DEFI	AME OF F	PROVIDER OR SUPPLIER				ODE	
<ul> <li>Hindi K. (EACH DETICENCY MUST BE PRÉCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>F 329 Continued From page 239 dates and times:</li> <li><i>"4/1/17</i> at 9:02 a.m., 6:35 p.m. 4/2/17 at 8:16 a.m., and 4:47 p.m. 4/2/17 at 8:16 a.m., and 4:47 p.m. 4/3/17 at 8:37 a.m., and 4:05 p.m. 4/6/17 at 8:16 a.m., and 6:24 p.m. 4/6/17 at 8:16 a.m., and 6:15 p.m. 4/10/17 at 9:02 a.m., and 5:55 p.m. 4/11/17 at 9:02 a.m., and 5:55 p.m. 4/11/17 at 9:02 a.m., and 5:25 p.m. 4/10/17 at 9:10 a.m., and 6:15 p.m. 4/11/17 at 9:02 a.m., and 3:25 p.m. 4/11/17 at 8:36 a.m., and 6:15 p.m. 4/12/17 at 8:36 a.m., and 6:37 p.m. 4/12/17 at 8:36 a.m., and 3:25 p.m. 4/12/17 at 8:36 a.m., and 3:26 p.m. 4/12/17 at 8:36 a.m., and 4:36 p.m. 4/12/17 at 8:36 a.m., and 4:36 p.m. 4/12/17 at 8:36 a.m., and 4:36 p.m. 4/12/17 at 8:37 a.m. 4/12/17 at 8:37 a.m. 4/22/17 at 8:38 a.m. 4/22/17 at 8:38 a.m. 4/22/17 at 8:38 a.m. 4/22/17 at 8:38 a.m. 4/</li></ul>	REDER	ICKSBURG HEALTH	AND REHAB				
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<ul> <li>4/19/17 at 10:08 a.m., and 4:00 p.m.</li> <li>4/20/17 at 8:42 a.m., and 4:25 p.m.</li> <li>4/21/17 at 4:15 a.m.</li> <li>4/22/17 at 8:42 a.m.</li> <li>4/23/17 at 8:42 a.m., and 5:00 p.m.</li> <li>4/24/17 at 3:55 p.m.</li> <li>4/25/17 at 8:27 a.m., and 5:00 p.m.</li> <li>4/26/17 at 7:49 p.m."</li> </ul> Notes on the April 2017 MAR and April 2017 nursing notes failed to reveal that non-pharmacological interventions were attempted prior to the administration of prn Ativan. On 4/26/17 at 1:25 p.m., an interview was conducted with Resident #14. Resident #14 stated that facility staff did not attempt other interventions prior to administering her prn			-				
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<ul> <li>4/22/17 at 8:42 a.m.</li> <li>4/23/17 at 8:12 a.m., and 5:00 p.m.</li> <li>4/24/17 at 3:55 p.m.</li> <li>4/25/17 at 8:27 a.m., and 4:46 p.m.</li> <li>4/26/17 at 7:49 p.m."</li> <li>Notes on the April 2017 MAR and April 2017</li> <li>nursing notes failed to reveal that</li> <li>non-pharmacological interventions were</li> <li>attempted prior to the administration of prn</li> <li>Ativan.</li> <li>On 4/26/17 at 1:25 p.m., an interview was</li> <li>conducted with Resident #14. Resident #14</li> <li>stated that facility staff did not attempt other</li> <li>interventions prior to administering her prn</li> </ul>							
<ul> <li>4/23/17 at 8:12 a.m., and 5:00 p.m.</li> <li>4/24/17 at 3:55 p.m.</li> <li>4/25/17 at 8:27 a.m., and 4:46 p.m.</li> <li>4/26/17 at 7:49 p.m."</li> <li>Notes on the April 2017 MAR and April 2017 nursing notes failed to reveal that non-pharmacological interventions were attempted prior to the administration of prn Ativan.</li> <li>On 4/26/17 at 1:25 p.m., an interview was conducted with Resident #14. Resident #14 stated that facility staff did not attempt other interventions prior to administering her prn</li> </ul>							
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Ativan. On 4/26/17 at 1:25 p.m., an interview was conducted with Resident #14. Resident #14 stated that facility staff did not attempt other interventions prior to administering her prn RECEIVED MAY 3 2037 VDH/OLC		nursing notes faile	d to reveal that				
conducted with Resident #14. Resident #14 stated that facility staff did not attempt other interventions prior to administering her prn		attempted prior to t		ŕ	ECEIVED		
stated that facility staff did not attempt other VDH/OLC interventions prior to administering her prn							
AND AND ADD TO ADD TO A STORE A 14 STORE		stated that facility s interventions prior	staff did not attempt other to administering her prn		/DH/OLC		

Facility ID: VA0088

If continuation sheet Page 240 of 278

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SOPPLIER/SCHA IDENTIFICATION NUMBER:       (X2) MOLTIFIC CONSTRUCTION       C         495240       B. WING       04/28/2         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         FREDERICKSBURG HEALTH AND REHAB       STREET ADDRESS, CITY, STATE, ZIP CODE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES ID       PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE						OMB NO. 0938-039 (X3) DATE SURVEY
under of PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2/P CODE       Status     STREET ADDRESS, CITY, STATE, 2/P CODE       Status     Status     Status       (%1)/D     SUMMARY STATEMENT OF DEFICIENCES.     UP     PROVIDER OR ADD       (%1)/D     SUMMARY STATEMENT OF DEFICIENCES.     UP     PROVIDER OR ADD       (%1)/D     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       (%2)/D     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     SUMMARY STATEMENT OF DEFICIENCES.     UP     Providence on ADD       TAC     On 4/26/17 at 1:45 p.m., an Interview was     Conducted with LPN 44 stated that fieldent?     Providence on ADD       Tactoreations Should be attempts non-pharmacological interventio	STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED
NMME OF PROVIDER OR SUPPLER       STREET ADDRESS. CITY, STATE, 2/P CODE         FREDERICKSBURG HEALTH AND REHAB       SUMMARY STATEMENT OF DERVIENCES       PREDERICKSBURG, VA 22407         (M) ID PRETIX       SUMMARY STATEMENT OF DERVIENCES       PREDERICKSBURG, VA 22407         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       PREDERICKSBURG, VA 22407         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       PREDERICKSBURG, VA 22407         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       PREDERICKSBURG, VA 22407         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       PREDERICKSBURG, VA 22407         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       PREDERICKSBURG, VA 22407         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       PREVENTION         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       PREVENTION         (F3) ID TAC       SUMMARY STATEMENT OF DERVIENCES       F329         (F3) ID TAC       On 4/26/17 at 1:45 p.m., an interview was conducted with LPN (Hon asked about the process staff follows prior to administering pri anti-anxiety medications. LPN 4# stated, "It depends on why the resident is anxious. Sometimes I do, sometimes I don't."       On 4/26/17 at 4:33 p.m., an interview was conducted with LPN #1, a nurse who administered Ativan to Resident #14 on some of the dates listed above. LPN #1 stated that Resident #14 will refuse non-pharmacological interventions should be attempted prior to administering pri atti-anxiety medications. LPN			495240	B. WING		04/28/2017
FREDERICKSBURG HEALTH AND REHAB     3300 PLANK ROAD       MILE     ICAN RESUMMENT STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAST BE PRECEDED BY FULL TAG     ID PREFX REGULATORY OR LSC DEMITIENTING INFORMATION)     ID PREFX ICAC CORRECTION ACTION ACCOUNT OF CEACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT OF LSC DEMITIENTING INFORMATION)     ID PREFX ICAC CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT ACCOUNT (EACH CORRECTION ACCOUNT	NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	
<ul> <li>If any the provided and the process of the proces of the process of the process of the proces of the process of t</li></ul>			AND REHAB			
<ul> <li>They just give it to me."</li> <li>On 4/26/17 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who administered Ativan on some occasions to Resident #14. When asked about the process staff follows prior to administering a prn anti-anxiety agent, LPN #4 stated that she would try to attempt non-pharmacological interventions such as diverting the resident #3 attention before giving the prn medication. When asked if she attempts non-pharmacological interventions every time prior to administering prn anti-anxiety agent. LPN #4 stated. "It depends on why the resident is anxious. Sometimes I don't."</li> <li>On 4/26/17 at 4:33 p.m., an interview was conducted with LPN #1, a nurse who administered Ativan to Resident #14 on some of the dates listed above. LPN #1 stated that the resident given attempted prior to administering prn anti-anxiety medications. LPN #1 stated that the resident will say that she aready attempted interventions when she requests her Ativan. When asked if this was documented in the clinical record. LPN #1 stated that the sident #14 will refuse non-pharmacological interventions prior to administering prn anti-anxiety medications. LPN #1 stated that the resident will say that she aready attempted interventions when she requests her Ativan. When asked if this was documented in the clinical record. LPN #1 stated that the information was not document the non-pharmacological interventions when she requests her Ativan. When asked if this or outine with her that I don't document."</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	( EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMPLETIC E APPROPRIATE DATE
Ch 4/26/17 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #4, a nurse who administered Ativan on some occasions to Resident #14. When asked about the process staff follows prior to administering a primerventions such as diverting the resident's attention before giving the primedication. When asked if she attempts non-pharmacological interventions every time prior to administering pri- anti-anxiety medications, LPN #4 stated, "It depends on why the resident is anxious. Sometimes I do, sometimes I don't." On 4/26/17 at 4:33 p.m., an interview was conducted with LPN #1, a nurse who administered Ativan to Resident #14 on some of the dates listed above. LPN #1 stated that non-pharmacological interventions should be attempted prior to administering prin attempted prior to administering printi-anxiety medications. LPN #1 stated that the resident will say that she already attempted interventions when she requests her Ativan. When asked if this was documented in the clinical record, LPN #1 stated that the sinformation was not document the non-pharmacological interventions the resident attempted interventions the resident attempted. LPN #1 stated that she does not document the non-pharmacological interventions the resident attempted. LPN #1 state disterventions the resident att	F 329	Continued From pa	age 240	F 3	29	
conducted with LPN (licensed practical nurse) #4, a nurse who administered Ativan on some occasions to Resident #14. When asked about the process staff follows prior to administering a pm anti-anxiety agent, LPN #4 stated that she would try to attempt non-pharmacological interventions such as diverting the resident's attention before giving the prn medication. When asked if she attempts non-pharmacological interventions every time prior to administering prn anti-anxiety medications, LPN #4 stated, "It depends on why the resident is anxious. Sometimes I do, sometimes I don't." On 4/26/17 at 4:33 p.m., an interview was conducted with LPN #1, a nurse who administered Ativan to Resident #14 on some of the dates listed above. LPN #1 stated that non-pharmacological interventions should be attempted prior to administering prn anti-anxiety medications. LPN #1 stated that Resident #14 will refuse non-pharmacological interventions prior to administering her Ativan. LPN #1 stated that the resident will say that she already attempted interventions when she requests her Ativan. When asked if this was documented in the clinical record, LPN #1 stated that thesi information was not document #14 on dily basis and that she does not document the non-pharmacological interventions the resident attempted. LPN #1 stated, "It's so routine with her that I don't document." On 4/26/17 at 5:00 p.m., ASM (administrative		•	•			
On 4/26/17 at 5:00 p.m., ASM (administrative		conducted with LPI a nurse who admin occasions to Resid the process staff fo prn anti-anxiety ag would try to attemp interventions such attention before giv asked if she attem interventions every anti-anxiety medica depends on why th Sometimes I do, so On 4/26/17 at 4:33 conducted with LP administered Ativa the dates listed ab non-pharmacologic attempted prior to medications. LPN refuse non-pharma administering her A resident will say th interventions when When asked if this record, LPN #1 sta not documented. L with Resident #14 does not document interventions the re stated, "It's so rout	N (licensed practical nurse) #4, histered Ativan on some lent #14. When asked about ollows prior to administering a ent, LPN #4 stated that she of non-pharmacological as diverting the resident's ving the prn medication. When pts non-pharmacological r time prior to administering prn ations, LPN #4 stated, "It he resident is anxious. cometimes I don't." p.m., an interview was N #1, a nurse who n to Resident #14 on some of ove. LPN #1 stated that cal interventions should be administering prn anti-anxiety #1 stated that Resident #14 wil acological interventions prior to Ativan. LPN #1 stated that the at she already attempted n she requests her Ativan. was documented in the clinica- ated that this information was .PN #1 stated that she works on daily basis and that she it the non-pharmacological esident attempted. LPN #1	1		
		On 4/26/17 at 5:00	) p.m., ASM (administrative the administrator and ASM #2.		VDH/OLC	

Facility ID: VA0088

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	RS FOR MEDICARE		Τ		OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDIN	WG	С
		495240	B. WING _		04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP	CODE
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2240	7
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC IE APPROPRIATE DATE
F 329	Continued From pa	age 241	F 32	29	
	the DON (Director of the above conce	or Nursing) were made aware erns.			
	The facility policy titled, "Chemical Restraint" documents in part, the following: "It is the policy of the facility to comply with OBRA regulations stating that the resident has the right to be free of chemical restraints imposed for the purpose of discipline or staff convenience, and which are not required to treat the resident's medical condition. PROCEDURE: Interventions to be used to avoid using psycho-pharmacologic drugs may include: exercise, all departments may be involved, verbal instructions, speak clearly, diversion activities such as TV/Videos, Music therapy, Bingo, Picture Books. etc., frequent visits, Massage/Therapeutic touch/warm hands, Pillows and other positioning aids, Food/Warm beverages, Toileting."				
	information was ob Institutes of Health	m.nih.gov/pubmedhealth/PMH			
F 360	disorder that slows food from the stom This information wa Institutes of Health	Delayed gastric emptying, or stops the movement of each to the small intestine. as obtained from The National DIET MEETS NEEDS OF	F 36	SO RECEIVED	
SS=D				IN VEIVEL/	
SS=D		ovide each resident with a		And the termination	
SS=D	nourishing, palatab	ovide each resident with a le, well-balanced diet that aily nutritional and special		NAME STORY	

Facility ID: VA0088

If continuation sheet Page 242 of 278

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391

And a second s			/Y2\ K# 0	TIPLE CONSTRUCTION			E SURVEY	
STATEMENT AND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED	
						1	С	
		495240	B. WING			04/:	28/2017	
NAME OF F	PROVIDER OR SUPPLIEF	ર		STREET ADDRESS, CITY, STATE, ZIP CO 3900 PLANK ROAD	JUE			
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA 22407				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD	IBE	(X5) COMPLETION DATE	
E 360	Continued From p	nage 242	F:	360				
1 300	preferences of ea			F360				
	This REQUIREMENT is not met as evidenced			1. Residents were offe	rod			
	by:	the staff intensions and facility		substitutes and refused				
	Based on observation, staff interview, and facility document review, it was determined that facility							
	staff failed to serv	e food at the appropriate		2. The Certified Dietary		ager	6-5-17	
	nutritive value.			re-educated dietary sta				
	The facility staff fa	ailed to ensure that the		following menu recipes		,		
	appropriate amou	int of meat was mixed into the		3. The Certified Dietary		-		
	second batch of meat sauce and failed to ensure that 14 residents were served the appropriate amount of protein for lunch on 4/25/17.			designee will conduct r				
				audits to ensure food is				
				the appropriate nutritive	e valu	e three	)	
	The findings inclu	de:		times a week times fou	r weel	ks and		
	On 4/25/17 at 11:	45 a.m., tray line was observed.		then monthly times two	mont	hs.		
	The following food	d items were being served:		<ol> <li>The Certified Dietary</li> </ol>	Mana	ager/		
	Spachatti			designee will report the	audit	S		
	Spaghetti Meat Sauce			results monthly to the C	Quality	/		
	Green Peas			Assurance Performanc	е			
	Mashed Potatoes Pureed Spaghetti			Improvement committe	e to e	nsure		
	Chicken Patty			continued compliance a				
	Meat/Hamburger	Steak		revision.				
	Fries Chicken noodle s	oup						
	The meat sauce v	was observed being served in a						
	6 ounce ladle. Th	e meat sauce was observed to		RECEIVED				
	be very chunky w			a 19 ferrar Saff ferrar 2 19 ferrar 1946.				
	On 4/25/17 at 12:33 p.m., the first batch of meat			MAY 3 1 2017				
	sauce was empty	<i>.</i>		VDH/OLC				
	(other staff memb	proximately 12:35 p.m., OSM per) #10, the Dietary manager, ring a can of red sauce to OSM		. 1999 II - U - 1994 - 1993 II				
				if an	ntinuntin	n choot F	Pane 243 of 2	

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

Event ID:6R5B11

Facility ID: VA0088

If continuation sheet Page 243 of 278

ATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES		TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
D PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	C
		495240	B. WING _		04/28/2017
AME OF F	PROVIDER OR SUPPLIEF	2		STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD	P CODE
REDER	ICKSBURG HEALTH	HAND REHAB		FREDERICKSBURG, VA 224	07
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETI HE APPROPRIATE DATE
F 360	Continued From p	page 243	F 3(	60	
	#11, the cook.				
	<ul> <li>#11, the cook was from the can into additional meat w pot of sauce.</li> <li>At approximately meat sauce was p second batch of n very little meat in appeared very thi residents were primeat sauce.</li> <li>On 4/25/17 at 12: conducted with O much meat was u sauce, OSM #11 pounds of meat." was used in the s stated, "I didn't ac OSM #11 stated t</li> </ul>	proximately 12:35 p.m., OSM s observed putting the sauce a pot onto the stove. No as observed being added to the 12:40 p.m. the second batch of blaced on the tray line. The neat sauce appeared to have the sauce. The sauce n (not chunky). 14 trays for 14 epared with the second batch of 59 p.m., an interview was SM #11. When asked how ised in the first batch of meat stated, "The recipe called for 20 When asked how much meat econd batch of sauce, OSM #11 Id meat. I only had sauce left." hat some remnants of meat h were mixed into the second			
	conducted with O when she ran out she had told the o stated that the die #11 a can of red s batch. OSM #11 for the kitchen to	0 a.m., further interview was SM #11. OSM #11 stated that of the meat for the meat sauce dietary manager. OSM #11 etary manager had given OSM sauce to use for the second stated that it was not common run out of food items. OSM #11 up to the Dietary Manager to d for each meal.		RECEIVED MAY 9.1 2007 VDH/OLC	

	OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C
		495240	B. WING _		04/28/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3900 PLANK ROAD FREDERICKSBURG, VA 2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLÉTIO O THE APPROPRIATE DATE DATE
F 360	When asked how the be used for the meat the recipe called for meat. When aske for the sauce on 4, didn't run out of mease cond pan of mease the second pan of mease the meat to the #10 stated, "No I did stated that the coord and that it might has batch of meat sauce On 4/26/17 at 5:00 staff member) #1, the DON (Director of the above finding)	SM 10, the Dietary Manager. much meat was supposed to eat sauce, OSM #10 stated that or 22 lbs (pounds) of ground d if the kitchen ran out of meat (25/17, OSM #10 stated, "We eat for the sauce. I pulled the at out of the oven for the cook. en asked if she saw the cook e second batch of sauce, OSM idn't see her add it." OSM #10 k had a second pan of meat ave all been added to the first ce.	F 3(	60	
	following: "Portion 95 Ingredient Beef 22 3/4 LB (pounds A policy could not I	Size 6 Oz (ounces), Servings: , Ground Lean, 80/20, Amount )." pe provided. No further			
F 364 SS=B	•	ovided prior to exit. JTRITIVE VALUE/APPEAR, FER TEMP	F 36	64	
	(d) Food and drink				
			(	RECEIVED	
	Each resident rece	eives and the facility provides-	3		
	(d)(1) Food prepar	ed by methods that conserve or, and appearance;			

Facility ID: VA0088

If continuation sheet Page 245 of 278

TATEMENT		E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETI
F 364	Continued From p	age 245	F 36	<sup>4</sup> F364	
	and at a safe and	appetizing temperature;		1. New thermometers w	ere
		NT is not met as evidenced		purchased for the dietar	
	by: Based on observa	ation, resident interview, staff		department.	5
	interview, and faci	lity document review, it was		2. The Certified Dietary	Manager re-
	determined that fa	cility staff failed to serve food at rature during the lunch meal on		educated the dietary sta	-
	$\frac{1}{4/25/17}$	rature during the lunch mean of	t ,	food at a palatable temp	in on oerving
				•	
	The findings includ	40.		3. The Certified Dietary conduct random audits (	•
	The multiga mout				
	On 4/25/17 at 11:3	80 a.m., temperatures of the		temperatures three time	
		vere conducted with OSM per) #24, the Regional District		times four weeks and th	en montniy
	Dietary Manager.	The following food items and		times two months.	
		e recorded in degrees		4. The Certified Dietary	-
	Fahrenheit.			designee will report the	
	Chicken Patty: 16			results monthly to the Q	•
	Hamburger Steak Green Peas: 191.3			Assurance Performance	
	Mashed Potatoes:			Improvement committee	to ensure
	Pureed Spaghetti:	161.8		continued compliance a	nd/or
	Pureed Peas: 163 Meat Sauce (Regi			revision.	
	Regular Spaghetti				
	On 4/25/17 at 12:	58 p.m., the last food cart was			
	taken to the West	1 unit. At 1:27 p.m. e taken of food items on the test			
	tray by OSM #10,	the Dietary Manager. The		RECEIVED	
	following food iten recorded in degree	ns and temperatures were es Fahrenheit:		MAX 31 297	
	Chicken Patty: 10- Hamburger Steak			vdH/olg	
	0 4/05/47 -+ 4-0	7 p.m., OSM #10 stated that the			

			(20) 841 8	TIPLE CONSTRUCTION	(X3) DATE :	938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPL	
					С	
		495240	B. WING			3/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 364	Continued From pa	age 246	F 3	64		
		have been broken because				
		v recordings. OSM #10 then ermometer from the kitchen.				
		and hamburger steak tasted				
		and another surveyor. The				
	hamburger steak a	lso tasted bland.				
		p.m., OSM #10 took				
		e following food items with the				
	second thermomet	er in degrees Fahrenheit:				
	Green Peas: 39.5 Mashed Potatoes:	46.5				
	second thermomet This writer and a se Green Peas and M tasted cold. The s	p.m., OSM #10 stated that the er must have been broken. econd surveyor tasted the ashed Potatoes. The food econd surveyor offered to grab er from kitchen staff.	1			
		p.m., the following food items vere recorded with the third grees Fahrenheit:				
	Spaghetti with mea Pureed peas: 41.2 Pureed Spaghetti: 4					
		p.m., this writer and a second spaghetti with meat sauce,		RECEIVED)		
	pureed peas and p	ureed spaghetti. The food				
		ietary manager was asked to The dietary manager stated		MAY 3 1 2017		
	that all three thermo	ometers must have been		VDH/OLC		
	broken because of recordings.	the low temperature		and the second sec		
	$O_{\rm D}  4/25/17  {\rm ot}  1.30$	p.m., an interview was				

Event ID:6R5B11

Facility ID: VA0088

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 495240 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

## F 364 Continued From page 247

conducted with OSM #10. When asked what she thought of the food, OSM #10 stated, "It tastes good." When asked what she thought of the temperature of the food, OSM #10 stated, "I am not going to say it was cold, the thermometers were broken." When asked how the temperature of the food felt to her, OSM#10 stated, "I thought it was luke warm." When asked if she would eat luke warm food, OSM #10 stated, "Yes."

On 4/26/17 at 10:10 a.m., further interview was conducted with OSM #10. OSM #10 stated that the reason why she was recording low temperatures was because all three thermometers were set to degrees Celsius not degrees Fahrenheit. OSM #10 stated that dietary staff usually record temperatures in degrees Fahrenheit.

The food temperatures that were recorded would have been the following in degrees Fahrenheit if the thermometer was set to degrees Celsius.

Chicken Patty: 104.5 degrees Celsius would convert to 220 degrees Fahrenheit. (The chicken patty was initially at a temperature of 162.8 degrees Fahrenheit on the steam table).

Hamburger Steak: 97.3 degrees Celsius would convert to 207.1 degrees Fahrenheit. (The hamburger steak was initially at a temperature of 160.1 degrees Fahrenheit on the steam table).

Green Peas: 39.5 degrees Celsius would convert to 103.1 degrees Fahrenheit. Mashed Potatoes: 46.5 degrees Celsius would convert to 115.7 degrees Fahrenheit. Spaghetti with meat sauce: 44.2 degrees Celsius would convert to 111.5 degrees Fahrenheit.

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

Facility ID: VA0088

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PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

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COMPLETED

04/28/2017

(X5)

COMPLETION

DATE

F 364

PRINTED: 05/11/2017 FORM APPROVED OMB NO 0938-0391

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

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0	OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495240	B, WING		C 04/28	3/2017		
	PROVIDER OR SUPPLIER	+332+0		STREET ADDRESS, CITY, STA				
				3900 PLANK ROAD				
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA	22407			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 364	Continued From pa	age 248	F:	364				
,		degrees Celsius would						
	convert to 106.1 de	egrees Fahrenheit.						
		40.5 degrees Celsius would						
	convert to 104.9 de	grees Ceisius.						
	Individual interview	s conducted with two						
		sidents revealed concerns that	t					
	the food was alway	s cold and not palatable.						
	On 4/26/17 at 2:30	p.m. a group interview was						
		en residents. Four residents						
	stated that the food	I was cold.						
	meeting, ASM (adm the administrator a	p.m. at the end of day ninistrative staff member) #1, nd ASM #2, the DON (Director ade aware of the above						
	Palatability" docum the center policy th methods that conse	tled, "Food: Quality and ents in part, the following: "It is at, food is prepared by erve nutritive value, flavor and is palatable, attractive and er temperature."	5					
F 371 SS=E	483.60(i)(1)-(3) FO	ion was presented prior to exit OD PROCURE, /SERVE - SANITARY		371				
		d from sources approved or ctory by federal, state or local		llandle dae is "ende" solvest to de "the de red anatore				
	autornoo.			RECEIVED				
	from local produce	e food items obtained directly rs, subject to applicable State						
	and local laws or re	egulations.		VDH/OLC				
					If continuation sheet Pag	0. 240 of 5		
)RM CMS-24	567(02-99) Previous Versions	s Obsolete Event ID: 6R5B	11	Facility ID: VA0088	in continuation sheet hay			

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

Facility ID: VA0088

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

PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391

6-5-17

CENIER	S FOR MEDIUANL	a MEDIONID OLIVIOLO			(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES ()		(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	COMPLETED
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILD	NG	
					C
		495240	B. WING		04/28/2017
			I	STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PI	ROVIDER OR SUPPLIER			3900 PLANK ROAD	
FREDERI	CKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 371	Continued From pa	age 249	· F:	<sup>371</sup> F371	
	(ii) This provision d	loes not prohibit or prevent		1. The Certified Dietary Mana	ager
	facilities from using	produce grown in facility		cleaned the debris from the n	
	gardens, subject to	compliance with applicable	plicable cleaned the debris i		
	safe growing and f	ood-handling practices.		The cook applied a beard gua	
		to a standarda residents		The Plant Ops Director clean	ed the
	(iii) This provision ( from consuming for	does not preclude residents ods not procured by the facility.		fan. The Certified Dietary Ma	nager
				disposed of the unlabeled for	od and
	(i)(2) - Store, prepa	are, distribute and serve food in		labeled the prepared serving	
	accordance with p	rofessional standards for food		• •	0
	service safety.			accordingly.	

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, and facility document review it was determined that facility staff failed to store, prepare, and serve food in a sanitary manner.

1. The facility staff failed to ensure the facility's mixer was free from debris.

2. The facility staff failed to wear hair restraints while in the facility kitchen.

3. The facility staff failed to ensure clean dishware was free from debris by a dusty fan.

4. The facility staff failed to label the open date of a plastic bag of opened meatballs; and facility staff failed to label the prepare date or use by date of seven bowls of applesauce, one bowl of cottage cheese, and 5 cups of fruit that were sitting on a rack in the refrigerator.

accordingly. 2. The Certified Dietary Manager re-

educated the dietary staff on storing, preparing, and serving food in a sanitary manner.

3. The Certified Dietary Manager will, conduct random audits of the kitchen to ensure equipment is free from debris, hair restraints are used, stored dish-ware is clean, and foods labeled three times a week times four weeks and then monthly times two months.

4. The Certified Dietary Manager/ designee will report the audits results monthly to the Quality Assurance Performance Improvement committee to ensure continued compliance and/or revision.

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

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				Va Nov	1. A.A	,			

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If continuation sheet Page 250 of 278

		AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495240	B. WING	·	C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2	2407
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ARAGA REFERENCED T	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 371	Continued From pa	age 250	F:	371	
	The findings includ	le:			
	1. The facility staff mixer was free fro	failed to ensure the facility's m debris.			
	was conducted. A observed to have t it. When the cover	a.m., inspection of the kitchen t 6:50 a.m., the mixer was the plastic cover over the top of was removed, dried up debris he outside of the bowl of the haside of the mixer.			
	conducted with OS dietary aide. When and ready to be us should be. OSM # lifted the cover. O clean." When ask ensuring the mixer "The cook cleans i mixer it is suppose	a.m., an interview was M (other staff member) # 9, a n asked if the mixer was clean ed, OSM #9 stated that it 9 walked over to the mixer and SM #9 stated, "No it's not ed who was responsible for was clean, OSM #9 stated, t. After we are done using the ed to be cleaned right away." am going to take the cover off is not clean."			
	conducted with OS When asked when OSM #10 stated, " stated the staff that responsible for cle	3 a.m., an interview was SM #10, the Dietary Manager. In the facility mixer was cleaned, After each use." OSM #10 It use the mixer, are aning the mixer when they are tated, "It has been taken care			
	staff member) #1,	p.m., ASM (administrative the Administrator and ASM #2, of Nursing) were made aware erns.			
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID: 6R5B		Facility ID: VA0088 EIVED	If continuation sheet Page 251 of 278

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	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			RINTED: 05/11/2017 FORM APPROVED MB NO: 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C
	495240	B. WING		04/28/2017
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION

#### F 371 Continued From page 251

The facility policy titled, "Equipment," documents in part the following: "It is the center policy that all foodservice equipment is clean, sanitary, and in proper working order. Action Steps: 1. The Food Service Director will ensure that all equipment is routinely cleaned and maintained in accordance to manufacturer directions and training materials. 2. The Food Service Director will ensure that all staff members are properly trained in the cleaning and maintenance of all equipment. 3. The Food Services Director ensures that all food contact equipment is cleaned and sanitized after every use. 4. The Food Services Director ensures that all non-food contact equipment is clean..."

No further information was presented prior to exit.

2. The facility staff failed to wear hair restraints while in the facility kitchen.

On 4/25/17 at 11:45 a.m., tray line was observed. OSM (other staff member) # 15, the cook, was observed in the kitchen preparing brownie mix. OSM #15 was observed with a short beard. He was not wearing a beard restraint. On 4/25/17 at 12:58 p.m., at the end of tray line, OSM # 15 was observed carrying the tray of brownie batter. He was not wearing a beard restraint.

On 4/25/17 at 1:37 p.m., an interview was conducted with OSM # 15. When asked what he should be wearing while preparing food, OSM #15 stated, "A beard net." When asked why a beard net or other hair restraints should be worn while preparing food, OSM # 15 stated, "So hair won't get into the food." OSM #15 confirmed that

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Facility ID: VA0088

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		AND HUMAN SERVICES					FORM	): 05/11/2017 1 APPROVED
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′			0	(X3) DA	0. 0938-0391 TE SURVEY MPLETED
		495240	B. WING				04	C / <b>28/2017</b>
NAME OF I	PROVIDER OR SUPPLIER		l		STREET ADDRESS, CITY, STATE	, ZIP CODE	<u> </u>	
EDEDED	ICKSBURG HEALTH				3900 PLANK ROAD			•
FREDER	ICASBURG REALTH				FREDERICKSBURG, VA 2	2407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROP	) BE	(X5) COMPLETION DATE
F 371	Continued From pa	age 252	F	371				
	he was not wearing the brownies in the	a beard net while preparing kitchen.						
	conducted with OS When asked what a in the kitchen, OSM facial hair must be beard net. When a hair restraints, OSM into the food." On 4/26/17 at 5:00 administrator and A Nursing) were mad concerns. The facility policy ti in part the following employees wear ap performance of the Food Services Dire members have the confined in a hair m properly restrained appropriate person Services Director in clean approved atti footwear (closed to for safety, daily"	<ul> <li>9 a.m., an interview was M #10, the dietary manager. staff should be wearing while A #10 stated that hair and restrained by a hair restraint or asked why staff should wear M #10 stated, "So hair won't fall</li> <li>p.m., ASM #1, the ASM #2, the DON (Director of le aware of the above</li> <li>tled, "Staff Attire," documents g, "It is the center policy that all oproved attire for the erit duties. Action Steps: 1. The ector insures that all staff ir hair off the shoulders, let or cap, and facial hair . 2. All staff will exhibit al hygiene. 3. The Food nsures all staff members wear ire including appropriate ie, full shoe, with non-slip sole)</li> <li>ion was presented prior to exit.</li> </ul>						
					VDH/QLC			
		failed to ensure clean from debris by a dusty fan.			,, esa e e APA			

Facility ID: VA0088

PRINTED: 05/11/2017 FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING С 04/28/2017 **B WING** 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 371 F 371 Continued From page 253 On 4/25/17 at 9:25 a.m., an observation of the dishwasher area was conducted. At 9:45 a.m., a wall mounted fan covered in black dirt was observed blowing on clean dishes, utensils, trays, and cups as they came out of the dish machine. On 4/25/17 at 12:58 p.m., an observation of the dishwasher area was conducted. The wall mounted fan covered in black dirt was observed blowing on clean cups that were sitting in crates underneath the fan. On 4/26/17 at 10:40 a.m., an observation of the dishwasher area was conducted with OSM (Other Staff Member) #9, the dietary aide. OSM #9 was observed putting dishes into the dishwasher. The fan was blowing debris onto the dishes as they came out of the dishwasher. On 4/26/17 at 10:40 a.m., an interview was conducted with OSM #9. When asked what she observed about the wall mounted fan, OSM #9 stated, "The fan is dirty." When asked why this was a problem, OSM #9 stated, "There is a 100 percent chance it is blowing on the dishes." OSM #9 stated, "I will call maintenance so they can disconnect and clean it." OSM #9 stated that maintenance was responsible for cleaning the fan. On 4/26/17 at 11:03 a.m., an interview was conducted with OSM #10, the Dietary Manager. When asked who was responsible for cleaning the fans in the dish washer area, OSM #10 stated, "Maintenance." On 4/27/17 at approximately 3:20 p.m., an interview was conducted with OSM #1, the Director of Maintenance. When asked who was If continuation sheet Page 254 of 278 Facility ID: VA0088 Event ID: 6R5B11

		AND HUMAN SERVICES				FORM	D: 05/11/2017 APPROVED ). 0938-0391
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		495240	B. WING			04	/28/2017
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COL	DE	
FREDER	ICKSBURG HEALTH	AND REHAB			) PLANK ROAD DERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	responsible for cle OSM #1 stated tha responsible, but di maintenance when stated, "They work not trying to put bl do not go into the stated that they cle On 4/26/17 at 5:00 meeting, ASM (ad the Administrator, Nursing) were ma concerns. A policy could not cleaning of fans in	age 254 eaning the fans in the kitchen, at maintenance was ietary staff needed to alert in the fans are dirty. OSM #1 < in that area everyday. I am ame on someone else but we kitchen every day." OSM #1 eaned the fans as needed. 0 p.m., at the end of day Iministrative staff member) #1, ASM #2 the DON (Director of de aware of the above be provided regarding the in the facility kitchen.		371			
	on a plastic bag o to label a prepare bowls of applesau and 5 cups of frui the refrigerator. On 4/25/17 at 6:4 was conducted. A refrigerator was o bag of meatballs open date or use bag.	ff failed to label the open date of opened meatballs; and failed date or use by date for seven uce, one bowl of cottage cheese t that were sitting on a rack in 7 a.m., inspection of the kitcher At 6:51 a.m., the facility observed to contain an opened in a plastic unlabeled bag. No by date could be found on the	1	- Andrew State Sta	RECEIVED MAY 31 2017 VDH/OLC		
	observed in the fa	ick of prepared food items were acility's refrigerator. A date coul seven bowls of applesauce, one	d		سترسم ورياي وياي ويولي ويوري . مراجع		

Facility ID: VA0088

If continuation sheet Page 255 of 278

and Linken OF DEPICIPINOES       MILE PROVIDERSUPPLER LOCAL       DX3 DATATE SUPPLY       DX3 DATATE SUPPLY         AND PLAND CONNECTION       495240       B WING       COMPLET       C         FREDERICKSBURG HEALTH AND REHAB       STREEL ADDRESS CITY, STALE, 2P CODE       300 PLANK ROAD       STREEL ADDRESS CITY, STALE, 2P CODE         FREDERICKSBURG HEALTH AND REHAB       STREEL ADDRESS CITY, STALE, 2P CODE       300 PLANK ROAD       STREEL ADDRESS CITY, STALE, 2P CODE         Prime Trace       ELEMANDAY STREEM TO DEPORTORS       Part Provobers PLAND or CORRECTION & CORREC			AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO: 0938-0391
495240     B. WNO     04/28/2017       NAME OF PREVIDER OR SUPPLIER     STREET ADDRESS, GITY, STATE, 20 PODE       FREDERICKSBURG HEALTH AND REHAB     STREET ADDRESS, GITY, STATE, 20 PODE       IMIL 0     SUMARY STATE, STREET ADDRESS (STREET ADDRESS, GITY, STATE, 20 PODE       PREFIX     SUMARY STATE, STREET ADDRESS (STREET ADDRESS, GITY, STATE, STREET ADDRESS, GENERATION       IMIL 0     SUMARY STATE, STREET ADDRESS, GITY, STATE, STREET ADDRESS, GENERATION     PREFIX, TARK       IMIL 0     SUMARY STATE, STREET ADDRESS, GITY, STATE, STREET ADDRESS, GENERATION     PREFIX, TARK       IMIL 0     SUMARY STATE, STREET ADDRESS, GITY, STATE, STREET ADDRESS, GENERATION     PREFIX, TARK       IMIL 0     SUMARY STATE, STREET ADDRESS, GITY, STATE, STREET ADDRESS, ST	STATEMEN	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			COMPLETED
FREDERICKSBURG HALTH AND REHAB     3800 PLANK ROAD FREDERICKSBURG, VA 22407       PRETEX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MST BE PRECEDED BY PLIL REGULATORY OR LSC IDENTIFYING INFORMATION)     D PRETEX TAG     PREDERICKSBURG, VA 22407       F 371     Continued From page 255 bowl of cottage cheese, and 5 cups of fruit.     D O 4/25/17 at 6.52 p.m., an interview was conducted with DSM (other staff member) # 21, a dietary aide. When asked when the bowls of applesauce, cottage cheese and fruit cups wcrc propared. OSM #21 stated, "I think yesterday." When asked if the prepared the food items, OSM #21 stated, "These weren't here when I left yesterday." When asked if food items should be jabeled when prepared, DSM #21 stated, "They should be."     SM # 21 and OSM # 22, a dietary aide were observed with the tray of uniabeled food items from the refrigerator and a marker. When asked if the odd items were prepared, OSM #22 stated, "They should be labeled." When asked the food items sore prepared, OSM #22 stated, "They should be labeled." When asked the food items were prepared, OSM #22 stated, "They weren't here yesterday."     SM # 21 and OSM # 22 stated, "They weren't here yesterday."       On 4/25/17 at 7:10 a.m., an observation was made of OSM # 21 and OSM # 22 discarding the unlabeled food items from the refrigerator. When asked when the food items was conducted with OSM # 10, the Dielary Manager. When asked when the bog of meaballs was opened, OSM # 10 stated, "Yesterday, built should have been labeled."     FECCENCED			495240	B. WING		
<ul> <li>First Recultation of the prepared to solve the prepared of the pr</li></ul>				3	900 PLANK ROAD	
<ul> <li>bowl of cottage cheese, and 5 cups of fruit.</li> <li>On 4/25/17 at 6:52 p.m., an interview was conducted with OSM (other staff member) # 21, a dictary aide. When asked the bowls of applesauce, cottage cheese and fruit cups wore prepared, OSM #21 stated, "I think yesterday." When asked if he prepared the food items, OSM #21 stated, "These weren't here when I left yesterday." When asked if he prepared the food items, OSM #21 stated, "They should be."</li> <li>On 4/25/17 at 7:06 a.m., OSM #21 and OSM # 22, a dictary aide were observed with the tray of unlabeled food items from the refrigerator and a marker. When asked if they were labeling the food items, OSM #22 stated, "Yes, they should be labeled." When asked when the food items were prepared, OSM # 22 stated, "Yes, they should be labeled." When asked when the food items were prepared, OSM # 22 stated, "They weren't here yesterday."</li> <li>On 4/25/17 at 7:10 a.m., an observation was made of OSM # 21 and OSM # 22 discarding the unlabeled food items from the refrigerator. When asked if they were throwing away the unlabeled food items from the refrigerator. When asked if they user throwing away the unlabeled food items from the refrigerator. When asked if they user and off. "It hough twe could label them but (Name of a cook, OSM # 11) said it should be discarded because we don't know when it was made."</li> <li>On 4/25/17 at 8:10 a.m., an interview was conducted with OSM # 10, the Dictary Manager. When asked when the bag of meatballs was opened, OSM # 10 stated, "Yesterday, but it should have been labeled." OSM # 10 stated that the part off apple and the aster of the part of and the prepared off they were throwing away the unlabeled food items form the refrigerator. When asked when the bag of meatballs was opened, OSM # 10, tabled, "Yesterday, but it should have been labeled." OSM # 10 stated that the part off apple and the part off apple and the provide the the bag off meatballs was opened. OSM # 10, tabled, "Yesterday, but it should have been labeled</li></ul>	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	DULD BE COMPLETION
<ul> <li>conducted with OSM (other staff member) # 21, a dietary aide. When asked when the bowls of applesauce, cottage cheese and fruit cups word prepared, OSM #21 stated, "I think yesterday." When asked if he prepared the food items, OSM #21 stated, "These weren't here when I left yesterday." When asked if food items should be labeled when prepared, OSM #21 stated, "They should be."</li> <li>On 4/25/17 at 7:06 a.m., OSM # 21 and OSM # 22, a dietary aide were observed with the tray of unlabeled food items from the refrigerator and a marker. When asked if they were labeling the food items, OSM #22 stated, "Yes, they should be labeled." When asked when the food items were prepared, OSM # 22 discarding the unlabeled food items from the refrigerator. When asked if they were labeled. "I down and of SM # 22 discarding the unlabeled food items from the refrigerator. When asked if they user labeled." When asked when the save and the unlabeled food items from the refrigerator. When asked if they user labeled.</li> <li>On 4/25/17 at 7:10 a.m., an observation was made of OSM # 21 and OSM # 22 discarding the unlabeled food items from the refrigerator. When asked if they user labeled them but (Name of a cook, OSM # 11) said it should be discarded because we don't know when it was made."</li> <li>On 4/25/17 at 8:10 a.m., an interview was conducted with OSM # 10, the Dietary Manager. When asked when the bag of meatballs was opened, OSM # 10 stated, "Yesterday, but it should have been labeled." OSM #10 stated that</li> </ul>	F 371		-	F 371		
<ul> <li>22, a dietary aide were observed with the tray of unlabeled food items from the refrigerator and a marker. When asked if they were labeling the food items, OSM #22 stated, "Yes, they should be labeled." When asked when the food items were prepared, OSM #22 stated, "They weren't here yesterday when I left at 2 p.m., so it must of have been yesterday."</li> <li>On 4/25/17 at 7:10 a.m., an observation was made of OSM # 21 and OSM #22 discarding the unlabeled food items from the refrigerator. When asked if they were throwing away the unlabeled food items from the refrigerator, OSM #21 stated, "I thought we could label them but (Name of a cook, OSM # 11) said it should be discarded because we don't know when it was made."</li> <li>On 4/25/17 at 8:10 a.m., an interview was conducted with OSM # 10, the Dietary Manager. When asked when the bag of meaballs was opened, OSM # 10 stated, "Yesterday, but it should have been labeled." OSM #10 stated that</li> </ul>		conducted with OS dietary aide. When applesauce, cottag prepared, OSM #2 When asked if he #21 stated, "These yesterday." When labeled when prep	M (other staff member) # 21, a n asked when the bowls of ge cheese and fruit cups wcrc 1 stated, "I think yesterday." prepared the food items, OSM weren't here when I left asked if food items should be			
<ul> <li>made of OSM # 21 and OSM # 22 discarding the unlabeled food items from the refrigerator. When asked if they were throwing away the unlabeled food items from the refrigerator, OSM #21 stated, "I thought we could label them but (Name of a cook, OSM # 11) said it should be discarded because we don't know when it was made."</li> <li>On 4/25/17 at 8:10 a.m., an interview was conducted with OSM # 10, the Dietary Manager. When asked when the bag of meatballs was opened, OSM # 10 stated, "Yesterday, but it should have been labeled." OSM #10 stated that</li> </ul>		22, a dietary aide w unlabeled food iter marker. When ask food items, OSM # labeled." When as prepared, OSM # 2 yesterday when I le	were observed with the tray of ns from the refrigerator and a ked if they were labeling the 22 stated, "Yes, they should be sked when the food items were 22 stated, "They weren't here			
conducted with OSM # 10, the Dietary Manager. When asked when the bag of meatballs was opened, OSM # 10 stated, "Yesterday, but it should have been labeled." OSM #10 stated that		made of OSM # 21 unlabeled food iter asked if they were food items from the "I thought we could cook, OSM # 11) s	and OSM # 22 discarding the ns from the refrigerator. When throwing away the unlabeled e refrigerator, OSM #21 stated, d label them but (Name of a aid it should be discarded			
opened, OSM # 10 stated, "Yesterday, but it should have been labeled." OSM #10 stated that VDH/OLC		conducted with OS	M # 10, the Dietary Manager.			
		opened, OSM # 10 should have been	) stated, "Yesterday, but it labeled." OSM #10 stated that			

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Facility ID: VA0088

If continuation sheet Page 256 of 278

RS FOR MEDICARI	E & MEDICAID SERVICES		*****	OMB NO. C	****
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPL	ETED
	495240	B. WING			8/2017
		1		IP CODE	
ICKSBURG HEALTH	AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIC DATE
On 4/26/17 at 5:00 Administrator and Nursing) were mad	p.m., ASM #1, the ASM #2, the DON (Director of de aware of the above findings. itled, "Food Storage" did not	F 371			
483.60(i)(4) DISPO PROPERLY (i)(4)- Dispose of g This REQUIREME by: Based on observa determined that fa dumpster in a sani The findings includ On 4/25/17 at 7:18 facility's dumpsters were observed on dumpster. The first to be half way ope additional trash wa (middle) dumpster On 4/25/17 at 8:10 conducted with OS the dietary manag- maintenance was dumpsters were fr On 4/25/17 at 4:24 conducted with OS maintenance direct	DSE GARBAGE & REFUSE arbage and refuse properly. NT is not met as evidenced ation and staff interview, it was cility staff failed to maintain the tary manner. de: a.m., observation of the s was conducted. Three gloves the ground in front of the first st dumpster was also observed n. A cardboard box filled with as observed behind the second a.m., an interview was SM (other staff member) #10, er. OSM #10 stated that responsible for ensuring the ee from debris. p.m., an interview was SM (other staff member) #1, the tor. When asked who was	Region of the	Housekeeping Direc debris around the du ensured the door was completely. 2. On April 27, 2017 Maintenance and Ho Director re-educated disposing of garbage properly. 3. The Housekeeping designee will random dumpster to ensure it debris and the doors properly weekly time and then monthly tim 4. The Housekeeping designee will report results monthly to th Assurance Performan committee for contin and/or revision.	tor removed the mpster and s closed ', the usekeeping staff regarding and refuse g Director/ hly inspect the t's free from are closed es four weeks hes two months. g Director/ the inspection e Quality nce Improvement	6-5-1
	PROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From pa On 4/26/17 at 5:00 Administrator and A Nursing) were mad The facility policy t address labeling o No further informa 483.60(i)(4) DISPO PROPERLY (i)(4)- Dispose of g This REQUIREME by: Based on observa determined that fa dumpster in a sani The findings includ On 4/25/17 at 7:18 facility's dumpsters were observed on dumpster. The firs to be half way ope additional trash wa (middle) dumpster On 4/25/17 at 8:10 conducted with OS the dietary manage maintenance was dumpsters were fro On 4/25/17 at 4:24 conducted with OS maintenance direct	DEF CORRECTION       IDENTIFICATION NUMBER:         495240         PROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 256         On 4/26/17 at 5:00 p.m., ASM #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above findings.         The facility policy titled, "Food Storage" did not address labeling of opened or prepared food.         No further information was presented prior to exit. 483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY         (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that facility staff failed to maintain the dumpster in a sanitary manner.         The findings include:         On 4/25/17 at 7:18 a.m., observation of the facility's dumpsters was conducted. Three gloves were observed on the ground in front of the first dumpster. The first dumpster was also observed to be half way open. A cardboard box filled with additional trash was observed behind the second (middle) dumpster.         On 4/25/17 at 8:10 a.m., an interview was conducted with OSM (other staff member) #10, the dietary manager. OSM #10 stated that maintenance was responsible for ensuring the dumpsters were free from debris.         On 4/25/17 at 4:24 p.m., an interview was conducted with OSM (other staff member) #10, the dietary manager. OSM #10 stated that maintenance was respons	OF DEFICIENCIES PECORRECTION       (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER.       (X2) MULTIPLE A BUILDING	OF DEFICIENCIES Froor DEFICIENCIES FOR DEFICIENCIES       (X1) PROVIDERSUPPLIER (2) (X2) MULTIFLE CONSTRUCTION A BUILDING         495240       STREET ADDRESS, CITY, STATE, Z 3000 PLANK ROAD FREDERICKSBURG, VA 224         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDERS PREVENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PROVIDERS PREVENT OF DEFICIENCIES (EACH CORRECTIVE ACT (EACH CORRECTIVE ACT (I)(4) - DISPOSE GARBAGE & REFUSE PROPERLY         No further information was presented prior to exit. 483.60(I)(4) DISPOSE GARBAGE & REFUSE PROPERLY       F 372         The findings include: On 4/25/17 at 7:18 a.m., observation of the facility's dumpsters was conducted. Three gloves were observed on the ground in front of the first dumpster. The first dumpster was also observed to be half way open. A cardboard box filled with additional trash was observed behind the second (middle) dumpster.         On 4/25/17 at 3:10 a.m., an interview was conducted with OSM (other staff member) #10, the dietary manager. OSM #10 stated that main	CS PUT MICULARY STATEMENT OF DEFICIENCIA IDENTIFICATION NUMBER       (2) MULTIPLE CONSTRUCTION A BUILDING         INCKSBURG HEALTH AND REHAB       STREET ADDRESS, CITY, STATE, 2IP CODE 3000 PLANK ROAD FREDERICKSBURG, VA 22407       (2) MULTIPLE CONSTRUCTION A BUILDING       (2) MULTIPLE CONSTRUCTION A BUILDING       (2) MULTIPLE CONSTRUCTION A BUILDING       (2) MULTIPLE CONSTRUCTION A BUILDING         INCKSBURG HEALTH AND REHAB       STREET ADDRESS, CITY, STATE, 2IP CODE 3000 PLANK ROAD FREDERICK SUBJER, VA 22407       (2) MULTIPLE CONSTRUCTION A BUILDING       (2) MULTIPLE CONSTRUCTIPLE CONSTRUCTION A BUILDING <td< td=""></td<>

		AND HUMAN SERVICES				APPROVED 0938-0391
TATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			Сом	E SURVEY IPLETED C
		495240	B. WING			
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STA 3900 PLANK ROAD	TE, ZIP CODE	
FREDERICKSBURG HEALTH AND REHAB				FREDERICKSBURG, VA		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE SIENCY)	(X5) COMPLETION DATE
F 372	effort between me, OSM #1 stated that dumpster that day making rounds on On 4/26/17 at 5:00 meeting, ASM (adr	is, OSM #1 stated, "It's a joint housekeeping, and dietary." t he did not check the but thought housekeeping was the dumpster that morning. p.m., at the end of day ninistrative staff member) #1,	F 37:	2		ī
F 441 SS=F	<ul> <li>meeting, ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. A policy could not be provided. No further information was presented prior to exit.</li> <li>F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, SS=F PREVENT SPREAD, LINENS</li> <li>(a) Infection prevention and control program.</li> <li>The facility must establish an infection prevention</li> </ul>		F 44	1. Resident #19 is dis 2. The Director of Nu RN on the infection c	rsing educated the staff ontrol program. The re-educated the licensed	
	a minimum, the fol (1) A system for pr investigating, and o communicable disc volunteers, visitors providing services arrangement base conducted accordi accepted national implementation is	eventing, identifying, reporting, controlling infections and eases for all residents, staff, , and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards (facility assessment Phase 2);		<ul> <li>wound care.</li> <li>3. The Director of Nu designee will audit nu wound care and the in accuracy and complet weeks and then month</li> <li>4. The Director of Nu report the audits resul Assurance Performance committee to ensure committee</li></ul>	rsing/Wound care RN/ arse competencies for affection control log for ion weekly times four aly times two months. rsing/designee will ts monthly to the Qualit ce Improvement	у
	(2) Written standar for the program, w limited to:	ds, policies, and procedures hich must include, but are not		and/or revision.		
	possible communi	veillance designed to identify cable diseases or infections read to other persons in the		MAY 3 1 2017 VDH/OLC		
DHCHES	567(02-99) Previous Version	s Obsolete Event ID: 6R5B	11	Facility ID: VA0088	If continuation sheet f	Page 258 of 3

		AND HUMAN SERVICES			FORM	D: 05/11/2017 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DA CO	TE SURVEY MPLETED C
		495240	B. WING			1/28/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD	ODE	
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA 2240	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	Continued From pa facility;	age 258	F 44	11		
	(ii) When and to w communicable dis reported;	hom possible incidents of ease or infections should be				
	(iii) Standard and t to be followed to p	ransmission-based precautions revent spread of infections;	5			
	(iv) When and hov resident; including	v isolation should be used for a but not limited to:				
	depending upon th involved, and (B) A requirement	duration of the isolation, he infectious agent or organism that the isolation should be the ssible for the resident under the				
	must prohibit emp disease or infected contact with reside	nces under which the facility loyees with a communicable d skin lesions from direct ents or their food, if direct hit the disease; and				
	(vi) The hand hygi by staff involved ir	ene procedures to be followed a direct resident contact.				
	(4) A system for re under the facility's actions taken by t	ecording incidents identified IPCP and the corrective he facility.		RECEIVED		
	(e) Linens. Perso process, and trans spread of infection	nnel must handle, store, sport linens so as to prevent the n.	Э	MAY 3 1 280		
	(f) Annual review.	The facility will conduct an ts IPCP and update their		VDH/OLC		

Facility ID: VA0088

If continuation sheet Page 259 of 278

CENTERS FOR MEDICARE & MEDICARD SERVICES         UNIT NU DESCRIPTION         UNIT NU DESCRIPTION           INAME OF PROVIDER OF SUPPLIER         A BUILDING         A BUILDING         C C           ABULT OF CONFECTION         A BUILDING         C C         OUT NU DESCRIPTION           NAME OF PROVIDER OF SUPPLIER         A BUILDING         SUPPLIER         C C           PREDERCKSBURG HEALTH AND REHAB         B WHY         SUPPLIER         OUT NU DESCRIPTION           PREDERCKSBURG HEALTH AND REHAB         D PROVIDER DATE OF SUPPLIER         D PROVIDER DATE OF SUPPLIER         OUT NU DESCRIPTION           PREDERCKSBURG HEALTH AND REHAB         D PROVIDER DATE OF SUPPLIER         D PROVIDER DATE OF S	DEPART	MENT OF HEALTH	AND HUMAN SERVICES					MAPPROVED D. 0938-0391
AND PLANCE CORRECTION       DEATTPICATION NUMBER       A BULDING       C       C         MARE OF PROVIDER OR SUPPLIER       B WING       Street Address, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE         PREDERICKSBURG HEALTH AND REHAB       Street Address, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE         OVELD       PROVIDER OR SUPPLIER       Street Address, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE         OVELD       Proceedings, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE         OVELD       Proceedings, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE         OVELD       Proceedings, City, STATE, 2P CODE       Street Address, Street, City, STATE, 2P CODE       Street Address, City, STATE, 2P CODE         Proceeding, City, Street, City, Street				(X2) MUL	TIPLE (	CONSTRUCTION	(X3) DA	TE SURVEY
495240         p. WINC         04/28/2017           NAME OF PROVIDER OF SUPPLIER         STREET ADJRESS, CITY, STATE, ZPF CODE         300 PLANK ROAD           PREEDERICKSBURG HEALTH AND REHAB         STREET ADJRESS, CITY, STATE, ZPF CODE         0           (M) 0         SUBMARY STATEMENT OF DEPORTORIES         0         PROVIDER OR STATEMENT OF DEPORTORIES         0           PREETX         TAG         SUBMARY STATEMENT OF DEPORTORIES         0         PROVIDER OR STATEMENT OF DEPORTORIES         0           PREETX         TAG         SUBMARY STATEMENT FILTER PERCENTIONS         0         PROVIDER OR STATEMENT OF DEPORTORIES         0           PREETX         TAG         SUBMARY STATEMENT FILTER PERCENTIONS         0         PROVIDER OR SHOLD BE         0           TAG         SUBMARY STATEMENT FILTER PERCENTIONS         0         PROVIDER OR SHOLD BE         0           TAG         SUBMARY STATEMENT FILTER PERCENTIONS         0         PROVIDER OR SHOLD BE         0           TAG         SUBMARY STATEMENT FILTER         0 <t< td=""><td>AND PLAN O</td><td>F CORRECTION</td><td>IDENTIFICATION NUMBER:</td><td></td><td></td><td></td><td>CO</td><td></td></t<>	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:				CO	
MARE OF HARMORE OF HARMAN EXPLANATION     3000 PLANK ROAD       PREDERICKSBURG HEALTH AND REHAB     PREDERICKSBURG, VA 22407       Image: Provide Percence of Missing Provide Research of Connections and the Provide Research of Provide Research of Connections and the Provide Research of C			495240	B. WING			04	1
FREDERICKSBURG, HEALTH AND REHAB     FREDERICKSBURG, VA 22407       (M) D FRED TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH EFFICIENCY WASTE DE PREDED BY FULL REGULATORY OR ISC DEVIDITIVING INFORMATION)     D FRAD FRED FRED FRED FRED FRED FRED FRED FRE	NAME OF F	PROVIDER OR SUPPLIER					E	
MAID TAG       The distance is and the prediction of the predi	FREDER	ICKSBURG HEALTH	AND REHAB			EDERICKSBURG, VA 22407		
<ul> <li>Program, as necessary. 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 maintain an infection control program, as evidenced by incomplete infection control tracking logs; and failed to maintain infection control practices during a wound care observation for one of 32 residents in the survey sample, Resident #19.</li> <li>1. The facility staff failed to maintain complete Infection Control Logs. The facility staff failed to document the date, site and results of cultures obtained on the Infection Control Logs for June, July, August, September, October 2016 and January, March and April 2017.</li> <li>2. For Resident #19, facility staff failed to maintain infection control practices while providing wound care to his sacral pressure ulcer [1].</li> <li>The findings include:</li> <li>1. The facility Infection Control Logs since the previous survey, were reviewed.</li> <li>The June 2016 logs contained 48 entries for infections, resident mames and dates. The column titled, "Cultures: date/site/results" was empty for all 48 entries of infections.</li> <li>The July 2016 logs contained 24 entries for infections, resident mames and dates. The column titled, "Cultures: date/site/results" was empty for all 24 entries of infections.</li> </ul>	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	×	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	COMPLETION
infections, resident names and dates. The column titled, "Cultures: date/site/results" was empty for all 24 entries of infections.	F 441	<ul> <li>program, as neces</li> <li>This REQUIREME</li> <li>by:</li> <li>Based on staff interant of the facility staff faile control program, as infection control transmintain infection of wound care observed the survey sample</li> <li>1. The facility staff Infection Control L</li> <li>document the date obtained on the Introduction of the survey sample</li> <li>1. The facility staff Infection Control L</li> <li>document the date obtained on the Introduction of the survey sample</li> <li>2. For Resident #1 maintain infection providing wound care obtained on the Introduction of the survey. The findings include</li> <li>1. The facility Infegree finding survey, work the survey survey. The survey survey of the survey of the survey survey of the survey survey of the survey of the survey survey survey of the survey survey survey survey of the s</li></ul>	sary. NT is not met as evidenced erview, facility document review review, it was determined that ed to maintain an infection s evidenced by incomplete acking logs; and failed to control practices during a vation for one of 32 residents ir , Resident #19. failed to maintain complete ogs. The facility staff failed to e, site and results of cultures fection Control Logs for June, ember, October 2016 and nd April 2017. 19, facility staff failed to control practices while are to his sacral pressure ulcer de: ection Control Logs since the vere reviewed. gs contained 48 entries for nt names and dates. The ltures: date/site/results" was ntries of infections.	1	141			
		infections, resider column titled, "Cu	nt names and dates. The Itures: date/site/results" was					

Facility ID: VA0088

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 05/11/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF F	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE	, ZIP CODE
FREDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2	2407
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	EACH CORRECTIVE A	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 441	Continued From pa	age 260	F	441	
1 441		ogs contained seven entries for	r		
	infections, resident	t names and dates. The			
	column titled, "Cull empty for all sever	tures: date/site/results" was n entries of infections.			
	The September 20	16 logs contained 17 entries dent names and dates. The			
	column titled, "Cul empty for all 17 en	tures: date/site/results" was			
	infections, residen	logs contained 33 entries for t names and dates. The tures: date/site/results" was ntries of infections.			
	The November an complete.	d December 2016 logs were			
	infections, residen column titled, "Cul complete for 14 of	logs contained 30 entries for at names and dates. The ltures: date/site/ results was no f these entries, missing either e of culture or results of culture			
	The February 201	7 logs were complete.			
	infections, resider column titled, "Org documented only	ogs contained 13 entries for ht names and dates. The ganism Cultured" was three times when there were			
	three other oppor	tunities for documentation.		RECEIVED	
	infections, resider	gs contained 21 entries for ht names and dates. The			
	column titled, "Cu complete. There v and only three cu	Iture: dates/site/results" was no were no dates in this column Iture results. There were five as for documentation.	ot	VDH/OLC	
	2567(02-99) Previous Versic	ons Obsolete Event ID:6R5	6B11	Facility ID: VA0088	If continuation sheet Page 261 of 2

	AS FOR MEDICARE	& MEDICAID SERVICES	T				NO. 0938-03 ) DATE SURVEY
ATEMENT ID PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONS		(×3	C
		495240	B. WING				04/28/2017
	PROVIDER OR SUPPLIER		T	STREET	ADDRESS, CITY, STATE, Z	ZIP CODE	
	ICKSBURG HEALTH				ANK ROAD RICKSBURG, VA 224	407	
REDEN				FREDE	PROVIDER'S PLAN OF		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x c	(EACH CORRECTIVE AC ROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	COMPLETIC
F 441	Continued From pa	age 261	F4	41			
1 -4-4 (	An interview was c	onducted with RN (registered					
	nurse) #1, the assi	stant director of nursing who is					
	responsible for the	infection control tracking, on					
	4/26/17 at 10:44 a.	m. When asked how long she ble for the infection control					
	logs, RN #1 stated	I, "Since November (2016)."					
	When asked why i	nfections were tracked, RN #1					
	stated, "We have t	to make sure we are practicing					
	good infection control and identify the spread of infections to other residents." When asked why						
	organisms were tra	acked on the infection control					
	logs RN #1 stated	I. "I track for trends and cluster					
	of infections and the accordingly."	hen do education with the staff					
		III ( Constantill					
	The facility policy,	e facility will monitor and					
	investigate the cau	use and spread of infection.					
	Continuous survei	llance will be provided by staff.					
	Any infection will b	be reported using the Infection cedure: 1. Obtain Infection					
	Report Form. Proc Report Form. 2 C	complete Resident Name, Age,					
	Sex, Unit and Roc	om Number. 3. Document date					
	infection was first	noted and Date of					
	Admission/Readm	nission if less than one month nt if evidence of infection was					
	prior. 4. Documer	admission. 5. Document risk					
	factors. 6. Check	appropriate boxes as it applies					
	to the resident. 7.	. Document if resident was					
	hospitalized due to	o this infection. 8. Document if date of culture, site and results					
	9. Turn completed	form in to Infection Control			RECEIVET	2	
	Nurse. 10. Infection all Infection Contr	on Control Nurse will investigate	)				
	The administrator	, director of nursing and ff member (ASM) #3, the interir	n		VDH/OLC		
	regional director of	of clinical services, were made ve concern on 4/26/17 at 6:37			93 se <sup>o</sup>		

Facility ID: VA0088

If continuation sheet Page 262 of 278

		& MEDICAID SERVICES	T		OMB NO. 0938-039 (X3) DATE SURVEY
IATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE,	ZIP CODE
	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22	2407
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O	F CORRECTION (X5) CTION SHOULD BE COMPLETIC D THE APPROPRIATE DATE
F 441	Continued From pa	age 262	F 4	41	
	p.m.				
	No further information was provided prior to exit. 2. The facility staff failed to maintain infection control practices while providing wound care to Resident #19's sacral pressure ulcer [1].				
	3/27/17 with diagned limited to high block hallucinations, maj cancer, and anxiet most recent MDS with Reference Date) of coded as being most the ability to make of 15 on the BIMS Status) exam. Re requiring extensive physical assist with dressing and limited member with locor	admitted to the facility on oses that included but were not of pressure, failure to thrive, or depressive disorder, liver y disorder. Resident #19's (minimum data set) was an th an ARD (Assessment f 4/3/17. Resident #19 was oderately cognitively impaired in daily decisions scoring 11 out (Brief Interview for Mental sident #19 was coded as a assistance with one person in transfers, ambulation, ed assistance from one staff motion on and off the unit.			
	(Physician Order S current order: "Sa (gram) (Collagena every day shift for	nt #19's most recent POS Sheet) revealed the following ntyl [2] Ointment 250 UNIT/GM ise) Apply to Sacrum topically Wound Care Cleanse wound , apply Santyl ointment and a		RECEIVED	
	care was conducte #6. RN #6 walked out a package of g placed them on to then pulled out Sa	D p.m., observation of wound ed with RN (registered nurse) d to the treatment cart, pulled gauze and saline bullets and op of the treatment cart. RN #6 antyl and squeezed the medicine cup and placed the		MAY 3 1 2017 VDH/OLC	
	2567(02,99) Previous Versio			Facility ID: VA0088	If continuation sheet Page 263 c

PRINTED: 05/11/2017 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С 04/28/2017 B. WING 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 441

## F 441 Continued From page 263

(X4) ID

PRÉFIX

TAG

cup on top of the treatment cart. RN #6 was not observed washing her hands prior to preparing the treatment supplies.

Next, RN #6 took her bare hands and pulled a stack of gauze out of the package and placed the gauze on top of the treatment cart. Nothing was underneath the stack of gauze. The gauze was flat touching the surface of the treatment cart. RN #6 then placed the stack of gauze in her scrub pocket and carried the saline bullets and medicine cup of Santyl with her bare hands. RN #6 walked into Resident #19's room, explained the procedure and walked out of his room. RN #6 was observed walking back to the treatment cart.

RN #6 was then observed taking the stack of gauze from the scrub pocket and placing it on top of a foam dressing package. RN #6 then gathered supplies again and walked to Resident #19's room. The supplies were placed on top of Resident #19's bedside table while his belongings were still on the table. The table was not wiped down, and a drape was not used. RN #6 was then observed placing the stack of gauze on the bedside table without a drape underneath the gauze. The gauze was flat against the bedside table.

RN #6 washed her hands, donned gloves and took the old dressing off Resident #19's sacral wound. She was not observed removing her gloves or washing her hands. She then took gauze from the top of the stack and wiped off Resident #19's wound.

Resident #19's wound was a tiny open area with slough. The area around the wound was

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

Facility ID: VA0088

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MAY 3 1 201

/nH/nH

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495240	B. WING		04/28/2017
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE	, ZIP CODE
	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 441	reddened non-blan the wound to be 3 #6 measured the w reddened non-blan RN #6 then change wound with norma She was not obser she changed her g RN #6 then chang wound with norma She was not obser she changed her g RN #6 then took s stack and wiped th Santyl on the woun with a foam dress rest of the gauze t procedure. The la were against the b	<ul> <li>ichable skin. RN #6 measured x 2 x 0 cm (centimeters). RN vound from one side of the ichable skin to the other side.</li> <li>ichable skin to the saline bullets.</li> <li>ichable from the saline bullets.</li> <li>ichable shine the saline bullets.</li> <li>ichable skine the saline bullets.</li> <li>ichable shine the saline bullets.</li> <li>ichable skine the saline bullets.</li> <li>ichable skine shine shine skine shine shine skine shine shine skine shine shine skine shine ski</li></ul>	F 4	.41	
	interview was con asked if she could have done differen RN #6 stated, "We underneath the su because central s napkin." When as gauze pads direct or on the resident	roximately 4:15 p.m., an ducted with RN #6. When l identify anything that she migh htly during the dressing change ell I usually use a drape upplies but I don't have a drape upply is locked. Or I will use a sked if it is good practice to put ly on the treatment cart surface 's bedside table surface, RN #6	<b>,</b>	RECEVED	
	stated, "Well I new and I usually place earlier when I put	ver use the bottom of the gauze e it on top of a package like I di the gauze on the foam	d	MAY 3 1 2017 VDH/OLC	
	package," When	asked if it was ever ok to place crub pocket, RN #6 stated, "No	i		10 10 10 10 10 10 10 10 10 10 10 10 10 1
FORM CMS	-2567(02-99) Previous Versic	ns Obsolete Event ID: 6R58	311	Facility ID: VA0088	If continuation sheet Page 265 of 2

PRINTED: 05/11/2017 FORM APPROVED

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD	
FREDER				FREDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETION
F 441	Continued From pa	age 265	F۷	41	
F 441	that would be kind in my pocket. I am the wound." When care observations, gauze. That was a	age 205 of gross. I don't ever put gauze very big about what touches a told RN #6 about the wound RN #6 stated, "That wasn't piece of paper the hospice I never put gauze in my			
	conducted with LP the wound care nu of maintaining infe change, LPN #1 st hands before she supplies and place use gauze that are #1 stated that she clean surface to pu asked if it was eve supplies directly of LPN #1 stated, "Ne what is on the tabl a stack of gauze to table if the nurse p stack after a dress "Well that is not go wasteful." When a treatment items in stated, "No. That i not clean anymore them in Ziploc bag would wash her ha the treatment. LP change her gloves takes the dirty dre stated, "If I am tak my hands."	p.m., an interview was N (licensed practical nurse) #1, rse. When asked the process ction control during a dressing ated that she would wash her gathered supplies, gather them into a Ziploc bags, and in individual packages. LPN would use the Ziploc bags as a ut her supplies on. When r ok to place treatment n the resident's bedside table, o. It is never ok. You don't know e." When asked if it was ok for be placed on the bedside blans to throw away the bottom sing change, LPN #1 stated, bod practice at all and it is asked if it was ever ok to place her scrub pocket, LPN #1 s never ok. The supplies are e. That's the reason why I place gs." LPN #1 stated that she ands right before she provides N #1 stated that she would also and wash her hands after she ssing off the resident. LPN #1 ting my gloves off, I am washing D p.m., ASM (administrative	) / )		

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Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 266 of 278

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF	PROVIDER OR SUPPLIER	, <b>1</b> , <b>1</b> ,		TREET ADDRESS, CITY, STATE, ZIP C	DDE
FREDER	RICKSBURG HEALTH	AND REHAB		000 PLANK ROAD REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTIC
F 441	Continued From p	age 266	F 441		
	staff member) #1, aware of the above	the administrator was made e concerns.			
	Dressing Changes following: "Purpos changing of dress and prevent infect hands 2. Explain p you are going to d can hear you. 3. P comfortable. 4. Es will be needed and 5. Open the dress protective pads un wound is located.	y titled, "General Rules for s," documents in part, the e: Proper cleaning and proper ing on a wound can aid healing ion. What to do: 1. Wash your procedure to the patient what o even if you do not think they osition patient so they are timate what dressing supplies d place on a clean work area. ing materials. 6. Place oder the body part where the 7. Place garbage bag nearby			
	for soiled dressing	IS.			

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495240	B. WING		C 04/28/2017
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIF	
REDER	ICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 2240	)7
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLÉTIC HE APPROPRIATE DATE
F 441	Continued From pa	age 267	F 44	1	
	from prolonged pre- from being confine in elderly and imme- ulcers may be pre- position, early amb skin lubricants and called bedsores. P Dictionary of Medic	buttocks, or heel), resulting essure on the area, usually ed to bed. Most frequently seen obilized persons, decubitus vented by frequently change of pulation, cleanliness, and use of a water or air mattress. Also ressure sores. Barron's cal Terms for the Non Medical el A. Rothenberg, M.D. and an. Page 155.			
F 514 SS=D	active enzymatic th removes necrotic t microscopic level. bed of microscopic granulation to proc occur. ( <http: www<br="">483.70(i)(1)(5) RES</http:>	ment is an FDA-approved herapy that continuously issue from wounds at the This works to free the wound cellular debris, allowing eed and epithelialization to v.santyl.com/about>) S PLETE/ACCURATE/ACCESSIB	F 514	1	
	standards and prac	with accepted professional ctices, the facility must ecords on each resident that			
	(i) Complete;			and and the second	
	(ii) Accurately docu	imented;	S.L		
	(iii) Readily access	ible; and			
	(iv) Systematically		s & 1000s	H/OLC	

Event ID: 6R5B11

Facility ID: VA0088

If continuation sheet Page 268 of 278

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRIN	TED:	05/11/2017
FC	DRM	APPROVED
OMB	NO	0938-0391

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. (	0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		495240	B. WING		C 04/2	8/2017
NAME OF	PROVIDER OR SUPPLIEF	ξ	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		
FRENER	CKSBURG HEALTH	AND REHAR		3900 PLANK ROAD		
TREDEN				FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	Continued From p	age 268	F 5	14 F514		
	(5) The medical re	cord must contain-		1. Closed records request	were	
	(i) Sufficient inform	nation to identify the resident;		obtained from previous co		
		lation to lucitary the resident,		Resident #2 records have		
	(ii) A record of the	resident's assessments;		corrected. Resident #1 me	dical	
	(iii) The comprehe	nsive plan of care and services		records were corrected.		
	provided;			2. The Director of Nursing	/designee	
	(iv) The results of	any preadmission screening		will re-educate licensed st	•	6-5-17
	and resident review	w evaluations and		accuracy and completene	ss of	0-3-17
	determinations cor	nducted by the State;		medical records.		
	(v) Physician's, nu	rse's, and other licensed		3. The Director of Nursing	/designee	
	professional's prog			will audit behavior monitor	-	
	(vi) Laboratory, rac	liology and other diagnostic		and skin sheets for comple	-	
	services reports as	s required under §483.50.		accuracy three times a we		
		NT is not met as evidenced		four weeks and then mont		
	by: Based on staff inte	erview, facility document		two months.	,	
		ord review and in the course of		4. The Director of Nursing	designee	
		gation, it was determined that ed to ensure access to clinical		will report the audits result	•	
		manner and failed to maintain		to the Quality Assurance F	-	2
		curate clinical record for three		Improvement committee to		5
	#2, and #1.	he survey sample, Residents		continued compliance and		
					0.101000	
		failed to ensure the closed re accessible to the survey				
	team in a timely ma	-		RECEIVED		
	2 The facility staff	failed to date three of Resident				
	#2's weekly skin in					
	Resident #1's beha	failed to accurately document aviors on the April 2017 stration record (MAR).		VDH/OLC		

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

Facility ID: VA0088

		& MEDICAID SERVICES			7	<u>O. 0938-039</u> ATE SURVEY
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		OMPLETED
						С
		495240	B. WING		0	4/28/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	RICKSBURG HEALTH	AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	ULD BE	(X5) COMPLETIO DATE
F 514	Continued From pa	age 269	F 5	14		
	The findings includ	e:				
	at 6:30 a.m. The er conducted with the administrative staff approximately 7:30 conference the clos #26, #27, and the I #31's records were	n entered the facility on 4/25/17 ntrance conference was director of nursing, member (ASM) #2 at a.m. During the entrance sed records of Residents #21, ast six months of Resident requested. The facility has ords and paper records. They electronic.				-
		#26's closed paper records /17 at approximately 11:00				
	ASM #1, the admin the interim regiona items were request Originally the reque and August 2016 b that was changed t May to August 2010 whole clinical recor following items wer	on 4/25/17 at 1:50 p.m. with histrator, ASM #2, and ASM #3, I director of clinical services, ted for Resident #27. est was for items dated July ut at the end of the interview o a request for items dated 6. ASM #1 stated that the d would be provided. The re requested: Face sheet, Rs (medication administration				
	records) and TARs records), physician	(treatment administration orders, laboratory test results		RECEIVED		
		tures, physician and nurse as notes, the MDS (minimum				
	interdisciplinary pro SBARS (Situation I	ogress notes to include any Background Assessment Wound doctor notes and any		VDH/OLC		

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING _		C 04/28/2017
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, Z 3900 PLANK ROAD FREDERICKSBURG, VA 224	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 514	Continued From pa	age 270	F 51	4	
	the previous owner	ronic medical records, from 's records, prior to November the survey team on 4/25/17 a p.m.	t		
p.m aga info	p.m., the closed rea again requested. T informed the surve	ay meeting on 4/25/17 at 5:10 cords for Resident #27 were he administrator, ASM #1 y team that she had requested s from the previous owners.	I		
	informed the surve	oximately 9:00 a.m. ASM #1 y team that the closed medica should be at the building at	l		
	ASM #, the interim services, were infor Resident #27's clos impeding the surve	p.m. ASM #1, ASM #2 and regional director of clinical med that the lack of access to ed clinical record was y process. They were been over 24 hours since the ested.			
	On 4/26/17 at 4:58 p.m. ASM #1 presented a small file containing medical records for Resident #27. Once reviewed the file contained records dating back to 2014 through 2015. No 2016 records were presented. When asked where this file came from, ASM #1 stated, "I asked medical				
	#27)'s clinical recor ASM #1 stated, "I c	heck for any of (Resident d. This is was she presented. ompleted the form and	AU NO	RECEIVED	
	owners)." ASM#1 w	name of person at former /as asked to provide all emails hen she contacted the		VDH/OLC	

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

### PRINTED: 05/11/2017 FORM APPROVED OMB NO: 0938-0391

<u>CENTER</u>	AS FOR MEDICARE	<u>= &amp; MEDICAID SERVICES</u>			0	<u>NR NO. 0838-038 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495240	B. WING			C 04/28/2017
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CC 3900 PLANK ROAD FREDERICKSBURG, VA 22407			<u>.</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE COMPLETION
F 514	them. On 4/26/17 at 5:00 provide the closed #27. Specifically a	age 271 24 hours after we requested p.m. ASM #1 was asked to clinical record for Resident sked for were wound consults, nd physician progress notes for	F S	514		
	During the end of t ASM #2, ASM #3, # #27 was again requ	Mary to August 2016. he day meeting with ASM #1, the closed record for Resident uested. ASM #1 stated that ould be available at 9:00 a.m.				
	survey team that the When the survey te missing the following physician progress wound tracking. As	a.m. ASM #1 informed the ney (the facility) had the record. eam reviewed the record it was ng items: physician orders, notes, wound consults and SM #1 assured the survey calling (name of former record.				
		a.m. ASM #1 showed this e was received and it lcopy."				
	On 4/27/17 at 10:05 a.m. other staff member (OSM) #5, the social worker, presented papers to the surveyor investigating Resident #27.					
		0 a.m. the papers just received		CEVIED 39		
	presented were fro	SM #2 as the papers m 2014 and 2015. ASM #2				
	gave the surveyor r 2015.	nore papers. They were again		VDH/OLC		
	On 4/27/17 at 10:20	0 a.m. ASM #2 informed this				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING С B. WING 495240 04/28/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 F 514 Continued From page 272 surveyor and the other surveyor that they had located the 2016 files and are printing them now. On 4/27/17 at 10:42 a.m. OSM #6, payroll/human resources, presented a stack of papers that contained the 2016 MARs. At 10:58 a.m. an interview was conducted with ASM #1, ASM #2, ASM #3 and ASM#5, the owner. The requested information was again asked for. At this time ASM #5 stated that (name of former owner) had come in and picked up all the records and had taken them. This surveyor and the long term care supervisor were also present during this interview. The administrative team was informed of the concern that the survey process was being impeded due to lack of cooperation in getting the closed record requested on 4/25/17 for Resident #27. On 4/27/17 at 11:55 a.m. ASM #1 gave another stack of papers to the surveyor. They were all nurse progress notes and the wound physician consults. On 4/27/17 at 12:05 p.m. ASM #1 was informed since no further records had been received as requested, there would be a citation related to impeding the survey process. During decision making on 4/28/17 at approximately 11:30 a.m. a paper was slid under the door of the conference room. The paper RECEIVEL documented, "Physician Orders: in date order discharge to admission (each month grouped as set); monthly physician order sheet (recaps); NAY 31 2217 physician order & signature form, and telephone VDH/OLC orders." Handwritten on this papers documented, "(Resident #27) have all these 5/1/16 to 8/31/16."

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				MPLETED
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		495240	B. WING			4/28/2017
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FREDER	(ICKODOKO NEALI)			FREDERICKSBURG, VA 2240		
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F 514	Continued From p	age 273	F 5	514		
	The facility policy,	"Electronic Signature for				
		ocumentation" documented in				
		hard copy of the clinical record veyors and others who are				
		to clinical records by law. All				
	state licensure an	d practice regulations continue				
t		te law is more restrictive that	_			
	state law."	nts, the facility will adhere to the	3			
		the device a second				
		tion was provided prior to exit.				
	2. The facility staft #2's weekly skin ir	failed to date three of Residen to date three of Residen to the state of the state	t			
	8/30/16 and readr Resident #2's diag limited to: multiple depressive disord MDS (minimum da status assessmen	admitted to the facility on nitted to the facility on 1/23/17. gnoses included but were not sclerosis, diabetes and major er. Resident #2's most recent ata set), a significant change in it with an ARD (assessment 1/30/17, coded the resident as ntact.				
	Review of Resident #2's weekly skin integrity checks (not present in the resident's chart) revealed LPN (licensed practical nurse) #2 signed and failed to date three skin checks. The form documented, "Signature Date." Each weekly skin integrity check form contained six places for		า	CENED		
		kin checks to be completed.	Ĩ			
		5 p.m., an interview was PN #2. LPN #2 stated, "I guess				
	I forgot to date be date." LPN #2 wa documented "sign	cause the form doesn't say to s made aware the form ature date." LPN #2 stated sho gotten to date the form.		VDH/OLC		

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С 04/28/2017 B. WING 495240 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 514 F 514 Continued From page 274 On 4/26/17 at 4:40 p.m., an interview was conducted with LPN (licensed practical nurse) #1 (the wound care nurse). LPN #1 confirmed weekly skin checks should be dated. When asked if the weekly skin checks were a part of the clinical record, LPN #1 stated she would have to refer that question to the director of nursing but could find out. On 4/26/17 at 4:52 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the weekly skin integrity checks were contained in a separate book on the unit because the form allowed spaces for multiple weeks' worth of checks. ASM #2 stated nurses were supposed to date the form when they completed a skin check and the form becomes a part of the clinical record when it becomes full. On 4/26/17 at 6:35 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2, and ASM #3 (the regional director of clinical services) were made aware of the above findings. The facility weekly skin assessment policy documented, "2. The evaluating nurse must date and sign each assessment ... " No further information was presented prior to exit. RECEIVED 3. The facility staff failed to accurately document MAY 3 1 2017 Resident #1's behaviors on the April 2017 medication administration record (MAR). VDH/OLC Resident #1 was admitted to the facility on 10/22/16 with diagnoses that included:

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		AND HUMAN SERVICES					DRM APPROVE NO. 0938-039
STATEMENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3	DATE SURVEY COMPLETED
		495240	B. WING	i			04/28/2017
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F 514	difficulty swallowin retention. The most recent M quarterly assessm reference date) of having scored an interview for menta was moderately in resident was code activities of daily li Review of the resi 10/24/16 did not e regarding docume Review of the phy documented, "Mon to) psychotropic m nursing note for al for non-pharmaco medications admi date 10/23/17." Review of the Apr "Monitor for BEHA psychotropic med nursing note for a for non-pharmaco	se (1), movement disorder, g, dementia and urinary IDS (minimum data set), a ent, with an ARD (assessment 4/18/17 coded the resident as 11 out of 15 on the BIMS (brief al status) indicating the resident paired cognitively. The d as requiring assistance for all ving. dent's care plan initiated on vidence documentation inting behaviors. sician's orders dated April 2017 hitor for BEHAVIORS r/t (related behaviors with documentation logical interventions, nistered and follow upOrder if 2017 MAR documented, VIORS r/t (related to) ications: there must be a I behaviors with documentation logical interventions,	1	514			
	date 10/23/17." In a "Y/N (yes or no)	nistered and follow upOrder the left hand column there was " On the following dates aviors were documented with a			RECEIVED		
	4/2/17 on the 7:00 4/3/17 on the 11:0 4/4/17 on the 11:0	) a.m. to 3:00 p.m. shift; 10 p.m. to 7:00 a.m. shift; 10 p.m. to 7:00 a.m. shift; 10 p.m. to 7:00 a.m. shift;			VDH/OLC		
	DE CZ(00,00) Browieus Versie			Encil	lity ID: VA0088	f continuation sh	eet Page 276 g

Facility ID: VA0088

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		ATE SURVEY OMPLETED
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F 514	Continued From pa	age 276	F 5	14			
	4/8/17 on the 11:00	) p.m. to 7:00 a.m. shift;					
		a.m. to 3:00 p.m. shift and the					
	11:00 to 7:00 p.m. 4/11/17 on the 11:0	snitt; 0 p.m. to 7:00 a.m. shift;					
	4/13/17 on the 11:0	0 p.m. to 7:00 a.m. shift;					
	4/18/17 on the 11:0 4/24/17 on the 3:00	00 p.m. to 7:00 a.m. shift and ) p.m. to 11:00 p.m. shift.					
		e's notes for those dates did					
	not evidence docur resident's behavior	nentation regarding the s					
	p.m. with LPN (lice nurse who docume behavior flow shee asked what the "Y" LPN #18, stated, "( no. for me I don't p not monitoring (the means I'm monitor a behavior I would she had observed behaviors, LPN #15 wrong I need some new here."	onducted on 4/25/17 at 1:05 nsed practical nurse) #18, the ented a "Y" on the resident's t eight out of 11 times. When means on the behavior MAR, On the MAR it pops up yes or ut in no because it means I'm behavior). When I check yes it ing the behavior and if there is write a note." When asked if Resident #1 having any 8 stated, "No." If I'm doing it cone to orient me, I'm pretty					
	p.m. with LPN #4, f asked what the "Y"	onducted on 4/26/17 at 1:15 the resident's nurse. When on the behavior flow sheet ated, "It means yes they have					

If continuation sheet Page 277 of 278

				VDH/OLC	
				Anna and Anna and Anna and	
	No further information	on was provided prior to exit.			3
		vere made aware of the	1 014		
F 514	Continued From pa	ge 277	F 514		:
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ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:			C
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## PRINTED: 05/11/2017 FORM APPROVED

State of Virginia							WAPPROVE
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Inspection 4/28/17. C with the Vi Licensure Code surve The censu 111 at the t consisted o (Residents	was cond corrections rginia Rul of Nursing ey/report is in this 1 time of the of 24 curre if 1 throu ight close	77 certified bed e survey. The s ent Resident re gh # 20, #28 th d record reviev	through or compliance ions for the e Life Safety d facility was survey sample views irough #30 and	۲ بر			
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Cross refer F244, F250	ence to F ), F252, F , F312, F	blicies and proc 153, F165, F22 279, F280, F28 314, F328, F32 441, F514	6, F240, 1, F282,				
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