

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

A SILLUMN STREET ADDRESS, CITY, STATE, ZIP CODE 3800 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 3800 PLANK ROAD FREDERICKSBURG, VA 22407 FREDERICKSBURG, VA		MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES HEEDERICKSBURG, VA 22407 PREPER CAPITE FROM THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORSECTION (EACH OPERCITY OF LIST DENTIFYING INFORMATION) PROPRIATE DEFICIENCY DIE APPROPRIATE	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER;	A. BUILD	ING _		COM	1PLETED
STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES HEEDERICKSBURG, VA 22407 PREPER CAPITE FROM THE APPROPRIATE DEFICIENCY TAG PROVIDER'S PLAN OF CORSECTION (EACH OPERCITY OF LIST DENTIFYING INFORMATION) PROPRIATE DEFICIENCY DIE APPROPRIATE								
REDERICKSBURG HEALTH AND REHAB 3900 PLANK ROAD FREDERICKSBURG, VA 22407			495240	B, WING			05/	25/2018
FREDERICKSBURG, VA 22407	NAME OF	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
RREDERICKSBURG, WA 22407 TAGE REGULATORY OR LSC IDENTIFYING INFORMATION PREETX TAGE REGULATORY OR LSC IDENTIFYING INFORMATION TAGE REGULATORY OR LARGE TAGE REGULATORY OR LSC IDENTIFYING INFORMATION TAGE REGULATORY OR LSC IDENTIFYING INFORMATION TAGE REGULATORY OR LSC IDENTIFYING INFORMATION TAGE REGULATORY OR LARGE TAGE TAG	EDENE	DICKEDING HEALTH	AND DELIAD		39	000 PLANK ROAD		
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced Emergency Preparedness survey was conducted on 5/24/18. Corrections are required for compliance with 42 CFR Part 48.3.73, Requirement for Long-Term Care Facilities. E 035 LTC and ICF/IID Sharing Plan with Patients SS=C CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility staff failed to have a complete emergency preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan was conducted with ASM (administrative staff member) #1, the administrator, and OSM (other	LKEDEL	RICKSDUKG REALIR	AND KEHAB		FF	REDERICKSBURG, VA 22407		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced Emergency Preparedness survey was conducted on 5/24/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. E 035 LTC and ICF/IID Sharing Plan with Patients SS=C CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility as emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Corrections or Egreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of Deficiencies. This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of Deficiencies. This Plan of Corrections or Egreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of Deficiencies. This Plan of Correction	(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION	N	(X5)
An unannounced Emergency Preparedness survey was conducted on 5/24/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. E 035 LTC and ICF/IID Sharing Plan with Patients Serc (CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents lor clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan with residents or client and their families or representatives. The facility staff failed to demonstrate the method the facility staff failed to have a complete emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) Constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statlenged or conclusions set forth in this statlenged or conclusions set forth in this statlenged or conclusions set forth in this statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law. 1. Maintenance Director posted location of the emergency preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administrator informed residents at Resident Council Meeting of location of Emergency Preparedness plan		`	·			CROSS-REFERENCED TO THE APPROF		COMPLETION
An unannounced Emergency Preparedness survey was conducted on 5/24/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. E 035 LTC and ICF/IID Sharing Plan with Patients Serc (CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents lor clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan with residents or client and their families or representatives. The facility staff failed to demonstrate the method the facility staff failed to have a complete emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) Constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statlenged or conclusions set forth in this statlenged or conclusions set forth in this statlenged or conclusions set forth in this statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law. 1. Maintenance Director posted location of the emergency preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administrator informed residents at Resident Council Meeting of location of Emergency Preparedness plan	E 000	Initial Comments		-	100	This Plan of Correction does not		
An unannounced Emergency Preparedness survey was conducted on 5/24/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. E 036 LTC and ICF/IID Sharing Plan with Patients SS=C CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility semergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) The findings include: The facility and preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other)	⊏ 000	miliai Comments			,000		nant hu	
survey was conducted on 5/24/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. E 035 E C and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility semergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law. E 035 1. Maintenance Director posted location of the emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administrator informed residents at Resident Council Meeting of location of Emergency Preparedness plan to facility television information station on May 29, 2018. The info		i						
are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. E 035 LTC and ICF/IID Sharing Plan with Patients SS=C CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility semergency prepared				i !				
483.73, Requirement for Long-Term Care Facilities. E 035 SS=C CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility semergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) 4. Maintenance Director posted location of the emergency preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administrator informed residents at Resident Council Meeting of location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are								
Facilities. E 035 LTC and ICF/IID Sharing Plan with Patients SS=C CFR(s): 483,73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents for clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency preparedness plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) E 035 required by State and Federal law. 1. Maintenance Director posted location of the emergency preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administrator informed residents at Resident Council Meeting of location of Emergency Preparedness plan on June 12, 2018. Maintenance Director posted location of Emergency Preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient				İ		Statement of Deficiencies. This Pl	an of	1
E 035 SS=C CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility se emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other) I. Maintenance Director posted location of the emergency preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administrator informed residents at Resident Council Meeting of location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan to June 12, 2018. Maintenance Director added location of Emergency Preparedness plan in the corridor bulletin cabinet, where pertinent facility notices and licenses are located on 5/24/18 at 4:30PM. The emergency plan is located at the receptionist desk where residents, families, or representatives can view them. 2. Residents who reside in facility are at risk for same deficient practice. 3. Administra			nt for Long-Term Care			Correction is prepared solely beca	use it is	
SS=C CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that compiles with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other	E 025	A CONTRACTOR OF THE CONTRACTOR	paring Plan with Patients		יפר			:
[(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other					135	The state of the federal lavy	•	
review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other	,	[(c) The [LTC facilit and maintain an en communication pla State and local law updated at least an plan must include a (8) A method for shemergency plan, this appropriate, with families or represer This REQUIREMEN by:	y and ICF/IID] must develop nergency preparedness in that complies with Federal, is and must be reviewed and nually.] The communication ill of the following: aring information from the at the facility has determined residents [or clients] and their intatives.			of the emergency preparedness the corridor bulletin cabinet, wh pertinent facility notices and lice located on 5/24/18 at 4:30PM. Temergency plan is located at the receptionist desk where resident families, or representatives can whem.	plan in ere nses are he s, riew	
The facility staff failed to demonstrate the method the facility had developed for sharing the emergency plan with residents or client and their families or representatives. The findings include: On 5/24/18 at 9:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with ASM (administrative staff member) # 1, the administrator, and OSM (other Resident Council Meeting of location of Emergency Preparedness plan on June 12, 2018. Maintenance Director added location of Emergency Preparedness plan to facility television information station on May 29, 2018. The information station plays throughout the facility in resident rooms and also in the main lobby television.		review it was deterr failed to have a con	nined that the facility staff	:		risk for same deficient practice.		
conducted with ASM (administrative staff resident rooms and also in the main member) # 1, the administrator, and OSM (other lobby television.		the facility had deve emergency plan wit families or represer The findings include	eloped for sharing the h residents or client and their statives.			Resident Council Meeting of loca Emergency Preparedness plan or 12, 2018. Maintenance Director location of Emergency Preparedn to facility television information s on May 29, 2018. The informatio	tion of June added ess plan tation	
conducted with ASM (administrative staff resident rooms and also in the main member) # 1, the administrator, and OSM (other lobby television.			:					ᇫᄦᆘ
member) # 1, the administrator, and OSM (other lobby television.	!				i	resident rooms and also in the ma	ain 🐧	, ,
ARORATORY DIRECTOR OF PROVIDER'S I IRRI IER REPRESENTATIVE S SIGNATURE	! !					lobby television.		: : :
	ADODATODY	DIRECTORISON DECLES	EDICUIDDUED DEDDESCRITATIVES SIG	IATUES	1	TITLE		1000 5 4 7 7

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 extection 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.

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

	OF DEFICIENCIES OF CORRECTION	(X1)-PROVIDER/SUPPLIER/CLIA	- (X2)-MULTIP A. BUILDING	PE-CONSTRUCTION		X3)-DATE-SURVEY COMPLETED	
		495240	B. WING		05/25/2018		
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT O F DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE :	(X5) COMPLETION DATE	
E 035	Review of the facili plan failed to demonstrate had developed for with residents or cl representatives. As preparedness bind along with the survif families and residemergency prepare in the binder for ad stated no. OSM #*	age 1 the director of maintenance. ty's emergency preparedness instrate the method the facility sharing the emergency plan ient and their families or SM # 1 stated the emergency ers were at the front desk ey results binder. When asked dents know about the facility's edness plan and know to look ditional information, ASM #1 I stated that maybe they rmation about the plan in their	E 035	4. Administrator will review Emer Preparedness Plan and share local with Quality Assurance Performan Committee (QAPI) during next mo QAPI and ensure posting is availab main corridor ongoing.	tion ce nth	6/26/18	
F 000	(administrative stafaware of the above ware of the above No further informat INITIAL COMMENTAL COMMENTAL COMMENTAL COMMENTAL CORRECTIONS are recommental to the census in this 104 at the time of the consisted of 34 cur (Residents #73, #8 #108, #37, #64, #5 #69, #18, #4, #11, #75, #27, #67, #70	ion was provided prior to exit. TS Medicare/Medicaid standard sted 5/23/18 through 5/25/18. quired for compliance with 42 eral Long Term Care Life Safety Code	F 000	This Plan of Correction does not constitute an admission or agreed the Provider of the truth of the fact alleged or conclusions set forth in Statement of Deficiencies. This Plant Correction is prepared solely becar required by State and Federal law.	this an of use it is		

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 2 of 223



STATEMENT OF CO		(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05/2	25/2018	
	IDER OR SUPPLIER	AND REHAB		39	REET ADDRESS, CITY, STATE, ZIP CODE 00 PLANK ROAD REDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE .	(X5) COMPLETION DATE	
SS=D CFI §48 The self accounts this self accounts s	determination, sess to persons a side the facility, section. 3.10(a)(1) A factor respect and digident in a manner quality of life, reviduality. The famote the rights of the sest to quality call erity of conditions to establish and citices regarding vision of service dents regardless as a resident esident of the Units as a resident esident can exercise the facility. 3.10(b)(1) The form the facility. 3.10(b)(2) The resident can exercise frence, coercing the facility.	at Rights. right to a dignified existence, and communication with and and services inside and including those specified in a lility must treat each resident grity and care for each er and in an environment that ince or enhancement of his or cognizing each resident's cility must protect and of the resident. acility must provide equal re regardless of diagnosis, and or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all so of payment source.	F5		 CNA #1 was re-educated on enresidents are provided with dig during meals regarding Resider & Resident #27, including the unapkins when assisting with meand ensuring residents are seat facing the table during meals. Residents who reside in facility risk for same deficient practice. Staff will be re-educated on resights to ensure residents are provided with dignity, including ensure they have a dignified direxperience. Department heads observe 5 meals per week for 4 weeks to ensure residents are provided a dignified dining experience. Issues identified with corrected immediately. Results of rounds will be review the monthly QAPI meeting. Treidentified will be addressed as needed. 	inity int #18 ise of eals iced are at idents ining will il be	6/26/18	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	E-CONSTRUCTION		COMPLETED	
	495240	B. WING		05	5/25/2018	
NAME OF PROVIDER OR SUPP FREDERICKSBURG HEA		3	STREET ADDRESS, CITY, STATE, ZIP COD 8900 PLANK ROAD FREDERICKSBURG, VA 22407	E.		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE	
subpart. This REQUIRE by: Based on obse document revie was determine provide dignity survey sample 1. The facility s dining experier feeding Reside assistant) #1 w the resident's oresident.	or page 3 or her rights as required under this important is not met as evidenced ervation, staff interview, facility and clinical record review, it do that the facility staff failed to for two of 37 residents in the Residents #18 and #27. Itaff failed to provide a dignified and the facility staff failed to provide and the facility staff failed to provide and the for Resident #18. While and #18, CNA (certified nursing as observed scraping food from the hin and feeding the food to the staff failed to feed Resident #27 in the interior in the bistro dining room.	F 550				
dining experier feeding Reside assistant) #1 w the resident's cresident. Resident #18 w 9/15/14. Resider were not limited and difficulty so recent MDS (m assessment will date) of 3/6/18 severely impair	clude: taff failed to provide a dignified ce for Resident #18. While nt #18, CNA (certified nursing as observed scraping food from hin and feeding the food to the ras admitted to the facility on ent #18's diagnoses included but to Huntington's disease (1), pain vallowing. Resident #18's most inimum data set), a quarterly than ARD (assessment reference coded the resident's cognition as ed. Section G coded Resident g limited assistance of one staff					

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

Event ID: 5S tP11

Facility ID: VA0088

If continuation sheet Page 4 of 223

RECEIVED
JUN 18 2018
VDH/OLC

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ′	FIPLE-CONSTRUCTION	(X3) DATE-SURVEY COMPLETED
AND PLAN 0	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COMPLETED
		495240	B. WING		05/25/2018
NAME OF F	PROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE	
EBEUED	CKSBURG HEALTH	I AND REHAB		3900 PLANK ROAD	
		TAND INCHAR		FREDERICKSBURG, VA 22407	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP	0.7-
				DEFICIENCY)	
F 550	Continued From page 1	age 4	F 5	50	
. 555	•	ent #18's comprehensive care	, 0		
		documented "(Name of		i !	
	Resident #18) is a	t risk for imbalanced nutrition &			
		ted to) hx (history) of dysphagia			
:	`	ng), edentulous (lacking teeth)			
		ar dentures, resident tant body movements/tremors			•
		esident needing altered			:
į	consistency diet, h	x sig (significant) wt (weight)			
	change, need for a	adaptive equipment,			:
	occasionally refuse				;
:	meaisAssist resi as tolerated"	dent with meals as needed &		:	
:	as totorated			:	
,		57 p.m., CNA #1 was observed		,	
; ;		#18 a pureed meal in the bistro			!
!		e feeding the resident, food was esident's chin. CNA#1 was	- -		
•		aping the food in an upward			
		sident's chin with a spoon and			:
	then placing the sp	poon containing the food in		•	!
		outh. This was observed four			
	times during the m	lear.			
		p.m., an interview was		· :	
		NA #2. CNA #2 was asked what			
		eding a resident and the food			
		nt's chin. CNA #2 stated, "Take their face and wipe it off and			:
		pocketing (holding food in the			
		was asked if staff should	!	:	:
	scrape food from a	a resident's chin and then place	l		
		mouth, CNA#2 stated, "That's		:	:
		ould do. To me it's not			•
		sked how she would feel if that CNA #2 stated, "Like a baby."			•
	was done to nel, c	NATAZ GIARGI, LING A DADY.	:		1
4		p.m., an interview was		!	
:	conducted with CN	NA #1. CNA #1 was asked what			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IOENTIFICATION NUMBER:		A. BUILD	LTIPLE CONSTRUCTION DING	(X	(X9) DATE SURVEY COMPLETEO	
		495240	B. WING)		05/25/2018
	PROVIOER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 224		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIA	
F 550	falls on the resider usually just take the asked if she uses. No." When asked from a resident's of the food in the resissue, CNA #1 states would feel if the stated, "I couldn't reding him (Residence)." On 5/24/18 at 3:53 conducted with LPLPN #4 was asked feeding a resident resident's chin. LFW hen asked how scraped food from into her mouth, LPW ant food scraped. On 5/24/18 at 5:53 staff member) #1 (the director of nurabove concern. The facility docume RIGHTS AND PROAND FEDERAL LARespect. You have	eding a resident and the food ht's chin. CNA #1 stated, "I be spoon and get it off." When a napkin, CNA #1 stated, "Um. if she viewed removing food hin with the spoon then placing ident's mouth as a dignity red, "No." When asked how hat was done to her, CNA #1 eally tell you. I'm just used to really the really tell you. I wouldn't off me." I p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the really would respect in full	F	550		
	:	tion was presented prior to exit.		:		,
		isease (HD) is an inherited				; ;

STATEMENT OF DEFICIENCIES (X1) PROVIDER SUPPLIER CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	LTIPLE CONSTRUCTION DING		COMPLETED	
		495240	B. WING	i	05	5/25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION OATE
F 550	defective gene, bu appear until middle may include uncor clumsiness, and be can take away the swallow. Some permembers. Others and are able to exinformation was old https://vsearch.nlmmeta?v%3Aproject medlineplus-bundle ase&_ga=2.23204-139120270.14779 2. The facility staff a dignified manner Resident #27 was 6/18/07 and readness that included but we swallowing, psychologically. The most recent Median properties of the most recent median properties o	ay. People are born with the at symptoms usually don't e age. Early symptoms of HD atrolled movements, alance problems. Later, HD ability to walk, talk, and eople stop recognizing family are aware of their environment press emotions." This otained from the website: n.nih.gov/vivisimo/cgi-bin/query-t=medlineplus&v%3Asources=e&query=huntington%27s+dise0607.1046050702.1527592979942321 failed to feed Resident #27 in in the bistro dining room. admitted to the facility on nitted on 8/1/12 with diagnoses were not limited to: difficulty osis, lack of coordination and and MDS (minimum data set), a ent, with an ARD (assessment 3/13/18 coded the resident as ero out of 15 on the brief al status indicting the resident ally able to make and sometimes understanding in twas coded as requiring activities of daily living including as made on 5/23/18 at 12:30	F	550		
		ervice in the bistro dining	:			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		-(X2): M⊎Ŀ A. BUILD		CONSTRUCTION	COMPLETED		
		495240	B. WING			05/	25/2018
	PROVIDER OR SUPPLIER			390	REET ADDRESS, CITY, STATE, ZIP CODE 10 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEF)CIENCY)	DBE	(X5) COMPLETION DATE
	table where three of CNA (certified nurs the right of the res feeding the resident and of the lunch service. Resident #27 was table where two ot #1 was sitting to the table while feed An interview was op.m. with CNA #1. was fed with her baresidents sat at the CNA #1 stated, "It's asked whom it was "For us. We can half the resident was experience, CNA # An interview was op.m. with LPN (lice When asked about back to the table weating, LPN #2 stathink they could give asked why she wormanner, LPN #2 statesidents are eating and turn my back to	7 was sitting with her back to a other residents were sitting. Sing assistant) #1 was sitting to ident facing the table while int. s made on 5/24/18 at 1:00 p.m. is in the bistro dining room. sitting with her back to the her residents were sitting. CNA is right of the resident facing ding the resident. conducted on 5/24/18 at 1:17 When asked why the resident ack to the table while other is table and ate their meals, is so much easier." When asked having a dignified dining	F 5	50			
	staff member) #1,	p.m., ASM (administrative the administrator and ASM #2, ing were made aware of the		• !			

	OF DEFICIENCIES OF CORRECTION	(XT) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! ' '	HPLE CONSTRUCTION	COMPLETED	
			A. BUILUI	NG		
		495240	B. WING		05/25/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD		
			<u> l</u>	FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CRDSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE COMPLÉTION	
F 550	RESIDENT RIGHT. UNDER STATE AN documented, "QUA must care for you ir that promotes the n enhancement of yo Respect. You have consideration, digni recognition of your	cy's document titled, "YOUR S AND PROTECTIONS D FEDERAL LAW" LITY OF LIFE A nursing home in manner and environment maintenance and ur quality of life. Dignity and the right to be treated with ty and respect in full individuality."	F 5	50		
SS=D	Notify of Changes (CFR(s): 483.10(g)(14) Notify (i) A facility must imconsult with the resconsistent with his crepresentative(s) w (A) An accident inversults in injury and physician intervention (B) A significant characteristic or psychosodeterioration in heastatus in either lifetic clinical complication (C) A need to alter the aneed to discontinut reatment due to accommence a new for (D) A decision to training the status of the second of the sec	ification of Changes. mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- plying the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lth, mental, or psychosocial threatening conditions or as); reatment significantly (that is, ue an existing form of verse consequences, or to orm of treatment); or ansfer or discharge the	F 5	 1. MD notified of Resident 82's Bloopressure readings on 6/14/18. ME reviewed B/P history from May 20 current. MD notified of 15's Bloodreadings on 6/14/18. MD revieweresident 15s blood sugar history fr April 2018 to current. 2. Residents who reside in this factor at risk for same deficient practice. 	18 to I sugar d om	

PR)NTED: 06/07/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	` '	SURVEYPLETED
71107 27110	77 001112011011		A. BUILD	ING _			,
		495240	B. WING			05/:	25/2018
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	·
	NOVODUDO MENTI	AND DELLAD		39	900 PLANK ROAD		
FREDER	CKSBURG HEALTH	AND KEHAB		F	REDER)CKSBURG, VA 22407		
(X4) ID		TEMENT OF DEFICIENCIES	ID	:	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACT(ON SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
	all pertinent informatics available and prophysician. (iii) The facility must resident and the resident (a) A change in resident (b) A change in resident (c) (10) of this section (iv) The facility must update the address phone number of the representative(s). §483.10(g)(15) Admission to a composite §483.5) must disclosite physical configur locations that composite shaded and must spectrom changes betwoeder §483.15(c)(9). This REQUIREMENT by: Based on staff integrand clinical record resident and clinical record resident.	n, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the talso promptly notify the sident representative, if any, and or roommate assignment 3.10(e)(6); or ident rights under Federal or ions as specified in paragraph on. It record and periodically (mailing and email) and he resident apposite distinct part. A facility distinct part (as defined in the se in its admission agreement ration, including the various rise the composite distinct sify the policies that apply to ween its different locations		380	3. Nursing staff will be re-educate notification of MD/RP for changes including notification when call parameters are outside specific or DON or designee will audit Medica Administration Records (MARs) to MD/RP notification is made accord parameter call instructions. Audit include 3 residents' records 2 x we weeks to ensure notification is malesues identified will be corrected immediately. 4. Results of audits will be reviewed the monthly QAPI meeting. Trend issues will be identified and address needed.	rders. ation ensure ding to will eek x 4 ade.	
	alter treatment for to	and/or a possible need to wo of 37 residents in the idents #82 and #15.		:			
:	1. The facility staff f practitioner/physicia pressures when the	ailed to notify the nurse in of Resident #82's blood by were below the physician for blood pressure medication					

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 10 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	THPLE CONSTRUCTION		COMPLETED	
		495240	B. WING		0:	5/25/2018
_	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULO BE E APPROPRIATE	(X5) COMPLETION OATE
F 580		age 10 failed to notify the doctor/nurse rated blood sugars for Resident	F 5	i80		
	practitioner/physic pressures when the ordered parameter administration. Resident #82 was 10/31/17. Resident were not limited to and anxiety disord MDS (minimum dawith an ARD (asset	failed to notify the nurse ian of Resident #82's blood ey were below the physician for blood pressure medication admitted to the facility on the #82's diagnoses included but diabetes, high blood pressure er. Resident #82's most recent at a set), a quarterly assessment reference date) of a resident as being cognitively				
	Review of Resider a physician's order documented to giv (milligrams) by mo bedtime and to ho	at #82's clinical record revealed dated 12/5/17 that e clonidine (1) 0.1 mg at the every morning and at d the medication if the essure is less than 120/70.				
	(electronic medica revealed: -On 5/9/18 at 6:00 pressure was 113/ administered (as e a nurse's initials).	at #82's May 2018 eMAR tion administration record) a.m., the resident's blood 68 and clonidine was videnced by a check mark and				

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		STRUCTION		FE-SURVEY
7.11.12.1.2.11.1			A. BUILD	NG			
		495240	B. WING			05	/25/2018
NAME OF I	PROVIDER OR SUPPLIER		<u>'</u>	STREET	ADDRESS, CITY, STATE, ZIP CODE		· ····································
	LOVEDUDG HEALTH	AND DELIAD		3900 PL	ANK ROAD		
FREDER	ICKSBURG HEALTH	AND RENAD		FREDE	RICKSBURG, 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 CORRECT (EACH CORRECTIVE ACTION SHOU PROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 580	Continued From pa	age 11	F 5	80			
	pressure was 110/6 administered (howe	68 and clonidine was ever, an interview with the tered the medication stated	: • • • • • • • • • • • • • • • • • • •				
	(including the May that dated 5/9/18 and 5/9	desident #82's clinical record 2018 eMAR and nurses' notes /19/18) failed to reveal the or physician was made aware ove blood pressures.					
	10/18/16 document status related to: dx Hypertension (high (history) of chest pa potassium), PVD (p	ions: Medications as ordered					
	conducted with LPN LPN #4 was asked administered medic checks and initials administration reconurses document a stated she checks in	p.m., an interview was N (licensed practical nurse) #4. how nurses document an cation. LPN #4 stated she the MAR (medication rd). LPN #4 was asked how held medication. LPN #4 the number "3" on the MAR, old/See nurses note" and by					
	coding a "3", a page for her to document was shown Resider clonidine and asked resident's blood pre #4 stated she would she would let the nu- know. When asked	e comes up on the computer t a progress note. LPN #4 nt #82's physician order for d what should be done if the essure is below 120/70. LPN d not give the medication and urse practitioner or doctor d why, LPN #4 stated, d to know if we are not giving a					

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

Event ID: 5S1P11

Facility ID: VA0088

(f continuation sheet Page 12 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	05/25/2018
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407 (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIA	03/23/2016
FREDERICKSBURG HEALTH AND REHAB (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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIA	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIA	
F 580 Continued From page 12 medication so they can adjust whatever they need to adjust." On 5/24/18 at 4:31 p.m., an interview was conducted with LPN #6 (the nurse who checked and initialed clonidine administration to Resident #82 on 5/9/18 at 6:00 a.m. and 5/19/18 at 6:00 a.m.) LPN #6 was asked how she documents that a medication is administered and how she documents that a medication is administered and how she documents that a medication is held. LPN #6 stated she signs the medication off when she administers it and there is an option in the computer system to document when a medication is held. LPN #8 was asked if she ever had to hold any of Resident #82's medications in May 2018. LPN #9 stated there were times where she documented the resident's blood pressure medication. When asked if she administered or held Resident #82's blood pressure medication on 5/9/18, LPN #6 stated she could not remember but she knew she held the medication on 5/9/18. When asked if she would notify the physician or nurse practitioner when a blood pressure medication is held, LPN #6 stated, "I don't think I'm supposed to do that unless it's critically low." On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 5/25/18 at 9:40 a.m., an interview was conducted with ASM #3 (the nurse practitioner). ASM #3 was made aware Resident #82 has a physician's order for clonidine with parameters to hold the medication if the resident's blood	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE COMF	SURVEY PLETED
		495240	B. WING		05/2	25/2018
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
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	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFIC(ENCY)	HOULD BE	(X5) COMPLETION OATE
F 580	Continued From pa	ige 13 I notify her if they have to hold	F 5	80		
	the medication due pressure being beld ASM #3 stated, "Ye running low consist changes. Decreas fluctuates." When her even if they onl once, ASM #3 state	to the resident's blood ow the ordered parameter. sah they should because if it's ently we need to make e or dc (discontinue). He asked if nurses should notify y have to hold the medication ed, "Yes."				·
	Administration Gen "2. If a dose of regu withheld, refused, o	ent titled, "Medication eral Guidelines" documented, alarly scheduled medication is or given at other than the example, the resident is not	! !			
	in the nursing care time, or a starter do space provided on dosage administrat explanatory note is the record provided documentation. If the starter of the	center at scheduled dose use of antibiotic is needed), the the front of the MAR for that ion is initialed and circled. An entered on the reverse side of for PRN (as needed) wo consecutive doses of a withheld or refused, the	:			
	(1) Clonidine is use	on was presented prior to exit. d to treat high blood pressure. as obtained from the website:				:
		gov/druginfo/meds/a682243.h		:		
		ailed to notify the doctor/nurse ted blood sugars for Resident		,		
	4/6/16 with a recent	edmitted to the facility on treadmission on 4/27/17, with aded but were not limited to:			; ;	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	NG	COMPLETED		
		495240	B. WING		05/2	25/2018
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	DBE	(X5) COMPLETION OATE
	metabolism due eit insulin secretion by of insulin to function COPD (chronic obs [general term for ch disease that is usual emphysema and ch blood pressure, heavalking. The most recent MI assessment, an ana assessment referer resident as scoring interview for mental is capable of makin Resident #15 was owith set up assistant daily living. The physician order documented, "Hum (HUMALOG is a ray analog indicated to adults and children inject as per sliding 199 = 6 unit, less th hypoglycemic proto doctor); 200 - 249 = MD, 250 - 299 = 10 350 - 399 = 14 units 500 = 20 units., sub at bedtime related to underlying condition complications. Call greater than 400, page 14 units 150 page	chart to partial or total lack of the pancreas or to the inability in normally in the body) (1), tructive pulmonary disease pronic nonreversible lungually a combination of the pancreas or to the inability in normally in the body) (1), tructive pulmonary disease pronic nonreversible lungually a combination of the pronic bronchitis]) (2), high part failure, pain, and difficulty of the pain, and the pain of the pain, and the pain of the pain of the pain, and the pain of the pain of the pain, and the pain of the pain of the pain of the pain, and the pain of th	F 5	80		

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		COMPLETED	
		495240	B. WING		0.5	5/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 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		HOULD BE	(X5) COMPLETION OATE	
F 580	Continued From pa	age 15	F 5	580			
	record) documente Lispro, inject as pe 150 - 199 = 6 unit, hypoglycemic proto units, greater than units, 300 - 349 = 1 400 - 450 = 16 units subcutaneously be related to diabetes condition with unsp MD if less than 70 a may check her BS	= 419 = 412 = 423 n. = 422 . = 423 . = 410 . = 425 m. = 432 . = 431 . = 445 . = 406					
:	to evidence any doc	e's notes for April 2018 failed cumented notification to the corded blood sugars					
	Solution Insulin Lisp if (blood sugar) 150 0 units, Follow hypo	R documented, "Humalog oro, inject as per sliding scale - 199 = 6 unit, less than 70 = oglycemic protocol and call units, greater than 500 call					

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

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	ITIPLE CONSTRUCTION DING			COMPLETED	
		495240	B. WING			05	/25/2018	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
	Jakobuba usaltu	AND DELLAD		390	00 PLANK ROAD			
FREDER	RICKSBURG HEALTH	AND REHAB		FR	EDERICKSBURG, VA 22407			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION OATE	
F 580	Continued From pa	ae 16	F5	580				
		units, 300 - 349 = 12 units;		:			:	
		s, 400 - 450 = 16 units, 451 ~		:				
		ocutaneously before meals and	:				1	
		o diabetes mellitus due to	 - -					
	underlying condition							
		MD if less than 70 and						
		atient may check her BS and			•			
		aff for insulin coverage."						
		umented blood sugars were						
	as follows:						:	
	5/1/18 at 9:00 p.m.			i				
	5/4/18 at 4:30 p.m.							
	5/5/18 at 9:00 p.m. 5/10/18 at 4:30 p.m			:				
	: 5/10/18 at 9:00 p.m							
	5/12/18 at 9:00 p.m		•				:	
	5/15/18 at 11:30 a.r		:					
	5/15/18 at 9:00 p.m						i	
	5/23/18 at 9:00 p.m	. = 439						
		e's notes for May 2018 failed						
		cumented notification to the	:					
		corded blood sugars	! I					
	documented above	•		:			:	
	The comprehensive	e care plan dated, 4/22/16 and						
		documented in part, "Focus: I						
		abolic Complications due to:		:			:	
	Diabetes Mellitus.							
	hyperglycemia at tir	nes." The "Interventions"					<u> </u>	
		, "Labs (laboratory tests) and		:			;	
		per physician order and PRN						
		inge in condition/manifestation						
		symptoms. Resident may						
		ner own accuchecks		:			:	
		ne used for obtaining blood	:				!	
		nonitor blood sugars) and	:				:	
		esults. Observed for high blood ncreased thirst, increased						
	sugar symptoms - I	noreaseu umst, moreaseu		i			•	

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

Even1 ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 17 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495240	B. WING_		05	5/25/2018	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP (3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY 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	(X5) COMPLETION DATE	
	practical nurse) #4 #4 reviewed the a When asked what if the resident's ble LPN #4 stated, "W doctor/nurse pract staff document the should be in the n An interview was of (administrative sta practitioner; on 5/2 reviewed the phys Humalog insulin s asked what is the resident's blood so #3 stated, "I would the doctor." When notify the doctor of #3 stated, "I would	conducted with LPN (licensed 4 on 5/24/18 at 2:21 p.m. LPN bove order for Humalog insulin. staff should do, per the order, bood sugar is greater than 400, /e should notify the titioner." When asked where at notification, LPN #4 stated, "It	F 5	80			
	the above concern	ASM #1 was made aware of non 5/24/18 at 5:26 p.m.					
	(1) Barron's Dictio Non-Medical Read Chapman, page 1 (2) Barron's Dictio Non-Medical Read Chapman, page 1	nary of Medical Terms for the der, 5th edition, Rothenberg and					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		E-SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	СОМ	IPLETED
		495240	B. WING	,	05/	05/0040
		493240	U: 11:10		U5/A	25/2018
NAME OF I	PROVIOER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CDENED	CKSBURG HEALTH	AND DELIAR		3900 PLANK ROAD		
FREDER	CKSBUNG HEALIN	AND KEHAB		FREDERICKSBURG, VA 22407		
(X4) ID	SUMMARY STA	TEMENT OF OEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IOENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
						:
F 580	Continued From pa	ge 18	F 58	0		
	https://dailvmed.nlm	n.nih.gov/dailymed/drugInfo.cf				
		-0e22-4fc7-a503-faa58c1b6f3f				İ
F 582		Coverage/Liability Notice	F 58	2		i
	CFR(s): 483.10(g)(1 00		facility	i
55=D	Ci 1((s), 400, 10(g)(17)(10)(i)-(v)		1. Resident #219 discharged from t	acility.	
	§483.10(g)(17) The	facility must				
		licaid-eligible resident, in		2. Residents who reside at this faci	lity are	
		of admission to the nursing		at risk for same deficient practice.		!
		e resident becomes eligible for				!
	Medicaid of-	Ţ.		3. Social service director and Busin	000	
:	(A) The items and s	services that are included in				
;	nursing facility servi	ices under the State plan and		Office Manager were re-educated	on	!
•	for which the reside	nt may not be charged;		requirements for Notice of Medica	ire	
	(B) Those other iter	ns and services that the		Non-Coverage and their right to ap	neal	
:	facility offers and fo	r which the resident may be			•	
	charged, and the ar	mount of charges for those		on June 13, 2018. Administrator o		
	services; and			designee will audit 3 resident reco	rds	
		dicaid-eligible resident when		pending discharge weekly for 4 we	eks, to	
:	changes are made	to the items and services		ensure resident are provided notic	enf	
	specified in §483.10)(g)(17)(i)(A) and (B) of this		· ·		
	section.			coverage liability and appeal rights	*•	
				Issues identified will be corrected		1
		facility must inform each		immediately.		
		at the time of admission, and		· !		
!		he resident's stay, of services		4. Describe of equity will be recipied	سائلما	
I		ity and of charges for those		4. Results of audits will be reviewe		
i i		any charges for services not		the monthly QAPI meeting. Trends	;	i
:		icare/ Medicaid or by the		identified will be addressed as nee	ded.	6/26/18
	facility's per diem ra					
		n coverage are made to items				4
		ed by Medicare and/or by the				
:		, the facility must provide				
		of the change as soon as is				
	reasonably possible					
!		are made to charges for other		;		# #
1		that the facility offers, the		•		
		the resident in writing at least		:		
	60 days prior to imp	lementation of the change.				

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

PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 582 Continued From page 19 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			ING		COMPLETED	
FREDERICKSBURG HEALTH AND REHAB 3900 PLANK ROAD FREDERICKSBURG, VA 22407			495240	B. WING		05	/25/2018	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 582 Continued From page 19 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident			AND REHAB		3900 PLANK ROAD			
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE	
representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. 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 evidence that one of 37 sampled residents, (Resident #219) or their resident representative was provided with a Notice of Medicare Non-Coverage and their right to appeal. Resident #219 was admitted on 4/13/18, and discharged on 4/19/18, and had used seven of 100 Medicare days. The findings include: Resident #219 was admitted on 4/13/18 with the diagnoses of but not limited to right knee replacement, high blood pressure, and polyosteoarthritis. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 4/19/18. The resident was coded as cognitively intact in ability to make daily	F 582	(iii) If a resident die transferred and doe facility must refund representative, or edeposit or charges per diem rate, for the resided or reserved facility, regardless of discharge notice re (iv) The facility must resident representative resident within a date of discharge from the resident within and the resident within and the facility must not contain the resident remains. This REQUIREMENT by: Based on staff interest and clinical record in the facility staff fails sampled residents, resident representative of Medicare to appeal. Resident 4/13/18, and discharged seven of 100 in the findings included Resident #219 was diagnoses of but no replacement, high the polyosteoarthritis. (Minimum Data Set assessment with an Reference Date) of	s or is hospitalized or is as not return to the facility, the to the resident, resident estate, as applicable, any already paid, less the facility's ne days the resident actually or retained a bed in the of any minimum stay or quirements. It refund to the resident or attive any and all refunds due do days from the resident's from the facility. It is not met as evidenced with the requirements of the inflict with the requirements of the original or the inflict with the requirement of the inflict with the requirement of the inflict with the requirement of the inflict with the requirement of the inflict was provided with a considering admitted on an arged on 4/19/18, and had medicare days. The most recent MDS of was an admission/5-day of ARD (Assessment 4/19/18. The resident was		582			

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

Even1 ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 20 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION. ING		COMPLETEO	
		495240	B. WING		05	i/25/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3900 PLANK ROAD			
FREDER	RICKSBURG 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 PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE	
F 582	requiring total care bed mobility, ambut independent for tra hygiene; and as co. A review of the clindated 4/17/18 which that a TCM (treatmeting was held wand the IDT (Interdisalert and oriented needs known to stany mood or behave often and is very sutherapy): The residis goodhe is able working on getting working on strength walking are great. results revealed he his leg. There is a scheduled for Thur Social Services: Thome on Thursday for home health with agency) for PT. The (durable medical enfamily are very excare looking forward Please continue PC. The above dischard the resident or their with the Notice of Monday in the state	resident was coded as for bathing; supervision for lation, and toileting; as nsfers, dressing, eating, and ntinent of bowel and bladder. ical record revealed a note h documented, "Please note ent care meeting)/discharge with the resident, his family, isciplinary team). The resident d and is able to make his aff. He has not presented with rior concerns. His family visits apportive. PT (physical dent's ROM (range of motion) to bend his knee. They are it straight. Therapy is also neninghis bed mobility and Nursing: The resident's test does not have a blood clot in omplain of occasional pain in follow-up appointment sday, April 26, 2018 at 1pm. The resident will be discharging and April 19, 2018 with a referral h (name of home health the resident has no DME quipment) needs. He and his ited about his discharge and to him returning home.	F 5	82			

	ANO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		A. BUILO		E CONSTRUCTION	COMPLETEO	
		495240	B. WING			05/	25/2018
NAME OF	PROVIOER OR SUPPLIER		T	S	TREET AOORESS, CITY, STATE, ZIP COOE	1 00/	20,2010
					900 PLANK ROAD		
FREDER	CKSBURG HEALTH	AND REHAB			REDERICKSBURG, VA 22407		
(X4) IO		TEMENT OF OEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
PREFIX TAG		' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)		OATE
F 582	Continued From pa	ge 21	F 5	582			
		ce of Medicare Non-Coverage umented that "Services Will address with a date portion was					
	The notice docume Medicare provider a determined that Me your current service indicated above. Yo services you receive RIGHT TO APPEAL the right to an immereview (appeal) of the coverage of these scontinue during the appeal, the independent review medical records and information. You do in writing, but you havish. If you choose independent review the detailed explanator services should this detailed notice of	o not have to prepare anything ave the right to do so if you to appeal, you and the er will each receive a copy of ation about why your coverage not continue. You will receive only after you request an					
	independent review longer be covered a indicated above; Ne will pay for these se stop services no late indicated above, you responsibilityHOV IMMEDIATE APPEA request to your Qua (also known as a Qui reviewer authorized)			The second secon			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED			
		495240	B. WING	í		05	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB	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		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION OATE
	possible, but no late the effective date in notify you of its dec generally no later the date of this notice if If you are in a Medigenerally notify you date of this notice At the end of the abstatement: "Please received and under notified that coverative effective date of appeal this decision. There was a blank a date. The date of matching the handwent of the signatives no signature of	al should be made as soon as er than noon of the day before dicated above. The QIO will ission as soon as possible, nan two days after the effective f you are in Original Medicare. care health plan, the QIO will of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision as soon as possible, and the effective of the its decision as soon as possible, and the effective of the effective of the its decision as possible, and the QIO will of its decision by the effective of the effective of the its decision as soon as possible, and the QIO will of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision by the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible, and the effective of its decision as possible of its decision as possible of its dec	F	582	2		
	#1 (Administrative S Administrator) she serviewed at the mediabove TCM/Dischala facility forgot to have representative sign did not document the	p.m., in an interview with ASM Staff Member, the stated that this notice was eting documented in the rge meeting note, but that the e the resident or their it. The above referenced note nat the appeal process was with the resident and/or their					
	Skilled Nursing Fac	ity policy, "Form Instructions ility Advanced Beneficiary rage (SNF ABN [skilled					

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			NG	COM	MPLETED	
		495240	B. WING		05/2	25/2018
	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 CORRECTI ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION OATE
	documented, "The information to the be (she/he) can decide care that may not be assume financial resortheir authorized resignature box to accumderstood the notion.	anced beneficiary notice]) ne SNF ABN provides eneficiary so that s/he e whether or not to get the e paid for by Medicare and esponsibilityThe beneficiary representative must sign the knowledge that they read and	F 5	82		
F 584	Safe/Clean/Comfor CFR(s): 483.10(i)(1 §483.10(i) Safe Env The resident has a comfortable and ho but not limited to resupports for daily live The facility must professible (i) This includes ensure the care and sephysical layout of the independence and (ii) The facility shall the protection of the or theft.	vironment. right to a safe, clean, melike environment, including ceiving treatment and ving safely. ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the e facility maximizes resident does not pose a safety risk. exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly,	F 5	1. Resident # 35s over bed table removed from the room and discon 5/24/18. Resident #35 was pronew over bed table by the maintedirector. 2. An environmental audit of resistation on 5/4 furniture was completed by Mainted Director and Administrator on 5/4 furniture was replaced as needed and/or removing furniture, if indition to maintenance for repair. Depair heads will complete Care Keeper Monday thru Friday to observe for environmental issues or concerns needing attention or corrective a Care keeper rounds are completed morning to correct and/or report appropriate department for corrective descriptions.	arded avoided a enance dent nance 29/18. d. corting cated, tment rounds ar etions. d in the to the	

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 24 of 223

RECEIVED
JUN 18 2018
VDH/OLC

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG		COMPLETED	
		495240	B. WING		05	/25/2018	
	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 PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	IX5) COMPLETION DATE	
F 584	in good condition; §483.10(i)(4) Privat resident room, as s §483.10(i)(5) Adequal levels in all areas; §483.10(i)(6) Comfolevels. Facilities init 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observat determined that the the resident's furnit 37 residents in the second to the bed table of the findings included the resident # 35 was a 11/01/06 with a readiagnoses that included the property of the second to the second the second to the second the second to the second the secon	bed and bath linens that are e closet space in each pecified in §483.90 (e)(2)(iv); that and comfortable lighting ortable and safe temperature ially certified after October 1, in a temperature range of 71 to e maintenance of comfortable NT is not met as evidenced ion and staff interview it was facility staff failed to maintain ture in good repair for one of survey sample, Resident # 35. ed to maintain Resident # 35's vas in good repair. e: admitted to the facility on dmission of 06/04/07 with ided but were not limited to e (1), dysphagia (2), art failure, and hypertension	F 5	Care keeper rounds are revimentally by the administrate designee. Care keeper roun ongoing quality assurance process. 4. Results of care keeper roun reviewed monthly in the QAT rends identified will be addingeded.	or or ds is an erformance unds are API meeting.	6/26/18	
: !	set), an annual asse	st recent MDS (minimum data essment with an ARD nce date) of 03/20/18, coded				:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ING		COMPLETED
		495240	B. WING			05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STAT 3900 PLANK ROAD FREDERICKSBURG, VA		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION OATE
F 584	interview for mental - 15, 2 (two) - being cognition for making 35 was coded as re of one staff membe On 05/23/18 at app	coring a 2 (two) on the brief status (BIMS) of a score of 0 severely impaired of g daily decisions. Resident # quiring extensive assistance r for activities of daily living.	F 5	584		
	The edges were ch gouged out in the m approximately size trim surrounding the	er the bed table was observed. Ipped and peeling, a hole was siddle of the top of the table of a person's thumb and the eleges of the table was table exposes the bare wood				
	# 35's over the bed edges were chipped gouged out in the m approximately size trim surrounding the	roximately 9:00 a.m., Resident table was observed. The d and peeling, a hole was siddle of the top of the table of a person's thumb and the edges of the table was table exposes the bare wood				
:	# 35's over the bed edges were chipped gouged out in the m approximately size trim surrounding the	roximately 2:05 p.m., Resident table was observed. The d and peeling, a hole was siddle of the top of the table of a person's thumb and the e edges of the table was table exposes the bare wood				
; ; ;	interview was condunursing assistants) procedure staff follo	roximately 2:27 p.m., an ucted with CNAs (certified # 3 and # 9, regarding the w when resident's damaged d. CNA # 3 stated, "Remove	:			

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

	(X3) DATE SURVEY COMPLETEO	
495240 B. WING 05/25	5/2018	
NAME OF PROVIOER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB STREET AOORESS, CITY, STATE, ZIP COOE 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) IO SUMMARY STATEMENT OF OEFICIENCIES IO PROVIOER'S PLAN OF CORRECTION PREFIX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULO BE TAG REGULATORY OR LSC IOENTIFYING INFORMATION) TAG CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE	
the damaged item from the resident's room if possible. I record it in a maintenance log at the nurse's station and notify my nurse the unit manager and maintenance when I see them but as soon as possible." When asked how often they observe the resident's furniture to ensure it is in good repair, CNA# 3 stated, "It yt to observe things when in the resident's room." At this time, CNA# 3 and #9 observed Resident #35's bedside table. CNA# 3 agreed the table was not in good repair. CNA# 3 stated due to the chipped edge, hole in the middle of the table and the trim falling off the edge, the table could not be cleaned or disinfected properly. When asked if the table was recorded in the maintenance log CNA# 3 stated,"No, I didn't notice the table earlier today." On 05/24/18 at approximately 2:38 p.m., an interview was conducted with LPN (licensed practical nurse) #8. When asked to describe the procedure staff follows when resident's damaged furniture is identified, the LPN #8 stated, "It is removed from the room, write it down in the maintenance log and call maintenance." LPN # 8 stated she was not aware of the condition of Resident # 35's over the bed table. Review of the maintenance logs from 05/01/18 through 05/24/18 for the East 2 unit failed to evidence a "Maintenance Request Form" for Resident # 35's over the bed table. On 05/24/18 at 3:00 p.m., an interview was conducted with OSM (other staff member) # 1, maintenance director. When asked to describe the procedure staff follows when resident's damaged furniture is identified, of repair,		

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

Event IO: 5S1P11

Facility IO: VA0088

If continuation sheet Page 27 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPEE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495240	B. WING _		05/25/2018
	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 BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
	log. We check the day." When asked table, OSM # 1 state about it and we just serviceable condition. On 05/24/18 at applied (administrative staff administrator and A were made aware on the work of the condition of the work of the condition of the work of the condition of the work of the work of the condition of the work of the wo	e it down in the maintenance log frequently throughout the about Resident #35's bedside ed, "I was already informed replaced it. It was not in on." roximately 5:55 p.m., ASM member) #1, the SM #2, director of nursing of the findings. on was provided prior to exit. that seriously affects a earry out daily activities). This ained from the website: .gov/medlineplus/alzheimersdi	F 58	34	
F 622	(4) High blood press obtained from the w	gov/medlineplus/highbloodpr	F 62	22	
00 - E	±. 14(0). 100.10(0)(1	//·//~//~/// /··/			:

STATEMENT OF AND PLAN OF (DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			SURVEY	
		495240	B. WING	i		05/2	25/2018
	OVIDER OR SUPPLIER	AND REHAB		39	TREET ADDRESS, CITY, STATE, ZIP CODE 900 PLANK ROAD REDERICKSBURG, 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 CORRECTION (EACH CDRRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
Selection (Figure 1) Selection (Figure 2) Selection (Figure 2) Selection (Figure 2) Selection (Figure 2) Selection (Figure 3) Selection	emain in the facility scharge the reside to the resident's welfare a cannot be met in the scharge the reside of the transfer or ecause the reside of the reside of the safety of in the safety of interest of the reside of the reside of the reside of the reside of the reside of the reside of the reside of the reside of the resident of	r and discharge- ity requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the nd the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would regered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not ry paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a ble charges under Medicaid;	F	622	1. Resident # 73 was transferred to hospital on 2/7/18 and report to hemergency room nurse was called 7:15pm by facility charge nurse. Resident 73 was readmitted on 2/with resumption of plan of care. (2/7/18 at 5:45pm, Resident #73's Infectious Disease (ID) physician of facility with orders to send resident hospital for evaluation and treatmed febrile illness [elevated temperatures (Polymer of the hospital emergency department following (Nurse Practitioner) NP examination related to injury sustaduring fall on 1/26/18 at 7:40pm. Resident returned from hospital emergency department on 1/27/11:50am with resumption of care. Resident # 262 was transferred to hospital per NP order due to critic results on 4/17/18. Resident #4 was transferred to hospital for evaluat following a fall per NP on 4/28/18 at 12:5 per NP due to fall and change in condition. Resident # 75 was examby NP on 3/20/18 at 7:37pm. NP consulted with Responsible Party and ordered transfer to the hospit further evaluation.	iospital at 12/18 Dn alled at to lent of lire}. The ained 8 at the allab as ion at ferred 1 AM anined (RP)	

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

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IOENTIFICATION NUMBER:		(X2) MUL A. BUILD	1		(X3) DATE COMP	SURVEY PLETED
		495240	B. WING			05/2	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	facility. The facility that failure to transf §483.15(c)(2) Docu When the facility tra resident under any in paragraphs (c)(1) section, the facility or discharge is documedical record and communicated to the institution or provide (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility atterneeds, and the service facility to meet the resident's periodical discharge is necessed. (A) or (B) of this section. (A) The resident's periodical discharge is necessed. (B) A physician when necessary under pathis section. (iii) Information proving the section. (iii) Information proving the section. (iii) Information proving the section. (iii) Information proving the section. (B) Resident represection of the contact information. (C) Advance Direction	dent or other individuals in the must document the danger er or discharge would pose. mentation. ansfers or discharges a of the circumstances specified b(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is a receiving health care er. In the resident's medical record the transfer per paragraph (c)(1) aragraph (c)(1)(i)(A) of this resident need(s) that cannot inpts to meet the resident receiving need(s). ion required by paragraph (c) must be made byhysician when transfer or ary under paragraph (c) (1) etion; and in transfer or discharge is ragraph (c)(1)(i)(C) or (D) of wided to the receiving provider mum of the following: tion of the practitioner care of the resident. entative information including	F 6		2. Residents residing in this facility risk for the same deficient practice. 3. Nursing staff, attending physicia NPs will be re-educated on documentation requirements for transfers and discharges to ensure appropriate documentation is proviote to the receiving health care instituted provider. Director of Nursing or dewill review 24 hour report during morning meeting to ensure resident transferred or discharge have documentation of appropriate noting the receiving facility and physician, documentation supports transfer. Or designee will audit 3 residents' roweekly for 4 weeks. 4. Results of audits will be reviewed the monthly QAPI meeting. Trends identified will be addressed as need.	rided tion or esignee hts Ces to /NP DON ecords	6/26/18

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

Event ID: 5S1P11

Façility ID: VA0088

If continuation sheet Page 30 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING		MPLETED
	495240	B. WING		0	5/25/2018
	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
ongoing care, as a (E) Comprehensive (F) All other necess copy of the resident consistent with §48 any other documer a safe and effective. This REQUIREME by: Based on staff intereview, it was deterfailed to meet the arequirements for sisample, Residents 1a. The facility staff required document provided to the receiving the needs the efforts to meet the needs the receiving the needs of Resid transfer. 2. The facility staff required information receiving provider for 1/26/18 for Residents.	ppropriate. e care plan goals; esary information, including a it's discharge summary, i3.21(c)(2) as applicable, and itation, as applicable, to ensure e transition of care. NT is not met as evidenced erview, and clinical record emined that the facility staff ippropriate transfer ix of 42 residents in the survey # 73, 58, 262, 30, 4, and 75. If failed to evidence that all ation and information was elving provider for a refer on 02/07/18 for Resident If failed to provide In the physician evidencing the facility could not meet, facility's those needs and the specific in facility could provide to meet ent # 73 for a facility initiated failed to evidence that all in was provided to the or a facility-initiated transfer on ent # 58. If failed to evidence that all in was provided to the or a facility-initiated transfer on ent # 58.	-			
		! ! !			
	Continued From paragraph ongoing care, as a (E) Comprehensive (F) All other necess copy of the resident consistent with §48 any other document a safe and effective This REQUIREME by: Based on staff intereview, it was deterfailed to meet the arequirements for sistent sample, Residents 1a. The facility staff required document provided to the receptable facility-initiated transprovided to the receptable facility in the needs the receiving the needs of Residents. 2. The facility staff required information receiving provider for 1/26/18 for Residents.	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined that the facility staff failed to meet the appropriate transfer requirements for six of 42 residents in the survey sample, Residents # 73, 58, 262, 30, 4, and 75. 1a. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 02/07/18 for Resident # 73. 1b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 73 for a facility initiated	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined that the facility staff failed to meet the appropriate transfer requirements for six of 42 residents in the survey sample, Residents # 73, 58, 262, 30, 4, and 75. 1a. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer on 02/07/18 for Resident # 73. 1b. The facility staff failed to provide documentation from the physician evidencing the specific needs the facility could not meet, facility's efforts to meet the those needs and the specific needs the receiving facility could provide to meet the needs of Resident # 73 for a facility initiated transfer. 2. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 01/26/18 for Resident # 58. 3a. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 01/26/18 for Resident # 58.	PROVIDER OR SUPPLIER ### A95240 STREET ADDRESS, CITY, STATE, ZIP CODE 3000 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB	A BULDING A BULDING B. WING STREET ADDRESS, CITY, STATE, 2IP CODE 300 PLANK ROAD FREDERICKSBURG HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 ongoing care as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, it was determined that the facility staff failed to meet the appropriate transfer requirements for six of 42 residents in the survey sample, Residents # 73, 58, 262, 30, 4, and 75. 1a. The facility staff failed to evidence that all required documentation and information was provided to the receiving provider for a facility-initiated transfer. 2. The facility staff failed to evidence that all required information was provided to the receiving provider to ra facility-initiated transfer. 2. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 01/26/18 for Resident # 73 for a facility-initiated transfer on 01/26/18 for Resident # 58. 3a. The facility staff failed to evidence that all required information was provided to the receiving provider for a facility-initiated transfer on control of the provider of the receiving provider of or a facility-initiated transfer on control of the receiving provider of or a facility-initiated transfer on control of the provider of or a facility-initiated transfer on control of the provider of or a facility-initiated transfer on control of the provider of or a facility-initiated transfer on control of the provider of or a facility-initiated transfer on control of the provider of or a facility-initiated transfer on control of the provider of or a facility-initiated transfer on control of

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		0.5	/25/2018
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP C	•	723/2010
	RICKSBURG HEALTH	AND DELIAD	j	3900 PLANK ROAD		
FREDER	CICKSBURG REALIR	AND REHAB		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 CDI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION OATE
F 622	Continued From pa	ige 31	F 6	22		
	specific needs the efforts to meet the needs the receiving	n the physician evidencing the facility could not meet, facility's those needs and the specific g facility could provide to meet ent # 262 for a facility initiated				
	specific needs the failed to provide a	n the physician evidencing the facility could not meet and copy of Resident #30's care illty initiated transfer to the				
	specific needs the t	n the physician evidencing the facility could not meet and copy of Resident #4's care planing facility for a facility initiated				:
	required documents provided to the received	failed to evidence that the ation and information was eiving facility when Resident d to the hospital on 3/20/18.	·			:
	The findings include	e:	: :			
	required documents provided to the rece	failed to evidence that all ation and information was eiving provider for a sfer on 02/07/18 for Resident				
;		admitted to the facility on dmission of 02/12/18 with				•

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		E CONSTRUCTION	COMPLETED		
			, Jui	-11.10			
		495240	B. WING	·		05/	/25/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EDENER	ICKSBURG HEALTH	AND DEHAR		I	900 PLANK ROAD		
INCOLN	IOROBORO HEALITI	AND INCIDED		F	REDERICKSBURG, 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 OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)) BE	(X5) COMPLETION OATE
					i Jenochor,		
F 622	Continued From pa	ae 32	F	322			
	;	uded but were not limited to	•				:
	human immunodefi		i				!
		eflux disease (2), convulsions			 		:
		ease (4), dementia (5) and					
	encephalopathy (6)						
	D:						
		admitted to the facility on dmission of 02/12/18 with					
	, and the second	uded but were not limited to					!
	human immunodefi				i 		
		eflux disease (2), convulsions					
		ease (4), dementia (5) and			· ·		
	encephalopathy (6)		:				
	D -: + // 70!		i !		•		:
		st recent MDS (minimum data i sessment with an ARD			-		
		nce date) of 04/24/18, coded					
		coring a 12 on the brief	:				:
		status (BIMS) of a score of 0					
	- 15, 12 - being cog	nitively for making daily					
		t # 73 was coded as requiring					: :
		assistance of one staff	i :				
	member for activitie	s of daily living.			! 		
	: The nurse's "Progre	ess Notes," dated 2/7/2018					
		for Resident # 73 documented	!		:		
		ling NPC (nonproductive			:		
		asal drainage. Medicated with			:		
!		x at that time and FNP (facility			!		1
		was notified. RP (responsible	i 				
		a Flu swab was obtained.					1
		F (Fahrenheit) at 6 p.m. (6:00	: 				
		der has been rec'd (received) (Name of Hospital) ER			: i		
:		for eval/tx (evaluation and					•
:		(fever) illness per direction of			:		
). Report was called to ER					
		ansportation was arranged			:		:
		ransportation Company).			:		

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG	COMPLETE	
	495240	B. WING		05/25/20	118
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COM	(X5) PLETION DATE
transported to ER (with ER staff @ (at) resident is still in the has been no detern The nurse's "Progre for Resident # 73 de (5:48 p.m.) Resident 2:55 p.m. from (Nat Transportation Com (emergency medical stretcher" On 05/25/18 at app interview was condu- practical nurse) # 3 provided to the rece facility-initiated transface sheet, code sta and treatments." We resident care plan ge believe so." Review of resident a evidence the receiv Resident # 73's care	at hospital. Resident was at) 7:15 p.m. A f/u (follow up) 23:00 (11:00 p.m.) and e examination area and there nination." Less Notes," dated 02/12/2018 occumented in part, "17:48 at readmitted into facility at me of Hospital) (by) (Name of Ipany) accompanied by EMT at technician) personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by) Local technician personnel (by)	F6	22		
(administrative staff	member) # 1, the SM # 2, director of nursing				
References:	on was provided prior to exit. uman immunodeficiency				
virus. It harms your the white blood cells	immune system by destroying s that fight infection. This puts us infections and certain				

ANO PLAN OF CORRECTION	F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILOING			COMPLETEO	
	495240	B. WING		05	5/25/2018
NAME OF PROVIOER OR SUPPLIER FREDERICKSBURG HEALTH AND	D REHAB		STREET AOORESS, CITY, STATE, ZIP COOE 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
PREFIX (EACH OEFICIENCY MU	MENT OF OEFICIENCIES IST BE PRECEOEO BY FULL OENTIFYING INFORMATION)	IO PREFI) TAG		ULO BE	(X5) COMPLETION DATE
of infection with HIV. N develops AIDS. HIV m unprotected sex with a also spread by sharing contact with the blood Women can give it to t pregnancy or childbirth obtained from the webs https://medlineplus.gov (2) Stomach contents t the esophagus and irrit was obtained from the https://www.nlm.nih.go (3) The term "seizure" interchangeably with "o the physical findings or occur after an episode activity in the brain. Th obtained from the webs https://medlineplus.gov (4) Any functional distu change in the spinal co nonspecific lesions, as pathological bone marr myelopath'ic. This info from the website: https https://medical-dictiona yelopathy. (5) A loss of brain funct diseases. It affects me judgment, and behavio obtained from the webs	for acquired drome. It is the final stage lot everyone with HIV nost often spreads through in infected person. It may a drug needles or through of an infected person. This information was site: //hivaids.html. to leak back, or reflux, into tate it. This information website: v/medlineplus/gerd.html. is often used convulsion." A seizure is changes in behavior that of abnormal electrical his information was site: //ency/article/003200.htm. irbance or pathological ord; often used to denote opposed to myelitis. 2. row changes. adj., adj. ormation was obtained: ary.thefreedictionary.com/m tion that occurs with certain mory, thinking, language, ir. This information was	F6			

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

"STATEMENT OF DEFICIENCIES" (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			COMPLETEO		
AND FLAN	JF CONNECTION	IOENTI IOATION NUMBER.	A. BUILO	ILOING		00,	
		495240	B. WING	;		05/	25/2018
NAME OF	PROVIOER OR SUPPLIER	1		s.	TREET ADDRESS, CITY, STATE, ZIP COOE	1 00/	
	NOVEBURG UEALTU	AND DELIAD		39	900 PLANK ROAD		
FREDER	CKSBURG HEALTH	AND REMAD		F	REDERICKSBURG, VA 22407		
(X4) IO	. —	ATEMENT OF OEFICIENCIES	10	111/	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETION
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEOEO BY FULL .SC IOENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCEO TO THE APPROP		DATE
			: :		OEFICIENCY)		<u> </u>
E 622	Continued From pa	25	= /	622			!
F 022	Continued From pa	age 33	Γ,	322			
	(6) A term for any c	liffuse disease of the brain that					
	alters brain function	n or structure. This information					! !
	was obtained from			!			
	y/encephalopathy.h	h.gov/disorders/encephalopath htm.					
	y, on oopha.opa.ing.			į			
	1b. The facility sta	ff failed to provide					
		n the physician evidencing the		i i			
		facility could not meet, facility's					1
		those needs and the specific gracility could provide to meet		:			:
		ent # 73 for a facility initiated					
	transfer.	,					
	The purse's "Progra	ess Notes," dated 2/7/2018					:
		for Resident # 73 documented					:
	in part, "Looses rat	tling NPC (nonproductive		:			
		asal drainage. Medicated with					!
		ex at that time and FNP (facility was notified. RP (responsible					
		a Flu swab was obtained.					
		F (Fahrenheit) at 6 p.m. (6:00		i			1
		der has been rec'd (received) (Name of Hospital) ER					
		for eval/tx (evaluation and					
	treatment) of febrile	e (fever) illness per direction of					
		n). Report was called to ER					:
		ransportation was arranged Fransportation Company).					1
		at hospital. Resident was		,			
		at) 7:15 p.m. A f/u (follow up)					· ·
) 23:00 (11:00 p.m.) and examination area and there					
	has been no detern						
		•					
	The nurse's "Progre	ess Notes," dated 02/12/2018					

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

Event IO: 5S1P11

Facility IO: VA0088

If continuation sheet Page 36 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

	ATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495240	B. WING		0:	5/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407					
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	(5:48 p.m.) Reside 2:55 p.m. from (N. Transportation Co (emergency media stretcher" Review of the phynotes dated Februfailed to evidence needs the facility to meet the those the receiving facilineeds of Resident hospital transfer of Con 05/25/18 at 1:3 conducted with AS member) # 3, the asked if they docufacility could not measure the receiving facility could proving facility facility staff facil	documented in part, "17:48 ent readmitted into facility at ame of Hospital) (by) (Name of impany) accompanied by EMT cal technician) personnel (by) sician's most recent progress lary 2018 through May 2018 documentation of the specific could not meet, facility's efforts needs and the specific needs ty could provide to meet the transfer of the facility initiated in 2/7/18. S8 p.m., an interview was SM (administrative staff nurse practitioner. When iment the specific needs the neet, facility's efforts to meet he specific needs the receiving de to meet the needs of the stated, "No." proximately 1:10 p.m. ASM off member) # 1, the ASM # 2, director of nursing of the findings. Ition was provided prior to exit.	F 6	22			
	Resident # 58 was	admitted to the facility on					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
495240		B. WING		O.F	05/25/2018		
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP (3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE	,20,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE	
	not limited to anox (2), seizures (3), or dementia (5) and Resident #58's moset), a quarterly as (assessment refer Resident # 58 as interview for ment - 15, 5 (five) - beir cognition for maki 58 was coded as assistance of one daily living. The nurse's "Prog Resident # 58 door Resident was four room @ (at) 7:40 Reported having a Bleeding observed floor. A large lace posterior scalp. Fin to examine resident (received) to send Hospital) ER (emeand tx (treatment) Transportation Comessage was left (Name of Sister) in The nurse's "Prog 01:54 (1:54 a.m.) in Resident returned staples to the parisbleeding noted vital services in the parisbleeding noted vital services in the parisbleeding noted vital services in the parisbleeding noted vital services in the parisbleeding noted vital services in the parisbleeding noted vital services in the parisbleeding noted vital services in the parisbleed in the parisble parisble in the parisble parisble parisble parisble parisble parisbleed in the parisble parisble parisble parisbleed in the parisble parisble parisble parisble parisble parisbleed in the parisble pa	page 37 gnoses that included but were cic brain damage (1), anxiety depressive disorder (4), muscle weakness. Dest recent MDS (minimum data assessment with an ARD rence date) of 04/17/18, coded scoring a 5 (five) on the brief al status (BIMS) of a score of 0 ag severely impaired of ang daily decisions. Resident # requiring limited to extensive staff member for activities of the staff member for activities of the sumented, "20:19 (8:19 p.m.) and sitting on the floor in his p.m. He was alert and talkative. In headache at that time. If on face, clothes and on the ration was noted on the NP (facility nurse practitioner) dent and an order was rec'd (Resident # 58) to (Name of the ergency room) for evaluation of head injury.	F 6	522			

AND BLAN OF CORRECTION IN INCREM		A. BUILDI	NG		COMPLETED		
		495240	B. WING		0:	5/25/2018	
	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	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
F 622	practical nurse) # 3 provided to the rec facility-initiated tran face sheet, code s and treatments." V care plan LPN # 3 Review of resident evidence the receiv Resident # 58's ca On 05/25/18 at app (administrative stat administrator and A were made aware No further informat References: (1) Not enough oxy information was ob https://www.nlm.nil 001435.htm (2) Fear. This inforwebsite: https://www.nlm.nil #summary. (3) Symptoms of a because of sudder the brain. This inforwebsite:	lucted with LPN (licensed B, regarding information eiving facility for a nafer. LPN # 3 stated, "The tatus, vitals, medication orders When asked if they send the stated, "I don't believe so." # 58's clinical record failed to ving facility received a copy of re plan goals. proximately 1:10 p.m. ASM of member) # 1, the ASM # 2, director of nursing	F 6				
ļ	(4) Depression ma	y be described as feeling sad,	: :			:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495240	B. WING			05/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 2240			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD I HE APPROPR	BE COMPLÉTION	į
F 622	Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This infor website: https://medlineplus. (5) A loss of brain for diseases. It affects judgment, and behave obtained from the western of the service of	erable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. unction that occurs with certain memory, thinking, language, avior. This information was	F 6	522			
	required information receiving provider for 04/17/18 for Resident # 262 was 12/24/17 with a readiagnoses that inclusepsis (1), dysarthrick disorder (4), demended (6). Resident #262's modata set), a quarter (assessment reference Resident # 262 as sometime interview for mental - 15, 5 (five) - being cognition for making 262 was coded as resident as resi	failed to evidence that all a was provided to the or a facility-initiated transfer on ent # 262. sadmitted to the facility on dmission of 05/01/18 with add but were not limited to a (2), aphasia (3), depressive that (5) and cerebral infarction ost recent MDS (minimum by assessment with an ARD ance date) of 04/17/18, coded acoring a 5 (five) on the brief status (BIMS) of a score of 0 severely impaired of a daily decisions. Resident # requiring limited to extensive taff member for activities of					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
	17:49 (5:49 a.m.) for in part, "(Name of Hwith critical hemogly practitioner) in facil send (Name of Hos" The nurse's "Progret 12:54 p.m., for Respart, "Resident was (Name of Transported" Review of resident evidence the receive Resident # 262's cased on 05/25/18 at appinterview was condipractical nurse) # 3 provided to the receive facility-initiated transface sheet, code stand treatments." We care plan goals, LP so On 05/25/18 at app (administrative staff administrator and Awere made aware on No further information.	ess Notes," dated 04/17/18 at or Resident # 262 documented dospital) lab (laboratory) called obin results at 5.8. NP (nurse ity. NON (new order now) to spital) ER (emergency room) ess Notes," dated 05/01/18 at ident # 262 documented in brought to the facility by tation Company) and put in # 262's clinical record failed to ing facility received a copy of are plan goals. roximately 9:21 a.m., an ucted with LPN (licensed, regarding information eiving facility for a sfer. LPN # 3 stated, "The atus, vitals, medication orders /hen asked if they send the N # 3 stated, "I don't believe roximately 1:10 p.m. ASM member) # 1, the SM # 2, director of nursing of the findings. on was provided prior to exit.	F6	22		
! ! !		ess in which the body has a ry response to bacteria or		· ·	; ;	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
			A. Bolesino				:
		495240	B. WING			05/	/25/2018
NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
FREDERICKSBURG HEALTH AND REHAB			390	0 PLANK ROAD			
FREDER	ICKSBOKG IILALIII	AND INCHAS		FR	EDERICKSBURG, VA 22407		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
	: :		!		DEFICIENCY)		
5 000	<u> </u>						
F 622	Continued From pa	•	; F6	322			:
		symptoms of sepsis are not					
		ns themselves. Instead, releases cause the response.					
		as obtained from the website:	!				
		.gov/ency/article/000666.htm.					
	Thipo,,,oam.op.do	.907, 01, 03, 01, 01, 01, 01, 01, 01, 01, 01, 01, 01	! !				!
	<u> </u>			i			i
		hich you have difficulty saying		:			
		problems with the muscles that					:
	i from the website:	s information was obtained					:
		.gov/ency/article/007470.htm.	!				i
	Titps://iicamiopido	.gov/chey/article/co/+/o.htm.					:
	(3) A disorder caus	ed by damage to the parts of		!			:
		ol language. It can make it	!				İ
		d, write, and say what you					
		information was obtained from					
	the website:						
	: nttps://www.nim.nir	n.gov/medlineplus/aphasia.htm					
			: 1	:			
		y be described as feeling sad,	:				:
		erable, or down in the dumps.					•
		way at one time or another for		:			
		ical depression is a mood		!			
		eelings of sadness, loss, anger,					
		ere with everyday life for weeks mation was obtained from the					
	website:	mation was obtained from the	:				
		.gov/ency/article/003213.htm.		:			
			:	:			
		unction that occurs with certain	· !				
		memory, thinking, language,		i			
		avior. This information was					:
	obtained from the v	vebsite: .gov/ency/article/000739.htm.	1	:			
	: nups.//meaiinepius :	.gov/ency/article/000739.ftm.	•	!			:
	(6) A stroke. Wher	blood flow to a part of the					1
		e is sometimes called a "brain					!

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

Event ID:5S1P11

Facility ID: VA0088

(f continuation sheet Page 42 of 223

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED	
		407040	- WING				
		495240	B. WING			05	/25/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FREDERICKSBURG HEALTH AND REHAB		İ	3	3900 PLANK ROAD			
FREDERICKSBURG HEALTH AND REHAD			F	FREDERICKSBURG, VA 22407			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	i ID		PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOU		COMPLÉTION OATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	OATE
			<u> </u>		1		· ·
E 000			!				:
F 622		-	F 6	322	2		!
	·	w is cut off for longer than a					
		rain cannot get nutrients and					
		can die, causing lasting					
		mation was obtained from the	1				
	website:	/					
	nttps://mealineplus	.gov/ency/article/000726.htm .					
	:						
	3b. The facility stat	ff failed to provide	1				
		n the physician evidencing the	:				
		facility could not meet, facility's					:
		those needs and the specific					:
		facility could provide to meet					
	the needs of Resid	ent # 262 for a facility initiated			•		:
	transfer.		:				
			•				
		ost recent MDS (minimum					:
		ly assessment with an ARD					:
		ence date) of 04/17/18, coded					
		scoring a 5 (five) on the brief I status (BIMS) of a score of 0	:				
		severely impaired of	: .				
		g daily decisions. Resident#					
		requiring limited to extensive			!		
•		taff member for activities of	į				•
	daily living.						:
		ess Notes," dated 04/17/18 at	:				i !
		or Resident # 262 documented					:
		lospital) lab (laboratory) called	1				· .
		obin results at 5.8. NP (nurse	:		1		i
		ty. NON (new order now) to			: :	•	: I
i	send (Name of Hos	pital) ER (emergency room)	!				1
:	•••		÷				
	Davious of the physic	cian's most recent progress	!		:		'
		cian's most recent progress ry 2018 through May 2018	1	•			·
		ocumentation of the specific					
	10 0 VIGOTIOO G	Julianianian of the opening					.]

	DELAN OF CORRECTION IN IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION		COMPLETED	
		495240	B. WING	10.000	05	05/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP COE 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 CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 622	to meet the those of the receiving facility needs of Resident hospital transfer of the conducted with AS member) # 3, the masked if they document facility could not member the could provide resident for facility stated, "No." On 05/25/18 at approximate the could provide the could provide a district of the could provide a state of the could provide a plan goals for a fact hospital on 4/25/18. Resident #30 was 8/27/18 and readment that included but we disease, depression pressure and chrospital on the could be could be compared to the could be co	ould not meet, facility's efforts needs and the specific needs y could provide to meet the #262 for facility initiated n 4/17/18. 8 p.m., an interview was M (administrative staff nurse practitioner. When ment the specific needs the eet, facility's efforts to meet ne specific needs the receiving de to meet the needs of the initiated transfers, ASM # 3 proximately 1:10 p.m. ASM ff member) # 1, the ASM # 2, director of nursing of the findings. Ition was provided prior to exit. failed to provide m the physician evidencing the facility could not meet and copy of Resident #30's care cility initiated transfer to the 3. admitted to the facility on itted on 5/3/18 with diagnoses ere not limited to: kidney n, dementia, low blood	F 6	22			
; ; ;	quarterly assessmereference date) of	IDS (minimum data set), a ent, with an ARD (assessment 3/13/18 coded the resident as out of 15 on the brief				: : : : : :	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495240	B. WING			05/25/2018	
•	PROVIDER OR SUPPLIER	AND REHAB		3900	EET ADDRESS, CITY, STATE, ZIP CODE D PLANK ROAD EDERICKSBURG, VA 22407	,, 00	12012010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 622	Review of the clinic note dated 4/25/18 documented, "Resi floor on the mat in by CNA (certified in practitioner was co (name of hospital). Review of the April notes and clinical redocumentation for required a facility in and the specific nethe facility for Residinitiated transfer. Review of the clinic documentation that with the resident to 4/25/18 facility initial. An interview was cop.m. with RN (registabout the process swas sent to the host to have a doctor's cassessment, if the the hospital we the what paperwork was resident, RN #1 stamedication list." Will care plan goals are	all status indicating the resident act to make daily decisions. Cal record revealed a nurses at 12:51 a.m. that dent was found sitting on the front of his bed at 11:25 (p.m.) ursing assistant)Nurse ntacted. Order to send him to were given." and May 2018 physician's ecord failed to evidence the reason the resident attacted transfer to the hospital eds that could not be met at dent #30's 4/25/18 facility cal record did not evidence any the care plan goals were sent the receiving facility for the ated transfer. Conducted on 5/24/18 at 2:06 tered nurse) #1. When asked staff follow when a resident spital, RN #1 stated, "We have order. First we do an doctor says to send to them to notify family." When asked as sent to the hospital with the ated, "The doctor's orders, the nen asked if the resident's sent, RN #1 stated, "No."	F€	522			
		onducted on 5/25/18 at 9:20 nsed practical nurse) #3, the	i :				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPEIER/CEIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG		COMPLETED	
		495240	B. WING		0.5	5/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 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 CORF ((EACH CORRECTIVE ACT(ON S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE	
F 622	when a resident we stated, "We notify doctor/nurse pract like to proceed. The asked what paper LPN #3 stated, "A medications, code (blood pressure, prespirations) and we resident." When assent, LPN #3 states An interview was a.m. with ASM (add the nurse practition information was downs transferred to I see them I dictated	arding the process staff follow as sent to the hospital. LPN #3 the MD/NP (medical itioner) to see how they would be family is notified." When work was sent to the hospital, face sheet, copy of status, recent set of vitals ulse, temperature and what's going on with the sked if the care plan goals are ed, "I don't believe so." conducted on 5/25/18 at 9:43 ministrative staff member) #3, mer. When asked what becumented when a resident the hospital, ASM #3 stated, "If e a note for why I send them mem I don't document it. I will	F 6	22			
	member) #1, the a director of nursing findings. No further informa 5. The facility staf documentation fro specific needs the failed to provide a goals to the receiv transfer to the hos	m the physician evidencing the facility could not meet and copy of Resident #4's care planing facility for a facility initiated					
	and readmitted on	5/6/18 with diagnoses that not limited to: diabetes, blood					

		(X1) PROVIDER/SUPPEIER/CLIA IDENTIFICATION NUMBER:	(X2) Muli A. BUILD	TIPEE CONSTRUCTION:	(X3) DATE SURVEY- COMPLETED		
	495240		B. WING		0.0	05/05/0040	
	PROVIDER OR SUPPLIEF	3	J 21 W V	STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	P CODE	5/25/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	with an ARD of 5/1 having scored a 13 interview for ments was cognitively into Review of the nurse p.m. documented, was found on floor resident what had to my closet from tout. I was walking hit the bedside tab practitioner) she gractitioner of the April notes and clinical redocumentation for required a facility is and the specific near the second of the April notes and clinical redocumentation for required a facility is and the specific near the second of the April notes and clinical required a facility is and the specific near the second of the April notes and clinical required a facility is and the specific near the second of the April notes and clinical required a facility is and the specific near the second of the April notes and clinical required a facility is and the specific near the second of the April notes and the specific near the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes and the second of the April notes are the second of the April notes and the second of the April notes are the second of the April notes and the second of the April notes are the s	on and anemia. **IDS*, a quarterly assessment, 5/18 coded the resident as 3 out of 15 on the brief al status indicating the resident act to make daily decisions. **IDS*, a quarterly assessment, 5/18 coded the resident act to make daily decisions. **IDS*, a quarterly assessment, 5/18 coded the resident act to make daily decisions. **IDS*, a quarterly assessment, 5/18 coded the resident act to make daily decisions. **IDS*, a quarterly assessment, 5/18 coded the resident act to make daily decisions. **IDS*, a quarterly assessment, 5/18 coded the resident act to make daily decisions. **IDS*, a quarterly assessment, 5/18 coded the resident act act to make daily decisions. **IDS*, a quarterly assessment, 5/18 coded the resident act act act act act act act act act ac	F6	522			
	p.m. with RN (regist about the process was sent to the host to have a doctor's assessment, if the the hospital we the what paperwork was resident, RN #1 standication list."	onducted on 5/24/18 at 2:06 stered nurse) #1. When asked staff follow when a resident spital, RN #1 stated, "We have order. First we do an doctor says to send to them to notify family." When asked as sent to the hospital with the ated, "The doctor's orders, the hen asked if the resident's e sent, RN #1 stated, "No."					

· · · · · · · · · · · · · · · · · · ·	
495240 B. WING	05/25/2018
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB STREET ADDRESS, CITY 3900 PLANK ROAD FREDERICKSBURG	, STATE, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFEREN	S PLAN OF CORRECTION (X5) CTIVE ACTION SHOULD BE COMPLETION NCED TO THE APPROPRIATE OATE DEFICIENCY)
An interview was conducted on 5/25/18 at 9:20 a.m. with LPN (licensed practical nurse) #3, the unit manager regarding the process staff follow when a resident was sent to the hospital. LPN #3 stated, "We notify the MD/NP (medical doctor/nurse practitioner) to see how they would like to proceed. The family is notified." When asked what paperwork was sent to the hospital, LPN #3 stated, "A face sheet, copy of medications, code status, recent set of vitals (blood pressure, pulse, temperature and respirations) and what's going on with the resident." When asked if the care plan goals are sent, LPN #3 stated, "I don't believe so." An interview was conducted on 5/25/18 at 9:43 a.m. with ASM (administrative staff member) #3, the nurse practitioner. When asked what information was documented when a resident was transferred to the hospital, ASM #3 stated, "If I see them I dictate a note for why I send them out. If I don't see them I don't document it. I will see them when they come back." On 5/25/18 at 1:20 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 6. The facility staff failed to evidence that the required documentation and information was provided to the receiving facility when Resident #75 was transferred to the hospital on 3/20/18. Resident #75 was admitted to the facility on 3/13/18 with the diagnoses of but not limited to heart failure, osteomyelitis, angina, peripheral	

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE-CONSTRUCTION-		TE-SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	co	COMPLETED	
					ŀ		
		495240	B, WING		05	/25/2018	
NAME OF	PROVIDER OR SUPPLIES	₹		STREET ADDRESS, CITY, STATE, ZIP			
			- 1	3900 PLANK ROAD			
FREDER	CKSBURG HEALTI	HAND REHAB		FREDERICKSBURG, VA 22407	•		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTIO	N SHOULD BE	COMPLETION DATE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE	
	! !		 			-	
F 622	Continued From p	nage 48	Fe	522 ·			
		respiratory failure, Alzheimer's		· : :			
		od pressure, diabetes, atrial		:			
		ovascular disease, chronic		· 			
		ombosis, and dysphagia. The		•			
		(Minimum Data Set) was an	1				
		assessment with an ARD	:			i	
		erence Date) of 4/18/18. The					
	; •	ed as severely cognitively	•			:	
		to make daily life decisions,		•		:	
	scoring a 2 out of	a possible 15 on the BIMS				!	
	(Brief Interview for	r Mental Status) exam.	!				
						:	
		nical record revealed the	!	•			
		's note dated 3/20/18					
		(nurse practitioner) reviewed	; !	į		2	
		ent. RP (responsible party) (the land was updated on resident's				:	
		in agreement with treatment.	l İ			:	
		ER (emergency room) updated				i	
		lition and why resident was		ļ !			
		" A second nurse's note dated	İ			:	
:		ed, "Resident was transported		•		1	
		al) via (name of ambulance	!				
	transport company	y) at 2030pm (8:30 p.m.), alert	İ	:			
		Name of hospital) was updated		:			
	on transport and r	eason for transfer."					
	On 5/25/18 at 0⋅20	a.m., in an interview with LPN				:	
:		tical Nurse), she stated that					
		sent to the hospital, that the		<u>:</u> !			
		d with the face sheet, code	!				
;		list, vital signs, a report of what					
:		the resident. LPN #3 stated	ı	:			
		ls are not sent to the hospital.				:	
	On E/0E/40 at 4:46	an the ACM 44 /the				:	
!) p.m., the ASM #1 (the					
:		ministrative Staff Member) was e findings. No further	:				
		rovided by the end of the	:			•	

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 49 of 223

RECEIVED
JUN 18 2018
VDH/OLC

	TOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILUI	ING		PLETED
		495240	B. WING		05/2	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADURESS, 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	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 622	Continued From pasurvey.	age 49	F6	22	:	
SS=E	Notice Requirement CFR(s): 483.15(c)(3) Notice Before a facility transident, the facility (i) Notify the resident representative(s) of the reasons for the language and man facility must send a representative of the Long-Term Care Of the Long-Term Care Of the reasons for the reasons for the language and man facility must send a representative of the Long-Term Care Of the reasons for the language and man facility must send a representative of the Long-Term Care Of the reasons discharge in the reasons discharge in the reasons discharge in the reasons discharge required (c)(8) of this section discharge required made by the facility resident is transfer of (a) The safety of in the endangered und this section; (b) The health of in the endangered, unthis section; (c) The resident's fallow a more immediate.	ce before transfer. Insfers or discharges a must- must- must- move in writing and in a mer they understand. The move of the notice to a me Office of the State mbudsman. Incons for the transfer or sident's medical record in maragraph (c)(2) of this section; motice the items described in this section. In g of the notice. ied in paragraphs (c)(4)(ii) and motion, the notice of transfer or under this section must be material at a soon as practicable made as soon as practicable	F6	1. Resident #73 Responsible Par requested resident transfer to he phone to the charge nurse on 2/5:06PM due to change in condit Resident #58 RP was notified by MD order to transfer to the hose 1/26/18 at 7:40 PM. Resident #2 was notified by phone on 4/17/5:49pm by charge nurse. Resident #4 Resident #4 Resident #4 Resident #4 Resident #4 Resident #4 Resident #4 Resident #4 Resident #75 RR Residen	ospital by 7/18 at on. phone of pital on 162s RP 18 at ent #30 ensfer to 18 AM by P was the 18 at ent #30 ensfer or copy of the tor of 24 hour to ensure	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495240	B. WING	· · · · · · · · · · · · · · · · · · ·	0	5/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON \$HOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 623	required by the resunder paragraph (c) (E) A resident has adays. §483.15(c)(5) Controtice specified in pust include the foliant include the foliant include the foliant include the foliant including the reason for fine for the foliant including the name and telephone numereceives such requite obtain an appeal completing the form hearing request; (v) The name, addrese of the protection and developmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adevelopmental disabilities, the maintelephone number of the protection and adversion a	ransfer or discharge is ident's urgent medical needs, o(1)(i)(A) of this section; or not resided in the facility for 30 ents of the notice. The written paragraph (c)(3) of this section llowing: ransfer or discharge; the of transfer or discharge; which the resident is larged; the resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State	F6	documentation of appropries sent. DON or designee we residents' records weekly 4. Results of audits will be the monthly QAPI meeting identified will be address.	vill audit 3 y for 4 weeks. e reviewed in ng. Trends	6/26/18	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE:CONSTRUCTION G	(X3) DATE-SURVEY COMPLETED		
		495240	B. WING _		05/25/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE	
(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 CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (E	ON SHOULD BE IE APPROPRIATE	(X5 COMPLETION OATE
F 623	If the information effecting the trans must update the ras practicable one becomes available \$483.15(c)(8) Not In the case of facithe administrator written notification to the State Surve State Long-Term the facility, and the well as the plan for relocation of the	anges to the notice. In the notice changes prior to fer or discharge, the facility ecipients of the notice as soon the the updated information	F 62	3		

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION DING		MPLETED
		495240	B. WING		05	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODI 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 PREFI TAG		OULD BE	(X5) COMPLETION DATE
	notification to Resid (RP) for a facility in on 04/17/18. 4. The facility staff or the resident's reprior to a facility init on 4/25/18. 5. The facility staff or the resident's reprior to a facility init on 4/28/18. 6. The facility staff Resident #75's resident #75's resident with writte	failed to provide written dent # 262's responsible party itiated transfer to the hospital failed to provide Resident #30 presentative written notification iated transfer to the hospital failed to provide Resident #4 presentative written notification iated transfer to the hospital failed to evidence that dent representative (RR) was a notification of the hospital esident went to the hospital on	F 6	523		
	The findings include	9 :	:			
	notification to Resid	failed to provide written lent # 73's responsible party itiated transfer to the hospital				
	05/21/13 with a rea diagnoses that incluhuman immunodefi gastroesophageal r	eflux disease (2), convulsions ease (4), dementia (5) and				
: :		st recent MDS (minimum data sessment with an ARD				

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IOENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILOING				COMPLETEO	
		495240	B. WING			05	5/25/2018	
	PROVIOER OR SUPPLIER	AND REHAB		3900 PLANK	RESS, CITY, STATE, ZIP COOE ROAD KSBURG, VA 22407			
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	X EAC	ROVIOER'S PLAN OF CORRECTH CORRECTIVE ACTION SHO S-REFERENCEO TO THE APP OEFICIENCY)	OULO BE	IX5) COMPLETION DATE	
	Resident # 73 as so interview for menta - 15, 12 - being cog decisions. Resider limited to extensive member for activities. The nurse's "Progre 23:41 (11:41 p.m.) in part, "Looses ratt cough) and clear na Tylenol and Mucine nurse practitioner) party) notified and a Temperature 100.8 p.m.) and a new ord to send resident to (emergency room) treatment) of febrile (Name of Physician charge nurse and tr Via (by) (Name of T Sister / RP to meet transported to ER (a with ER staff @ (at) resident is still in the has been no determ. The nurse's "Progref for Resident # 73 de (5:48 p.m.) Resider 2:55 p.m. from (Nar Transportation Com	coring a 12 on the brief a status (BIMS) of a score of 0 nitively for making daily at #73 was coded as requiring assistance of one staff as of daily living. Ses Notes," dated 2/7/2018 for Resident #73 documented ling NPC (nonproductive asal drainage. Medicated with ax at that time and FNP (facility was notified. RP (responsible a Flu swab was obtained. F (Fahrenheit) at 6 p.m. (6:00 fer has been rec'd (received) (Name of Hospital) ER for eval/tx (evaluation and (fever) illness per direction of 1). Report was called to ER ansportation was arranged fransportation Company). at hospital. Resident was at 7:15 p.m. A f/u (follow up) 23:00 (11:00 p.m.) and a examination area and there	F6	23				
		oximately 9:21 a.m., an ucted with LPN (licensed		:			:	

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

Event IO:5S1P11

Facility IO: VA0088

If continuation sheet Page 54 of 223

RECEIVED
JUN 18 2018
VDH/OLC

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

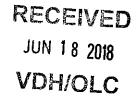
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION	(X3)	COMPLETED	
		495240	B, WING			05/25/2018	
NAME OF I	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
FREDER	CKSBURG HEALTH	I AND REHAR		3900 PLANK ROAD			
· NEDEN	ionobono nenen			FREDERICKSBURG, VA	22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	NOF CORRECTION ACTION SHOULD BE TO THE APPROPRIAT IENCY)	X5) COMPLETION E OATE	
F 623	Continued From p	age 54	F 6	623		!	
	practical nurse) # provided to the res asked how the not hospital to the fam stated, "Notificatio When asked if sta	3, regarding information sponsible party (RP) When ification for transfer to the filly is conducted, LPN # 3 n to family is over the phone." If provide any written ily, LPN # 3 stated, "Only if they					
	evidence the RP re	nt # 73's clinical record failed to eceived a written notification of cility initiated transfer to the					
	(administrative sta	proximately 1:10 p.m. ASM ff member) # 1, the ASM # 2, director of nursing of the findings.					
:	No further informa	tion was provided prior to exit.				:	
	virus. It harms you the white blood celyou at risk for serio cancers. AIDS sta immunodeficiency of infection with HI develops AIDS. Hunprotected sex walso spread by sha contact with the blowders and give it.	syndrome. It is the final stage V. Not everyone with HIV IV most often spreads through ith an infected person. It may aring drug needles or through ood of an infected person. It to their babies during birth. This information was website:					
		nts to leak back, or reflux, into				·	

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 55 of 223



	TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' /	TIPLE CONSTRUCTION		(X3)-DATE-SURVEY	
		495240	B. WING		05	5/25/2018	
	PROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407			
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL .SC IDENTIFYING INFORMATION)	IO PREFI) TAG	PROVIDER'S PLAN OF COIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE OEFICIENCY)	I SHOULO BE	X5) COMPLETION DATE	
F 623	Continued From pa	age 55 I irritate it. This information	F 6	23		:	
	was obtained from		!			:	
	the physical finding occur after an epis activity in the brain obtained from the	th "convulsion." A seizure is as or changes in behavior that ode of abnormal electrical . This information was					
	change in the spina nonspecific lesions pathological bone i myelopath'ic. This from the website: h	disturbance or pathological al cord; often used to denote a as opposed to myelitis. 2. marrow changes. adj., adj information was obtained attps: ionary.thefreedictionary.com/m					
	diseases. It affects judgment, and beh obtained from the whttps://medlineplus (6) A term for any calters brain function was obtained from	gov/ency/article/000739.htm. diffuse disease of the brain that or structure. This information the website: h.gov/disorders/encephalopath					
	notification to Resid	failed to provide written dent # 58's responsible party itiated transfer to the hospital					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
	495240	B. WING		05	/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH A	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3900 PLANK ROAD FREDERICKSBURG, VA 22407			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION OATE	
o1/01/16 with diagnor not limited to anoxic (2), seizures (3), dependentia (5) and multiple dementia (5) and multiple dementia (5) and multiple dementia (5) and multiple dementia (5) and multiple dementia (5) and multiple dementia (5) assessment referer Resident # 58 as so interview for mental - 15, 5 (five) - being cognition for making 58 was coded as recassistance of one stable daily living. The nurse's "Progre Resident # 58 docur p.m.) Resident was froom @ (at) 7;40 p.r. Reported having a half bleeding observed of floor. A large laceral posterior scalp. FNF in to examine reside (received) to send (Flospital) ER (emergand tx (treatment) of Transportation Commessage was left for (Name of Sister) in rown The nurse's "Progreson: 54 (1:54 a.m.) for "Resident returned fistaples to the parieta"	admitted to the facility on oses that included but were brain damage (1), anxiety pressive disorder (4),	F6	523			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		495240	B. WING			05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		3	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 BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
	interview was condupractical nurse) # 3 provided to the respasked how the notific conducted LPN # 3 is over the phone." any written information in the providence of the RP respective of Resident evidence the RP resident # 73's transcript (administrative staffiadministrative staffia	roximately 9:21 a.m., an acted with LPN (licensed regarding information consible party (RP) When ication to the family is stated, "Notification to family When asked if they provide ion to family LPN # 3 stated, tit." # 73's clinical record failed to be every a written notification of easier. roximately 1:10 p.m. ASM member) # 1, the SM # 2, director of nursing		523			

FORM APPROVED OMB NO. 0938-0391

		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FREDERICKSBURG HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 58 (4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was			495240	B. WING			05/	25/2018
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 58 (4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was			AND REHAB		39	900 PLANK ROAD		
(4) Depression may be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. Clinical depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for weeks or more. This information was obtained from the website: https://medlineplus.gov/ency/article/003213.htm. (5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES	DBE	(X5) COMPLETION OATE
https://medlineplus.gov/ency/article/000739.htm. 3. The facility staff failed to provide written notification to the responsible party (RP) of a facility initiated transfer to the hospital on 04/17/18 for Resident # 262. Resident # 262 was admitted to the facility on 12/24/17 with a readmission of 05/01/18 with diagnoses that included but were not limited to sepsis (1), dysarthria (2), aphasia (3), depressive disorder (4), dementia (5) and cerebral infarction (6). Resident #262's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/17/18, coded Resident # 262 as scoring a 5 (five) on the brief interview for mental status (BIMS) of a score of 0 - 15, 5 (five) - being severely impaired of cognition for making daily decisions. Resident # 262 was coded as requiring limited to extensive assistance of one staff member for activities of daily living.		(4) Depression may blue, unhappy, misc Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This information website: https://medlineplus. (5) A loss of brain for diseases. It affects judgment, and beha obtained from the whitps://medlineplus. 3. The facility staff notification to the refacility initiated trans 04/17/18 for Reside Resident # 262 was 12/24/17 with a read diagnoses that inclusepsis (1), dysarthridisorder (4), demen (6). Resident #262's modata set), a quarter (assessment reference Resident # 262 as sinterview for mental 15, 5 (five) - being cognition for making 262 was coded as massistance of one sides.	be described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. unction that occurs with certain memory, thinking, language, avior. This information was rebsite: gov/ency/article/000739.htm. failed to provide written esponsible party (RP) of a sefer to the hospital on nt # 262. It admitted to the facility on dmission of 05/01/18 with reded but were not limited to a (2), aphasia (3), depressive tia (5) and cerebral infarction est recent MDS (minimum y assessment with an ARD nce date) of 04/17/18, coded coring a 5 (five) on the brief status (BIMS) of a score of 0 severely impaired of daily decisions. Resident # equiring limited to extensive	F	323			

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		0:	5/25/2018	
NAME OF	PROVIDER OR SUPPLIEF	8	•	STREET ADDRESS, CITY, STATE, ZIP (
FREDER	ICKSBURG HEALTH	I AND REHAB		3900 PLANK ROAD FREDERICKSBURG, VA 22407	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 623	Continued From p	age 59	F6			:	
	The nurse's "Prog 17:49 (5:49 a.m.) in part, "(Name of with critical hemog practitioner) in fac send (Name of Ho "	ress Notes," dated 04/17/18 at for Resident # 262 documented Hospital) lab (laboratory) called globin results at 5.8. NP (nurse ility. NON (new order now) to ospital) ER (emergency room)					
	12:54 p.m., for Re part, "Resident wa	sident # 262 documented in s brought to the facility by rtation Company) and put in				! ! :	
,	interview was compractical nurse) # provided to the resasked how the not conducted LPN # is over the phone.	proximately 9:21 a.m., an ducted with LPN (licensed 3, regarding information sponsible party (RP) When ification to the family is 3 stated, "Notification to family" When asked if they provide ation to family LPN # 3 stated, st it."			,		
	_	nt # 73's clinical record failed to eceived a written notification of ansfer.					
	(administrative sta	proximately 1:10 p.m. ASM ff member) # 1, the ASM # 2, director of nursing of the findings.					
:	No further informa	tion was provided prior to exit.	!	: : !			
:	severe, inflammate	ness in which the body has a ory response to bacteria or symptoms of sepsis are not	:				

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 60 of 223

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05/2	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, S 3900 PLANK ROAD FREDERICKSBURG, V			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD CED TO THE APPROPE FICIENCY)	BE.	(X5) COMPLETION DATE
F 623	chemicals the body This information wa https://medlineplus. (2) A condition in wi words because of p help you talk). This from the website: https://medlineplus. (3) A disorder cause the brain that contro hard for you to read mean to say) This is the website:	ge 60 as themselves. Instead, releases cause the response. as obtained from the website: gov/ency/article/000666.htm. Thich you have difficulty saying problems with the muscles that information was obtained gov/ency/article/007470.htm. The deby damage to the parts of oll language. It can make it life, write, and say what you information was obtained from the gov/medlineplus/aphasia.htm		623	FICIENC 1)		
	blue, unhappy, mise Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This inforwebsite: https://medlineplus. (5) A loss of brain fudiseases. It affects judgment, and beha obtained from the whttps://medlineplus.	be described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, re with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. unction that occurs with certain memory, thinking, language, avior. This information was rebsite: gov/ency/article/000739.htm.					
:	brain stops. A stroke	e is sometimes called a "brain w is cut off for longer than a		:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495240	B. WING		0:	5/25/2018	
	PROVIDER OR SUPPLIEF		390	REET ADDRESS, CITY, STATE, ZIP (00 PLANK ROAD EDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION OATE	
	oxygen. Brain cells damage. This inforwebsite: https://medlineplus 4. The facility staff resident's represent a facility initiated Resident #30. Resident #30 was 8/27/18 and readminated included but with disease, depressing pressure and chroomore the most recent May as a compart of the most recent of the clinical of the clinical of the most recent of the clinical of the most recent of the clinical of the most recent of the clinical of the most recent of the clinical of the most recent of the clinical of the most recent of the clinical of the most recent of	prain cannot get nutrients and so can die, causing lasting rmation was obtained from the segov/ency/article/000726.htm. If alled to provide the resident or notative written notification prior detransfer to the hospital for admitted to the facility on notited on 5/3/18 with diagnoses were not limited to: kidney on, dementia, low blood nic pain. IDS (minimum data set), a ent, with an ARD (assessment 3/13/18 coded the resident as 3 out of 15 on the brief all status indicating the resident act to make daily decisions. Cal record revealed a nurses 3 at 12:51 a.m. that ident was found sitting on the front of his bed at 11:25 (p.m.) pursing assistant)Nurse ontacted. Order to send him to	F 623				
	that written docum- transfer was given	entation for the need of the to the resident or resident's the facility initiated hospital					
		onducted on 5/24/18 at 2:06 stered nurse) #1 regarding how					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495240	B. WING			05/	25/2018
	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	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 623	Continued From pa	ge 62	F 6	23			:
-	stated, "We talk to t	of a hospital transfer. , RN #1 hem." When asked if there on is given to the family, RN					
	a.m. with LPN (licer unit manager, regar of a transfer to the h call them." When as	enducted on 5/25/18 at 9:20 ased practical nurse) #3, the ding how the family is notified nospital. LPN #3 stated, "We sked if the family is given of the transfer, LPN #3 stated					
	member) #1, the ad	o.m. ASM (administrative staff ministrator and ASM #2, the vere made aware of the					
	No further information	on was provided prior to exit.					:
	or resident's represe	failed to provide the resident entative written notification ated transfer to the hospital					
	and readmitted on 5	mitted to the facility on 7/1/17 //6/18 with diagnoses that of limited to: diabetes, blood and anemia.					
	with an ARD of 5/15 having scored 13 ou for mental status inc	OS, a quarterly assessment, 718 coded the resident as at of 15 on the brief interview dicating the resident was make daily decisions.					:
	p.m. documented, "/	's notes dated 4/28/18 at 2:08 At 1130 (11:30 a.m.) resident ying on her right side. Asked		:			:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495240	B. WING		0:	5/25/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE		
F 623	to my closet from tout. I was walking hit the bedside tab practitioner) she ga (emergency room) Review of the clinic that written docum given to the reside for the facility initia 4/28/18. An interview was cop.m. with RN (regist the family is notifie stated, "We talk to	happened she stated, "I walked he bathroom to get something to my bed when I fell and head leNotified (name of nurse ave order to send out to ER	F 6	523				
	a.m. with LPN (lice unit manager, regard of a transfer to the call them." When a written notification they did not. On 5/25/18 at 1:20 member) #1, the acceptance of the call them.	onducted on 5/25/18 at 9:20 nsed practical nurse) #3, the ording how the family is notified hospital. LPN #3 stated, "We sked if the family is given of the transfer, LPN #3 stated p.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the						
:	6. The facility staff Resident #75's resi provided with writte	failed to evidence that dent representative (RR) was notification of the hospital esident went to the hospital on		•				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	1	495240	B. WING	;		05/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE
	3/13/18 with the dia heart failure, osteon vascular disease, redisease, redisease, redisease, high blood fibrillation, cerebrov embolism and thron most recent MDS (Nadmission/5-day as: (Assessment Referencesident was coded impaired in ability to scoring a 2 out of a (Brief Interview of the clinic	admitted to the facility on agnoses of but not limited to myelitis, angina, peripheral espiratory failure, Alzheimer's pressure, diabetes, atrial vascular disease, chronic mbosis, and dysphagia. The Minimum Data Set) was an sessment with an ARD ence Date) of 4/18/18. The as severely cognitively make daily life decisions, possible 15 on the BIMS Mental Status) exam.	F	623			
	and assess resident RP's name) called a condition and was in (name of hospital) E on resident's condition being transferred." 3/20/18 documented to (name of hospital transport company) and responsive. (Nation transport and real Con 5/25/18 at 9:08 at #3 (Other Staff Mem stated that when a rishe does not provide	nurse practitioner) reviewed t. RP (responsible party) (the and was updated on resident's n agreement with treatment. ER (emergency room) updated ion and why resident was A second nurse's note dated d, "Resident was transported l) via (name of ambulance at 2030pm (8:30 p.m.), alert ame of hospital) was updated					

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05/25/2018	
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 625	#3 (Licensed Practi when a resident is s resident represental stated that a written was necessary, but On 5/25/18 at 1:10 Administrator - Administrator - Administrator was proposed aware of the information was proposed by the survey. Notice of Bed Hold CFR(s): 483.15(d)(2)	a.m., in an interview with LPN cal Nurse), she stated that sent to the hospital, that the tive is notified via phone. She notification might be sent if it that usually it was not. o.m., the ASM #1 (the ninistrative Staff Member) was findings. No further vided by the end of the Policy Before/Upon Trnsfr	F 623			
	§483.15(d)(1) Notice nursing facility transithe resident goes or nursing facility must the resident or resident or resident or resident or resident or resident or resident or resident, during which the return and resume refacility; (ii) The reserve bed plan, under § 447.44(iii) The nursing facility bed-hold periods, we paragraph (e)(1) of resident to return; as (iv) The information of this section.	specified in paragraph (e)(1) old notice upon transfer. At		2. Residents residing in this facility risk for the same deficient practice. 3. Nursing staff, social services, and admission director will be re-educa Bed Hold Policy to ensure residents received a written copy of the notic before/upon transfer. Director of N or designee will review 24 hour rep during morning meeting to ensure residents transferred or discharge had documentation of appropriate notic sent. DON or designee will audit 3 residents' records weekly for 4 weekly	ted on ce dursing port nave	

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 66 of 223

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		39	TREET ADDRESS, CITY, STATE, ZIP CODE 900 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		BE .	(X5) COMPLETION DATE
	facility must provide resident representar specifies the duration described in paragra. This REQUIREMEN by: Based on staff interview, it was determ to provide the bed horesidents in the survise, 262, 30, 4, and 1. The facility staff facility staf	erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. IT is not met as evidenced rview, and clinical record mined that facility staff failed old policy for six of 42 vey sample, Residents # 73, 75. ailed to provide Resident # written notification of the bed e resident was transferred to 3. Failed to provide Resident # written notification of the bed e resident was transferred to 3. Failed to provide Resident # a written notification of the bed e resident was transferred to 3. Failed to provide Resident # a written notification of the bed e resident was transferred to 3. Failed to provide the resident or active a bed-hold notification atted transfer to the hospital 4/25/18. Failed to provide the resident contactive a bed-hold notification acted transfer to the hospital acted transfer to the hospital	F 6	25	4. Results of audits will be reviewed the monthly QAPI meeting. Trend identified will be addressed as need to be a decided as a decided to be a decided as a decided to be a decided as a decided to be a decided as a decided to be a decided as a decided to be a decided to	s	6/26/18
!	6. The facility staff f	ailed to evidence that		:			!

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495240	B. WING		05	5/25/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 2240	IP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 625	provided with writte	ident representative was en notification of the of the bed he resident was transferred to 0/18.	F 6	25				
	1. The facility staff 73's representative hold policy when the hospital on 02/07/1 Resident # 73 was 05/21/13 with a readiagnoses that inclinuman immunodef gastroesophageal in the staff of the staff o	failed to provide Resident # written notification of the bed e resident was transferred to 8. admitted to the facility on dmission of 02/12/18 with uded but were not limited to iciency virus (1), reflux disease (2), convulsions ease (4), dementia (5) and						
	set), a quarterly ass (assessment refere Resident # 73 as so interview for menta - 15, 12 - being cog decisions. Resider	est recent MDS (minimum data sessment with an ARD ence date) of 04/24/18, coded coring a 12 on the brief I status (BIMS) of a score of 0 initively for making daily at # 73 was coded as requiring assistance of one staffes of daily living.						
	23:41 (11:41 p.m.) in part, "Looses raticough) and clear na Tylenol and Mucine nurse practitioner) party) notified and a	ess Notes," dated 2/7/2018 for Resident # 73 documented ling NPC (nonproductive asal drainage. Medicated with x at that time and FNP (facility was notified. RP (responsible a Flu swab was obtained.						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE	LTIPLE CONSTRUCTION DING	((X3) DATE SURVEY COMPLETED	
		495240	B. WING			05/2	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP (3900 PLANK ROAD FREDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD (E APPROPR	3E	(X5) COMPLETION OATE
	to send resident to (emergency room), treatment) of febrile (Name of Physician charge nurse and tr Via (by) (Name of T Sister / RP to meet transported to ER (with ER staff @ (at) resident is still in the has been no determ. The nurse's "Progrefor Resident # 73 do (5:48 p.m.) Resider 2:55 p.m. from (Nar Transportation Com (emergency medical stretcher" Further review of Refailed to reveal the finformation regarding Resident #73"s report on 05/25/18 at 9:01 conducted with OSF admissions director When asked about stated, "The bed hold admission packet. transferred, I call the bed hold. I don't do supposed to give the copy of the bed hold We follow up with the copy of the bed hold we follow up with the copy of the bed hold we follow up with the copy of the bed hold we follow up with the copy of the bed hold we follow up with the copy of the page 1.	der has been rec'd (received) (Name of Hospital) ER for eval/tx (evaluation and e (fever) illness per direction of e). Report was called to ER cansportation was arranged fransportation Company). at hospital. Resident was at) 7:15 p.m. A f/u (follow up) e) 23:00 (11:00 p.m.) and e) examination area and there nination." ess Notes," dated 02/12/2018 ocumented in part, "17:48 at readmitted into facility at me of Hospital) (by) (Name of apany) accompanied by EMT all technician) personnel (by) esident # 73's clinical record facility staff provided written and the bed hold policy to resentative. a.m., an interview was M (other staff member) # 2, regarding the bed hold policy, the bed hold policy, OSM # 2 Id policy is given in the When a resident is e family and ask if they want a cument it. The nurse is e resident and/or family a d policy at the time of transfer.	F	325			
		M # 3, the social worker		:			i

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	,	05	5/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION OATE	
	responsible party in the bed hold policy OSM # 3 stated, "It on 05/25/18 at application (administrative stated administrator and aware made aware). No further informated References: (1) HIV stands for virus. It harms you the white blood celevou at risk for serie cancers. AIDS stated immunodeficiency of infection with HI develops AIDS. Hunprotected sex walso spread by shad contact with the blow women can give it pregnancy or child obtained from the https://medlineplus.	hold policy. When asked if the signification of at the time of the transfer, No." proximately 1:10 p.m. ASM ff member) # 1, the ASM # 2, director of nursing of the findings. tion was provided prior to exit. human immunodeficiency rimmune system by destroying its that fight infection. This puts bus infections and certain ands for acquired syndrome. It is the final stage V. Not everyone with HIV IV most often spreads through ith an infected person. It may aring drug needles or through bod of an infected person. It to their babies during birth. This information was website: a.gov/hivaids.html.	F 6.)		
:	(3) The term "seizu interchangeably wi the physical finding occur after an epis	n.gov/medlineplus/gerd.html. ure" is often used th "convulsion." A seizure is gs or changes in behavior that ode of abnormal electrical . This information was					

STATEMENT OF OEFICIENCIES (X ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(.	(X3) OATE SURVEY COMPLETEO		
		495240	B. WING			05/:	25/2018	
	PROVIOER OR SUPPLIER		STREET AOORESS, CITY, STATE, ZIP COOE 3900 PLANK ROAD FREDERICKSBURG, VA 22407					
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCEO TO TH OEFICIENCY	ON SHOULO E RE APPROPRI		(X5) COMPLETION OATE	
	(4) Any functional of change in the spins nonspecific lesions pathological bone of myelopath'ic. This from the website: https://medical-dictyelopathy. (5) A loss of brain of diseases. It affects	website:gov/ency/article/003200.htm. disturbance or pathological al cord; often used to denote a, as opposed to myelitis. 2. marrow changes. adj., adj	F 6	25				
	(6) A term for any calters brain function was obtained from	.gov/ency/article/000739.htm. liffuse disease of the brain that n or structure. This information the website: h.gov/disorders/encephalopath						
	58's representative hold policy when the hospital on 01/26/1 Resident # 58 was 01/01/16 with diagrant limited to anoxic (2), seizures (3), dedementia (5) and market resident #58's most r	admitted to the facility on noses that included but were to brain damage (1), anxiety epressive disorder (4), nuscle weakness.						
:		sessment with an ARD ence date) of 04/17/18, coded					:	

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05	/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		39	REET ADDRESS, CITY, STATE, ZIP CODE 00 PLANK ROAD REDERICKSBURG, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	interview for menta - 15, 5 (five) - being cognition for makin 58 was coded as re assistance of one s daily living. The nurse's "Progre Resident # 58 docu Resident was found room @ (at) 7:40 p Reported having a Bleeding observed floor. A large lacera	coring a 5 (five) on the brief I status (BIMS) of a score of 0 g severely impaired of g daily decisions. Resident # equiring limited to extensive taff member for activities of ess Notes," dated 01/26/18 for mented, "20:19 (8:19 p.m.) I sitting on the floor in his m. He was alert and talkative. The eadache at that time. On face, clothes and on the ation was noted on the	F6	225			
	in to examine reside (received) to send (Hospital) ER (emergand tx (treatment) of Transportation Commessage was left for	P (facility nurse practitioner) ent and an order was rec'd Resident # 58) to (Name of gency room) for evaluation of head injury. (Name of apany) was arranged a voice or sister/RP (responsible party) regards to this event"					
	01:54 (1:54 a.m.) fo "Resident returned: staples to the pariet	r Resident # 58 documented, from ER with brother 6 (six) al area of his head no active signs within normal limits."					
	failed to reveal the f	esident # 58's clinical record acility staff provided written ag the bed hold policy to esentative.					
:	conducted with OSM admissions director	a.m., an interview was I (other staff member) # 2, regarding the bed hold policy. the bed hold policy, OSM # 2		:			

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 72 of 223

RECEIVED
JUN 18 2018
VDH/OLC

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		0,	5/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3900 PLANK ROAD FREDERICKSBURG, VA 23	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE	
	admission packet. transferred, I call to bed hold. I don't cosupposed to give to copy of the bed how we follow up with On 05/25/18 at 9:00 conducted with Os regarding the bed responsible party in the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy of the bed hold policy OSM # 3 stated, "It On 05/25/18 at application of the bed hold policy of the bed hold policy of the bed hold policy of the bed hold policy of the bed hold policy of the bed hold policy of the bed hold policy of the bed hold policy of the bed hold policy of the bed ho	when a resident is the When a resident is the family and ask if they want a locument it. The nurse is the resident and/or family a old policy at the time of transfer. the phone call." 88 a.m., an interview was SM # 3, the social worker hold policy. When asked if the s given written notification of at the time of the transfer, No." proximately 1:10 p.m. ASM ff member) # 1, the ASM # 2, director of nursing		525			

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION F CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495240	B. WING			0	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		3900 PLANE	ORESS, CITY, STATE, ZIP C KROAD CKSBURG, VA 22407	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EA	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION OATE
F 625	(4) Depression may blue, unhappy, mise Most of us feel this short periods. Clini disorder in which fe or frustration interfe or more. This inforwebsite: https://medlineplus. (5) A loss of brain fudiseases. It affects judgment, and behap obtained from the warms.	be described as feeling sad, erable, or down in the dumps. way at one time or another for cal depression is a mood elings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the gov/ency/article/003213.htm. unction that occurs with certain memory, thinking, language, evior. This information was	F	025			
	262's representative hold policy when the hospital on 04/17/18 Resident # 262 was 12/24/17 with a readiagnoses that inclusepsis (1), dysarthrighted	failed to provide Resident # e written notification of the bed e resident was transferred to 3. s admitted to the facility on dmission of 05/01/18 with eded but were not limited to a (2), aphasia (3), depressive tia (5) and cerebral infarction					
	data set), a quarterl (assessment refere Resident # 262 as s interview for mental - 15, 5 (five) - being cognition for making	est recent MDS (minimum y assessment with an ARD nce date) of 04/17/18, coded scoring a 5 (five) on the brief status (BIMS) of a score of 0 severely impaired of g daily decisions. Resident # equiring limited to extensive					

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING				(X3) OATE SURVEY COMPLETEO	
		495240	B. WING			05	/25/2018	
	PROVIOER OR SUPPLIE			39 00	EET AOORESS, CITY, STATE, ZIP COOE PLANK ROAD DERICKSBURG, VA 22407			
(X4) IO PREFIX TAG	(EACH OFFICIENC	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LO BE	(X5) COMPLETION DATE	
F 625	daily living. The nurse's "Prog 17:49 (5:49 a.m.) in part, "(Name of with critical hemogoractitioner) in factorial send (Name of Homestry "Prog 12:54 p.m., for Repart, "Resident was	staff member for activities of ress Notes," dated 04/17/18 at for Resident # 262 documented Hospital) lab (laboratory) called globin results at 5.8. NP (nurse ility. NON (new order now) to espital) ER (emergency room) ress Notes," dated 05/01/18 at sident # 262 documented in as brought to the facility by entation Company) and put in	F 6	525				
	failed to reveal the	Resident # 262's clinical record a facility staff provided written ling the bed hold policy to representative.	:					
	conducted with OS admissions director When asked about stated, "The bed hadmission packet, transferred, I call the bed hold. I don't consupposed to give the admission bed hold.	O1 a.m., an interview was SM (other staff member) # 2, or regarding the bed hold policy. It the bed hold policy, OSM # 2 hold policy is given in the When a resident is he family and ask if they want a document it. The nurse is the resident and/or family a hold policy at the time of transfer. the phone call."						
	conducted with Os regarding the bed responsible party	08 a.m., an interview was 6M # 3, the social worker hold policy. When asked if the s given written notification of vat the time of the transfer		:				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05/2	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 625	(administrative staff administrator and A were made aware of No further information References: (1) Sepsis is an illnessevere, inflammator other germs. The scaused by the germ chemicals the body This information was	o." roximately 1:10 p.m. ASM f member) # 1, the SM # 2, director of nursing	F 6				
:	words because of phelp you talk). This from the website: https://medlineplus. (3) A disorder cause the brain that controbard for you to read mean to say). This if the website: https://www.nlm.nih.l. (4) Depression may blue, unhappy, mise Most of us feel this short periods. Clinic disorder in which feel	nich you have difficulty saying roblems with the muscles that information was obtained gov/ency/article/007470.htm. ed by damage to the parts of oll language. It can make it write, and say what you information was obtained from gov/medlineplus/aphasia.htm be described as feeling sad, erable, or down in the dumps, way at one time or another for call depression is a mood elings of sadness, loss, anger, re with everyday life for weeks					
		nation was obtained from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING _		05	/25/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
F 625	(5) A loss of brain diseases. It affect judgment, and be obtained from the https://medlineplu (6) A stroke. Whe brain stops. A stroattack." If blood fl few seconds, the oxygen. Brain cell damage. This info website: https://medlineplu. 4. The facility staff resident's represe prior to a facility in for Resident #30 was 8/27/18 and readn that included but v disease, depressive and chrohat included but v disease, depressive and chrothat included but v disease,	s.gov/ency/article/003213.htm. function that occurs with certain s memory, thinking, language, havior. This information was website: s.gov/ency/article/000739.htm. en blood flow to a part of the oke is sometimes called a "brain low is cut off for longer than a brain cannot get nutrients and s can die, causing lasting ermation was obtained from the s.gov/ency/article/000726.htm. If failed to provide the resident or intative a bed-hold notification intiated transfer to the hospital on 4/25/18. admitted to the facility on initted on 5/3/18 with diagnoses were not limited to: kidney on, dementia, low blood onic pain. MDS (minimum data set), a lent, with an ARD (assessment 3/13/18 coded the resident as 3 out of 15 on the brief al status indicating the resident act to make daily decisions.	F 62	25			
: : : !	documented, "Res	3 at 12:51 a.m. that sident was found sitting on the front of his bed at 11:25 (n m)	 - 	!			

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	;		05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		;	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE
F 625	practitioner was co (name of hospital) Review of the clinic documentation tha representative wernotification prior to the hospital for Restant the hospital for Restant representative was cp.m. with RN (regist a bed-hold notification resident representations for RN #1 standoes." An interview was ca.m. with OSM (other admissions directonotice is given to the OSM #2 stated, "Tithe bed-hold policy	ursing assistant)Nurse ntacted. Order to send him to		625	· · ·		
	An interview was can with OSM #3, asked if a bed-hold resident or resident the time of transfer stated that social was can with LPN (lice unit manager. When	onducted on 5/25/18 at 9:08 the social worker. When notification is given to the trepresentative prior to or at to the hospital, OSM #3 orkers did not provide that. Onducted on 5/25/18 at 9:20 ensed practical nurse) #3, the en asked if a bed-hold to the resident					

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 78 of 223

RECEIVED
JUN 18 2018
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	5/25/2018	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		TION SHOULD BE THE APPROPRIATE	IX5) COMPLETION DATE	
	the hospital, LPN adoes that." On 5/25/18 at 1:20 member) #1, the adirector of nursing findings. No further informa 5. The facility staf or resident's repreprior to a facility in for Resident #4 was a and readmitted on included but were infection, depressi The most recent with an ARD of 5/1 having scored 13 of for mental status in cognitively intact to Review of the nurse p.m. documented, was found on floor resident what had to my closet from tout. I was walking	or to or at the time of transfer to #3 stated, "The social worker or p.m. ASM (administrative staff administrator and ASM #2, the were made aware of the sentative a bed-hold notification itiated transfer to the hospital 4/28/18. dmitted to the facility on 7/1/17 5/6/18 with diagnoses that not limited to: diabetes, blood	F 6	525			
: : :	(emergency room) An interview was c	for evaluation." onducted on 5/24/18 at 2:06 stered nurse) #1. When asked					

	T OF DEFICIENCIES DF CORRECTION				(X3) DATE SURVEY COMPLETED		
		495240	B. WING		05	5/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	PCODE	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 62 5	Continued From pa	ge 79	F6	625		:	
	if a bed-hold notificates resident representa	ation is given to the resident or tive prior to or at the time of ted, "I believe admissions					
	a.m. with OSM (oth admissions director notice is given to th OSM #2 stated, "Th the bed-hold policy, was, OSM #2 stated	enducted on 5/25/18 at 9:01 er staff member) #2, the r. When asked if a bed-hold e family at the time of transfer, he nurse is supposed to give "When asked what her role d, "We follow up with the e family and ask if they want					
	a.m. with OSM #3, asked if a bed-hold resident or resident the time of transfer	onducted on 5/25/18 at 9:08 the social worker. When notification is given to the representative prior to or at to the hospital, OSM #3 orkers did not provide that.					
	a.m. with LPN (licer unit manager. When notification is given representative prior	onducted on 5/25/18 at 9:20 ased practical nurse) #3, the n asked if a bed-hold to the resident or resident to or at the time of transfer to 3 stated, "The social worker					
; ; ;	member) #1, the ad	p.m. ASM (administrative staff ministrator and ASM #2, the vere made aware of the					
:	No further information	on was provided prior to exit.		:			
		failed to evidence that dent representative was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05/25/2018	
	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 PREFIX TAG		ON SHOULD BE COMPLÉTION IE APPROPRIATE DATE	
F 625		en notification of the of the bed	F6	25	:	
	hold policy when the the hospital on 3/20	e resident was transferred to 0/18.			,	
; ;	3/13/18 with the dia heart failure, osteon vascular disease, re	admitted to the facility on agnoses of but not limited to myelitis, angina, peripheral espiratory failure, Alzheimer's				
; †	fibrillation, cerebrovembolism and thrormost recent MDS (I pressure, diabetes, atrial vascular disease, chronic mbosis, and dysphagia. The Minimum Data Set)				
	(Assessment Refer resident was coded	sessment with an ARD rence Date) of 4/18/18. The d as severely cognitively o make daily life decisions,		:		
	scoring a 2 out of a (Brief Interview for	possible 15 on the BIMS Mental Status) exam.		:		
: : :	following: A nurse's documented, "NP (nurse practitioner) reviewed				
	RP's name) called a condition and was i	nt. RP (responsible party) (the and was updated on resident's n agreement with treatment.				
:	on resident's condit being transferred."	ER (emergency room) updated : tion and why resident was A second nurse's note dated ad, "Resident was transported				
· : :	to (name of hospita transport company)	I) via (name of ambulance at 2030pm (8:30 p.m.), alert lame of hospital) was updated			· :	
:	on transport and re-	ason for transfer."				
:	#2 (Other Staff Mer that nurses are sup	a.m., in an interview with OSM to the stated posed to provide a written en the resident goes to the				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/ 2 5/ 2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5 COMPLETION OATE
F 655 SS=D	a phone call to find representative wan #2 stated she does bed-hold was offered On 5/25/18 at 9:20 #3 (Licensed Pract when a resident is worker provides the nursing does not. On 5/25/18 at appreinterview with OSM social worker) she sent to the hospital written bed-hold no resident representative of the information was prosurvey. Baseline Care Plan CFR(s): 483.21(a)(§483.21 Comprehe Planning §483.21(a) Baseline \$483.21(a)(1) The trimplement a baseline that includes the inseffective and person that meet professio The baseline care professio The baseline care professio The baseline care professio that meet professio The baseline care profession the profession The baseline care profession The baseline care profession The baseline care profession The baseline care profession The professi	stated that she follows up with out if the resident or resident ts the bed-hold or not. OSM not document that the ed/provided. a.m., in an interview with LPN ical Nurse), she stated that sent to the hospital, the social be bed-hold. LPN #3 stated that eximately 11:00 a.m., in an #3 (Other Staff Member, the stated that when a resident is, she does not provide a tice to the resident or the ative. p.m., the ASM #1 (the ministrative Staff Member) was findings. No further exided by the end of the eximately 11:03 and the care plan for each resident structions needed to provide in-centered care of the resident nal standards of quality care.	F 6		care plan sidents in the leted by baseline care	

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

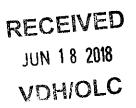
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING		05/	25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE
	necessary to prope including, but not li (A) Initial goals bas (B) Physician orde (C) Dietary orders. (D) Therapy services (E) Social services (F) PASARR recording services (F) PASARR re	imum healthcare information erly care for a resident imited to- sed on admission orders. rs. es. inmendation, if applicable. facility may develop a re plan in place of the baseline mprehensive care planithin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of a facility must provide the representative with a summary e plan that includes but is not a forther esident. In the resident. It is of the resident and it is not treatments to be the facility and personnel acting	F 6	3. An audit of resident care were admitted within the was completed on 6/15/16 will be re-educated on pol procedure to ensure residing representative provided a summary within 48 hours. Director of Nursing or desireview 24 hour report during to ensure new additional provided a base line care provided a base line care provided a base line care provided and/or RP designee will audit 3 residing per week for 4 weeks. 4. Results of audits will be the monthly QAPI meeting identified will be addressed education provided as needs.	last 30 days 8. Nursing staff licy and ent and/or care plan of admission. ignee will ring morning dmissions were plan summary . DON or lents' records e reviewed in g. Trends ed and re-	6/26/18
	care plan summar	y to the resident representative				

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

EvenI ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 83 of 223



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495240	B. WING		05/25/2018
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 2240	P CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES :Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE COMPLETION HE APPROPRIATE DATE
F 655	Continued From p	age 83	F 6	855	
	The findings include	de:	:	1	! :
	4/26/18 with the di respiratory failure, failure to thrive. T Data Set) was an a with an ARD (Asse 5/3/18. The reside persistent vegetati	admitted to the facility on agnoses of but not limited to Alzheimer's disease, and adult he most recent MDS (Minimum admission/5-day assessment essment Reference Date) of ent was coded as being in a ve state and as requiring total of activities of daily living.			
:	"Baseline Care Pla was a multi-copy f a yellow copy laye both copies, as of	nical record revealed a an Summary" form. This form form (a white original layer and r). The form was intact with the date of survey on 5/25/18, month after the resident was			
	"Acknowledgement documented, "I act this summary of more care has been explicated by a sk question changes as I feel a lines for the reside facility representation the lines contained th	the form revealed an area titled at of Receipt." This area knowledge that I have received y Baseline Care Plan and my lained to me. I understand that as at any time and request are necessary." There were nt, resident representative, and five to sign and date. None of I any signatures to indicate that sentative was provided with the n Summary.			
	LPN #10 (Licensee "the Baseline Care	5 p.m., in an interview with d Practical Nurse), she stated Plan Summary has to be during the admission period			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495240	B. WING _		05/2	5/2018
	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION OATE
F 655	F 655 Continued From page 84 but I don't know the time frame." When asked, if the time frame had passed since Resident #90		F 65	5		
	(date of survey), LF have been provided A review of the facing Preparation" did no	lity policy, "Care Plan of include any direction for			:	-
	Summary of the car On 5/25/18 at 1:10 Administrator - Admade aware of the information was presurvey.	p.m., the ASM #1 (the ninistrative Staff Member) was findings. No further ovided by the end of the	: • • • • •	4. Decident #27 is discharged from		
SS=E	S483.21(b)(1) The system of th	ehensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable frames to meet a resident's nd mental and psychosocial utified in the comprehensive omprehensive care plan must	F 65	facility. Resident #37 is discharged from facility. Resident #46 was re-assess hot liquids and plan of care updated appropriate interventions. MD/RP notified of Resident #11's wound car interventions not followed as order 6/14/18. MD notified of Resident # wound care interventions not follow ordered on 6/14/18. MD/RP notified Resident #19s weight not obtained ordered on 6/14/18. MD/RP notified Resident #82 cardiovascular medical administration interventions not for as ordered on 6/14/18. MD/RP notified as ordered on 6/14/18.	d with are ed on 15 wed as ed of as ed of ation llowed ified o shoe ed on	

AND DIAN OF CODDECTION DENTIFICATION NUMBER.		1 ' '	PLE CONSTRUCTION G		(3) DATE SURVEY COMPLETED	
495240				05/:	05/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH (X4) ID SUMMARY STA	AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDER CKSBURG, VA 22407 ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLÉTION OATE	
rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation versident's represent (A) The resident's general desired outcomes. (B) The resident's general desired outcomes. (B) The resident's general future discharge. Fawhether the resident community was assolicated contact agency entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMENT by: Based on observated document review as was determined that develop and implent plan for eight of 37 sample, Residents 35. 1. The facility staff fimplement a compriliquid precautions a liquid assessment for the plan for eight of 37. The facility staff fimplement a compriliquid precautions a liquid assessment for the plan for eight of 37.	83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)- goals for admission and preference and potential for acilities must document at's desire to return to the sessed and any referrals to sies and/or other appropriate pose. Is in the comprehensive care e, in accordance with the with in paragraph (c) of this NT is not met as evidenced dion, staff interview, facility and clinical record review, it at the facility staff failed to ment the comprehensive care residents in the survey #37, 46, 11, 15, 19, 82, 95 and failed to develop and ehensive care plan for hot s documented on the hot	F 65	2. Residents residing in this facili risk for the same deficient practi 3. Nursing staff will be re-educat implementation and provision of care plans to ensure intervention followed. Director of nursing or will audit 3 resident care plans profor 4 weeks to ensure resident care followed. 4. Results of audits will be review the monthly QAPI meeting. Trenidentified will be addressed and education provided as needed.	ed on f resident ns are designee er week are plans wed in	6/26/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05	/25/2018
	NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			390	EET ADDRESS, CITY, STATE, ZIP CODE 0 PLANK ROAD EDERICKSBURG, VA 22407	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	#11's comprehens of wound treatmer 4. The facility staff #15's comprehens of wound treatmer 5. The facility staff #19's care plan for administration per 7. The facility staff #95's care plan for 8. The facility staff	-		656			
	1/24/13 and readm diagnoses that incl lung disease, depr psychosis and mus	as admitted to the facility on hitted on 10/25/17 with luded but were not limited to: ession, high cholesterol,					
	quarterly assessm reference date) of having scored a se interview for menta	ent, with an ARD (assessment 3/20/18 coded the resident as even out of 15 on the brief al status indicating the resident ired cognitively. The resident		:			· · · · · · · · · · · · · · · · · · ·

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495240	B. WING		05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 6 3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
F 656	Continued From pa	age 87 iring assistance for bed	F 6	56	
	mobility, dressing a	and toileting. The resident was set up assistance with the			
	of Resident #37. The breakfast tray	s made on 5/24/18 at 8:35 a.m. ne resident was lying in bed. was on the over bed table next fee cup was on the tray without			
	10/15/17 document assessment identifinjury while handlin Place a check mark resident being assecognitive impairmenthe resident's percelliquids and safety not limited to: altered compairment. 4. Alterwas checked). 8. (behavior which couwhile the resident is checked) 1. Cup wi	quid safety evaluation dated ted, "A. Safety Evaluation. This tes if the resident is at risk for g and drinking hot liquids. It is the following apply to the essed: 1. (box checked) Has a not or drowsiness that impacts eption and awareness to hot measures including but not comprehension and/or memory red muscle strength (hands box checked) Episodes of Id cause injury if occurring a handling hot liquids.11. (box the lid or other adaptive cup. traff assistance. 4. To drink hot it."			
	initiated on 10/7/17	ent's comprehensive care plan did not evidence arding a hot liquid safety plan			
	p.m. with RN (regis coordinator. When plans, RN #2 stated	onducted on 5/24/18 at 12:57 tered nurse) #2, the MDS asked why residents had care d, "To care for the resident, the ent driven. It's to inform others		· ·	:

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING B. WING			(X3) OATE SURVEY COMPLETEO 05/25/2018	
		495240					
NAME OF	PROVIOER OR SUPPLIER			STRE	ET AOORESS, CITY, STATE, ZIP COOE		
EDENEE	DICKSBUIDG HEALTH	AND DEHAR		3900	PLANK ROAD		
FREDERICKSBURG HEALTH AND REHAB				FRE	DERICKSBURG, ∨A 22407		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROFORE OEFICIENCY)) BE	(X5) COMPLETION DATE
F 656	Continued From pa	ne 88		556			
1 000		-	г	000			
		he resident." When asked		İ			
		plan, RN #2 stated, "Everyone the resident's care. The					1
		ve to sign their care plan; the		i			
		olved in their care plan." When		:			
		be care planned, RN #2 stated,					
		, I work off the CAA (care area					
		heet, according to the					
		gs I make sure of is that					•
		e plan for pain, ADLS					•
		ving), mobility and what they					
		ooking at their diagnoses and together a picture on how to					:
		" When asked if a care plan		1			
		for a resident who had been					
		ty risk from hot liquids, RN #2					
		se they are at high risk for		i			
	burns if not supervis	sed."		!			
	An interview was co	onducted on 5/25/18 at 8:11		:			
		nsed practical nurse) #8, the					
		n asked why residents had					
	care plans, LPN #8						
		other disciplines." When					
		would be developed if a ssed to be a safety risk from		!			
	hot liquids, LPN #8						
	Tiot liquids, El 14 Ho	stated, 103.		:			
	An interview was co	onducted on 5/25/18 at 8 :20					
	a.m. with CNA (cert	ified nursing assistant) #3, the					
		en asked how she knew what					
		ded, CNA stated, "We look at					:
:	. •	kardex at the nurse's station.					:
		eat, how they ambulate."		į			· .
		re plan or kardex would have dent were a safety risk from					
		stated, "It should be." When					
		y residents who were a safety		,i			
		CNA #3 stated, "No."		i			

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		390	REET ADDRESS, CITY, STATE, ZIP CODE 00 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP		BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 89	F 6	556			
		ent's CNA kardex did not tation regarding hot liquids					
	member) #1, the ac	p.m. ASM (administrative staff Iministrator and ASM #2, the were made aware of the					
	PLAN PREPARATION directs the patient's to discharge. The w	y's document titled, "CARE ON" documented, "A care plan nursing care from admission ritten action plan is based on that have been formulated					
:	after reviewing asse embodies the comp processNurses up through-out the pati	essment findings, and it conents of the nursing codate and revise the plan ent's stay, and the document permanent patient record."					
!	No further informati	on was provided prior to exit.					
:	Williams and Wilkin documented, "A wri	mentals of Nursing Lippincott is 2007 pages 65-77 tten care plan serves as a among health care team					:
	members that helps careThe nursing of information about the and goals. It contains	s ensure continuity of care plan is a vital source of ne patient's problems, needs, ns detailed instructions for established for the patient					
	and is used to direct revise and update to	t careexpect to review, ne care plan regularly, when n condition, treatments, and					
		f Nursing Lippincott Williams incott Company Philadelphia					

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 90 of 223

					(X3) DATE SURVEY COMPLETED		
	495240	B. WING	WING			05/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			3900 PLA	NK ROAD			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHO		IOULD BE	(X5) COMPLETION OATE		
pages 65-77. Basic Nursing, Ess (Potter and Perry, reference for care a written guideline promoting continui criteria to be used care. The written onursing care priorit professionals. The coordinates resour care. A correctly for easy to continue calf the patient's state nursing diagnosis and longer appropriaglan. An out of data compromises the compromises the compromises the complex and precautions a liquid precautions a liquid assessment. Resident #46 was 1/24/13 and readmediagnoses that including disease, anxiet muscle weakness. The most recent Mannual assessment reference date) of having scored a 14 interview for mental	sentials for Practice, 6th edition, 2007, pages 119-127), was a plans. "A nursing care plan is for coordinating nursing care, ty of care and listing outcome in the evaluation of nursing care plan communicates ies to other health care e care plan also identifies and ces used to deliver nursing ormulated care plan makes it are from one nurse to another. us has changed and the and related interventions are ate, modify the nursing care te or incorrect care plan quality of nursing care." failed to develop and rehensive care plan for hot as documented on the hot for Resident #46. admitted to the facility on itted on 10/25/17 with uded but were not limited to: ety, insomnia, heart failure and IDS (minimum data set), an t, with an ARD (assessment 5/15/18 coded the resident as out of 15 on the brief all status indicating the resident	F6	56				
was cognitively into	act to make daily decisions. oded as requiring assistance						
	PROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENCE REGULATORY OR I Continued From parages 65-77. Basic Nursing, Essement of the parages of the promoting continuice care. The written of the parages of the patient's state nursing diagnosis are no longer appropriate plan. An out of data compromises the compromises that including disease, anxious muscle weakness. The most recent Mannual assessment of the compromises of the c	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90	PROVIDER OR SUPPLIER RECKSBURG HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 pages 65-77. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan also identifies and coordinates resources used to deliver nursing care. The written care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 2. The facility staff failed to develop and implement a comprehensive care plan for hot liquid precautions as documented on the hot liquid assessment for Resident #46. Resident #46 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, anxiety, insomnia, heart failure and muscle weakness. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 5/15/18 coded the resident as having scored a 14 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance	PROVIDER OR SUPPLIER **A SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) **Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care plan is roof-generated by formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan for hot liquid precautions as documented on the hot liquid assessment for Resident #46. Resident #46 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, anxiety, insomnia, heart failure and muscle weakness. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 5/15/18 coded the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance	PROVIDER OR SUPPLIER 10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 pages 65-77. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 2. The facility staff failed to develop and implement a comprehensive care plan for hot liquid precautions as documented on the hot liquid assessment for Resident #46. Resident #46 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, anxiety, insomnia, heart failure and muscle weakness. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 5/15/18 coded the resident as having scored a 14 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance	A BULDING 495240 B. WINS STREET ADDRESS, CITY, STATE, ZIP CODE 3930 PLANK ROAD FREDERICKSBURG, VA 22407 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 90 pages 65-77. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 2. The facility staff failed to develop and implement a comprehensive care plan for hot liquid precautions as documented on the hot liquid precautions as documented on the hot liquid precautions as documented on the hot liquid assessment for Resident #46. Resident #46 was admitted to the facility on 1/24/13 and readmitted on 10/25/17 with diagnoses that included but were not limited to: lung disease, anxiety, insomnia, heart failure and muscle weakness. The most recent MDS (minimum data set), an annual assessment, with an ARD (assessment reference date) of 5/15/18 coded the resident as having scored a 14 out of 15 on the brief interview for mental status indicating the resident was cognitively intact to make daily dec	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	•	495240	B. WING			05/25/2018	
	NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			STREET ADDRESS, CITY, 3900 PLANK ROAD FREDERICKSBURG,			
(X4) ID PREFIX TAG			H DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (E/			N (X5) BE COMPLETION RIATE OATE	
F 656	An observation was a.m., of Resident # in bed eating break have a lid on it. An observation was a.m., of Resident # in bed eating break observed drinking f not have a lid on it. Review of the hot lit 5/20/17 documente assessment identificing injury while handling Place a check mark resident being assess trength (hands wa or other adaptive cuassistance. (box check the control of the resident being assess trength (hands wa or other adaptive cuassistance.)	assistance with meals. Is made on 5/24/18 at 8:30 46. The resident was sitting up fast. The coffee cup did not Is made on 5/25/18 at 8:01 46. The resident was sitting up fast. The resident was rom a coffee cup. The cup did In made on 5/25/18 at 8:01 Guid safety evaluation dated do, "A. Safety Evaluation. This es if the resident is at risk for g and drinking hot liquids. If the following apply to the essed: 4. Altered muscle is checked). 11. 1. Cup with lidup. (box checked) 2. Staff ecked)." In made on 5/25/18 at 8:01 In mad	F 6		EFICIENCY)		
; ; ;	p.m. with RN (regis coordinator. When developed for a res as a safety risk from	enducted on 5/24/18 at 12:57 tered nurse) #2, the MDS asked if a care plan would be ident who had been assessed in hot liquids, RN #2 stated, are at high risk for burns if not					
	a.m. with LPN (licer unit manager. Whe	onducted on 5/25/18 at 8:11 nsed practical nurse) #8, the n asked why residents had stated. "In order to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495240	B. WING		05/25/2018
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP C 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		SHOULD BE COMPLETION
F 656	asked if a care plan resident were asses hot liquids, LPN #8 An interview was coa.m. with CNA (cert resident's aide. Who care a resident nee the care plan or the It'll tell us how they When asked if a cainformation if a residiquids, CNA #3 stat asked if she had an risk for hot liquids, CReview of the reside evidence document precautions. On 5/25/18 at 1:20 member) #1, the addirector of nursing v findings. No further information. 3. The facility staff for #11's comprehensive of wound treatments. Resident #11 was a 2/5/15 with a readminer.	e other disciplines." When would be developed if a seed to be a safety risk from stated, "Yes." Inducted on 5/25/18 at 8:20 ified nursing assistant) #3, the en asked how she knew what ded, CNA stated, "We look at kardex at the nurse's station. eat, how they ambulate." re plan or kardex would have dent was a safety risk from hot ed, "It should be." When y residents who were a safety CNA #3 stated, "No." ent's CNA kardex did not ation regarding hot liquids o.m. ASM (administrative staff ministrator and ASM #2, the were made aware of the on was provided prior to exit. ailed to implement Resident to e care plan for the provision is as ordered by the physician. dmitted to the facility on ission on 12/21/17 with	F6		
	end stage renal dise procedure used in v are removed from the	ded but were not limited to: ease requiring hemodialysis (a which wastes and impurities ne blood by a special ssion, dementia, high blood			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	05/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, Z 3900 PLANK ROAD FREDER CKSBURG, VA 224	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE	
F 656	assessment, a significant with an assessment coded the resident was coded the resident was codecisions. Reside extensive assistant most of her activity. The comprehensity documented in paralteration in skin into occasional bow requires assistant pressure ulcers. It is a likely as a companied this wound on Resider conducted. The was nown as .9 cm (centimal removed from the hydrocolloid dress was in the shape sides of the buttoo think he had order was no date on the care, ASM #4 reviand stated he had	MDS (minimum data set) gnificant change assessment, ent reference date of 2/27/18, it as scoring a "15" on the BIMS mental status) score, indicating cognitively intact to make daily int #11 was coded are requiring ince of one staff member for ies of daily living. We care plan dated, 4/2/18, irt, "Focus: I am at risk for integrity/pressure ulcers related rel and bladder incontinence and re with bed mobility, history of have shear wounds at this rentions" documented in part, idered." 1 p.m., Administrative staff 4, the wound care doctor, writer and an observation of the int #11's right upper buttock was ound was described as a d not a pressure ulcer. The area interes) by .5 cm. The dressing wound by ASM #4 was a sing. The hydrocolloid dressing of a butterfly and covered both oks. ASM #4 stated he didn't red that kind of dressing. There he dressing. After the wound ewed his orders for the wound, not ordered the hydrocolloid ordered medi-honey and a		56			

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOII	TIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO
		495240	B. WING_		05/25/2018
	FREDERICKSBURG HEALTH AND REHAB			STREET AOORESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE COMPLETION
	"Right Upper Butto saline), apply medi honey used to trea (2), cover with dry per week, every everi." An interview was copractical nurse) #3. When asked the puffs stated, "It's the interview to take care of are, what their goal helps to assist how transfers, meals." It to the care plan, LF workers, nursing arasked if the care plastated, "Yes." When followed, LPN #3 stand it give the best The administrator (member]) #1 and Awere made aware (5/25/18 at 1:10 p.m. No further informat (1) Barron's Diction Non-Medical Reado Chapman, page 26 (2) This information following website:	r dated, 5/18/18, documented, ck; cleanse with NS (normal choney (a certified medical twounds and inhibit infections) protective dressing, three days ening shift every Mon, Wed, and on 5/25/18 at 11:46 a.m. arpose of the care plan, LPN individualized plan of care on the resident, what their needs are while they are here. It we take care of them, when asked who has access PN #3 stated, "Everyone, social administration." When an should be followed, LPN #3 in asked why it should be tated, "It's resident specific care for the resident." ASM [administrative staff SM #2, the director of nursing of the above findings on it. ion was provided prior to exit. ary of Medical Terms for the ear, 5th edition, Rothenberg and	F 6	56	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ² A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED 05/25/2018	
	495240		B. WING		05		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 3900 PLANK ROAD FREDERICKSBURG, VA 224	IP CODE		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pa	age 95	F6	56		1	
	#15's comprehension of wound treatment of wound treatment would be wound treatment with the would be with a recent diagnoses that including the work of the work o	failed to implement Resident ive care plan for the provision its as ordered by the physician. admitted to the facility on at readmission on 4/27/17, with uded but were not limited to: ex and chronic disorder of ther to partial or total lack of the pancreas or to the inability in normally in the body) (1), structive pulmonary disease pronic nonreversible lungually a combination of pronic bronchitis]) (2), high art failure, pain, and difficulty					
	assessment, an an assessment referer resident as scoring interview for mental is capable of makin Resident #15 was with set up assistant daily living. The comprehensive revised on 3/7/18, where the potential for diabetes, obesity lower extremities. I areas noted on toes "Interventions" door as ordered."	umented in part, "Treatments					
!	Observation was m	ade of Resident #15's left foot					

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 96 of 223



AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495240	B. WING _		05/25/2018
NAME OF PROVIDE	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407	
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉTION
F 656 Con	tinued From p	age 96	F 65	66	
residence was the content of the con	dent's foot was interviewed at dressing is supbut it's not dorshe would retunever came bathas had the tothe callus on the callus on the physician order heel cleanse apply silver hyded for the mide an antimic sing) daily evond toe - clear i-honey (a cert	1 a.m. The dressing on the dated 5/21/18. Resident #15 this time. The resident stated posed to be changed every the every day. The nurse told rn to do the dressing last night tack. Resident #15 stated that the wound for over four years the heel has split open. The area dated, 3/20/18 documented, with NS (normal saline). Path drogel (Hydrogel Dressing is an agement of wounds and to robial barrier (3)) and dry dsgery evening shift. Left plantar use with NS, pat dry, apply diffied medical honey used to nhibit infections (4)) and dry ening shift."			
reco comp An ir prace the v at 4: dress off I of 5/23/ LPN callir me.	rd) documented bleted as order the view was obtical nurse) #1 wound as comes of 55 p.m. When sing on 5/22/1 did it." The obtical with the date #1. LPN #1 stong the nurse well told the reside the order of the side of the reside the order of the side of the reside of the side of the	R (treatment administration ed the dressing had been red on 5/22/18. onducted with LPN (licensed, the nurse who documented pleted on 5/22/18, on 5/24/18 asked if she completed the 8, LPN #1 stated, "If I signed it servation of the dressing on the of 5/21/18 was shared with ated, "I got distracted. I was ho was supposed to relieve ent I would be back to do the never went back." When			
aske treat	d why she wo	uld document that she did the e did not do it, LPN #1 stated,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495240	B. WING_		05	5/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 2240	P CODE		
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pa	age 97	F 65	56		:	
	practical nurse) #3 When asked the present with the present was stated, "It's the how to take care or are. What their goat helps to assist how transfers, meals." It to the care plan, LF workers, nursing an asked if the care presented, "Yes." Whe followed, LPN #3 sand it give the best the administrator (member]) #1 and A	onducted with LPN (licensed, on 5/25/18 at 11:46 a.m. urpose of the care plan, LPN individualized plan of care on f the resident, what their needs als are while they are here. It was take care of them, When asked who has access PN #3 stated, "Everyone, social administration." When lan should be followed, LPN #3 in asked why it should be tated, "It's resident specific to care for the resident." (ASM [administrative staff ASM #2, the director of nursing of the above findings on in.					
	(1) Barron's Diction Non-Medical Read Chapman, page 16 (2) Barron's Diction Non-Medical Read Chapman, page 12 (3) This information following website: https://dailymed.nlr gxsl.cfm?setid=91: 7a6b09e1. (4) This information following website:	nary of Medical Terms for the er, 5th edition, Rothenberg and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	i	05	5/25/2018
,	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE
F 656	Continued From p	page 98	F6			
		f failed to implement Resident or obtaining weights.	:	:		:
	3/17/17. Residen were not limited to major depressive Resident #19's m set), an annual as (assessment refe resident's cognitive decision-making a coded Resident # five percent or more in Review of Reside a physician's order weights. Resident #19) is a (related to) dx (dia (2) for nutrition & 1).	as severely impaired. Section K 19 as having a weight gain of ore in the last month or ten in the last six months. In th				
	weight obtained o	nt #19's weights revealed a n 4/24/18 was 130.2 pounds. /as not obtained until 5/9/18 (15 as 133.8 pounds.				
	conducted with LF LPN #4 was aske LPN #4 stated "To an updated calend patient and to hav	3 p.m., an interview was PN (licensed practical nurse) #4. d the purpose of the care plan. b keep knowledgeable and it's dar of what's going on with the e goals that are to be met by in according to what problems				

NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB IXINATION (SECONDARY STATE, ZIP CODE) STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407 FREDERICKSBURG, VA 22407 FRETEX TAG FREDERICKSBURG, VA 22407 FRETEX TAG FREDERICKSBURG, VA 22407 FRETEX TAG FREDERICKSBURG, VA 22407 FRETEX TAG FREDERICKSBURG, VA 22407 FREDERICKSBURG, VA 22	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
REDERICKSBURG HEALTH AND REHAB 3900 PLANK ROAD PREDERICKSBURG, VA 22407 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTED TO THE APPROPRIATE DEFICIENCY) F 656 Continued From page 99 they may have." When asked how staff ensures residents care plans are implemented, LPN #4 stated, "It should be on the orders." LPN #4 was asked when physician ordered weekly weights should be obtained. LPN #4 stated the unit managers' hand out weekly weights when they are due and it is within a week. When asked to clarify, LPN #4 stated the weight should be obtained within seven days or sooner. Resident #19's physician order for weekly weights and the resident's weights as documented above were shown to LPN #4. LPN #4 confirmed another weight should have been obtained between 4/24/18 and 5/9/18. On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment.			495240	B. WING	i	05	/25/2018
F656 Continued From page 99 they may have." When asked how staff ensures residents' care plans are implemented, LPN #4 stated, "It should be or other offers." LPN #4 was asked when physician ordered weekly weights should be obtained. LPN #4 stated in every are due and it is within a week. When asked to clarify, LPN #4 stated the weight should be obtained within seven days or sooner. Resident #19's physician order for weekly weights and the residents weights as documented above were shown to LPN #4. LPN #4 confirmed another weight should be been obtained between 4/24/18 and 5/5/18. On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment			AND REHAB		3900 PLANK ROAD		
they may have." When asked how staff ensures residents' care plans are implemented, LPN #4 stated, "It should be on the orders." LPN #4 was asked when physician ordered weekly weights should be obtained. LPN #4 stated the unit managers' hand out weekly weights when they are due and it is within a week. When asked to clarify, LPN #4 stated the weight should be obtained within seven days or sooner. Resident #19's physician order for weekly weights and the resident's weights as documented above were shown to LPN #4. LPN #4 confirmed another weight should have been obtained between 4/24/18 and 5/9/18. On 5/24/18 at 5:53 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Huntington's disease (HD) is an inherited disease that causes certain nerve cells in the brain to waste away. People are born with the defective gene, but symptoms usually don't appear until middle age. Early symptoms of HD may include uncontrolled movements, clumsiness, and balance problems. Later, HD can take away the ability to walk, talk, and swallow. Some people stop recognizing family members. Others are aware of their environment	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI	IX (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE
information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query- meta?v%3Aproject=medlineplus&v%3Asources= medlineplus-bundle&query=huntington%27s+dise ase&_ga=2.232040607.1046050702.1527592979 -139120270.1477942321	F 656	they may have." W residents' care plan stated, "It should be asked when physicishould be obtained managers' hand our are due and it is wit clarify, LPN #4 state obtained within seve #19's physician orderesident's weights a shown to LPN #4. I weight should have 4/24/18 and 5/9/18. On 5/24/18 at 5:53 staff member) #1 (the director of nursiabove concern. No further information (1) "Huntington's distinct disease that causes brain to waste away defective gene, but appear until middle may include uncont clumsiness, and ba can take away the aswallow. Some permembers. Others and are able to expliniformation was obthough the side of the plus-bundle ase&_ga=2.232040	hen asked how staff ensures is are implemented, LPN #4 is on the orders." LPN #4 was an ordered weekly weights. LPN #4 stated the unit it weekly weights when they hin a week. When asked to ed the weight should be en days or sooner. Resident er for weekly weights and the is documented above were in LPN #4 confirmed another is been obtained between in been obtained between in line were administrator) and ASM #2 ing) were made aware of the income and inherited in line were cells in the interest of the intere		356		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05	5/25/2018	
	PROVIDER OR SUPPLIER			3900	ET ADDRESS, CITY, STATE, ZIP CO PLANK ROAD DERICKSBURG, VA 22407	DDE		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE	
F 656	Continued From pa	age 100	F6	56				
	gastrostomy, a pro feeding tube is place and into the stoma and/or medications stomach, bypassin This information wa	r percutaneous endoscopic cedure in which a flexible ced through the abdominal wall ch. PEG allows nutrition, fluids to be put directly into the g the mouth and esophagus." as obtained from the website: org/home/for-patients/patient-infinding-peg						
		failed to implement Resident cardiovascular medication physician's orders.		:		•		
	10/31/17. Residen were not limited to and anxiety disorde MDS (minimum da with an ARD (asset	admitted to the facility on t #82's diagnoses included but diabetes, high blood pressure er. Resident #82's most recent ta set), a quarterly assessment ssment reference date) of resident as being cognitively						
	10/18/16 documen status related to: di Hypertension (high (history) of chest pa potassium), PVD (p	tions: Medications as ordered						
	physician's order d	t #82' clinical record revealed a ated 12/5/17 that documented) 0.1 mg (milligrams) by mouth						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495240	B. WING				05/2	5/201 8
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CC	DE		
	IOVODUBO UEALTU	AND DELLAD		3	8900 PLANK ROAD			
FREDER	ICKSBURG HEALTH	AND REHAB		F	REDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION OATE
F 656	Continued From page	age 101	Fε	556	! :			
	every morning and	at bedtime and to hold the						
		esident's blood pressure is less			:			
		ew of Resident #82's May 2018					:	
		medication administration						
		n 5/9/18 at 6:00 a.m., the			:			
	resident's blood pr	essure was 113/68 and			! •			
	clonidine was adm	inistered (as evidenced by a			1		:	
		nurse's initials). Further review						
		eview of nurses' notes dated						
:		eal documentation that the					:	
	5/9/18 6:00 a.m. do	ose of clonidine was held.			:			
	O= 5104140 -+ 0.50				:			
		p.m., an interview was N (licensed practical nurse) #4.						
		I the purpose of the care plan.					•	
		keep knowledgeable and it's						
		ar of what's going on with the						į
		e goals that are to be met by						
		n according to what problems			•		·	
		When asked how staff ensures					:	
		residents' care plans, LPN #4						
!		e on the orders." LPN #4 was						
		document administered					:	
	medication. LPN#	t4 stated she checks and						
	initials the MAR (m	edication administration					:	
!	•	as asked how nurses			:		;	
		nedication. LPN #4 stated she						
;		r "3" on the MAR, which						
		ee nurses note" and by coding			•		•	
:		es up on the computer for her						
		gress note. LPN #4 was						
		32's physician order for						
		d what should be done if the			:			
:		essure is below 120/70. LPN					:	
		d not give the medication and urse practitioner or doctor					:	
		ifirmed it looked like clonidine					٠	
		to Resident #82, when it should						
	have been held on				i			

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILC		(X3) DATE SURVEY COMPLETED			
		495240	B. WING			05	/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		3900	ET ADDRESS, CITY, STATE, ZIP CODE PLANK ROAD DERICKSBURG, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 102	F6	: 356			
	conducted with LPN and initialed cloniding #82 on 5/9/18 at 6:00 how she documents administered and homedication is held. The medication off when a medication she ever had to holomedications in May were times where so blood pressure medication administered or held.	p.m., an interview was N #6 (the nurse who checked ne administration to Resident 20 a.m.) LPN #6 was asked at that a medication is ow she documents that a LPN #6 stated she signs the n she administers it and there omputer system to document is held. LPN #6 was asked if d any of Resident #82's 2018. LPN #6 stated there he documented the resident's dication was given but she edication. When asked if she d Resident #82's blood n on 5/9/18, LPN #6 stated mber.					
	staff member) #2 (t made aware of the 10:20 a.m., ASM #1 made aware of the	B a.m., ASM (administrative he director of nursing) was above concern. On 5/25/18 at (the administrator) was above concern. on was presented prior to exit.		:			
	(1) Clonidine is use This information wa	d to treat high blood pressure. s obtained from the website: gov/druginfo/meds/a682243.h					
		ailed to implement Resident no shoe to the right foot.					
	Resident #95 was a	dmitted to the facility on					

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

Event ID: 5S1P11

Facility ID: VA0088

(f continuation sheet Page 103 of 223



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	5/25/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
EREDER	CKSBURG HEALTH	AND REHAB		3900 PLANK ROAD		
INCOLN	ICKSBOKG HEALIN	AND KEIRD		FREDERICKSBURG, VA 22407	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 CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE
F 656 Continued From page		age 103	F 6	56 ⁻		
	- "	#95's diagnoses included but				T.
		diabetes, morbid obesity and				
		g. Resident #95's most recent				•
		ta set), a quarterly assessment		:		
		ssment reference date) of				:
		esident's cognition as severely		•		*
		G coded Resident #95 as		:		
		assistance of one staff with				:
		notion on the unit and dressing.		:		
				:		i
		nprehensive care plan dated 🔠				!
		ed, "(Name of Resident #95) is		•		:
	at risk for ALTERA					*
		SURE ULCERS due to:		•		1
		d in bed mobility, Bowel				i
		sity. (Name of Resident #95)		•		:
		lower extremities r/t (related to)				1
	traumaIntervention	ons: No shoe to right foot"				ė
		t #95's clinical record revealed		:		
	a physician's order					d.
		shoe to Right Foot every shift."				
		y 2018 eTAR (electronic				1
!		ration record) documented,		:		
	"No shoe to Right F	oot every shift."		•		4
	A =(==1 = 1.1, (I					
		e wound care physician on				•
		l a wound on the right second				
		ntimeters (length) by 0.6				
:		. The note documented a d a recommendation to		• •		
;	off-load the wound.					
· ·	On 5/23/18 at appre	oximately 8:15 a.m., 5/23/18 at		:		r
:		0 a.m. and 5/24/18 at			•	
		a.m., Resident #95 was				
:		elchair in the bedroom. A shoe				
		ne resident's right foot. A sign		•		!
	on Resident #95's	closet documented, "(Name of				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05	/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		3900	EET ADDRESS, CITY, STATE, ZIP CODE D PLANK ROAD EDERICKSBURG, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION OATE
	On 5/24/18 at 3:09 conducted with CN #1 (the CNA caring was asked if Residrestrictions. CNA # to have a shoe on why, CNA #1 stated his toe." CNA #1 wobserved a shoe or morning. CNA #1 sresident's foot as a transferring the resforgot to remove th aware this surveyor #95's right foot duri CNA #1 stated she	p.m., an interview was A (certified nursing assistant) for Resident #95). CNA #1 ent #95 had any footwear for stated, "He's not supposed his right foot." When asked d, "I believe he has a sore on has made aware this surveyor has Resident #95's right foot this stated she put a shoe on the safety precaution while ident with a sit to stand lift and he shoe. CNA #1 was made hobserved a shoe on Resident high the previous morning. hought the restorative staff he the resident's foot to	F	356			
	conducted with LPN LPN #4 was asked LPN #4 stated "To I an updated calenda patient and to have the plans you put in they may have." W residents' care plan stated, "It should be asked why Resident for no shoe to the ri Resident #95 had sthought was that his toes. When asked to have a shoe on t wheelchair, LPN #4	p.m., an interview was I (licensed practical nurse) #4. the purpose of the care plan. Keep knowledgeable and it's ar of what's going on with the goals that are to be met by according to what problems then asked how staff ensures as are implemented, LPN #4 e on the orders." LPN #4 was at #95 had a physician's order ght foot. LPN #4 stated crapes on his toes and the shoes were irritating his if Resident #95 was supposed the right foot when sitting in the stated the resident should or soft slipper as opposed to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	6		05/25/2018
	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE 3900 PLANK ROAD FREDERICKSBURG, VA 2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	ACTION SHOULD BE O THE APPROPRIAT	
F 656	LPN #4 the shoe t right foot. LPN #4 preferred a slipper foot. On 5/24/18 at 5:53 staff member) #1 (age 105 Dep.m., this surveyor showed hat had been on Resident #95's stated she would have to be on the resident's right p.m., ASM (administrative (the administrator) and ASM #2 sing) were made aware of the	F€	656		
	No further informa	tion was presented prior to exit.				
		f failed to implement Resident # he use of two fall mats and a				
	11/01/06 with a readingnoses that included Alzheimer's diseas	admitted to the facility on admission of 06/04/07 with luded but were not limited to se (1), dysphagia (2), eart failure, and hypertension				;
	set), an annual ass (assessment refer Resident # 35 as s interview for menta - 15, 2 (two) - being cognition for making 35 was coded as more of one staff members	ost recent MDS (minimum data sessment with an ARD ence date) of 03/20/18, coded acoring a 2 (two) on the brief al status (BIMS) of a score of 0 g severely impaired of a daily decisions. Resident # equiring extensive assistance er for activities of daily living.				
:		0 a.m., an observation of ealed she was lying in her bed.		: :		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING _		05	5/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION OATE	
F 656	Continued From p	-	F 65	66		:	
	Further observation next to the right significant formula in the right significant formula in the right of th	n revealed a fall mat on floor de of the bed.					
	Resident # 35 reve	:24 a.m., an observation of ealed she was lying in her bed. n revealed a fall mat on floor de of the bed.					
	(certified nursing a from the maintena Resident # 35's ro- member was carry maintenance staff	proximately 10:28 a.m., a CNA assistant) and a staff member nce department arrived at om. The maintenance staff ring a fall mat. The CNA and entered Resident # 35's room mat down on the floor to the .					
	measurement was Resident # 35 was carpenter's ruler R measured. Measu	5 p.m., an observation and made of Resident # 35's bed. Iying in bed. Using a standard esident # 35's bed height was uring from the floor to the tress the height of the bed a half inches.					
! !	measurement was Resident # 35 was carpenter's ruler R measured. Measu	5 p.m., an observation and made of Resident # 35's bed. Iying in bed. Using a standard esident # 35's bed height was uring from the floor to the tress the height of the bed					
	documented, "Foc falls related to use Dx (diagnoses) of Psychosis. Demor	Resident # 35 dated 03/28/18 us: (Resident # 35) is at risk for of antidepressant medication, Alzheimer's Dementia and nstrates cognitive loss and poor Has history of falls." Under					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/25/2018
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, 2		
				3900 PLANK ROAD		
FREDER	ICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA 224	407	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
F 656	Continued From pa	· -	F 6	56		:
		ocumented, "Bed in lowest				
		d related to history of falls.	i			:
		3/2016" and "Fall mats at				
	bedside while in be	d. Date initiated: 05/23/18."				
	On 05/23/18 at 1:3	0 p.m., interview and				:
		dent # 35's bed was conducted	ı			:
		nursing assistant) # 3. Upon				:
		nt's room and observing the				· i
		NA#3 was asked if the bed				
	was in the lowest p	osition. CNA#3 stated,"l	ı	1		
		r." Upon measuring the height		1		:
		agreed it measured 19 inches		 		
,		A#3 then picked up the	•			,
		he bed and lowered the bed.				
		e height of the bed from the	i			:
		of the mattress it measured				·
		3 looked at the ruler and		:		!
		surement., When asked who				:
		r ensuring the bed was in the		:		:
		A#3 stated, "The nurse and ed how often the height of the				
		A # 3 stated, "Everytime	•			
		the room." When asked when				:
		as in Resident # 35's room				
		About 15 minutes ago. I		:		
		lent # 35)." When asked if she	·			
		of the bed CNA#3 stated,				!
:		r tray and repositioned her. It	;			:
	was overlooked."	•				:
	0.05/00/10 11:11					
		7 p.m., an interview with RN				•
		1. When asked to describe	:			
į		care plan RN # 1 stated, "It is	İ	•		•
		of care. It tells you how to				:
;		tient. If it is on the care plan it " After being informed of the	: :			:
!		fall mat and bed height and	! !			
;		plan for Resident # 35, RN # 1	: 			

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE 3900 PLANK ROAD FREDERICKSBURG, VA 2	E, ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE COMPLETION O THE APPROPRIATE OATE
F 656	On 05/24/18 at 1:30 conducted with LPN 9, unit manager. We purpose of the care individual's plan of care of the patient. should be followed observations of the reviewing the care stated, "The care portion of the reviewing the care of the patient." The care portion of the reviewing the care stated, "The care portion of the reviewing the care of the care	lan was not followed." 5 p.m., an interview was N (licensed practical nurse) # /hen asked to describe the plan LPN # 9 stated, "It is the care. It tells you how to take If it is on the care plan it "After being informed of the fall mat and bed height and plan for Resident # 35, LPN #9 fan was not followed." roximately 5:55 p.m. ASM f member) # 1, the SM # 2, director of nursing of the findings. on was provided prior to exit. that seriously affects a farry out daily activities). This fained from the website: .gov/medlineplus/alzheimersdi	F 6	556	
!	(4) High blood press	sure. This information was			·

	OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	•	495240	B. WING		05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB	3	TREET ADDRESS, CITY, STATE, ZIP CODE 1900 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 657 SS=D	essure.html. Care Plan Timing a CFR(s): 483.21(b)(§483.21(b) Compres §483.21(b)(2) A column be- (i) Developed within the comprehensive (ii) Prepared by an includes but is not l (A) The attending p (B) A registered num resident. (C) A nurse aide wi resident.	vebsite: n.gov/medlineplus/highbloodpr and Revision 2)(i)-(iii) chensive Care Plans mprehensive care plan must n 7 days after completion of assessment. interdisciplinary team, that imited to	F 657	 Care plan was revised for Resident on 6/13/18 with fall interventions indicated. Residents residing in facility are for same deficient practice. DON or designee will re-educate nursing staff on the care plan procincluding interventions related to fouring morning meeting, DON or designee will review 24 hour reportensure current changes are review 	at risk e ess, falls. et to
	the resident and the An explanation must medical record if the and their resident renot practicable for the resident's care plant (F) Other appropriate disciplines as deteror as requested by (iii)Reviewed and reteam after each assessments. This REQUIREMENT by: Based on staff intereview, it was determined in the standard of the review in the standard of the standa	te staff or professionals in mined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the		and/or updated on residents care An audit of 5 resident care plans poweek for 4 weeks will be complete DON or designee, to ensure care power are reviewed or revised as indicated. 4. Results of audits will be reviewed the monthly QAPI meeting. Trendidentified will be addressed and refeducation provided as needed.	er d by lans ed. ed in s

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION BING		DATE SURVEY COMPLETED
		495240	B. WING			05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, Z 3900 PLANK ROAD FREDERICKSBURG, VA 224	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE AC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 657	Resident #58. The facility staff fail	ents in the survey sample, led to review and/or revise mprehensive care plan	F6	557		
	01/01/16 with diagr	admitted to the facility on loses that included but were brain damage (1), anxiety epressive disorder (4), auscle weakness.				
	set), a quarterly ass (assessment refere Resident # 58 as so interview for menta - 15, 5 (five) - being cognition for making 58 was coded as re	st recent MDS (minimum data sessment with an ARD ence date) of 04/17/18, coded coring a 5 (five) on the brief I status (BIMS) of a score of 0 severely impaired of g daily decisions. Resident # equiring limited to extensive taff member for activities of				
	The clinical record fall on 02/24/18.	for Resident # 58 revealed a	:			
	Resident # 58 docu doing prior to fall? (What may have can without assist (assi- injury? Yes RT (righ by one inch)." The the physician was r	nvestigation" dated 2/24/18 for mented, "What was resident of up to go to the bathroom, used the accident? Ambulation stance), Did resident sustain ht) shin 3in x 1in (three inches "Fall Investigation" revealed notified on 02/24/18 at 7:00 are left for the family on				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		ATE SURVEY DMPLETED
		495240	B. WING		0:	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 657	Investigation" documented. The comprehensive documented, "Focument and continues to be injury related to: His antidepressants, and Parkinson's, Brain of Seizure. Date Initial review of the fall candocumentation of a plan following the fall conducted with RN assessment coording describe the process resident's care plan event, the nurse on updating the care plan event, the nurse on updating the care plan event, the nurse on updating the care plan event, the nurse on updating the care plan event, the nurse on updating the care plan event, the nurse on updating the care plan event, the nurse on updating the care plan event, the nurse on updated the investigation time as intervention for the Resident # 58's carregarding Resident stated she would chob/25/18 at 8:52 a.r. plan was not updated with the appropriate On 05/24/18 at appropriate On 05/24/18 at appropriate on 05/24/18 a	mented that the care plan was exact plan for Resident # 58 s: Resident has had actual fall at risk for further fall related story of falls, use of ad pain medication, damage, Dementia and sted 11/14/2017. Further re plan failed to evidence review or revision of the care all on 02/24/18. a.m., an interview was (registered nurse) # 2, the nator. When asked to s for reviewing or revising the RN # 2 stated, "If there is an that shift is responsible for lan. For a fall it may take a exact plan because of the nd develop the appropriate resident." When asked about the plan being updated # 58's fall on 2/24/18. RN # 2 seck the care plan." On n., RN # 2 stated, "The care and it should have been intervention." Toximately 5:55 p.m. ASM member) # 1, the SM # 2, director of nursing	F 6	57		
		,		:		:

AND PLAN OF CORRECTION IDE	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG		E SURVEY MPLETED
	495240	B. WING _		05/	/25/2018
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND RE	EHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407	·	
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
References: (1) Not enough oxygen ge information was obtained thttps://www.nlm.nih.gov/m001435.htm (2) Fear. This information website: https://www.nlm.nih.gov/m#summary. (3) Symptoms of a brain probecause of sudden, abnorn the brain. This information website: https://www.nlm.nih.gov/mml. (4) Depression may be desplue, unhappy, miserable, Most of us feel this way at short periods. Clinical dependisorder in which feelings or frustration interfere with or more. This information website: https://medlineplus.gov/enc/spites//medlin	tting to the brain. This from the website: redlineplus/ency/article/ was obtained from the edlineplus/anxiety.html roblem. They happen mal electrical activity in was obtained from the edlineplus/seizures.ht scribed as feeling sad, or down in the dumps. one time or another for pression is a mood of sadness, loss, anger, everyday life for weeks was obtained from the cy/article/003213.htm. that occurs with certain ty, thinking, language, this information was cy/article/000739.htm. ofessional Standards sive Care Plans	F 65			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
		495240	B. WING _		05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 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	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 658	must- (i) Meet professional This REQUIREMEN by: Based on staff intereview, and clinical determined the faci professional standaresidents in the sur #15, #95, and #70. 1. a. The facility sta #9 could receive he versus by feeding to documented by mo via feeding tube for 1. b. The facility sta #9's physician ordered To degrees F (Fahrent (medication administ the Tylenol the staff medication for pain. 2. a. The facility sta notification of elevat #15. 2. b. The facility sta and assess Reside blood glucose (sugat 3. The facility staff forder to include the	omprehensive care plan, al standards of quality. NT is not met as evidenced rview, facility document record review, it was lity staff failed to follow urds of practice for four of 37 vey sample, Residents #9, ff failed to clarify if Resident or medications by mouth ube. The medication orders uth for some medications and other medications. ff failed to clarify Resident or for Tylenol. Resident #9's fylenol for fever over 100 neit). The April 2018 MAR estration record documented was administering the ff failed to clarify the order for ted blood sugars for Resident aff failed provide education ont #15's ability to do her own	F 68	1. Resident # 9 medication clarified by physician on 5/2 administered by mouth. RE Resident # 9's Tylenol medi was clarified by physician on Resident # 15's order for not parameters of blood sugars on 6/14/18. Resident #15's education assessed for the monitor her own blood gluct Resident #95 order for CPAI settings was clarified on 6/1 clarified daily fluid consump Resident #70 on 5/18/18. 2. Residents residing in facilifor same deficient practice. 3. DON or designee will resent proders, providing resident eself-administration assessmore residents, and process to more sidents with fluid restrictions.	25/18 to be P made aware. ication order on 5/25/18. otification is was clarified was provided ability to cose (sugar). P machine 11/18. Facility otion for lity are at risk educate hysician inducation and cents for onitor	

CENTE	KO FOR MEDICARE	A MEDICAID SERVICES				<u>INIR INO.</u>	<u>0938-0391</u>
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
		495240	B, WING		<u> </u>	05/	25/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	RICKSBURG HEALTH	AND REHAB			900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	NI.	
PREFIX TAG	(EACH DEF)CIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACT)ON SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From pa	ne 11 <i>1</i>		۵.			
. 000	•		F6	56			:
		ailed to document the amount			DON/designee will review new		:
	physician ordered fl	hile Resident #70 was on a			admissions and residents with new	j	
	priysician ordered ii	did restriction.			orders daily in the morning meetin	io and	
					also the stand down meeting in the	-	
	The findings include): :					
		· ·			afternoon. In addition, a 24 hour		;
	1. a. The facility state	ff failed to clarify if Resident			check will be completed by 11-7 st		:
		r medications by mouth		i	any changes needed will be verifie	d at	:
		be. The medication orders			that time. An audit will be comple	ted 2 x	-
		uth for some medications and			week on 10 resident records x 4 w		İ
	via feeding tube for	other medications.			ensure physician orders are follow		
!	Resident #0 was ad	mitted to the facility on 5/5/17			and/or clarified as indicated. An a		
		included but were not limited				i	
:		ctures, feeding tube, anemia,			resident who self-administer medi		
;		(a slowly progressive			or treatments will be completed to		
		ed by resting tremor, shuffling		:	ensure residents receive education	and	
:		e, rolling motions of the			are assessed with ability to perform	ท	
		must weakness, sometimes			tasks.		
		bility (1)), insomnia, asthma,				:	
i		hrive (a geriatric syndrome			/ Possite of audita will be made.		
:		rive" has been described, loss, decreased appetite,		į	4. Results of audits will be reviewe	i	
1		nactivity, often accompanied			the monthly QAPI meeting. Trends		
	by dehydration, den	ressive symptoms, impaired			identified will be addressed and re-	- ;	
	immune function, ar Failure	nd low serum cholesterol.		:	education provided as needed		6/26/18
		oth acute and chronic forms,					
		unctional status, morbidity					
		sure sores, and increased				:	
	The most recent MD	S (minimum data set)					
	assessment, a signit	ficant change assessment,				!	
1	with an assessment	reference date of 3/2/18,					
	coded the resident a	s scoring a "9" on the BIMS		i			
	(brief interview for m	ental status) score, indicating					
4	she was moderately	impaired to make cognitive					

	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILC	LTIPLE CONSTRUCTION DING	_		TE SURVEY MPLETEO
		495240	B. WING	j		05	/25/2018
	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, ST 3900 PLANK ROAD FREDERICKSBURG, VA			120/2010
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	IX (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULO EO TO THE APPROPR ICIENCY)	BE	(X5) COMPLETION DATE
	totally dependent use members for all of Section K - Nutrition coded as having be mechanically altered resident was coded her nutrition via the "Metoprolol Tartrated blood pressure (3)) tablet via G-Tube (gknown as a feeding related to hypertens Pravachol Tablet 20 cholesterol and trig G-tube one time a commented, "Amloto treat high blood pressure (5)), Give 1 tablet virelated to hypertens The physician order "Carbidopa-Levodo Parkinson's disease via G-tube three times."	e resident was coded as being pon one or more staff her activities of daily living. In n/Swallowing, the resident was oth a feeding tube and a act diet. Under K0710, the diet as receiving 25% or less of artificial route (feeding tube). The dated, 5/5/17, documented: Tablet (used to treat high 50 mg (milligrams); give 1 gastrostomy tube otherwise tube (14)) two times a day sion (high blood pressure). In mg (used to treat elevated lycerides (4)); Give 20 mg via day." The dated, 5/25/17, adocumented, pa dated, 5/26/17, documented, pa Tablet (used to treat elevated lycerides (4)); Give 20 mg via day." The dated, 5/26/17, documented, pa Tablet (used to treat elevated lycerides) and heart disease as G-tube one time a day sive."	F	558			
:	"Baclofen Tablet (us	sed to relax certain muscles in . , Give 5 mg via G-tube every					
	"Thera-M Tablet (me give 1 tablet by mou	dated, 9/27/17, documented, ultiple vitamins and minerals); th one time a day for give in PEG (Percutaneous		: : :			

	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILC		CONSTRUCTION		ATE SURVEY OMPLETEO
		495240	B. WING			0	5/25/2018
	PROVIOER OR SUPPLIER			3900	EET AOORESS, CITY, STATE, ZIP COOE D PLANK ROAD EDERICKSBURG, VA 22407		0/20/2010
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG	x	PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP OEFICIENCY)	DULO BE	(X5) COMPLETION DATE
F 658	The physician orde "Pepcid tablet (use reflux disease (8))	age 116 stomy feeding (14)) tube." er dated, 10/2/17, documented, ed to treat gastroesophageal via PEG-tube at bedtime cophageal reflux disease."	F6	58			
	"Potassium Chlorio (milli-equivalent) (u	er dated, 10/9/17, documented, de Packet 20 mEq used to replace potassium in u)) Give 1 packet via Peg-tube		1			
	antioxidant. It is im and connective tiss helps the body abs	er dated, 12/14/18, min C (Vitamin C is an portant for your skin, bones, sue. It promotes healing and orb iron (10)), tablet 500 mg; uth two times a day for					
	"Remeron Tablet (Medical depression (11)) G	or dated, 1/31/18, documented, Mirtazapine) (used to treat ive 7.5 mg by mouth at adult failure to thrive."				·	
;	"Ferrous Sulfate Lie milliliter); (used to t	r dated, 2/28/18, documented, quid 220 mg/ml (milligrams per reat iron deficiency anemia via PEG-tube in the morning					
! : : : : : : : : : : : : : : : : : : :	and revised on 5/17 "Focus: (Resident #	e care plan dated, 10/18/17, 7/18, documented in part, #90 has potential for npresence of PEG with					:
:	An interview was co	anducted with LPN (licensed					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(. ,	SURVEY PLETED
		495240	B. WING	S		05/2	25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 3900 PLANK ROAD FREDERICKSBURG, VA 2240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD E HE APPROPRI	BE ATE	(X5) COMPLÉTION OATÉ
F 658	#4 was asked how medications. LPN by mouth but we stabove were review stated, "They all do #4 was asked how receiving all of her #4 stated, "One to asked if the physic should coincide with being administered asked if these ordestated, "Yes." On 5/24/18 at 3:19 conducted with adr (ASM) #3, the nurs asked how Resider ASM #3 stated, "The orders above were ASM #3 confirmed instructed for medifeeding tube and his documented by monurse LPN #4 state #9's medications by need to clarify thos. The facility policy, "documented in part appears inappropri	non 5/24/18 at 2:08 p.m. LPN Resident #9 takes her #4 stated, "She takes her pills fill flush her peg." The orders red with LPN #4. LPN #4 pon't say the same thing." LPN long the resident had been medications by mouth. LPN two months." LPN #4 was ian orders for medications h how the medications are l. LPN #4 stated, "Yes." When rers need to be clarified, LPN #4 p.m. An interview was ministrative staff member re practitioner. ASM #3 was not #9 receives her medications. The reviewed with ASM #3, and that half the medication orders cations to be given via the alf the medication orders buth. ASM #3 was informed the red she gives all of Resident by mouth, ASM #3 stated, "We re orders." Medication Orders" t, 2. Any dose or order that ate considering the resident's regies or diagnosis is verified by	F	658			
:	order that is unclea	the prescriber any medication r or seems inappropriate." (13)					
	THE auministrator v	vas made aware of the above					l

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495240	B. WING		0!	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 658	Non-Medical Reade Chapman, page 43 (2) This information following website: https://grants.nih.go 022.html. (3) This information following website: https://www.ncbi.nlr T0011186/?report=(4) This information following website: https://dailymed.nlmm?setid=897AD8B72A2DA. (5) This information following website: https://www.ncbi.nlr T0008948/?report=(6) This information following website: https://dailymed.nlmm?setid=abff005f-2. (7) This information following website: https://www.ncbi.nln T0009200/?report=(8) This information following website:	ary of Medical Terms for the er, 5th edition, Rothenberg and 7, was obtained from the ov/grants/guide/pa-files/PA-93-was obtained from the m.nih.gov/pubmedhealth/PMH details. was obtained from the n.nih.gov/dailymed/drugInfo.cf 7-921D-EB02-A61C-3419E66 was obtained from the m.nih.gov/pubmedhealth/PMH details. was obtained from the n.nih.gov/pubmedhealth/PMH details. was obtained from the n.nih.gov/dailymed/drugInfo.cf 3fc-4d1e-b469-88aa07589a43 was obtained from the n.nih.gov/pubmedhealth/PMH		558		
	T0010262/?report=0 (9) This information following website:					

NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB STREET ADDRESS, CITY. STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407 (X4) ID PREFEX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCE OF THE APPROPRIATE DEFICIENCY) F 658 Continued From page 119 m?setid=af7ef02a-1a51-4747-b4a0-7e270136f16		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł''	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
REDERICKSBURG HEALTH AND REHAB (X4) ID PREFIX TAG REGULATORY OR LSc IDENTIFYING INFORMATION) F 658 Continued From page 119 m?setid=af7ef02a-1a51-4747-b4a0-7e270136f16 1. (10) This information was obtained from the following website: https://medlineplus.gov/vitaminc.html. (11) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fdu/glnfo.cf m?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1 a1 (13) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cf m?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1 a1 (14) This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cf m?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1 a1 (15) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cf m?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1 a1 (16) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cf m?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1 a1 (17) This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm 1. b. The facility staff failed to clarify Resident #9's physician ordered Tylenol. Resident #9's physician ordered Tylenol for fever over 100			495240	B. WING		0:	5/25/2018
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 119 m'setid=af7ef02a-1a51-4747-b4a0-7e270136f16 1. (10) This information was obtained from the following website: https://medlineplus.gov/vitaminc.html. (11) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDru gXsl.cfm?id=62223. (12) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf m'setid=a017eb78-8c70-4b59-b7c0-22ec6945c1 a1 (13) This information was obtained from Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 553. (14) This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm 1. b. The facility staff failed to clarify Resident #9's physician ordered Tylenol. Resident #9's physician ordered Tylenol for fever over 100					3900 PLANK ROAD	CODE	
m?setid=af7ef02a-1a51-4747-b4a0-7e270136f16 1. (10) This information was obtained from the following website: https://medlineplus.gov/vitaminc.html. (11) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/fda/fdaDru gXsl.cfm?id=62223. (12) This information was obtained from the following website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf m?setid=a017eb78-8c70-4b59-b7c0-22ec6945c1 a1 (13) This information was obtained from Fundamentals of Nursing, 5th edition, Lippincott, Williams & Wilkins, page 553. (14) This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm 1. b. The facility staff failed to clarify Resident #9's physician ordered Tylenol. Resident #9's physician ordered Tylenol for fever over 100	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI.	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE BE APPROPRIATE	COMPLETION
(medication administration record documented the Tylenol the staff was administering the medication for pain. The physician order dated, 5/25/17, documented, "Acetaminophen Tablet (Tylenol - used to treat fever and mild pain (1)) 325 mg; give 2 tablets via PEG-tube (Percutaneous endoscopic gastrostomy or feeding tube (2)) every 4 hours as needed for fever over 100 degrees F (Fahrenheit). Take two tablets to equal 650 mg via peg tube for fever over 100 degrees." The April 2018 medication administration record		m?setid=af7ef02a-1. (10) This informatic following website: https://medlineplus (11) This informatic following website: https://dailymed.nlr gXsl.cfm?id=62223 (12) This informatic following website: https://dailymed.nlr m?setid=a017eb78 a1 (13) This informatic Fundamentals of N Williams & Wilkins (14) This informatic website: https://medlineplus 1. b. The facility sta #9's physician ordered degrees F (Fahren (medication adminithe Tylenol the staf medication for pain The physician order "Acetaminophen Tafever and mild pain PEG-tube (Percuta gastrostomy or fee needed for fever on (Fahrenheit). Take via peg tube for fever feeded for fever on the part of the pa	chast-4747-b4a0-7e270136f16 con was obtained from the segov/vitaminc.html. con was obtained from the m.nih.gov/dailymed/fda/fdaDru segov.accomplete from the m.nih.gov/dailymed/druglnfo.cf segov.accomplete from segov.accomplete from segov.accomplete from segov.accomplete from the segov.accomplete from th	F 6	558		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	A1	0:	5/25/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
F 658	mg; give 2 tablets needed for fever of tablets to equal 68 over 100 degrees 4/1/18 as having & The nurse's note of documented, "Rest to back, scale 4/1 worse pain ever) a resident in chair." on 4/1/18 documented was: 0." The comprehensing revised 5/17/18, documente	ed, "Acetaminophen Tablet 325 via PEG-tube every 4 hours as over 100 degrees F. Take two 50 mg via peg tube for fever F." It was documented on been administered at 2:22 p.m. dated, 4/1/18 at 2:22 p.m. dated, 4/1/18 at 2:22 p.m. dident c/o (complained of) pain 0 (four of ten - ten being the assisted and reposition while The nurse's note at 5:41 p.m. anted, "Effective follow up Pain ve care plan dated, 5/9/17 and ocumented in part, "Focus: gement and monitoring related d muscle spasms, wounds, ssion fractures." The cumented in part, "Administer as ordered."	F 6	558			
	conducted with LF LPN #4 was asked Tylenol. When ask be administered p "Every four hours medication was do administered by a "There should be one for fever." An interview was of staff member (ASI 5/24/18 at 3:20 p.r	B p.m., an interview was PN (licensed practical nurse) #4. In the read the physician order for ked when the medication would be the order, LPN #4 stated, for fever." When informed the ocumented as being nurse for pain, LPN #4 stated, a separate order for pain and conducted with administrative M) #3, the nurse practitioner, on m. When asked if an order for ed to give the medication for					

STATEMENT OF DEFICIENCIES AND PLAN OF CDRRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		0	(X3) DATE SURVEY CDMPLETED		
		495240	B. WING				05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		39	TREET ADDRESS, CITY, STATE, ZIP CDE 900 PLANK ROAD REDERICKSBURG, VA 22407	DE	03,20,20,0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PRDVIDER'S PLAN DF CORRI (EACH CORRECTIVE ACTION SI CRDSS-REFERENCED TO THE AP DEFICIENCY)	HDULD B	
F 658	The facility policy, "documented in part shall specify the cobeing administered pain.' The dose mu example, '1 tablet for moderate pain." The administrator with findings on 5/24/18 No further information following website: https://dailymed.nlmgXsl.cfm?setid=1620ecfb7 (2) This information following webiste:	dered for fever, it's not en for pain." Medication orders" , "3. PRN (as-needed) orders ndition for which they are for example, 'as needed for st also be specified, for or mild pain or 2 tablets for	F6	958 	DEFICIENCY)		
• ;		ff failed to clarify the order for ted blood sugars for Resident	:				
	4/6/16 with a recent diagnoses that inclu- diabetes (a complex metabolism due eith insulin secretion by of insulin to function	dmitted to the facility on readmission on 4/27/17, with ded but were not limited to: and chronic disorder of her to partial or total lack of the pancreas or to the inability normally in the body (1)), tructive pulmonary disease					:

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05/25/2018		
	PROVIDER OR SUPPLIER	AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
F 658	disease that is usual emphysema and cholood pressure, heavalking. The most recent MI assessment, an anassessment references ident as scoring interview for mental is capable of making Resident #15 was owith set up assistant daily living. The physician order documented, "Humalog indicated to adults and children inject as per sliding 199 = 6 unit, less the hypoglycemic protor doctor); 200 - 249 = MD, 250 - 299 = 10 350 - 399 = 14 units	pronic nonreversible lung ally a combination of bronchitis] (2)), high art failure, pain, and difficulty and assessment, with an ace date of 2/27/18, coded the a 15 on the BIMS (brief status) score, indicating she g cognitive daily decisions. oded as requiring supervision as for all of her activities of a dated, 11/10/17, alog Solution Insulin Lispro action of acting human insulin improve glycemic control in with diabetes mellitus. (3)) scale if (blood sugar) 150 - an 70 = 0 units, Follow col and call MD (medical 8 units, greater than 500 call units, 300 - 349 = 12 units; 400 - 450 = 16 units, 451 -	F	658	DEFICIENCY			
:	at bedtime related to underlying condition complications. Call greater than 400, pa	cutaneously before meals and or diabetes mellitus due to with unspecified MD if less than 70 and atient may check her BS eport number to staff for						
	record) documented Lispro, inject as per	(medication administration I, "Humalog Solution Insulin sliding scale if (blood sugar) ess than 70 = 0 units, Follow						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	5/25/2018
NAME OF	PROVIDER OR SUPPLIER	,	·	STREET ADDRESS, CITY, STATE, ZI		
				3900 PLANK ROAD		
FREDER	RICKSBURG HEALTH	AND REHAB		FREDERICKSBURG, VA 2240	07	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE
F 658	units, greater than units, 300 - 349 = 1 400 - 450 = 16 units subcutaneously bet related to diabetes condition with unsp MD if less than 70 amay check her BS	col and call MD; 200 - 249 = 8 500 call MD, 250 - 299 = 10 2 units; 350 - 399 = 14 units, s, 451 - 500 = 20 units., fore meals and at bedtime mellitus due to underlying ecified complications. Call and greater than 400, patient and report number to staff for Resident #15's documented as follows: = 419 = 412 = 423 n. = 422 . = 423 n. = 425 m. = 432 . = 431 . = 445 . = 406	F	358		
	Solution Insulin Lisp if (blood sugar) 150 0 units, Follow hypo MD; 200 - 249 = 8 L MD, 250 - 299 = 10 350 - 399 = 14 units 500 = 20 units., sub at bedtime related t underlying condition complications. Call greater than 400, pareport number to sta	R documented, "Humalog pro, inject as per sliding scale - 199 = 6 unit, less than 70 = 199 to glycemic protocol and call units, greater than 500 call units, 300 - 349 = 12 units; s, 400 - 450 = 16 units, 451 - 10 cutaneously before meals and to diabetes mellitus due to a with unspecified MD if less than 70 and attent may check her BS and aff for insulin coverage."				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	•		05/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 3900 PLANK ROAD FREDERICKSBURG, V	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION FIVE ACTION SHOULD E CED TO THE APPROPRI FICIENCY)		
	5/1/18 at 9:00 p.m 5/4/18 at 4:30 p.m 5/5/18 at 9:00 p.m 5/10/18 at 9:00 p.m 5/10/18 at 9:00 p.m 5/10/18 at 9:00 p.m 5/12/18 at 9:00 p.m 5/15/18 at 11:30 a 5/15/18 at 9:00 p.m 5/23/18 at 9:00 p.m 5/23/18 at 9:00 p.m The comprehensive revised on 3/7/18, am at Risk for Med Diabetes Mellitus. hyperglycemia at the documented in particular blood sugar check (as needed) for chof clinical signs or assist or complete glucometer maching reading) and show for high blood sugar beautical nurse) #4 was asked to reinsulin. Once review to be clarified as to the blood sugar beautical nurse of the blood sugar beautical n	. = 455 . = 485 . = 421 m. = 414 m. = 417 m. = 437 .m. = 439 m. =	F. 6	558			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTIDN NG		(X3) DATE SURVEY COMPLETED		
		495240	B. WING		05	5/25/2018	
	PROVIDER OR SUPPLIER ICKSBURG HEALTH	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	PROVIDER'S PLAN OF CO (, (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE	
F 658	Continued From page 125		F 6	58:		 	
	documented in part appears inappropriage, condition, aller nursing with the pre "Always clarify with	Medication Orders" 2. Any dose or order that ate considering the resident's gies or diagnosis is verified by escriber." the prescriber any medication or seems in appropriate." (4)					
	The administrator v concern on 5/24/18	vas made aware of the above at 5:26 p.m.				7	
:	staff member) #1, t	7 a.m., ASM (administrative he administrator, stated the ard of practice for the facility					
;	No further informati	on was provided prior to exit.					
	Non-Medical Reade Chapman, page 16 (2) Barron's Diction	ary of Medical Terms for the er, 5th edition, Rothenberg and				:	
	(3) This information following website: https://dailymed.nlm	was obtained from the n.nih.gov/dailymed/drugInfo.cf 0e22-4fc7-a503-faa58c1b6f3f					
:		was obtained from: ursing, 5th edition, Lippincott, page 553.					
; ; ;		aff failed provide education nt #15's ability to do her own ar) monitoring.					

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MUL [*] A. BUILOI	TIPLE CONSTRUCTION NG		(X3) OATE SURVEY COMPLETEO	
		495240	B. WING		0:	5/25/2018
	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 22407	COOE	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCEO TO THI OEFICIENCY)	N SHOULO BE E APPROPRIATE	IX5) COMPLETION OATE
F 658	LPN (licensed pract LPN #1 stepped in had asked Resider level had read. LP checked her own be down on a notepact staff check in with insulin to give. Resident of Humalog sliding scale. Review of Resident evidence education documenting that Fable to check her of Review of Resident dated 4/22/16, doc information: "I am a Complications due episodes of hypergexperience minimal associated with hyllong term complicated will be managed the InterventionsResher own accucheck to obtain blood gluonursing the results. On 5/24/18 at 12:1 conducted with LPI process if a resider their own medication would have to do a side of the conducted with the process if a resider their own medication would have to do a side of the conducted with the conducted with LPI process if a resider their own medication would have to do a side of the conducted with the conducted with LPI process if a resider their own medication would have to do a side of the conducted with the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have to do a side of the conducted with LPI process if a resider their own medication would have the conducted with LPI process if a resider their own medication would have the conducted wit	p.m., medication ervation was conducted with ctical nurse) # 1. At 5:29 p.m., to Resident #15's room and nt #15 what her blood sugar N #1 stated that Resident #15 blood sugars and wrote them d. LPN #1 stated that nursing her to determine how much sident #15 had stated that her D5. LPN #1 then administered (2) to Resident #15 per ordered It #15's clinical record, failed to n or an assessment Resident #15 was safe and win blood sugars. It #15's diabetic care plan umented the following at risk for Metabolic to: Diabetes Mellitus. I have allycemia at times. Goal: I will all signs and symptoms berglycemia/hypoglycemia and tions associated with disease rough next review date. ident may assist or complete as (brand of glucometer used cose monitoring) and show If p.m., an interview was N #2. When asked the nt wanted to self- administer on, LPN #2 stated that nurses n assessment to determine if	F6	58		
		n assessment to determine if able of administering their own	:			

STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	5/25/2018
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD		
FREDER	CKSBURG HEALT	H AND REHAB		FREDERICKSBURG, VA 2240	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 658	the resident do a asked if this asse clinical record, LF to have paper doo	#2 stated that they would have return demonstration. When ssment was documented in the N #2 stated that the facility used cumentation but that there was	F 6	58		
	system. LPN #2 the assessment in the physician wou the resident is ablumedication, LPN need an order to	m since moving to the computer stated that she would document in a nursing note. When asked if all have to be made aware that it is to administer their own the stated that the resident would administer their own medication is cian would have to sign off on				
	the order. When applied to a reside accuchecks, LPN process would ap would want to ma ability to check the proper technique and make sure in the resident is tak #2 could not recal	asked if the same process ent who wanted to do their own #2 stated that the same ply. LPN #2 stated that nursing ke sure that the resident has the eir own blood sugar, have the to take their own blood sugar fection control is maintain while ing their own blood sugar. LPN I if Resident #15 had an bing her own accuchecks.				
	conducted with LF process if a reside their own medicat DON (director of assessment to de safe to administer was not sure whe assessment. LPN did not determine self-administer methe resident can a medications, it wo	58 p.m., an interview was PN #4. When asked the ent wanted to self-administer ions, LPN #4 stated that the nursing) would do an termine that the resident was their own medication. LPN #4 re the DON documented this I #4 stated that the floor nurses the resident's ability to edications. LPN #4 stated that if dminister their own uld be written on the care plan.				

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG	(X3) OATE SURVEY COMPLETEO
		495240	B. WING _		05/25/2018
	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 2240	P COOE
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCEO TO T OEFICIENC	ION SHOULO BE COMPLETION HE APPROPRIATE OATE
	medications. On 5/24/18 at 1:30 conducted with AS member) #2, the EWhen asked the pself administer the stated that the stated that the stated that the stated she would extend the resident administer their owstated she would extend the more sident administer due. ASM #2 stated have to approve for medications at the asked if the same resident who wante ASM #2 stated that assess to determinoriented, and capa accuchecks. ASM expect that the resiglucometer appropri	age 128 dminister their own D. p.m., an interview was M (administrative staff DON (Director of Nursing). rocess if a resident wanted to ir own medication, ASM #2 If would assess to see if the and oriented enough to wn medication. ASM #2 then expect the nursing staff to give edication and watch the r the medication each time it is ed that the physician would ir the resident to have ir bedside to take. When process would apply for a ed to do their own accuchecks, t she would expect her staff to ne that the resident was alert, ble enough to do their own #2 stated that she would ident would be able to hold the briately. ASM #2 stated that she bursing staff to have the	F 65		Υ)
	stated that she wo assessment in a not that if the resident blood sugars, she care plan. ASM #2 was not required for accuchecks. On 5/24/18 at 1:54 conducted with Re could not recall if s	n demonstration. ASM #2 uld expect to see the urse's note. ASM #2 stated was safe to check their own would expect to see that on the 2 stated that a physician's order or a resident to do their own p.m., an interview was sident #15. Resident #15 he was provided education or r own accuchecks Resident			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05	/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		390	REET ADDRESS, CITY, STATE, ZIP CODE 00 PLANK ROAD REDERICKSBURG, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 658	On 5/24/18 at 3:01 could not find any ethe resident was as accuchecks. ASM aused as a profession According to Lippin Practice Eighth Edi Care Guidelines: Could betes Mellitus: A disease and ability Alert: Assess elderly such as impaired vitremors that may have a source of the could be according to Portate and According	has been doing her own enty years. p.m., ASM #2 stated that she education or any evidence that is sessed to do her own #2 stated that Lippincott was onal reference. cott Manual of Nursing tion, page 921, "Standards of aring for Patients With When caring for patients with is sess level of knowledge of to care for self." "Gerontologic y patients for sensory deficits, sion, hearing, fine touch, and ave impact on learning" (2)	F	558			
:	Diabetes Mellitus: "	Third Edition, page 216, Patient teaching: Be sure to ring of blood glucose level."					
:	staff member) #1, t	p.m., ASM (administrative he administrator and ASM #2, of Nursing) were made aware rns.					:
	No further informati	on was presented prior to exit.	· • • • •	:		•	
	improve glycemic c with diabetes mellits subcutaneously, HU onset of action and	insulin analog indicated to ontrol in adults and children us. When given JMALOG has a more rapid a shorter duration of action insulin. This information was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495240	B. WING _		05	05/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From p	age 130	F 65	58			
	https://dailymed.nl	National Institutes of Health at m.nih.gov/dailymed/drugInfo.cf 5-86b8-4926-b8c3-b42133ca7a					
	Lippincott Manual	on was obtained from: of Nursing Practice Eighth Williams & Wilkins, page 921.				;	
	ŘŃ, The All- in On	n was obtained from: Portable e Nursing Reference Third Williams & Wilkins, page 216.					
	order to include the	failed to clarify a physician's e settings for Resident #95's positive airway pressure)					
	7/12/17. Resident were not limited to difficulty swallowin MDS (minimum dawith an ARD (asse 3/1/18, coded the impaired. Section requiring extensive	admitted to the facility on #95's diagnoses included but diabetes, morbid obesity and g. Resident #95's most recent ata set), a quarterly assessment reference date) of resident's cognition as severely G coded Resident #95 as a assistance of one staff with notion on the unit and dressing.	:				
	a physician's order machine each eve bed and take off in and night shift." R (electronic medica documented, "App shift when residen	at #95's clinical record revealed that documented, "Apply Cpap ning shift when resident is in the morning every evening esident #95's May 2018 eMAR tion administration record) by Cpap machine each evening to in bed and take off in the uning and night shift."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495240	B. WING			0	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		390	EET ADDRESS, CITY, STATE, ZIP CODE 0 PLANK ROAD EDERICKSBURG, 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 APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 658	Resident #95 during on 5/23/18. Resident plan dated 12/2/16 Respiratory Status Sleep apnea, CHF Allergic Rhinitis. Frown CPAP" On 5/24/18 at 3:53 conducted with LPN LPN #4 was asked should contain. LP the settings on it be according to another settings. I don't put We have the setting company). Whether shift nurses) check, come in, I would was should be. I would On 5/24/18 at 4:45 conducted with LPN (a 3:00 p.m. to 11:0 confirmed the setting machine were adjust on the machine. On 5/24/18 at 5:53 staff member) #1 (till (the director of nurse above concern. AS a CPAP order should status on the should status on the setting on the machine.	g the evening and night shifts on #95's comprehensive care documented, "Alteration in Due to Dx (diagnosis) OF (congestive heart failure) and requently removes and refuses p.m., an interview was I (licensed practical nurse) #4. what details a CPAP order N #4 stated, "It should have cause the CPAP is set up er company; they make the it on. I'm strictly day shift. I don't know. If I were to ant to know what the settings think the order would have it." p.m., an interview was I (licensed practical nurse) #5 op.m. shift nurse). LPN #5 ags on Resident #95's CPAP stable and were not locked in p.m., ASM (administrative he administrator) and ASM #2 ing) were made aware of the M #2 was asked what details Id contain. ASM #2 stated the in the settings because they	F6	58			
	The facility policy tit MEDICATION ORD	led, "NON-CONTROLLED ERS" documented,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495240	B. WING				05/	25/2018
	PROVIDER OR SUPPLIE			390	REET ADDRESS, CITY, STATE, ZIP (0 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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 658	of a clear and cor lawfully authorized No further informa	administered only upon receipt nplete, signed order by a person	:	658				
	Airway Pressure CPAP is a treatme to keep your brea It involves using a mask or other dev your nose and mo mask, a tube that machine 's motor the tube. CPAP is breathing disorde may be used to tr underdeveloped li CPAP over other apnea, your insura device company t	ent that uses mild air pressure thing airways open. a CPAP machine that includes a vice that fits over your nose or outh, straps to position the connects the mask to the r, and a motor that blows air into s used to treat sleep-related rs including sleep apnea. It also eat preterm infants who have ungs. If your doctor prescribes creatment options for your sleep ance will work with a medical o provide you with a CPAP disposable mask and tube.						
	Your doctor will se pressure settings while, your doctor company will wan your machine to c CPAP device and pressure settings eliminate apnea e information was o https://www.nhlbi. 4. The facility staf of fluid consumed physician ordered	et up your machine with certain After using your machine for a and possibly your insurance t to check the data card from onfirm that you are using your to see if the machine and its are working to reduce or vents while you sleep." This btained from the website: nih.gov/health-topics/cpap I failed to document the amount while Resident #70 was on a						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	j	05	/ 25/20 18	
NAME OF PROVIDER				STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
limited depress The m day as referer having interview was confirmed with the reference of t	8 with diagnate: muscle was and high ost recent Massesment, was careful of scored a 15 ew for mental ognitively into sident was of the resident was cativities of the resident of the May ented, "Fluid eters)/day." If of the May stration received a 1800 cares' initials ented evident consumed of the May ented evident consumed of the May ented evident consumed of the May ented evident consumed or the May ented evident	oses that included but were not weakness, bipolar disorder (1), gh blood pressure. IDS (minimum data set), a 14 with an ARD (assessment 4/24/18 coded the resident as 5 out of 15 on the brief al status indicting the resident act to make daily decisions. Coded as requiring assistance daily living except for eating could perform after the tray Ident's care plan initiated on d., "Focus. (Name of resident) estriction." 2018 physician's orders d. Restriction 1800cc (cubic 2018 medication ord (MAR) documented, "Fluid Aday." There were check marks on each shift. There was no nace of the amount of fluid the d. 2018 nurse's notes did not nace of the amount of fluid the d. conducted on 5/25/18 at 9:36 nsed practical nurse) #8.	F	358			
when a	ı resident wa	the process staff followed as on a fluid restriction, LPN #8 estriction should be on the		•			

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

A95240 NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB (X4) ID SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407 ID PROVIDER'S PLAN OF CORRECTION	/25/2018	
V. 7		
	(X5) COMPLETION OATE	
MAR (medication administration record) for the nurses to indicate how much is given each shift per department." When asked if staff were to document the actual amount the resident consumed, LPN #8 stated, "Yeah." When asked why it was important to keep track of the intake, LPN #8 stated, "The doctor has them on a restriction for a purpose and we have to be able to monitor it." LPN #8 was asked to review Resident #70's May 2018 MAR. When asked how staff or the physician know how much fluid the resident had consumed, LPN #8 stated, "You cant." An interview was conducted on 5/25/18 at 9:45 a.m. with LPN #3. When asked how staff track the volume of fluid consumed if a resident was on a fluid restriction, LPN #3 stated, "It's calculated by the dietitian." When asked where this information was documented, LPN #3 stated, "It usually pops up on the MAR or the TAR (treatment administration record) and it asks for the input and we put it in." When asked if it is important to document the residents input, LPN #3 stated, "Yes, it's following the doctor's orders." LPN #3 was asked to review Resident #70's MAR/TAR. When asked how staff or the physician know if the resident was staying within the fluid restriction, LPN #3 stated, "I don't see it documented. It should it be documented." On 5/25/18 at 1:20 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. When asked what professional standards they used, ASM #2 stated, "Lippincott." Review of the facility's document titled, "DOCUMENTATION" documented."		

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 135 of 223

RECEIVED
JUN 18 2018
VDH/OLC

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DATE
F 684	complete record of tool for communical members. Accurate extent and quality of the outcomes of that education that the properties of the education that the properties of the education that the properties of the education that the properties of the education that the properties of the education that the properties of the education that knowledge, skills, a professional nursing. No further information. In the education of the edu	che process of preparing a a patient's care and is avital tion among health care team a, detailed charting shows the f the care that nurses provide at care and treatment and patient still needs. valuable method for the nurse has applied nursing and judgment according to g standards." on was obtained prior to exit. Bipolar disorder is a serious on was obtained prior to exit. Bipolar disorder is a serious on who have it go through the sees. They go from very tive to very sad and hopeless, a, and then back again. They moods in between. The up hia. The down feeling is ormation was obtained from: gov/bipolardisorder.html	F 6		
	practice, the compre care plan, and the ra This REQUIREMEN by:	ofessional standards of ehensive person-centered esidents' choices. IT is not met as evidenced ion, resident interview, staff			
			•	÷	

OLIVIL	NOT ON MEDICATE	A MEDIO/ (ID CETAVICE)				T	0000 0001		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495240	B. WING			05/	25/2018		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
	LOKODUDO UE ALTU	AND DELIAD		3900 PLANK ROAD					
FKEDER	ICKSBURG HEALTH	AND REHAB		F	REDERICKSBURG, VA 22407				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(X5) COMPLETION		
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		X (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 684	Continued From pa	ge 136	E (884 ⁻	1. Resident # 9 medication orders	were			
. 001	· •	cument review, and clinical	Γ,		clarified by physician on 5/25/18 t	o be	· :		
		is determined the facility staff		:	administered by mouth. RP made				
		t five of 37 residents in the			aware. Resident # 9's Tylenol				
		sidents #9, #11, #15, #19, and		i	medication order was clarified by		:		
#95), received treatr with professional sta		ment and care in accordance			physician on 5/25/18. MD/RP noti	find			
		andards of practice, and the			of Resident #11's wound care	Heu	:		
	comprenensive per	son-centered care plan.			interventions not followed as orde	orod			
	1. a. The facility sta	ff failed to administer Resident			on 6/14/18. MD notified of Reside				
		er the route ordered by the			15 wound care interventions not	3NL#			
	physician.			İ					
	1 h The facility sta	ff failed to administer Tylenol			followed as ordered on 6/14/18.		!		
		der for Resident #9.			MD/RP notified of Resident #19s v	_			
					not obtained as ordered on 6/14/ MD/RP notified of Resident #95	10.			
	2. The facility staff f the physician order	ailed to apply a dressing per			interventions for no shoe to right	foot			
	the physician order	Tot resident #11.		i	•				
		aff failed to change a dressing der for Resident #15.			not followed as ordered on 6/14/3	10.	:		
	her are hardered				2. Residents residing in facility are	at	i		
:		ff failed to follow the physician on of elevated blood sugars for		:	risk for the same deficient practic				
	Resident #15.			:	3. DON/designee will re-educate				
	4. The facility staff fa	ailed to obtain Resident #19's			nursing staff to ensure treatment	and			
		4/24/18 through 5/9/18, per			care is provided in accordance wit		i :		
	physician's order.				professional standards of practice				
	E The feelity stoff f				6/24/18. Education will include	٠,			
:		ailed to follow Resident #95's no shoe to the right foot.		:		on of			
;	pyo.o.a o.ao. 101 1	is one to the right root.			clarifying physician orders, provision of wound care, treatments, and				
	The finalty ! ! !	-			interventions per orders, notificat	ion of			
	The findings include):			physician of call parameters, and	.5.101			
	1. a. The facility stat	ff failed to administer Resident			monitoring weights. DON/design	ee will			
;	#9's medications per the route ordered by the			:	review 24 hour report in morning				
	physician.				· · · · · · · · · · · · · · · · · · ·				
priyololari.				meeting and afternoon stand dow	/11				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05/2	25/2018
	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION OATE
	with diagnoses that to: dementia, contra Parkinson's disease disorder characteriz gait, stooped postu fingers, drooling an with emotional insta and adult failure to termed "failure to the consisting of weigh poor nutrition, and i by dehydration, depimmune function, a Failure to thrive occurs in bleading to impaired	ge 137 Imitted to the facility on 5/5/17 Included but were not limited actures, feeding tube, anemia, e (a slowly progressive zed by resting tremor, shuffling re, rolling motions of the d must weakness, sometimes ability (1)), insomnia, asthma, thrive (a geriatric syndrome urive" has been described, t loss, decreased appetite, nactivity, often accompanied oressive symptoms, impaired and low serum cholesterol. Toth acute and chronic forms, functional status, morbidity sure sores, and increased	F 684	meeting. In addition, a 24 hour charcheck will be completed by 11-7 shand any changes needed will be veat that time. A random audit of medication and treatment orders veat completed 3 x week x 4 weeks be DON/designee to ensure orders are followed as indicated. DON/design will residents on weekly and month weights to ensure care plan and/or physician order is being followed and/or documentation to support weights were not obtained. Audits be completed during weekly weigh meetings.	ift rified vill by e nee nly why	
	assessment, a sign with an assessmen coded the resident (brief interview for r she was moderately daily decisions. The totally dependent up members for all of the Section K - Nutrition coded as having be mechanically altere resident was coded her nutrition via the The physician order "Metoprolol Tartrate"	os (minimum data set) ificant change assessment, t reference date of 3/2/18, as scoring a "9" on the BIMS mental status) score, indicating y impaired to make cognitive e resident was coded as being on one or more staff mer activities of daily living. In n/Swallowing, the resident was th a feeding tube and a d diet. Under K0710, the as receiving 25% or less of artificial route (feeding tube). Tablet (used to treat high 50 mg (milligrams); give 1		4. Results of audits will be reviewed monthly QAPI meeting. Trends identified will be addressed immediately and re-education provas needed.		6/26/18
! !		50 mg (milligrams); give 1 gastrostomy tube otherwise				į

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495240	B. WING		0	5/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPRÖPRIATE	(X5) COMPLETION OATE	
F 684	related to hyperter Pravachol Tablet 2 cholesterol and trig G-tube one time a The physician order documented, "Aml to treat high blood (5)), Give 1 tablet or related to hyperter The physician order "Carbidopa-Levode Parkinson's diseas via G-tube three time. The physician order "Baclofen Tablet (uthe body (7)) 10 m 8 hours for spasms. The physician order "Thera-M Tablet (no give 1 tablet by mosupplement. Do not endoscopic gastrosco	g tube (14)) two times a day sion (high blood pressure). O mg (used to treat elevated glycerides (4)); Give 20 mg via day." ers dated, 5/25/17, odipine Besylate Tablet (used pressure and heart disease via G-tube one time a day sive." er dated, 5/26/17, documented, opa Tablet (used to treat se (6)) 25-100 mg; give 1 tablet mes a day." er dated, 6/16/17, documented, ised to relax certain muscles in g, Give 5 mg via G-tube every 3." er dated, 9/27/17, documented, buttiple vitamins and minerals); buth one time a day for out give in PEG (Percutaneous stomy feeding (14)) tube." er dated, 10/2/17, documented, and to treat gastroesophageal via PEG-tube at bedtime ophageal reflux disease."	F 6	84			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05	/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		3900 PL	ADDRESS, CITY, STATE, ZIP CODE ANK ROAD RICKSBURG, 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 CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION OATE	
F 684	antioxidant. It is impand connective tiss helps the body absorbed give 1 tablet by more supplement." The physician orde "Remeron Tablet (Magnession (11)) Gibedtime related to a The physician order "Ferrous Sulfate Lic milliliter); (used to the (12)), Give 220 mg related to anemia." The comprehensive and revised on 5/17 "Focus: (Resident # imbalanced nutrition flushes only." An interview was copractical nurse) #4 #4 was asked how medications. LPN #4 by mouth but we still above were reviewed.	*	F6	84				
	#4 was asked how receiving all of her r #4 stated, "One to t asked if the physicia should coincide with being administered."	ong the resident had been medications by mouth. LPN wo months." LPN #4 was an orders for medications are LPN #4 stated, "Yes." When is need to be clarified, LPN #4						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	5/25/2018	
	PROVIDER OR SUPPLIE		1	STREET ADDRESS, CITY, STATE, 3900 PLANK ROAD FREDERICKSBURG, VA 22	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		T)ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE	
F 684	conducted with ac (ASM) #3, the nur asked how Resid ASM #3 stated, orders above wer ASM #3 confirme instructed for med feeding tube and documented by murse LPN #4 sta #9's medications need to clarify the The facility policy, documented in paappears inapprop	9 p.m. An interview was dministrative staff member ree practitioner. ASM #3 was ent #9 receives her medications. Through her PEG tube." The reviewed with ASM #3, and d that half the medication orders dications to be given via the half the medication orders nouth. ASM #3 was informed the ted she gives all of Resident by mouth, ASM #3 stated, "We	F 6	684			
	order that is uncled. The administrator concerns on 5/24/ No further information References: (1) Barron's Diction Non-Medical Reactions.	th the prescriber any medication ear or seems inappropriate." (13) was made aware of the above /18 at 5:26 p.m. ation was provided prior to exit. onary of Medical Terms for the der, 5th edition, Rothenberg and					
	Chapman, page 4 (2) This information following website: https://grants.nih.square.	37. on was obtained from the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	i		0:	5/25/2018
	PROVIDER OR SUPPLIER			3900	EET ADDRESS, CITY, STATE, ZIP CODE) PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 684	following website: https://www.ncbi.n T0011186/?reports (4) This information following website: https://dailymed.nl m?setid=897AD8I 2A2DA. (5) This information following website: https://www.ncbi.n T0008948/?report (6) This information following website: https://dailymed.nl m?setid=abff005f (7) This information following website: https://dailymed.nl m?setid=abff005f (7) This information following website: https://www.ncbi.n T0009200/?report (8) This information following website: https://www.ncbi.n T0010262/?report (9) This information following website: https://dailymed.nl m?setid=af7ef02a 1. (10) This information following website: https://medlineplus (11) This information following website: https://dailymed.nl gXsl.cfm?id=6222	alm.nih.gov/pubmedhealth/PMH edetails. In was obtained from the im.nih.gov/dailymed/drugInfo.cf im. and obtained from the im.nih.gov/pubmedhealth/PMH edetails. In was obtained from the im.nih.gov/dailymed/drugInfo.cf im. and obtained from the im.nih.gov/dailymed/drugInfo.cf im. and obtained from the im.nih.gov/pubmedhealth/PMH edetails. In was obtained from the im.nih.gov/pubmedhealth/PMH edetails. In was obtained from the im.nih.gov/pubmedhealth/PMH edetails in was obtained from the im.nih.gov/dailymed/drugInfo.cf im. and obtained from the im.nih.gov/dailymed/drugInfo.cf im. and obtained from the im.nih.gov/dailymed/fda/fdaDru im. and obtained from the im.nih.gov/dailymed/fda/fdaDru im. and obtained from the im.nih.gov/dailymed/fda/fdaDru im. and obtained from the im.nih.gov/dailymed/fda/fdaDru	F	384			

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		495240	B. WING	i		05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE
F 684	m?setid=a017eb78 a1 (13) This information Fundamentals of N Williams & Wilkins, (14) This information website: https://medlineplus. 1. b. The facility state per the physician order "Acetaminophen Tafever and mild pain PEG-tube (Percutal gastrostomy or feed needed for fever ov (Fahrenheit). Take the via peg tube for fever the April 2018 med (MAR) documented mg; give 2 tablets via peg tube for fever ov tablets to equal 650 over 100 degrees F4/1/18 as having be The nurse's note dadocumented, "Resident in chair." The sident in chair." The sident in chair." The resident in chair." The content of the con	n.nih.gov/dailymed/drugInfo.cf -8c70-4b59-b7c0-22ec6945c1 on was obtained from ursing, 5th edition, Lippincott, page 553. on was obtained from the gov/ency/article/002937.htm If failed to administer Tylenol der for Resident #9. I dated, 5/25/17, documented, blet (Tylenol - used to treat (1)) 325 mg; give 2 tablets via neous endoscopic ding tube (2)) every 4 hours as	F	684			

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

• • • • • • • • • • • • • • • • • • • •		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	S	05	5/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5 COMPLETION DATE	
F 684	The comprehensive revised 5/17/18, do Needs pain manag to contractures and history of compress "Interventions" door pain medications at On 5/24/18 at 2:13 conducted with LPN LPN #4 was asked Tylenol. When asked be administered pe "Every four hours for medication was docadministered by a reverse of the comprehensive section of the comprehensive section was docadministered by a reverse of the comprehensive section of the	re care plan dated, 5/9/17 and ocumented in part, "Focus: gement and monitoring related d muscle spasms, wounds, sion fractures." The cumented in part, "Administer	F	684			
	staff member (ASN 5/24/18 at 3:20 p.m Tylenol documenter fever, is the nurse a #3 stated, "If it's ord supposed to be given." The facility policy, "documented in part shall specify the cobeing administered pain." The dose mu example, '1 tablet for moderate pain."	"Medication orders" tt, "3. PRN (as-needed) orders ondition for which they are tt, for example, 'as needed for ust also be specified, for for mild pain or 2 tablets for was made aware of the above					
: :	·	tion was provided prior to exit.	: :			·	

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 144 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	5/25/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From բ	page 144	: F6	884		:
	following website: https://dailymed.n gXsl.cfm?setid=1 0ecfb7 (2) This informatic following webiste: https://medlineplu 2. The facility staf the physician orde Resident #11 was 2/5/15 with a reac diagnoses that incend stage renal d procedure used in are removed from	Im.nih.gov/dailymed/fda/fdaDru 622f694-4d63-4c56-8737-fae31f on was obtained from the s.gov/ency/article/002937.htm If failed to apply a dressing per er for Resident #11. If admitted to the facility on Imission on 12/21/17 with cluded but were not limited to: isease requiring hemodialysis (an which wastes and impurities in the blood by a special ression, dementia, high blood				
	assessment, a sig with an assessme coded the resider (brief interview for the resident was of decisions. Reside extensive assistant most of her activity. The comprehensi documented in paralteration in skin it to occasional bow.	MDS (minimum data set) gnificant change assessment, ent reference date of 2/27/18, at as scoring a "15" on the BIMS mental status) score, indicating cognitively intact to make daily nt #11 was coded are requiring nce of one staff member for ties of daily living. In we care plan dated, 4/2/18, art, "Focus: I am at risk for integrity/pressure ulcers related well and bladder incontinence and the with bed mobility, history of				

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 145 of 223

RECEIVED
JUN 18 2018
VDH/OLC

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING	;		05/:	25/2 018
	PROVIDER OR SUPPLIER			39	TREET ADDRESS, CITY, STATE, ZIP CODE 900 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE
F 684	time." The "Intervel "Treatments as ord	have shear wounds at this ntions" documented in part, dered."	Fé	684			
	On 5/23/18 at 4:21 p.m., Administrative staff member (ASM) #4, the wound care doctor, accompanied this writer and an observation of the wound on Resident #11's right upper buttock was conducted. The wound was described as a "shear" wound and not a pressure ulcer. The area was .9 cm (centimeters) by .5 cm. The dressing removed from the wound by ASM #4 was a hydrocolloid dressing. The hydrocolloid dressing was in the shape of a butterfly and covered both sides of the buttocks. ASM #4 stated he didn't think he had ordered that kind of dressing. There was no date on the dressing. After the wound care, ASM #4 reviewed his orders for the wound, and stated he had not ordered the hydrocolloid dressing but had ordered medi-honey and a protective dressing.						
	"Right Upper Buttoo saline), apply medi- honey used to treat (2), cover with dry p	er dated, 5/18/18, documented, ck; cleanse with NS (normal -honey (a certified medical t wounds and inhibit infections) protective dressing, three days ening shift every Mon, Wed,					
	nurse practitioner, of asked if applying a ordered could caus	onducted with ASM #3, the on 5/25/18 at 9:43 a.m. When dressing to a wound that is not se any problems, ASM #3 fect the healing of the wound."	:				
 	5/25/18 at 10:15 a.i	onducted with ASM #4 on m. When asked if having the the wound could affect the		:			: : :

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING		05	05/25/2018	
	PROVIDER OR SUPPLIE		•	STREET ADDRESS, CITY, STATE, 3900 PLANK ROAD FREDERICKSBURG, VA 22	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG			(X5) COMPLETION DATE	
F 684	say yes, but in thi as good as the man as good as the man as good as the man as good as the man as good as the man as good as the man as good as the man as good as the man as good as	stated, "If any other case, I would s case it was okay. It was just edi-honey that I had prescribed." "Skin Program" documented in with wounds will have ment. If there is deterioration or ound within 2 weeks, the changed." ing changes was requested from etor of nursing on 5/25/18 at 15 p.m. The ASM #1 and the director of were made aware of the above 18 at 1:10 p.m. ation was provided prior to exit. Conary of Medical Terms for the der, 5th edition, Rothenberg and 266. The control of the state of the der, 5th edition, Rothenberg and 266. The control of the state of the der, 5th edition, Rothenberg and 266. The control of the derector of the der, 5th edition, Rothenberg and 266. The control of the derector of the der, 5th edition, Rothenberg and 266. The control of the derector of		384			
	Resident #15 was 4/6/16 with a recediagnoses that indiabetes (a compostabolism due e	staff failed to change a dressing order for Resident #15. s admitted to the facility on ent readmission on 4/27/17, with cluded but were not limited to: lex and chronic disorder of either to partial or total lack of by the pancreas or to the inability					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	05/25/201 8	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 224	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE	
	COPD (chronic of general term for disease that is us emphysema and blood pressure, hwalking. The most recent lassessment, an assessment refer resident as scoring interview for mentis capable of mak Resident #15 was	coage 147 con normally in the body) (1), bistructive pulmonary disease chronic nonreversible lung ually a combination of chronic bronchitis]) (2), high eart failure, pain, and difficulty MDS (minimum data set) annual assessment, with an ence date of 2/27/18, coded the eg a 15 on the BIMS (brief tal status) score, indicating she ing cognitive daily decisions. Is coded as requiring supervision ance for all of her activities of	F6	84			
	on 5/23/18 at 10:4 resident's foot wa was interviewed at the dressing is su day but it's not do her she would retibut never came be she has had the tand the callus on "Left heel cleansed dry, apply silver hintended for the morovide an antimic (dressing) daily ex Second toe - clea medi-honey (a ce	made of Resident #15's left foot 41 a.m. The dressing on the s dated 5/21/18. Resident #15 at this time. The resident stated pposed to be changed every ne every day. The nurse told urn to do the dressing last night ack. Resident #15 stated that oe wound for over four years the heel has split open. Hers dated, 3/20/18 documented, with NS (normal saline). Pat ydrogel (Hydrogel Dressing is nanagement of wounds and to crobial barrier (3)) and dry dsg very evening shift. Left plantar nse with NS, pat dry, apply rtified medical honey used to inhibit infections (4)) and dry					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05/25/2018	
	PROVIDER OR SUPPLIER			3900	ET ADDRESS, CITY, STATE, ZIP CODE PLANK ROAD DERICKSBURG, VA 22407	Ē	
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
F 684	Continued From pa	age 148	F				
		R (treatment administration ed the dressing had been red on 5/22/18.		•			
	revised on 3/7/18, have the potential to: diabetes, obesit	e care plan dated, 6/21/17 and documented in part, "Focus: I for impaired skin integrity due by, recurring edema to bilateral have altered skin integrity with s and heels." The					
:	"Interventions" doc as ordered."	umented in part, "Treatments	! !				:
	practical nurse) #1 the wound as compat 4:55 p.m. When dressing on 5/22/1 off I did it." The obs 5/23/18 with the da LPN #1. LPN #1 st calling the nurse w me. I told the resid dressing. I guess I asked why she woo	onducted with LPN (licensed, the nurse who documented bleted on 5/22/18, on 5/24/18 asked if she completed the 8, LPN #1 stated, "If I signed it servation of the dressing on the of 5/21/18 was shared with ated, "I got distracted. I was ho was supposed to relieve ent I would be back to do the never went back." When all document that she did the e did not do it, LPN #1 stated,					
	5/24/18 at 5:11 p.m dressing is ordered the wound treatme "You have between get it done." When cannot complete the	onducted with LPN #5 on i. LPN #5 was asked if a if every evening, when it should int be done. LPN #5 stated, ii 3:00 p.m. and 11:00 p.m. to ii asked what staff do if they iie dressing change, LPN #1 it on to the next shift and don't					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	member) #1 and the were made aware 5/25/18 at 1:10 p.m. No further informa. (1) Barron's Diction Non-Medical Read Chapman, page 16 (2) Barron's Diction Non-Medical Read Chapman, page 12 (3) This information following website: https://dailymed.nligXsl.cfm?setid=91 7a6b09e1. (4) This information following website: obtained from the following website:	ASM (administrative staff ne director of nursing, ASM #2 of the above concern on n. tion was provided prior to exit. mary of Medical Terms for the er, 5th edition, Rothenberg and 33. mary of Medical Terms for the er, 5th edition, Rothenberg and 24. In was obtained from the m.nih.gov/dailymed/fda/fdaDru 244d66-ed63-4a70-a1ce-e2b7 In was obtained from the (2) This information was	F6	84			
	orders for notificati Resident #15. Resident #15 was 4/6/16 with a recendiagnoses that includabetes (a complementabolism due either insulin secretion by of insulin to function	aff failed to follow the physician on of elevated blood sugars for admitted to the facility on it readmission on 4/27/17, with uded but were not limited to: ex and chronic disorder of ther to partial or total lack of the pancreas or to the inability in normally in the body) (1), structive pulmonary disease					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING			()5/25/2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDER) CKSBURG, VA 22407				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
F 684	disease that is usue emphysema and oblood pressure, he walking. The most recent Massessment, an an assessment refere resident as scoring interview for mentalis capable of making Resident #15 was with set up assistated adults and children inject as per sliding 199 = 6 unit, less thypoglycemic protection as per sliding 199 = 6 unit, less thypoglycemic protection; 200 - 249 MD, 250 - 299 = 16 350 - 399 = 14 unit 500 = 20 units., suat bedtime related underlying condition complications. Cargreater than 400, problems (blood sugar) and insulin coverage."	chronic nonreversible lungually a combination of chronic bronchitis]) (2), high eart failure, pain, and difficulty and difficulty and difficulty assessment, with an ence date of 2/27/18, coded the gal 15 on the BIMS (briefied status) score, indicating sheing cognitive daily decisions, coded as requiring supervision ance for all of her activities of a dated, 11/10/17, malog Solution Insulin Lisprospid acting human insuling improve glycemic control in with diabetes mellitus. (3)) giscale if (blood sugar) 150 - han 70 = 0 units, Follow occloud call MD (medical = 8 units, greater than 500 call 0 units, 300 - 349 = 12 units; ts, 400 - 450 = 16 units, 451 - bcutaneously before meals and to diabetes mellitus due to on with unspecified II MD if less than 70 and patient may check her BS report number to staff for	F6	84			
	record) documente Lispro, inject as pe	ed, "Humalog Solution Insuliner sliding scale if (blood sugar) less than 70 = 0 units, Follow					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05/25/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 224	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE	
F 684	units, greater than units, 300 - 349 = 400 - 450 = 16 units subcutaneously be related to diabetes condition with uns MD if less than 70 may check her BS insulin coverage." blood sugars were 4/2/18 at 9:00 p.m 4/4/18 at 6:30 a.m 4/8/18 at 9:00 p.m 4/11/18 at 9:00 p.m 4/11/18 at 9:00 p.m 4/21/18 at 9:00 p.m 4/22/18 at 9:00 p.m 4/25/18 at 9:00 p.m 4/29/18 at 9:00 p.m	ocol and call MD; 200 - 249 = 8 500 call MD, 250 - 299 = 10 12 units; 350 - 399 = 14 units, ts, 451 - 500 = 20 units., efore meals and at bedtime mellitus due to underlying pecified complications. Call and greater than 400, patient and report number to staff for Resident #15's documented as follows: . = 419 . = 412 . = 423 m. = 422 n. = 423 m. = 425 m. = 431 n. = 445 n. = 446	F	584			
	to evidence any do	ocumented notification to the ecorded blood sugars				· · · · · · · ·	
	Solution Insulin Lis if (blood sugar) 15 0 units, Follow hyp MD; 200 - 249 = 8 MD, 250 - 299 = 14 350 - 399 = 14 unit 500 = 20 units., su	R documented, "Humalog spro, inject as per sliding scale 0 - 199 = 6 unit, less than 70 = oglycemic protocol and call units, greater than 500 call 0 units, 300 - 349 = 12 units; ts, 400 - 450 = 16 units, 451 - bcutaneously before meals and to diabetes mellitus due to an with unspecified					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		0	5/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 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 CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	greater than 400, p report number to st Resident #15's doc as follows: 5/1/18 at 9:00 p.m. 5/4/18 at 4:30 p.m. 5/5/18 at 9:00 p.m. 5/10/18 at 9:00 p.m. 5/10/18 at 9:00 p.m. 5/15/18 at 11:30 a.r. 5/15/18 at 9:00 p.m. Review of the nurse to evidence any doc physician for the re- documented above The comprehensive revised on 3/7/18, of am at Risk for Meta Diabetes Mellitus. hyperglycemia at tir documented in part	I MD if less than 70 and atient may check her BS and aff for insulin coverage." umented blood sugars were = 455 = 485 = 421 i. = 414 i. = 417 i. = 437 ii. = 439 ii. = 439 ii. = 439 iii. = 439 iii. = 449 iii. = 460 cumented notification to the corded blood sugars iii. = 42/16 and documented in part, "Focus: I abolic Complications due to:	F6				
	(as needed) for cha of clinical signs or s assist or complete I (glucometer machin sugar readings to m show nursing the re	ange in condition/manifestation symptoms. Resident may ner own accuchecks ne used for obtaining blood nonitor blood sugars) and sults. Observed for high blood ncreased thirst, increased					
i	practical nurse) #4	onducted with LPN (licensed on 5/24/18 at 2:21 p.m. LPN ove order for Humalog insulin.					

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		· · · · · · · · · · · · · · · · · · ·	05	/25/2018
	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 Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 684	if the resident's block LPN #4 stated, "We doctor/nurse practists staff document that should be in the number of the following practitioner; on 5/2 reviewed the physic Humalog insulin slig asked what is the number of the following the doctor." When a notify the doctor of #3 stated, "I would the doctor." When a notify the doctor of #3 stated, "I would elevated blood suggeomplications." The administrator, the above concern No further information. Non-Medical Reade Chapman, page 16 (2) Barron's Diction Non-Medical Reade Chapman, page 12 (3) This information following website:	staff should do, per the order, od sugar is greater than 400, e should notify the tioner." When asked where notification, LPN #4 stated, "It rse's notes." Inducted with ASM fmember) #3, the nurse 4/18 at 3:22 p.m. ASM #3 cian order above for the ding scale. ASM #3 was then urses should do when the gar is greater than 400, ASM expect them to notify me or asked why it is important to elevated blood sugars, ASM need to adjust her insulin and ars can cause medical ASM #1 was made aware of on 5/24/18 at 5:26 p.m. on was provided prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and 3. ary of Medical Terms for the er, 5th edition, Rothenberg and 4. I was obtained from the	F	584			
	m?setid=c8ecbd7a-4. The facility staff f	n.nih.gov/dailymed/drugInfo.cf -0e22-4fc7-a503-faa58c1b6f3f ailed to obtain Resident #19's 4/24/18 through 5/9/18, per					;

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 154 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		0;	5/25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
	3/17/17. Resident were not limited to major depressive Resident #19's moset), an annual assessment refer resident's cognitive decision-making a coded Resident #1 five percent or more in Review of Residert a physician's order weights. Resident plan dated 3/24/17 Resident #19) is a (related to) dx (dia (2) for nutrition & h	admitted to the facility on #19's diagnoses included but Huntington's disease (1), disorder and high cholesterol. It is trecent MDS (minimum data sessment with an ARD ence date) of 3/6/18, coded the eskills for daily severely impaired. Section K 19 as having a weight gain of the last six month or ten the last six months. In #19's clinical record revealed and dated 2/22/18 for weekly #19's comprehensive care of documented, "(Name of the trisk for imbalanced nutrition r/tagnosis) dependence on PEG and and the property of the six of th	F 6	684		
:	weight obtained or	nt #19's weights revealed a n 4/24/18 was 130.2 pounds. as not obtained until 5/9/18 (15 s 133.8 pounds.				
	conducted with LP LPN #4 was asked weekly weights shatted the unit man weights when they When asked to clashould be obtained	s p.m., an interview was N (licensed practical nurse) #4. If when physician ordered ould be obtained. LPN #4 nager's hand out weekly are due and it is within a week. It is within a week within seven days or sooner. In Resident #19's physician				

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		0:	5/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, 3900 PLANK ROAD FREDERICKSBURG, VA 22	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	weights documente another weight shot between 4/24/18 at 5:53 staff member) #1 (the director of nursabove concern. The facility documente Resident' documente residents of the fact admission and more by the physician or committee." No further informated the fact and in the waste away defective gene, but appear until middle may include unconclumsiness, and bacan take away the swallow. Some permembers. Others and are able to expinformation was obhttps://vsearch.nlmmeta?v%3Aproject medlineplus-bundle ase&_ga=2.232040-139120270.14779	eights and shown the resident's ed above. LPN #4 confirmed uld have been obtained and 5/9/18. p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the ented, "At a minimum, all ility shall be weighed upon athly unless ordered otherwise as directed by the weight ion was presented prior to exit. sease (HD) is an inherited as certain nerve cells in the y. People are born with the symptoms usually don't age. Early symptoms of HD trolled movements, lance problems. Later, HD ability to walk, talk, and ople stop recognizing family are aware of their environment ress emotions." This tained from the website: .nih.gov/vivisimo/cgi-bin/query=medlineplus&v%3Asources=e&query=huntington%27s+dise 1607.1046050702.1527592979 42321	F 6	584			
		percutaneous endoscopic codure in which a flexible		:			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	li in			
		495240	B. WING	- 111.		05/25/2018	/25/2018	
	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 PREFII TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			ON	
F 684	and into the stoma and/or medications stomach, bypassin This information wa	ced through the abdominal wall ch. PEG allows nutrition, fluids to be put directly into the g the mouth and esophagus." as obtained from the website: rg/home/for-patients/patient-inf		84				
	physician order for Resident #95 was a 7/12/17. Resident were not limited to difficulty swallowing MDS (minimum dawith an ARD (asses 3/1/18, coded the rimpaired. Section requiring extensive bed mobility, locom Review of Resident a physician's order documented, "No s Resident #95's May treatment administreatment administreatment administreatment administreatment was 0.5 ce centimeters (width)	choe to Right Foot every shift." y 2018 eTAR (electronic ration record) documented, Foot every shift." e wound care physician on a wound on the right second ntimeters (length) by 0.6 The note documented a d a recommendation to						
	Resident #95's com	inrehensive care plan dated						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
495240 B. WING	05/25/2018
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD 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 APPROPRIATION DEFICIENCY)	
Continued From page 157 2/14/18 documented, "(Name of Resident #95) is at risk for ALTERATION IN SKIN INTEGRITY/PRESSURE ULCERS due to: Assistance required in bed mobility, Bowel incontinence. Obesity. (Name of Resident #95) has open areas to lower extremities r/t (related to) traumaInterventions: No shoe to right foot" On 5/23/18 at approximately 8:15 a.m., 5/23/18 at approximately 11:00 a.m. and 5/24/18 at approximately 8:45 a.m., Resident #95 was observed in a wheelchair in the bedroom. A shoe was observed on the resident's right foot. A sign on Resident #95). NO Shoe to Right Foot." On 5/24/18 at 3:09 p.m., an interview was conducted with CNA (certified nursing assistant) #1 (the CNA caring for Resident #95). CNA #1 was asked if Resident #95 had any footwear restrictions. CNA #1 stated, "He's not supposed to have a shoe on his right foot." When asked why, CNA #1 stated, "He's not supposed to have a shoe on Resident #95's right foot this morning. CNA #1 stated she put a shoe on the resident's foot as a safety precaution while transferring the resident with a sit to stand lift and forgot to remove the shoe. CNA #1 was made aware this surveyor observed a shoe on Resident #95's right foot during the previous morning. CNA #1 stated she put a shoe on the resident's foot as a safety precaution while transferring the resident with a sit to stand lift and forgot to remove the shoe. CNA #1 was made aware this surveyor observed a shoe on Resident #95's right foot during the previous morning. CNA #1 stated she thought the restorative staff also puts a shoe on the resident's foot to complete exercises. On 5/24/18 at 3:53 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked why Resident #95 had a physician's order for no shoe to the right foot.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 684	toes and the thoug irritating his toes. It was supposed to his when sitting in the resident should have as opposed to a harmonic of the second	ident #95 had scrapes on his nt was that his shoes were When asked if Resident #95 ave a shoe on the right foot wheelchair, LPN #4 stated the ve a slipper sock or soft slipper	F 68	84		
	Free of Accident HacCFR(s): 483.25(d)(§483.25(d) Accident The facility must en §483.25(d)(1) The facility must en free of accident \$483.25(d)(2)Each supervision and assaccidents. This REQUIREMENT by: Based on observation document review at was determined that ensure an environment of the facility of	azards/Supervision/Devices 1)(2) uts.	F 68	1. Resident #37 is discharged from facility. Resident #46 was re-asse for hot liquids and plan of care up with appropriate interventions. Maintenance director removed the commercial power strip from Resident #35 no longer resides at facility. Maintenance director repaired West 1 shower redoor on 5/25/18. 2. Residents residing in facility are for the same deficient practice.	ssed dated e dent # 5 was enance oom	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		SURVEY PLETED
		495240	B. WING		05/3	25/2018
	PROVIDER OR SUPPLIER		3	TREET ADDRESS, CITY, STATE, ZIP CODE 900 PLANK ROAD REDERICKSBURG, VA 22407		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	one of six shower West 1). 1. The facility staff and to supervise the liquids per the hot Resident #37. 2. The facility staff and to supervise the liquids per the hot Resident #46. 3. The facility staff commercial power Resident #51's part 4a. The facility faile in place when Res Resident #35 was occasions with onl of the bed. 4b. The facility staff room door in a man of six shower room The findings included the findings included the side of	is #37, 46, 51 and 35); and in rooms, (the shower room on failed to serve coffee with a lid he resident while drinking hot liquid safety evaluation for failed to serve coffee with a lid he resident while drinking hot liquid safety evaluation for failed to ensure that strips were not in use in tient vicinity. The document that strips were not in use in tient vicinity. The document that strips were not in use in the tient with the strips were not in use in the strips were not in use in the strips were not in use in the strips were not in use in the strips were not in use in the strips were not in use in the strips were not in use in the strips were not in use in the strips were not in use in the strips were not in the strips were not in the strips were not in the strips were not limited to the facility on the strips were not limited to: ession, high cholesterol,	F 689	3. Administrator/designee will restaff on safety standards to ensure residents receive supervision as and the environment is free of achazards. Re-education will include ensuring residents receive super with hot liquids and/or coffee lidicare plan, reporting hazards and needing repair by 6/24/18. Administrator/designee will re-eresidents on safety, including to extension cords or power strips in room during next resident counce meeting. Department Heads and Maintenance director will condurounds daily, Mon — Fri to ensure resident rooms and resident care are free of hazards. Department will observe 5 meals per week for weeks to ensure residents receives supervision and/or devices per power. Issues identified will be addimmediately. 4. Results of audits and rounds we reviewed in the monthly QAPI monthly Trends identified will be address corrective measures put in place.	needed ccident de vision ds per /or areas ducate not use in their cil d cct e areas heads or 4 /e blan of dressed will be neeting. sed and	6/26/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CDRRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY CDMPLETED	
		495240	B. WING		0	5/25/2018
	PRDVIDER OR SUPPLIE			3900 PLANK ROAD	REET ADDRESS, CITY, STATE, ZIP CDDE 00 PLANK ROAD REDERICKSBURG, VA 22407	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TIDN SHDULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From p	page 160	F6	89		
	quarterly assessmereference date) of having scored a sinterview for ment was severely impays as coded as requiring coded as requiring meal tray. An observation was of Resident #37. The breakfast tray	MDS (minimum data set), a nent, with an ARD (assessment 3/20/18 coded the resident as even out of 15 on the brief ral status indicating the resident aired cognitively. The resident uiring assistance for bed and toileting. The resident was g set up assistance with the as made on 5/24/18 at 8:35 a.m. The resident was lying in bed. If was on the over bed table next offee cup was on the tray without				
	10/15/17 docume assessment ident injury while handli Place a check ma resident being assecognitive impairm the resident's peroliquids and safety limited to: altered impairment. 4. Alwas checked). 8. could cause injury is handling hot liquichecked) 1. Cup v	liquid safety evaluation dated nted, "A. Safety Evaluation. This ifies if the resident is at risk for ng and drinking hot liquids. rk if the following apply to the sessed: 1.(box checked) Has a sent or drowsiness that impacts ception and awareness to hot measures including but not comprehension and/or memory tered muscle strength (hands Episodes of behavior which if occurring while the resident uids.(box checked) 11. (Boxes with lid or other adaptive cup. Staff assistance. 4. To drink hot y."				
	10/7/17 did not ev	dent's care plan initiated on idence documentation uid safety plan of care.				

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED 05/25/2018	
		495240	B. WING		05		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 2240	P CODE	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION OATE	
F 689	Continued From	page 161	F 6	89			
	for a resident who risk from hot liqui they are at high ri An interview was a.m. with LPN (licunit manager. Whe developed if a safety risk from h	care plan would be developed by had been assessed as a safety ds, RN #2 stated, "Yes because sk for burns if not supervised." conducted on 5/25/18 at 8:11 tensed practical nurse) #8, the nen asked if a care plan would resident were assessed to be a ot liquids, LPN #8 stated, "Yes." LPN #8 stated to help keep the					
	a.m. with CNA (ce resident's aide. We care a resident not the care plan or the lt'll tell us how the When asked if a conformation if a reliquids, CNA #3 stasked if she had a	conducted on 5/25/18 at 8:20 ertified nursing assistant) #3, the /hen asked how she knew what beded, CNA stated, "We look at the kardex at the nurse's station. By eat, how they ambulate." care plan or kardex would have sident was a safety risk from hot tated, "It should be." When any residents who were a safety, CNA #3 stated, "No."					
	·	ident's CNA kardex did not entation regarding hot liquids					
	member) #1, the	0 p.m. ASM (administrative staff administrator and ASM #2, the g were made aware of the					
	No further informa	ation was provided prior to exit.					
		f failed to serve coffee with a lid the resident while drinking hot		:		:	

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 162 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		495240	B. WING	·		05/	/25/2018
	PROVIDER OR SUPPLIER			39	REET ADDRESS, CITY, STATE, ZIP CODE 100 PLANK ROAD REDERICKSBURG, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 689	Continued From pa liquids per the hot Resident #46.	age 162 iquid safety evaluation for	F (689			
	1/24/13 and readm diagnoses that incl lung disease, anxie muscle weakness.						
	annual assessmen reference date) of having a 14 out of mental status indic cognitively intact to resident was code	DS (minimum data set), an t, with an ARD (assessment 5/15/18 coded the resident as 15 on the brief interview for ating the resident was make daily decisions. The das requiring assistance for all ring. The resident was coded ance with meals.					
	a.m., of Resident # in bed eating break	s made on 5/24/18 at 8:30 46. The resident was sitting up fast. The coffee cup did not ere was no staff in the room.		:			
	the unit where the was in an insulated When asked if this residents on the ur #8, the dietary mar then took the temp	a.m., the food cart arrived on resident resided. The coffee pitcher on top of the cart. was the coffee for all of the lit, OSM (other staff member) ager stated it was. OSM #8 erature of the coffee using a r and the temperature reading fahrenheit.					
	of Resident #46. The bed eating breakfa drinking from a cof	s made on 5/25/18 at 8:01 a.m. ne resident was sitting up in st. The resident was observed fee cup. The cup did not have as no staff in the room.					:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) ,TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 689	Review of the hot li 5/20/17 documente assessment identifinjury while handlin Place a check mar resident being assestrength (hands was or other adaptive crassistance (box cheview of the resid 5/22/17 did not evic regarding a hot lique. An interview was cop.m. with RN (regis coordinator. When developed for a resident as a safety risk from Yes because they supervised." An interview was communicate to the care plans, LPN #8 communicate to the asked if a care plan resident was assess hot liquids, LPN #8 why the resident was iquids, LPN #8 why the resident was assess hot liquids, LPN #8 why the resident	iquid safety evaluation dated ed, "A. Safety Evaluation. This ies if the resident is at risk for g and drinking hot liquids. k if the following apply to the essed: 4. Altered muscle as checked). 11. 1. Cup with lidup. (Box checked) 2. Staff	F6	89		

STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	i	0	5/25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 3900 PLANK ROAD FREDERICKSBURG, VA 224	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	"	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE
	a.m. with CNA (cer resident's aide. When are a resident need the care plan or the lt'll tell us how they When asked if a case information if a resident grand and the care plan or the liquids, CNA #3 states asked if she had an arisk for hot liquids, Review of the reside evidence document precautions. On 5/25/18 at 1:20 member) #1, the addirector of nursing findings. No further information. The facility staff commercial power Resident #51's pat Resident #51 was 2/1/13 with diagnostic staff.	onducted on 5/25/18 at 8:20 rtified nursing assistant) #3, the nen asked how she knew what eded, CNA stated, "We look at e kardex at the nurse's station. eat, how they ambulate." are plan or kardex would have ident was a safety risk from hot ated, "It should be." When ny residents who were a safety CNA #3 stated, "No." dent's CNA kardex did not station regarding hot liquids p.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the tion was provided prior to exit. failed to ensure that a strip was not in use in ient vicinity (1). admitted to the facility on ses that included but were not		689		
	The most recent M an ARD of 4/10/18 15 out of 15 on the status indicating th intact to make daily coded as requiring	e deficit, diabetes, arthritis, and high blood pressure. DS, quarterly assessment with coded the resident as having a brief interview for mental e resident was cognitively decisions. The resident was assistance from staff for all ring except for eating which the	•			

STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CDNSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05	5/25/2018
	PROVIDER OR SUPPLIER			3900 PLANK	RESS, CITY, STATE, ZIP COD ROAD KSBURG, VA 22407		72072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	An observation wa of Resident #51's recommercial power the bed. The reside telephone charger strip. An interview was op.m. with OSM (otherwise) (othe	as made on 5/24/18 at 1:53 p.m. room. The resident had a strip lying on the floor next to ent's refrigerator, television and were plugged into the power conducted on 5/24/18 at 2:34 her staff member) #1, the nance. When asked which we power strips, OSM #1 hen asked the process staff nic equipment or a power strip the facility, OSM #1 stated, "If		889			
	building we are sup asked to observe t #51's room, OSM are are not supposed t (indicating the pow "What we've been and we are upgrad	anything electronic into the pposed to check it." When the power strip in Resident #1 stated, "Some things they to have like that in there ver strip)." OSM #1 stated, doing is taking all of the outlets ling them, that's a room that we skeover on yet. I'm going to					
	p.m. with OSM #9,	conducted on 5/24/18 at 2:40 a housekeeper. When asked h have a power strip, OSM #9 use it's not safe".					i
	p.m. with CNA (cer When asked if a re strip, CNA#1 state CNA#1 stated, "I g	conducted on 5/24/18 at 2:42 rtified nursing assistant) #1. esident could have a power ed, "No." When asked why, guess it could cause fires."					

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING	3	05	05/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 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		SHOULD BE	(X5) COMPLETION DATE	
F 689	"Remove it and let On 5/25/18 at 1:20 member) #1, the addirector of nursing findings. No further informat 1 Patient care vicin Care Facilities (NF patient care area a facility wherein patiexamined or treate be used within these examining, and tresimilar areas in whinto contact with elespecifies that chase exceed 300 microawas increased from microamperes.) Ho exceptions under colleakage currents upermitted if the lear represent a hazard grounding connections is leakage from the area exceeds permits the use of	room, CNA #1 stated, maintenance know." p.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the were made aware of the with the made aware of the standard for Health PA 99), (1) NFPA defines a s'any portion of a health care ents are intended to be d." For equipment intended to be areas-which include patient, atment rooms, as well as any ich the patient is likely to come ectrical devices-NFPA sis leakage currents should not imperes. (Note that this limit in the pre-1993 limit of 100 owever, NFPA does permit ertain conditions; for example, p to 500 microamperes are kage current does not to the patient and if the ion remains intact. Also, when om equipment that will be used as 500 microamperes, NFPA leakage current reduction adding an isolation transformer		689			
٠	requires that any explacement near the requirements. NFP	care area, NFPA further quipment intended for e patient meet additional A refers to the area near the ent care vicinity, which it					

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 167 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` .	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	I	05	/25/2018
	PROVIOER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 3900 PLANK ROAD FREDERICKSBURG, VA 22407	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	IX5) COMPLETION DATE
	the examination a extending 6 ft (1.8 of the bed, chair, the patient [an above the floor." F space, NFPA requirements of the bed, chair, the patient [an above the floor." F space, NFPA requirements of the stricter of the stric	ce, within a location intended for and treatment of patients, and beyond the normal location or other device that supports and vertically to 7 ft 6 in (2.3 m). For equipment to be used in this aires that the resistance we chassis surfaces and a ng point not exceed 0.50 W. If the concept of a patient care entire room would not need to equirement.) This information	F6	689		
	(4). Resident # 35's m set), an annual as (assessment refer Resident # 35 as interview for ment - 15, 2 (two) - beir cognition for maki 35 was coded as in the second sec	ost recent MDS (minimum data sessment with an ARD rence date) of 03/20/18, coded scoring a 2 (two) on the brief al status (BIMS) of a score of 0 ng severely impaired of ng daily decisions. Resident #requiring extensive assistance per for activities of daily living.				

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

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	;_			05/25/2018	
NAME OF	PROVIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
FDEDEE	NOVODUDO UEALTI	LAND DELIAD			3900 PLANK ROAD			
FREDER	RICKSBURG HEALTH	HAND REHAB			FREDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	Continued From p	page 168	F6	689	9			
		10 a.m., an observation of						
		ealed she was lying in her bed.						
		on revealed a fall mat on the					!	
	floor next to right							
		_						
		224 a.m., an observation of						
		ealed she was lying in her bed.						
	floor next to right	on revealed a fall mat on the						
	HOOF HEXT TO FIGHT	side of the bed.					i I	
	On 05/23/18 at ap	proximately 10:28 a.m., a CNA						
		assistant) and a staff member					i I	
		ance department arrived at					:	
		oom. The maintenance staff					i :	
		erved carrying a fall mat. The					!	
		ance staff entered Resident #						
		ced the fall mat down on the e of Resident #35's bed.						
	illoor to the left side	e of Nesident #33's bed.						
	The care plan for	Resident # 35 dated 03/28/18						
		cus: (Resident # 35) is at risk for	:					
		e of antidepressant medication,						
		Alzheimer's Dementia and					1	
		instrates cognitive loss and poor					*	
		. Has history of falls." Under						
		ocumented, "Fall mats at ed. Date initiated: 05/23/18."			•			
	E DEGISIAC WITHOUT D	ca. Bate initiated. 00/20/10.						
	On 05/23/18 at ap	proximately 10:32 a.m., an	:					
		ducted with CNA#10. When	: : :		:			
		lacement of the second fall mat					4	
		rocedure regarding fall mats,						
	:	"When a resident has had a fall						
		re should be two fall mats						
		ide of the resident's bed." a second fall mat was placed					į	
		CNA # 10 stated, "I was asked						
		o fall mats in Resident # 35's					•	
		there never has been. I was						

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 169 of 223

JUN 18 2018
VDH/OLC

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY APLETED
		495240	B. WING			05/	/25/2018
	PROVIDER OR SUPPLIEF			390	REET ADDRESS, CITY, STATE, ZIP CODE 10 PLANK ROAD EDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	then told to go get On 05/23/18 at 1: conducted with LF 3. When asked t use of a fall mat, I has a history of fa fall mat." When a resident receives stated, "I don't kno get back to you." # 3 stated, "The ni specific." On 05/23/18 at 1:4 registered nurse): the procedure for stated, "If the resid don't get out of be independent the m falls." When aske resident receives a stated, "Most of th the right and left s what the facility's p of fall mats, RN # 05/23/18 at 2:06 p number of fall mat care planned upor management." W is required, RN # intervention but it i was asked to revie 35 dated 03/28/18	_		589			
: : :	preceding informa interpret the stater word "mats" was p	tion, RN # 1 was asked to ment. RN # 1 stated that the slural and that there should mats for Resident # 35.		:			

	OF DEFICIENCIES OF CORRECTION	DRRECTION IDENTIFICATION NUMBER: A. BUILDING			(3) DATE SURVEY COMPLETED		
		495240	B. WING		The state of the s	05	/25/2018
	PROVIDER OR SUPPLIE			39	REET ADDRESS, CITY, STATE, ZIP CODE 00 PLANK ROAD REDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5 COMPLETION DATE
F 689	conducted with LF asked why Reside mat on 05/23/18, It was suppose to On 05/24/18 at ap (administrative standard administrator and were made aware No further information was on https://www.nlm.nsease.html. (2) A swallowing of obtained from the https://www.nlm.nsorders.html. (3) Makes your borders. This information was on the https://www.nlm.nsorders.html.	35 p.m., an interview was PN # 9, unit manager. When ent # 35 was given a second fall LPN # 9 stated, "She required it. be in place." approximately 5:55 p.m. ASM aff member) # 1, the ASM # 2, director of nursing of the findings. ation was provided prior to exit. are that seriously affects a carry out daily activities) This btained from the website: ih.gov/medlineplus/alzheimersdictisorder. This information was	F6	689	JEHOLINOT)		
	s.html. (4) High blood pre obtained from the	ih.gov/medlineplus/osteoporosi ssure. This information was website: ih.gov/medlineplus/highbloodpr					
							:

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		495240	B. WING	i	, , , , , , , , , , , , , , , , , , ,	0:	5/25/2018
	PROVIDER OR SUPPLIE			3900	ET ADDRESS, CITY, STATE, ZIP CO PLANK ROAD DERICKSBURG, VA 22407	ODE	
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	4b. The facility sta 35's bed was in the resident was lying On 05/23/18 at 5: measurement wa Resident # 35 wat carpenter's ruler is measured. Meas	aff failed to ensure Resident # ne lowest position while the g in bed. 15 p.m. an observation and s made of Resident # 35's bed. s lying in bed. Using a standard Resident # 35's bed height was uring from the floor to the ttress the height of the bed	F	689			
	measurement wa Resident # 35 wa carpenter's ruler I measured. Meas	15 p.m., an observation and s made of Resident # 35's bed. s lying in bed. Using a standard Resident # 35's bed height was uring from the floor to the ttress the height of the bed nes.					
	documented, "For falls related to use Dx (diagnoses) of Psychosis. Demo safety awareness "Interventions" it of	Resident # 35 dated 03/28/18 cus: (Resident # 35) is at risk for e of antidepressant medication, Alzheimer's Dementia and constrates cognitive loss and poor. Has history of falls." Under documented, "Bed in lowest ed related to history of falls. 18/2016."		The second section in the second in the second section is			
	observation of res with CNA (certified entering the resid height of the bed was in the lowest think it can go low of the bed CNA#	30 p.m., interview and sident # 35's bed was conducted d nursing assistant) # 3. Upon ent's room and observing the CNA # 3 was asked if the bed position. CNA # 3 stated, "I yer." Upon measuring the height 3 agreed it measured 19 inches					

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 172 of 223

JUN 18 2018

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495240	B. WING		05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407	CODE
(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 CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 689	remote control for t Upon measuring th floor to the surface 15 inches. CNA#3 confirmed the measures responsible for lowest position CNA myself." When ask bed is checked CN someone goes into the last time she was CNA#3# stated," repositioned (Residence)	he bed and lowered the bed. e height of the bed from the of the mattress it measured 3 looked at the ruler and surement., When asked who r ensuring the bed was in the A#3 stated, "The nurse and ed how often the height of the A#3 stated, "Everytime the room." When asked when as in Resident #35's room About 15 minutes ago. I lent #35)." When asked if she of the bed CNA#3 stated, r tray and repositioned her. It	F6	89	
	conducted with LPN the bed height for relight should be in the how often the height 9 stated, "Wheneve the room and when 9 was then informe	5 p.m., an interview was N # 9, unit manager regarding esident # 35. LPN # 9 stated, lowest position. When asked at of the bed is checked LPN # er the nurse or CNA goes into they conduct rounds." LPN # d of the observations and Resident # 35's bed. LPN # 9			
	(administrative staf	SM # 2, director of nursing			
:	No further informati	on was provided prior to exit.		-	:
	room door in a mar	ailed to maintain a shower iner to prevent hazards in one s, shower room on West 1.			· · !

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495240	B. WING		0	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, 3900 PLANK ROAD FREDERICKSBURG, VA 22	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	IX5) COMPLETION OATE
F 689	Continued From page	age 173	F6	89		
	West 1 on 5/22/18 The bottom of the spart of the plastic phalf of the door and bottom left lower coapproximately two to five inches high. were sharp.	ade of the shower room on at approximately 9:15 a.m. shower door was missing a rotective cover on the lower d had many scratches. The orner was broken off to three inches wide and four The edges of the plastic cover vey process, residents were				
		the shower room with the	i			: : : !.
	member (OSM) # 1 on 5/24/18 at 2:42 door to the shower #1 stated he was a but he was unawar piece of the plastic #1 stated that the e	onducted with other staff, the director of maintenance; o.m., OSM #1 was shown the room opposite room 78. OSM ware of the need for painting e of the sharp edges and the cover that was missing. OSM edges of the door could be a ents using this shower room.				
	nursing assistant) # When asked what a something broken, the book." A red bo front was shown to about the process a something broken to	onducted with CNA (certified #1, on 5/24/18 at 2:47 p.m. she does if she finds CNA #1 stated, "We put it in ok with West 1 written on the this surveyor. When asked staff follows if they find hat is a danger or hazard to #1 stated, "We page or call				
:	the facility did not h	quest Form" was presented as ave a policy on reporting erns. The form documented in		:		i

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 174 of 223

RECEIVED
JUN 18 2018
VDH/OLC

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

STATEMENT OF OEFICIENCI ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		E CONSTRUCTION		E SURVEY PLETEO
		49524 0	B. WING			05/2	25/2018
NAME OF PROVIOER OR S		AND REHAB		39	REET AOORESS, CITY, STATE, ZIP COOE 1000 PLANK ROAD REDERICKSBURG, VA 22407		
PREFIX (EACH OF	FICIENCY	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE	JX5J COMPLETION DATE
possible. Mocontacted A if a Life Safe minor issue painting or wilsted in the maintenance soon as the Administrate administrate nursing, were on 5/25/18 at No further in Drug Regim CFR(s): 483 §483.45(d) (Each reside unnecessary drug when used with the same search of the same se	se fill ou laintena SAP (as ety concess not invested with (see with (see at 1:10 per see at 1:	t with as much detail as nce personnel should be soon as possible) if the issue tern. All request for major and volving life safety (such as atches/marks) can just be nance request log and sic) address the issues as thank you." member (ASM) #1, the ASM #2, the director of aware of the above concernoum. on was provided prior to exit. the from Unnecessary Drugs 1)-(6) ssary Drugs-General. gregimen must be free from An unnecessary drug is any cessive dose (including apy); or excessive duration; or but adequate monitoring; or but adequate indications for its apprecance of adverse the indicate the dose should be asserted.	F 6	389	1. Resident # 82 physician was not blood pressure medication was no per parameter on 5/9/18. Nursing notified physician on 6/14/18. 2. Residents residing in facility are for same deficient practice. 3. DON/designee will re-educate n staff on unnecessary drugs, follow physician orders and notification of physician by 6/24/18. A random a medication administration records completed 3 x week x 4 weeks by DON/designee to ensure orders are followed and physician is notified a indicated. Issues identified will be addressed immediately.	at risk sursing ing of sudit of s will be	

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

Event IO:5S1P11

Facility IO: VA0088

If continuation sheet Page 175 of 223

JUN 18 2018 VDH/OLC

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
		495240	B. WING		0.5	5/25/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE SE APPROPRIATE	(X5) COMPLETION OATE
F 757	stated in paragraphs section. This REQUIREM! by: Based on staff in and clinical record the facility staff faresidents in the survey was free from unrun. The facility staff fablood pressure mordered parameter. The findings inclusively discord most limited to and anxiety discord MDS (minimum discord with an ARD (assettion).	y combinations of the reasons obs (d)(1) through (5) of this ENT is not met as evidenced terview, facility document review d review, it was determined that iled to ensure one of 37 arvey sample, Resident #82, necessary medications. ailed to hold Resident #82's edication per the physician's ers on 5/9/18.	F 757	4. Results of audits and ro reviewed in the monthly C Trends identified will be a re-education provided as i	QAPI meeting. ddressed and	6/26/18
	Review of Reside physician's order to give clonidine (every morning and medication if the rethan 120/70. ReveMAR (electronic record) revealed or resident's blood period clonidine was admits and the resident's properties.	nt #82' clinical record revealed a dated 12/5/17 that documented 1) 0.1 mg (milligrams) by mouth d at bedtime and to hold the resident's blood pressure is less riew of Resident #82's May 2018 medication administration on 5/9/18 at 6:00 a.m., the ressure was 113/68 and ninistered (as evidenced by a nurse's initials). Further review				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
	495240	B. WING	;	1	05/25/2018	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CDDE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
5/9/18 failed to reversible 5/9/18 6:00 a.m. do Resident #82's com 10/18/16 document status related to: dx Hypertension (high (history) of chest papotassium), PVD (pdisease)Interventible by physician and Other fectiveness" On 5/24/18 at 3:53 conducted with LPN LPN #4 was asked administered medic checks and initials the administration reconnurses document a stated she checks the which indicates, "How coding a "3", a page for her to document was shown Resident was shown Resident clonidine and asked resident's blood pre #4 stated she would she would let the nuknow. When asked "Because they need medication so they oneed to adjust." At 2018 eMAR was reconfirmed it looked	view of nurses' notes dated val documentation that the se of clonidine was held. In prehensive care plan dated ed, "Impaired Cardiovascular (diagnosis) of anemia and blood pressure) and hx in and hypokalemia (low eripheral vascular ons: Medications as ordered oserve use and D.m., an interview was I (licensed practical nurse) #4. how nurses document an ation. LPN #4 stated she he MAR (medication of). LPN #4 was asked how held medication. LPN #4 he number "3" on the MAR, old/See nurses note" and by the comes up on the computer a progress note. LPN #4 at #82's physician order for I what should be done if the ssure is below 120/70. LPN I not give the medication and arse practitioner or doctor why, LPN #4 stated, I to know if we are not giving a can adjust whatever they this time, Resident #82's May viewed with LPN #4. LPN #4 like clonidine was sident #82 when it should	F 7	757			

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		DATE SURVEY COMPLETED
	*	495240	B. WING			05/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE AP P ROPRIATE	(X5) COMPLETION OATE
F 757	conducted with LPN and initialed clonidi #82 on 5/9/18 at 6:0 how she document administered and h medication is held. medication off when is an option in the county when a medication she ever had to hol medications in May were times where shood pressure medication she could not reme On 5/24/18 at 5:53	p.m., an interview was N #6 (the nurse who checked ne administration to Resident 20 a.m.) LPN #6 was asked as that a medication is ow she documents that a LPN #6 stated she signs the n she administers it and there computer system to document is held. LPN #6 was asked if d any of Resident #82's 2018. LPN #6 stated there he documented the resident's dication was given but she edication. When asked if she d Resident #82's blood n on 5/9/18, LPN #6 stated	F7	757		
	(the director of nurs above concern. The facility docume Administration Gen "Medication Administered in acc the prescriberDoc who administers the administration on the following the medical of regularly schedul refused, or given at (for example, the recare center at schedose of antibiotic is on the front of the N	nt titled, "Medication eral Guidelines" documented, stration: 1. Medications are ordance with written orders of sumentation: 1. The individual e medication dose, records the e resident's MAR immediately ation being given2. If a dose ed medication is withheld, other than the scheduled time sident is not in the nursing duled dose time, or a starter needed), the space provided				

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

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL´ A. BUILDI	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		495240	B. WING		05/:	25/2018
NAME OF	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION OATE
F 758	the record provided documentation" No further information with the control of	entered on the reverse side of d for PRN (as needed) ion was presented prior to exit. ed to treat high blood pressure. as obtained from the website: .gov/druginfo/meds/a682243.h esychotropic Meds/PRN Use 3)(e)(1)-(5)	F 7	58 1. Residents # 70 physician to reassess the need for PR anti-anxiety medication on	N [as needed] 6/14/18.	
	affects brain activit processes and beh but are not limited categories: (i) Anti-psychotic; (ii) Anti-depressant (iii) Anti-anxiety; an (iv) Hypnotic	ies associated with mental avior. These drugs include, to, drugs in the following		Resident # 9's medications reviewed by NP on 5/24/18 appropriate diagnosis for u antidepressant. 2. Residents residing in faci for same deficient practice.	and provided se of lity are at risk	:
	sychotropic drugs unless the medicat specific condition a in the clinical record \$483.45(e)(2) Residrugs receive grad behavioral interven	dents who have not used are not given these drugs ion is necessary to treat a s diagnosed and documented		3. DON/designee will re-ed staff on unnecessary drugs, psychotropic drug use, ensu appropriate diagnoses are i medications, and process to residents after 14 days of P psychotropic medications. I consultant will review resid psychotropic medications in provide recommendations a	including uring n place for pre-assess RN Pharmacy ents receiving	

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

Event ID:5S1Pt1

Facility ID: VA0088

If continuation sheet Page 179 of 223



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		495240	B. WING _		05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODI 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 APP DEFICIENCY)	OULD BE	(X5] COMPLETION DATE
	psychotropic drugs unless that medical diagnosed specific in the clinical recorning the clinical recorning the clinical recorning the same limited to 14 days, and same limited to 14 days, and same limited for the beyond 14 days, he rationale in the resignationale in the resignational in the resignation of the drugs are limited to renewed unless the prescribing practition the appropriatenes. This REQUIREMED by: Based on staff integrated and facility staff failed residents in the surn Resident #9, were medications. 1. The facility staff an anti-anxiety medication required for Resident 2. The facility staff and staff an	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and I orders for psychotropic drugs ays. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their ident's medical record and on for the PRN order. I orders for anti-psychotic of 14 days and cannot be e attending physician or oner evaluates the resident for sof that medication. NT is not met as evidenced erview, clinical record review ent review, it was determined ed to ensure two of 37 recy sample, Resident #70 and free from psychoactive failed to reassess the need for dications after 14 days as ent #70. failed to have an appropriate se of an antidepressant for	F 75	facility and physician. DON/dereview residents receiving psymedications weekly during the (reduction) meeting to ensure are re-assessed after 14 days of psychotropic med use. DON/designee review resident psychotropic medications duri weekly chemical restraint redumeeting to ensure residents repsychotropic medications have appropriate diagnosis for use, assessed and/or gradual dose indicated. Issues identified are as indicated. 4. Results of audits will be revimonthly QAPI meeting. Trends will be addressed immediately education provided as needed	chotropic e restraint residents of ts receiving ng the uction eceiving are re- reduction if addressed ewed in s identified and re-	:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05/25/2018	
	PROVIDER OR SUPPLIER			3900	EET ADDRESS, CITY, STATE, ZIP CODE D PLANK ROAD EDERICKSBURG, VA 22407	3	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION OATE
F 758	Continued From page 180		F	758			
	4/10/18 with diagnimited to: muscle of depression and high the most recent M day assessment, we reference date) of having scored 15 c for mental status in cognitively intact to	as admitted to the facility on oses that included but were not weakness, bipolar disorder (1), gh blood pressure. IDS (minimum data set), a 14 with an ARD (assessment 4/24/18 coded the resident as out of 15 on the brief interview adicting the resident was a make daily decisions. The das requiring assistance for all					
	activities of daily liv	ring except for eating which the orm after the tray was set up.					
	Review of the resident's care plan initiated on 4/11/18 documented, "Focus. (name of resident) has a potential for drug related complications associated with use of PSYCHOTROPIC medications related to: Anti-anxiety medication, Anti-psychotic medication. Interventions. Provide Medications as ordered by physician and evaluate for effectiveness."						:
	documented, "Clor 3.75 MG (milligram	2018 physician orders azepate Dipotassium (2) tablet a) Give 2 tablet (sic) by mouth eeded for anxiety. Order Date.					
	Dipotassium tablet tablet (sic) by mou anxiety. Order Date	ord documented, "Clorazepate 3.75 MG (milligram) Give 2 th every 8 hours as needed for e. 04/10/2018." The medication is given on four occasions					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05/25/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREF)X TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 758	documentation remedication. An interview was p.m. with ASM (acphysician. When a #70, ASM #5 state process he follow medications, ASM (psychiatry) take of this morning." An interview was p.m. with LPN #8, needed anti-anxie	page 181 resician's notes did not evidence garding the effectiveness of the conducted on 5/24/18 at 2:20 dministrative staff member) #5, asked if he cared for Resident ed he did. When asked the ed for as needed anti-anxiety 1/43 stated, "I usually let psychoare of those. They were here conducted on 5/24/18 at 2:25 When asked how long an asty medication order was good to weeks. We usually consult	F 7	758		
	Review of the psy not evidence doct anti-anxiety medic clinical record did regarding a psych. An interview was a.m. with ASM #3 asked about the president prescribe medication, ASM (benzodiazepine) 14 days. The polic them on any kind When asked to re clorazepate dipote should have been	chiatric note dated 5/17/18 did umentation about the cation. Further review of the not evidence documentation iatric note for 5/24/18. conducted on 5/25/18 at 11:35, the nurse practitioner. when rocess she followed for a d an as needed anti-anxiety #3 stated, "If it's a benzo it needs to be re-evaluated in cy would be you're only to have of antipsychotic for 14 days." view Resident #70's assium order, ASM #3 stated it re-evaluated in 14 days. ASM chiatric nurse practitioner was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		INSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05/25/2018	
	PROVIDER OR SUPPLIE			3900 F	ET ADDRESS, CITY, STATE, ZIP COD PLANK ROAD DERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	administrator and were made aware Review of the fact Monitoring" did not re-assessing an amedication every No further information of the happy, "up," and a "down," and inact often have normaticeling is called metal independent of the have normaticeling is called metal independent of the have normaticeling is called metal independent of the have normaticeling is called metal independent of the have normaticeling is called metal independent of the have normaticeling is called metal independent of the have normaticely in the have n	0 p.m. ASM #1, the ASM #2, the director of nursing e of the findings. ility's policy titled, "Medication of specifically address anti-anxiety as needed	F	758	DEFICIENCY)		
	(GABA) on the GA site that is distinct inhibitory effect is GABA-mediated cevents, leading to inhibition. This inf https://www.ncbi.r	gamma-aminobutyric acid ABA-A receptors by binding to a from the GABA binding site. Its caused by an increase in chloride channel opening hyperpolarization and synaptic formationw as obtained from: hlm.nih.gov/medgen/3122 If failed to have an appropriate use of an antidepressant for					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/25/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	with diagnoses that to: dementia, conforted parkinson's diseat disorder character gait, stooped post fingers, drooling a with emotional instand adult failure to consisting of weig poor nutrition, and by dehydration, deimmune function, Failure to thrive or forms, leading to it.	admitted to the facility on 5/5/17 at included but were not limited tractures, feeding tube, anemia, se (a slowly progressive rized by resting tremor, shuffling ure, rolling motions of the nd must weakness, sometimes tability (1)), insomnia, asthma, o thrive (a geriatric syndrome thrive" has been described, ht loss, decreased appetite, inactivity, often accompanied expressive symptoms, impaired and low serum cholesterol. ccurs in both acute and chronic mpaired functional status, ection, pressure sores, and	F 7	58		
:	assessment, a sig with an assessme coded the residen (brief interview for she was moderate daily decisions. The totally dependent members for all of Section I - Active I coded for any Psy including depression The physician order "Remeron Tablet (Tablets are indicated depressive disorder).	MDS (minimum data set) inificant change assessment, int reference date of 3/2/18, it as scoring a "9" on the BIMS mental status) score, indicating ely impaired to make cognitive he resident was coded as being upon one or more staff if her activities of daily living. In Diagnoses, the resident was not chiatric/Mood disorders on. er dated, 1/31/18 documented, REMERON® (mirtazapine) ted for the treatment of major er (3)); give 7.5 mg (milligrams) me related to ADULT FAILURE				

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 184 of 223

RECEIVED
JUN 18 2018
VDH/OLC

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	3		05/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 224			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(X5) COMPLETION OATE			
F 758	"Remeron Tablet; of bedtime related to THRIVE." The med administered every 2018. The "Psychiatric Edocumented in par Plan: Dementia, Father The Comprehensing documented in par related complication psychotropic medic Anti-depressants; I and symptoms) of being tearful, feeling sad." An interview was conficial nurse of the was asked what used for. LPN #4 standard transpectite." When as appropriate diagnostated, "No, it's an An interview was constant of the was asked if failure to the diagnosis for the was asked if failure to the diagnosis for the wastated, "No, I've be s	2018 Medication ord (MAR) documented, give 7.5 mg by mouth at ADULT FAILURE TO dication was documented as a day during April and May valuation" dated, 4/18/18, t, "Diagnosis, Assessment and ailure to thrive." The Care Plan dated, 3/13/18, t, "Focus: Potential for drug ons associated with use of cations related to am at risk of having s/s (signs depressed mood such as: ag hopeless, feeling down and conducted with LPN (licensed on 5/24/18 at 2:16 p.m. LPN to the Remeron is prescribed and stated, "For appetite and sleep. ant and given at night for sked if failure to thrive is an ses for Remeron, LPN #4	F	758			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05	/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		39	REET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 758	concern on 5/24/18 The following in par of Remeron: "REMI antidepressant med side effects, includir 7. Sleepiness. It is to close to bedtime. 10. Increases in app	vas made aware of the above at 5:26 p.m. It are documented side effects ERON and other dicines may cause serious	F 7	758			
	Non-Medical Reade Chapman, page 43' (2) This information following website: https://grants.nih.go 022.html. (3) This information following website: https://dailymed.nlmgXsl.cfm?id=62223 Label/Store Drugs a CFR(s): 483.45(g) Labeling Drugs and biological labeled in accordan professional princip appropriate accessinstructions, and the applicable.	was obtained from the ov/grants/guide/pa-files/PA-93-was obtained from the n.nih.gov/dailymed/fda/fdaDru and Biologicals n)(1)(2) g of Drugs and Biologicals als used in the facility must be ce with currently accepted les, and include the		761			

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 186 of 223

JUN 18 2018
VDH/OLC

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING _		05/2	25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 761	Federal laws, the fibiologicals in locket temperature control personnel to have §483.45(h)(2) The locked, permanent storage of control the Comprehensive Control Act of 1970 abuse, except whe package drug districtly guantity stored is rightly be readily detected. This REQUIREME by: Based on observation five facility medication five facility medication five facility staff medication cart on 2. The facility staff medications were cart on the West 1. The findings include 1. An observation a.m. of the West 2 was against the wat there were no staff At 10:20 a.m. a Characteristics.	coordance with State and facility must store all drugs and ed compartments under proper ols, and permit only authorized access to the keys. facility must provide separately tly affixed compartments for ed drugs listed in Schedule II of ee Drug Abuse Prevention and and other drugs subject to en the facility uses single unit ribution systems in which the minimal and a missing dose cand. ENT is not met as evidenced ation, staff interview and facility as determined facility staff failed as in a safe manner for two of tion carts, the West 2 cart and failed to lock an unattended the West 2 unit. failed to ensure discontinued not stored in the medication unit.	F 76	1. LPN #2 was re-educated medication carts are locke unattended by the Unit M 5/25/18. Unit manager dibox of Budesonide Inhalat 5/25/18. 2. Residents residing in factor the same deficient pra 3. DON/designee will re-estaff on medication storage ensuring medication carts when unattended and expressions are discarded DON/designee will conducensuring medication carts medications are securely DON/designee will audit 2 carts per week x 4 weeks expired medications are of indicated. Issues identified addressed immediately. 4. Results of audits will be monthly QAPI meeting. To will be addressed immediated education provided as ne	d when anager on scarded the ion Solution on Solution on Solution on Solution on Solution on Solution on Solution on Solution on Solution on Solution on Solution on Solution on Solution of Solution	6/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495240	B. WING	i	- 1	05/	05/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8900 PLANK ROAD FREDERICKSBURG, VA 22407		:	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICS)	DBE	(X5) COMPLETION OATE	
F 761	practical nurse) #2 returned and locked An interview was coa.m. with LPN #2. Version care to be locunattended, LPN #2 could get in it if it's atthere." On 5/25/18 at 1:20 member) #1, the action of nursing version findings. Review of the facility Administration. Ger "POLICY. Medication specifications, good practices and only be to do so. Medication administration of medical skept closed and locked."	t. At 10:24 a.m. LPN (licensed walked past the cart and then	F	761				
:	unlocked."	ministering medications when						
	2. The facility staff medications were n cart on the West 1 to On 5/23/18 at 11:00 medication cart on to conducted. A box were a state of the conducted of the	a.m., observation of a						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/25/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
FRENER	ICKSBURG HEALTH	AND REHAR		3900 PLANK ROAD		
INCOLIN	MORODORO HEALH	AND RELIAD		FREDERICKSBURG, VA 2240	ງ7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 761	Continued From p	age 188	F 7	761.		:
1 701		_	1 /			
	(milligrams)/2 ml (the following expir box: 6/2018. The r	alation Suspension 0.25 mg milliliters). The medication had ation date on the bottom of the medication also had a label that ollowing: "Discard after:				
	conducted with LP 4. When asked if #4 stated that the pharmacies and th after: 2/15/18" was #4 stated nursing s "6/2018" for the ne the Pulmicort had When asked wher discontinued, LPN When asked who the medication car medications, LPN check the carts. L should be checkin #4 also stated that	2 a.m., an interview was N (licensed practical nurse) # the Pulmicort was expired, LPN facility had recently switched at the label that stated "discard from the old pharmacy. LPN staff go by the expiration date we pharmacy. LPN #4 stated been discontinued anyway. It the Pulmicort was #4 stated she was not sure. Was responsible for checking the for expired or discontinued #4 stated that all nurses could PN #4 stated that nurses go the carts once a week. LPN pharmacy also checks the LPN #4 stated that the				
	discontinued medi medications cart, I not. When asked a for getting rid of die #4 stated she coul pharmacy that are facility for greater is she would discard order to discontinu	sed. When asked if cations should be on the LPN #4 stated that they should about the process staff follows scontinued medications, LPN d not send medications back to opened or have been in the than 30 days. LPN #4 stated the medication. A copy of the e the Pulmicort was requested.				
		ed. The Pulmicort was		:		

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495240	B, WING			05/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 900 PLANK ROAD REDERICKSBURG, VA 22407	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		BE	(X5) COMPLETION DATE
F 761	Continued From pa	ge 189	F	761			
	staff member) #1, ti	p.m., ASM (administrative he administrator and ASM #2, of Nursing) were made aware rns.					
	documents in part, contaminated, disco medications and the or without secure cl	led, "Medication Storage," the following: "Outdated, ontinued or deteriorated ose that are cracked, soiled, osures are immediately k, disposed of according to lication disposal."					
	(1) Budesonide inhindicated for the masthma. This inform National Institutes ohttps://dailymed.nlmm?setid=4f339e84-7f	n.nih.gov/dailymed/drugInfo.cf 33be-44d1-bbae-e0579da12c					
	laboratory services residents. The facility and timeliness of the (i) If the facility proviservices, the service requirements for lab of this chapter. This REQUIREMENT by:	1)(i) ory Services. acility must provide or obtain to meet the needs of its ty is responsible for the quality		7770			

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 190 of 223

RECEIVED
JUN 1 8 2018

VOHIOLO

	T DF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CDNSTRUCTIDN NG	(X3	(3) DATE SURVEY COMPLETED	
		495240	B. WING			05/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, C 3900 PLANK ROAD FREDERICKSBUR			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDE (EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)		
F 770	the facility staff fai per physician's ord the survey sample 1. The facility staff (comprehensive m #38 per a physicial Instead, a BMP (b obtained.	review, it was determined that led to obtain laboratory services ders for two of 37 residents in e, Residents #38 and #70. failed to obtain a CMP netabolic panel (1)) for Resident in's order dated 4/9/18. asic metabolic panel (1)) was failed to obtain a physician of specimen for Resident #70.	F 7	BMP (basic m facility on 4/9 by nursing sta #70 physician specimen not 5/7/18 as ord notified by face 2. Residents r	38 physician was notified tetabolic panel) obtained 1/18. Physician was notified from 6/14/18. Resident was notified of laborated or lered. Physician was cility staff on 6/14/18. The siding in facility are at cient practice.	d by fied t ory	
	6/28/16. Resident were not limited to depressive disorder Resident #38's moset), a quarterly as (assessment refer the resident's cognitive Section G coded Fextensive assistant mobility, dressing Review of Resider a nurse's note data "Resident need (si (activities of daily lorder) NP (nurse publication of the pain/distress." And documented, "Writtle daughter and condition of the properties of the pain/distress."	de: as admitted to the facility on #38's diagnoses included but difficulty swallowing, major er and muscle weakness. Set recent MDS (minimum data seessment with an ARD rence date) of 3/20/18, coded nition as moderately impaired. Resident #38 as requiring ace of one staff with bed toilet use and personal hygiene. at #38's clinical record revealed ed 4/9/18 that documented, ic) more assistance with ADL iving), feeling weak, N/O (New practitioner) blood CBXC (sic), ate 75% lunch, denies any other nurse's note dated 4/9/18 ter spoke with resident's cerns voiced regarding 'noticing ed difficulty standing and has		staff on facilit services, incluas ordered. De hour report in afternoon staphysician ordered. In check will be overify orders a DON/designed Monday — Fridweekly x 4 we are followed a monthly QAPI will be addres	nee will re-educate nursity process for laboratory iding obtaining specime DON/designee will review morning meeting and and down meeting to ensers with labs are obtained addition, a 24 hour charcompleted by 11-7 shift are obtained as indicate e will audit labs daily, day for 2 weeks, then eeks; to ensure lab order as orders. The will be reviewed in meeting. Trends identificated immediately and resolvided as needed.	ns w 24 sure ed art to ed.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495240	B. WING _		0.5	5/25/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 224	P CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(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 HE APPROPRIATE	(X5] COMPLETION OATE	
	assistant) stated of care. Spoke with [laboratory tests] at therapy) for eval (monitor resident's A physician's order "Blood CBC (2), Crelated to MUSCL #38's April 2018 eadministration red CMP on 4/10/18 of MUSCLE WEAKN Further review of revealed lab result a BMP. On 5/24/18 at 3:5 conducted with LFLPN #4 was aske between a CMP are "One is a complet is a basic metabootests in them." LF process staff folloobtained as order lab papers. We are technicians who do comes back and wo of course we are getter that the state of the right tests." CResident #38's cli	CNA (Certified nursing the same observations during NP and plans to order labs and consult PT (physical evaluation). Will continue to sweakness and intake." For dated 4/9/18 documented, CMP on 4/10/18 one time a day E. WEAKNESS" Resident for the cord of the condition of the cord of the condition of the cord of th					
:		3 p.m., ASM (administrative (the administrator) and ASM #2	:			:	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L'incorrection de l'i) MULTIPLE CONSTRUCTION BUILDING		TE SURVEY MPLETED
		495240	B. WING		0.5	5/25/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE 3900 PLANK ROAD FREDERICKSBURG, VA 2	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION OATE
	above concern. The facility/lab do Services for Skille documented, "(Na provide diagnostic skilled nursing facility Medical Practition will be communicated).	cument titled, "Laboratory ed Nursing Facilities" ame of Lab Company) will esservices for patients in the cility (SNF) as ordered by a ler. Orders received by the SNF ated to (name of Lab Company).	F	770		
	analyzed with respect to some sufficient and to assist the respect to the respect	numan specimen will be ults reported to the SNF. Result immunicated by the preferred redia of the SNF. Laboratory as are provided to meet the ints at the skilled nursing facility nursing team to meet the e level of well being for each				
	(1) "A metabolic p measures differer These tests are u (plasma) part of b information about and metabolism. information about heart), bones, and and liver. There are two typ (BMP) and compr (CMP). The BMP calcium, and elect tests such as creat function. The CM well as tests of you	anel is a group of tests that and chemicals in the blood. Sually done on the fluid blood. The tests provide your body's chemical balance. They can give doctors your muscles (including the dorgans, such as the kidneys es: basic metabolic panel behensive metabolic panel behansive				

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

Event ID:5S1P11

Facility ID: VA0088

if continuation sheet Page 193 of 223

JUN 1 8 2018
VDH/OLC

	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:				X3) OATE SURVEY COMPLETEO	
	•	495240	B. WING		05/	/25/2018	
	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	COOE		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCEO TO TH OEFICIENCY)	N SHOULO BE E APPROPRIATE	(X5) COMPLETION OATE	
	(2) A CBC (comple measures different This information was https://vsearch.nlm meta?v%3Aproject medlineplus-bundle 91.1046050702.15.2321 2. The facility staff ordered laboratory Resident #70 was a 4/10/18 with diagnoral limited to: muscle was depression and high the most recent M day assessment, was reference date) of a having scored 15 of for mental status in cognitively intact to resident was coded activities of daily liversident could perform the resident was coded activities of daily liversident could perform the resident cou	.gov/metabolicpanel.html te blood count) is a test that components in the blood. as obtained from the website: .nih.gov/vivisimo/cgi-bin/query-=medlineplus&v%3Asources=e&query=cbc&_ga=2.265218127592979-139120270.147794 failed to obtain a physician specimen for Resident #70. admitted to the facility on oses that included but were not veakness, bipolar disorder (1), h blood pressure. DS (minimum data set), a 14 with an ARD (assessment 4/24/18 coded the resident as ut of 15 on the brief interview dicting the resident was make daily decisions. The das requiring assistance for all ing except for eating which the form after the tray was set up. ent's care plan initiated on ad, "Focus. (Name of resident) ovascular status related to: rventions. Lab (laboratory) ordered by physician."	F 7	70			
	Review of the 5/5/1 documented, "BMP	8 physician orders 7 (2) on Monday 5/7/18.		•		1	
:	Review of the 5/5/1	8 laboratory log did not		:		•	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495240	B. WING			05	/25/2018
	PROVIDER OR SUPPLIE			3900	EET ADDRESS, CITY, STATE, ZIP CODE D PLANK ROAD DERICKSBURG, VA 22407	• • • •	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	IX5) COMPLETION OATE
F 770	Review of the clin documentation re	ntation indicating the laboratory	F 7	770			
	from ASM (admin	ide on 5/24/18 at 8:15 a.m., istrative staff member) #2, the g for evidence of the laboratory		***************************************			
		st was made on 5/24/18 at 2:15 2 for evidence of the laboratory					
	made from ASM (O p.m., a third request was administrative staff member) tor and ASM #2, the director of coratory results.					
	have those." Whe were to follow to o ASM #2 stated, "V day it was ordered and Thursday. Th	O p.m. ASM #2 stated, "I don't n asked about the process staff obtain laboratory specimens, Ve put it into our lab log for the d. Our lab comes on Tuesday e results are faxed back and em notify the physician."					
	Services for Skille documented, "PR be completed by t to include the nec	lity's policy titled, "Laboratory d Nursing Facilities" OCEDURE. C. A requisition will he SNF (skilled nursing facility) essary details and orders as ledical Practitioner."					
	No further informa	ation was provided prior to exit.	: : :				;
	1. Bipolar disorder	Bipolar disorder is a serious			4.		•

NAME OF PRDVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD	/2018
FREDERICKSBURG HEALTH AND REHAB FREDERICKSBURG, VA 22407	
	(X5) OMPLETION DATE
mental illness. People who have it go through unusual mood changes. They go from very happy, "up," and active to very sad and hopeless, "down," and inactive, and then back again. They often have normal moods in between. The up feeling is called mania. The down feeling is depression. This information was obtained from: https://medlineplus.gov/bipolardisorder.html 2. "A metabolic panel is a group of tests that measures different chemicals in the blood. These tests are usually done on the fluid (plasma) part of blood. The tests provide information about your body's chemical balance and metabolism. They can give doctors information about your muscles (including the heart), bones, and organs, such as the kidneys and liver. There are two types: basic metabolic panel (BMP) and comprehensive metabolic panel (CMP). The BMP checks your blood sugar, calcium, and electrolytes. The BMP also has tests such as creatinine to check your kidney function. The CMP includes all of those tests, as well as tests of your cholesterol, protein levels, and liver function." This information was obtained from the website: https://medlineplus.gov/metabolicpanel.html F 773 Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must-(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practice laws. (ii) Promptly notify the ordering physician,	

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE COMF	SURVEY PLETED
		495240	B. WING		05/2	25/2018
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	s	STREET ADDRESS, CITY, STATE, ZIP CODE		
FREDER	ICKSBURG HEALTH	AND REHAB		8900 PLANK R⊅AD 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 773	Continued From pa	age 196	F 773			
	physician assistant	t, nurse practitioner, or clinical		1. Resident #38 physician was notif	fied of	
		laboratory results that fall		BMP (basic metabolic panel) obtain	ned by	
		eference ranges in accordance		facility on 4/9/18. Physician was no		
		and procedures for		by nursing staff on 6/14/18.		
	physician's orders.	actitioner or per the ordering	;		1	
		NT is not met as evidenced		2. Residents residing in facility are	at vlala	
	by:		: 	for same deficient practice.	atrisk	
		erview, facility document review		for same deficient practice.		
	•	review, it was determined that			_	
		ained a laboratory test not sician for one of 37 residents		3. DON/Designee will re-educate n	_	
	in the survey samp			staff on physician notification rega	rding	
				labs and residents plan of care.	i	
		tained a BMP (basic metabolic	· ·	DON/designee will review 24 hour	report	
:		a physician's order. The	•	in morning meeting and afternoon	stand	
		CMP (comprehensive)) for Resident #38, and not a		down meeting to ensure physician	orders	
	BMP.	1) for Resident #30, and not a		with labs are obtained as ordered.	[n	
				addition, a 24 hour chart check will	l be	
				completed by 11-7 shift to verify or		
	T			are obtained as indicated. DON/de		
:	The findings includ	e:		will audit labs daily, Monday – Frid	_	
i	Resident #38 was :	admitted to the facility on		2 weeks, then weekly x 4 weeks; to	•	
	6/28/16. Resident	#38's diagnoses included but		ensure lab orders are followed as o		
	were not limited to	difficulty swallowing, major	!		raers	
		r and muscle weakness.		and physician is notified.		
		st recent MDS (minimum data				
		sessment with an ARD ence date) of 3/20/18, coded		4. Results of audits will be reviewed		
		ition as moderately impaired.		monthly QAPI meeting. Trends ider		
!		esident #38 as requiring		will be addressed immediately and	re-	
:		ce of one staff with bed		education provided as needed.	•	6/26/18
	mobility, dressing to	oilet use and personal hygiene.				
	Review of Residen	t #38's clinical record revealed	,			
1		d 4/9/18 that documented,				
:		c) more assistance with ADL				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
•	495240	B. WING		0,	5/25/2018	
NAME OF PROVIDER OR SUPPLIFREDERICKSBURG HEAL			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
order) NP (nurse BMP, pt (patient pain/distress." A documented, "W daughter and co dad is having more weakness assistant) stated care. Spoke with [laboratory tests] therapy) for eval monitor resident. A physician's ord "Blood CBC (2), related to MUSC #38's April 2018 administration re CMP on 4/10/18 MUSCLE WEAK. Further review or revealed lab rest a BMP. On 5/24/18 at 3:: conducted with L LPN #4 was ask between a CMP "One is a completis a basic metab tests in them." L process staff foll is obtained only "We do the lab p they (the lab teck come but if it cor	y living), feeling weak, N/O (New e practitioner) blood CBXC (sic), ate 75% lunch, denies any another nurse's note dated 4/9/18 driter spoke with resident's neerns voiced regarding 'noticing ore difficulty standing and has 'CNA (Certified nursing the same observations during the NP and plans to order labs and consult PT (physical (evaluation). Will continue to 's weakness and intake." Her dated 4/9/18 documented, CMP on 4/10/18 one time a day cleet WEAKNESS" Resident eTAR (electronic treatment ecord) documented, "Blood CBC, one time a day related to	F 7	73			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	5/25/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 773	4:20 p.m., Reside reviewed with LP was obtained on order. On 5/24/18 at 5:5 staff member) #1 (the director of nuabove concern. The facility/lab do Services for Skilled documented, "(Naprovide diagnostic skilled nursing face Medical Practition will be communication million be communication million be communication million diagnostic services and to assist the highest practicable patient." No further information information about and metabolism. information about and metabolism.	e right tests." On 5/24/18 at ent #38's clinical record was N#4. LPN #4 confirmed a BMP 4/10/18, without a physician's 3 p.m., ASM (administrative (the administrator) and ASM #2 ersing) were made aware of the cument titled, "Laboratory ed Nursing Facilities" ame of Lab Company) will a services for patients in the cility (SNF) as ordered by a er. Orders received by the SNF eted to (name of Lab Company). In the cumulation of the SNF. Result municated by the preferred etedia of the SNF. Laboratory es are provided to meet the ents at the skilled nursing facility nursing team to meet the elevel of well being for each eation was presented prior to exit. Tanel is a group of tests that the chemicals in the blood. Sually done on the fluid alood. The tests provide your body's chemical balance. They can give doctors your muscles (including the dorgans, such as the kidneys.)	F 7	773			
	and liver.	a organis, such as the kidneys	!			!	

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 199 of 223

JUN 1 8 2018
VOH/OLC

		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:				(X3) OATE SURVEY COMPLETEO	
		495240	B, WING		05	/25/2018	
	PROVIOER OR SUPPLIE			STREET AOORESS, CITY, STATE, 2 3900 PLANK ROAD FREDERICKSBURG, VA 224			
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES ICY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFI TAG		TION SHOULO BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 812	(BMP) and compine (CMP). The BMF calcium, and electests such as creating function. The CM well as tests of you and liver function from the website: https://medlineplu. (2) A CBC (compine assures different This information white the compine assures different This information white the compine assures different This information white the compine assures different This information white the compine assures different This information white the compine assures different This information white the compine assure that the compine assure that the compine assure that the compine assure that the compine assure that the compine and local laws or the compine and local laws or the compine assure that the compine and local laws or the compine and local laws or the compine assure that the compine assu	rehensive metabolic panel rehensive metabolic panel checks your blood sugar, strolytes. The BMP also has attinine to check your kidney MP includes all of those tests, as our cholesterol, protein levels, "This information was obtained is gov/metabolicpanel.html lete blood count) is a test that he tomponents in the blood. was obtained from the website: m.nih.gov/vivisimo/cgi-bin/query-ct=medlineplus&v%3Asources=lle&query=cbc&_ga=2.2652181527592979-139120270.147794 Int,Store/Prepare/Serve-Sanitary (1)(2) refety requirements. Decure food from sources idered satisfactory by federal, norities. de food items obtained directly ers, subject to applicable State		1. Dietary manager clear beneath the ice machin CNA #2 was re-educate handling by the Admini 5/23/18. 2. Residents residing in for same deficient practice.	e on 5/24/18. d on safe food strator on facility are at risk		
:	:		:	:			

	OF DEFICIENCIES OF CORRECTION	(X1)° PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		495240	B. WING		*****	05/:	25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		39	TREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE	
	serve food in according standards for food of This REQUIREMENDY: Based on observat document review it staff failed to serve the kitchen and for survey sample, Resobservation in one of Bistro. 1. The facility staff of the ice machine, free the ice machine, free the certified nursing as cart with a bare hand an same bare hand an same bare hand an same bare hand an same to the ice machine, free the ice machine, free the ice machine, free the ice machine, free the ice machine, free the ice machine, free the ice machine, free the ice machine, and of the ice machine ice machine, and of the ice machine, and of the ice machine, and of half-anapkins. When ask	e, prepare, distribute and dance with professional service safety. IT is not met as evidenced ion, staff interview, and facility was determined the facility food in a sanitary manner in one of 37 residents in the sident #14, and during dining of two dining rooms, the ailed to keep the floor, under the from clutter and trash. ailed to serve food to anitary manner. CNA sistant) #2 touched the food d then touched a roll with the d served the roll to Resident ailed to serve food in a the Bistro dining room.	F&	312	3. Administrator/designee will re-estaff on ensuring food is served in a sanitary manner, ensuring food is reduched with bare hands and proposand hygiene is performed. Dietar manager re-educated dietary on clastandards and schedules on 5/31/1 Department heads will observe 5 m week for 4 weeks to ensure resider served meals in a sanitary manner. Dietary manager/designee will coman audit of the kitchen areas 5 times weeks for 4 weeks to ensure clean throughout the kitchen. 4. Results of audits will be reviewed monthly QAPI meeting. Trends idea will be addressed immediately and education provided as needed.	er y eaning .8. neals a nts are nplete es a liness d in	6/26/18	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495240	B. WING		05/25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407	ODE
(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 COMPLÉTION
F 812	and mop the kitch The facility policy, part, "All food prepareas and dining a clean and sanitary Dining Services D kitchen is maintair manner, including and ventilation4. will ensure that a r place for all cooking areas and surface The administrator ASM #1 was made on 5/24/18 at 5:26 2. The facility staff Resident #14 in a (certified nursing a cart with a bare has same bare hand a #14. Resident #14 was 12/20/12. Resident were not limited to and anxiety disord MDS (minimum dates)	stated, "The staff is to sweep en after every meal." "Environment" documented in paration areas, food service areas will be maintained in a condition. Procedures: 1. The irector will ensure that the ned in a clean and sanitary floors, walls, ceilings, lighting. The Dining Services Director outine cleaning schedule is in neg equipment, food storage s." (administrative staff member) a aware of the above concern p.m. failed to serve food to sanitary manner. CNA assistant) #2 touched the food and then touched a roll with the nd served the roll to Resident admitted to the facility on the facility of the facility on the facility of	F8	12	
	2/27/18, coded the intact. On 5/23/18 at 12:4 serving meal trays sanitizer, opened to	eresident reference date) of a resident as being cognitively at p.m., CNA #2 was observed . CNA #2 applied hand the food cart with her right bare meal tray from the cart and			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495240	B. WING_		05	/ 25/20 18	
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 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 COR (EACH CORRECT)VE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE	
	Resident #14's roo wrap, and placed the tray with her bare rip.m., the roll was night #14's meal tray. The roll. On 5/23/18 at conducted with CN food should be hand CNA #2 stated, "Yo bare hands. It's no someone touching CNA #2 stated, "Saunclean. Even with the Saran wrap and made aware this sure Resident #14's roll touching the food crushing during means."	rt. CNA#2 then entered m, removed a roll from plastic ne roll on the resident's meal ght hand. On 5/23/18 at 12:51 to longer observed on Resident ne resident stated he ate the 2:40 p.m., an interview was A#2. CNA#2 was asked how dled in a sanitary manner. u shouldn't touch with your t your food. I wouldn't want my food." When asked why, nitary issues. Nails are the bread, you work around don't touch." CNA#2 was arveyor observed her touch with her bare hand after art. CNA#2 stated she was I service and it was possible I with her bare hand.	F 8	12			
	staff member) #1 (the director of nursabove concern. The facility docume documented, "6. Proto prevent contamination maintenance contropoint-of-service din No further informations. The facility staff is sanitary manner in						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBÉR:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	A Company of the Comp	05/	/25/2018	
	PROVIDER 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 PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION OATE	
F 812	served a resident ti CNA (certified nurs another resident, p with her bare hand moved on to assist An interview was co p.m. with CNA #5. their hands, CNA # after you use a har for 20 seconds." W to handle resident's #5 stated, "No." Wi stated, "It's not good was then informed On 5/25/18 at 1:20 member) #1, the ad	istro dining room. CNA #5 heir meal and cut up their food. ing assistant) #5 then went to icked up the resident's bread s, and buttered it. CNA #5 then	F8	112			
SS=D	Resident Records - CFR(s): 483.20(f)(5) Resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of	dent-identifiable information. It release information that is the to the public. It release information that is the to an agent only in It contract under which the agent the disclose the information It the facility itself is permitted	F8	1. LPN # 6 was re-educat Manager regarding inacc documentation of reside pressure medication. Re physician was notified of medication being withhe parameters in May 2018 notified by facility staff of	curate ent #82 blood esident # 34 f blood pressure eld due to hold s. Physician was	•	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		E SURVEY IPLETED
	495240	B. WING_		05/	25/2018
NAME OF PROVIDER OR SUPPL FREDERICKSBURG HEAL			STREET ADDRESS, CITY, STATE, ZIP CO 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
PREFIX (EACH DEFICII	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL PROPERTY)	SHOULD BE	(X5) COMPLETION OATE
professional stamust maintain rathat are- (i) Complete; (ii) Accurately data (iii) Readily according formation or regardless of the records, except (i) To the individes representative was (ii) Required by (iii) For treatment operations, as payith 45 CFR 16 (iv) For public has neglect, or domactivities, judicial law enforcement purposes, reseamedical examinal a serious threat by and in complement of the period of (ii) Five years frow there is no required.	accordance with accepted andards and practices, the facility medical records on each resident occumented; essible; and ally organized one facility must keep confidential contained in the resident's records, the form or storage method of the when release islual, or their resident where permitted by applicable law; Law; or health care permitted by and in compliance 4.506; the latest activities, reporting of abuse, the purposes, organ donation arch purposes, or to coroners, the permitted directors, and to avert to health or safety as permitted liance with 45 CFR 164.512.	F 84	2. Residents residing in facility for same deficient practice. 3. DON/designee will re-edustaff on documentation start ensure documentation is acreflects services provided. Now will be re-educated on physomotification, to include documentation, to include documentation audit of medication treatment orders will be convected when the physician is not random audit of medication treatment orders will be convected when the physician supports can and physician notified is documentation supports can and physician notified is documentation. 4. Results of audits will be remonthly QAPI meeting. Tremwill be addressed immediate education provided as need.	ucate nursing ndards, to curately lursing staff ician imentation is otified. A and impleted 3 x signee to re provided cumented in eviewed in inds identified ely and re-	6/26/18

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

Event ID: 5\$1P11

Facility ID: VA0088

If continuation sheet Page 205 of 223

JUN 18 2018
VOH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/25/2018	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, 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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	Continued From plegal age under S	_	F 8	42			
	§483.70(i)(5) The (i) Sufficient inform (ii) A record of the (iii) The comprehe provided; (iv) The results of and resident revie determinations co (v) Physician's, nu professional's pro (vi) Laboratory, ra services reports a This REQUIREME by: Based on staff in and clinical record the facility staff fai clinical record for	medical record must contain- nation to identify the resident; resident's assessments; ensive plan of care and services any preadmission screening we evaluations and inducted by the State; arse's, and other licensed					
	documented Resi medication was a the medication on 2. The facility staf physician was not	f failed to document that the ified that the blood pressure eld seven out of 24					
	10/31/17. Reside were not limited to and anxiety disord	de: vas admitted to the facility on nt #82's diagnoses included but diabetes, high blood pressure ler. Resident #82's most recent ata set), a quarterly assessment					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING		05	/25/2018	
	PROVIDER OR SUPPLIE		39	REET ADDRESS, CITY, STATE, ZIP O 00 PLANK ROAD REDERICKSBURG, VA 22407			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE	
F 842	Continued From p	page 206	F 842				
		essment reference date) of e resident as being cognitively					
	physician's order to give clonidine (every morning an medication if the	ent #82' clinical record revealed a dated 12/5/17 that documented 1) 0.1 mg (milligrams) by mouth d at bedtime and to hold the resident's blood pressure is less view of Resident #82's May 2018					
	eMAR (electronic record) revealed of resident's blood policing was addressed from the eMAR and 5/19/18 failed to record record.	medication administration on 5/19/18 at 6:00 a.m., the ressure was 110/68 and ninistered (as evidenced by a nurse's initials). Further review review of nurses' notes dated eveal documentation that the dose of clonidine was held.					
	10/18/16 failed to	omprehensive care plan dated document information e medication administration					
	conducted with LF LPN #4 was aske administered med checks and initials	3 p.m., an interview was PN (licensed practical nurse) #4. d how nurses document an dication. LPN #4 stated she is the MAR (medication cord). LPN #4 was asked how					
	nurses document stated she checks which indicates," coding a "3", a pa for her to docume	a held medication. LPN #4 s the number "3" on the MAR, Hold/See nurses note" and by ge comes up on the computer ent a progress note. At this time,					
	with LPN #4. LPN	ay 2018 eMAR was reviewed N #4 confirmed it looked like ninistered to Resident #82 when en held on 5/9/18					

	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION NG		TE SURVEY MPLETEO
		495240	B. WING		0.5	5/25/2018
	PROVIOER OR SUPPLIE I CKSBURG HEAL TI		1	STREET AOORESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	COOE	
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCEO TO TH OEFICIENCY	ON SHOULO BE IE APPROPRIATE	(X5) COMPLETION DATE
F 842	Continued From p	page 207	F8	42		
	conducted with LF and initialed clonic #82 on 5/19/18 at how she documer administered and medication is held medication off whis an option in the when a medication she ever had to he medications in Mawere times where blood pressure medication of he pressure medications in held the nadministered or he pressure medications.	1 p.m., an interview was PN #6 (the nurse who checked dine administration to Resident 6:00 a.m.) LPN #6 was asked hats that a medication is how she documents that a l. LPN #6 stated she signs the en she administers it and there computer system to document in is held. LPN #6 was asked if old any of Resident #82's by 2018. LPN #6 stated there she documented the resident's edication was given but she nedication. When asked if she eld Resident #82's blood on on 5/19/18, LPN #6 stated cation although she gave it.				
	staff member) #1	3 p.m., ASM (administrative (the administrator) and ASM #2 rsing) were made aware of the				
	Administration Ge "Documentation: administers the madministration on following the med of regularly sched refused, or given a (for example, the care center at schedose of antibiotic on the front of the	nent titled, "Medication neral Guidelines" documented, I. The individual who edication dose, records the the resident's MAR immediately cation being given2. If a dose uled medication is withheld, at other than the scheduled time resident is not in the nursing eduled dose time, or a starter is needed), the space provided MAR for that dosage nitialed and circled. An				

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	<u> </u>	05	05/25/2018	
	PROVIDER OR SUPPLIER	AND REHAB		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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE	
F 842	the record provided documentation" No further informat (1) Clonidine is use This information was https://medlineplus tml 2. The facility staff physician was notif medication was hel opportunities for Resident #34 was a 6/2//17 with diagno limited to: dementia high blood pressure. The most recent M assessment, with a resident as having brief interview for m resident was mode The resident was contact the state of the resident was contact the state of t	entered on the reverse side of a for PRN (as needed) ion was presented prior to exit. In the treat high blood pressure. It is obtained from the website: It is obtained from	· F {	342			
	Review of the resid 6/6/17 documented Cardiovascular stat abnormal vital signs	ent's care plan initiated on , "Focus. I have impaired cus. Interventions. Observe for s (blood pressure, pulse, mperature) and report."				;	
	documented, "Core Give 1 tablet by mo	2018 physician's orders g (1) 3.125 MG (milligram) buth one time a day related to IARY) HYPERTENSION Hold					

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 209 of 223

RECEIVED
JUN 1 8 2018
VDH/OLC

1, 7,		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	' ') MULTIPLE CONSTRUCTION BUILOING		(X3) OATE SURVEY COMPLETEO	
		495240	B. WING _		05	/25/2018	
	PROVIOER OR SUPPLIER	AND REHAB		STREET AOORESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407			
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	I SHOULO BE	(X5) COMPLETION DATE	
	number) <110 or HI Review of the May administration recording administration recording administration recording administration recording administration recording administration recording administration recording administration recording administration of 24 documented in the codes at the bottom "3=Hold/See Nurse Review of the May a evidence document been notified that the An interview was cop.m. with RN (regist nurse. When asked follows if a medication make sure they're a (responsible party) were expected to do was notified, RN #1 5/25/18 at 9:43 a.m. staff member) #3, the asked if staff were expected to do was notified, RN #1 staff member) #3, the sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified, RN #1 sked if staff were expected to do was notified in the low blood pressed and the low blood pre	cood pressure, the upper R (heart rate) <55." 2018 MAR (medication rd) documented, "Coreg Tablet blet by mouth one time a day AL (PRIMARY) fold for SBP <110 or HR<55." opportunities a "3" was cox. Review of the chart of the page documented, Notes." 2018 nurse's notes did not ation that the physician had e medication had been held. Inducted on 5/24/18 at 2:06 ered nurse) #1, the resident's about the process staff on is held, RN #1 stated, If we we notify the doctor and ware of it, let the RP know." When asked if staff ocument that the physician	. F 84	12			
	On 5/25/18 at 1:20 p	o.m. ASM #1, the					

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495240	B. WING	_	0.5	5/25/2018
NAME OF PROVIOER OR SU		AND REHAB		STREET AOORESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	COOE	
PREFIX (EACH OE	FICIENC	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCEO TO TH OEFICIENCY	ON SHOULO BE IE APPROPRIATE	(X5) COMPLETION DATE
Review of the Administration Medications accordance good nursing person legall PROCEDUR regularly scherefused, or guimethe spund MAR for that and circled. A reversed side needed) doctor of a vital medical physician is a series of the Administration of the physician is a series of the Administration of t	r and A aware of e facilit on" doc are ad with ma g princi y autho iES. Do eduled iven at acer p dosag An exple e of the umenta dication notified	SM #2, the director of nursing of the findings. y's policy titled, "Medication umented, "POLICY. ministered as prescribed in anufacturers' specifications, poles and practices and only by prized to do so. ocumentation. 2. If a dose of medication is withheld, other than the scheduled rovided on the front of the e administration is initialed anatory note is entered on the record provided for PRN (as ation. If two consecutive doses a are withheld or refused, the ""	F 8-	42		
1. Coreg Cof mild-to-se or cardiomyo diuretics, AC survival and, hospitalization Clinical Studio obtained from https://dailymm?setid=fdb.6 F 880 Infection Press=D CFR(s): 483.	OREG vere che pathic E inhib also, to n [see es (14. n: ed.nlm 12700- vention 80(a)(1)(2)(4)(e)(f)	F 88	30		

STATEMENT OF DEFICIENCIES (X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CDNSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING_		05/:	25/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 3900 PLANK ROAD FREDERICKSBURG, VA 2240	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT DF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PRDVIDER'S PLAN OF C (EACH CDRRECTIVE ACTII CRDSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	designed to provide comfortable environdevelopment and diseases and infection of the seases and infection of the seases and infection of the seases and infection of the seases and infection of the seases are not accepted national seases are not limited (i) A system of surpossible communicable of the seases of	on and control program de a safe, sanitary and conment and to help prevent the transmission of communicable ctions. on prevention and control establish an infection prevention am (IPCP) that must include, at ollowing elements: ystem for preventing, identifying, ating, and controlling infections the diseases for all residents, visitors, and other individuals to under a contractual and upon the facility assessment ling to §483.70(e) and following standards; tten standards, policies, and the program, which must include, to: recillance designed to identify icable diseases or they can spread to other	F 88	1. Resident #108's cathete properly anchored to previous the floor on 5/24/18. Resident #15 were assessed with by nursing staff on 6/15/12. Residents residing in fator same deficient practice. 3. DON/Designee will restandards, including hand providing incontinence cathems from touching the finitection control practice medication administration. DON/designee will conductate observations/audits weeks. Observations will medication administration of incontinence care to econtrol standards are being 4. Results of audits will be monthly QAPI meeting. Twill be addressed immedication provided as near the standards are secondary of the summedication provided as near the summedicat	vent touching sident #11, #99, ithout remark 18. It cility are at risk ce. educate nursing tion and Control d hygiene when are, preventing floor, and es during in. Let 3 resident per week for 4 I include in and provision in sure infection ing followed. Let reviewed in trends identified liately and re-	6/26/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		495240	B. WING _		05	5/25/2018
	PROVIDER OR SUPPLIER	AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
	least restrictive post circumstances. (v) The circumstan must prohibit employing the contact with reside contact will transmit (vi) The hand hygiet by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must hat transport linens so infection. §483.80(f) Annual of the facility will contact the facility will contact the facility will contact the facility staff failed to practices for one of sample, Resident fresidents in the Meresidents #11, #9901. The facility staff hygiene during Residents #15.	that the isolation should be the saible for the resident under the ces under which the facility byees with a communicable skin lesions from direct ints or their food, if direct it the disease; and ine procedures to be followed direct resident contact. Istem for recording incidents afacility's IPCP and the aken by the facility. Indle; store, process, and as to prevent the spread of review. Induct an annual review of its ineir program, as necessary. In its not met as evidenced it was determined that the ormaintain infection control if 37 residents in the survey it 108 and for three of 7 dication Administration task,	F 88			
:	collection bag off th					·

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING	;		05/	25/2018
	PROVIDER OR SUPPLIER	AND REHAB		3	STREET ADDRESS, CITY, STATE, ZIP CODE 8900 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION OATE
F 880	hands in between a Resident #11, #99 a 3. The facility staff	failed to wash or sanitize their administering medications to and #15. failed to sanitize the rubber top rior to the insertion of the	F	880			
	The findings includ	e:					
	hygiene during Res	failed to use proper hand ident # 108's incontinence eep Resident # 108's catheter ie floor.					
	10/22/16 with a rea diagnoses that inclu Parkinson's disease prostatic hyperplas	s admitted to the facility on dmission of 08/05/17 with uded but were not limited to e (1), dysphagia (2), benign ia (3), depressive disorder (4), disease (5) and heart disease					
	data set), a significan ARD (assessme coded Resident # 1 brief interview for mof 0 - 15, 5 (five) - 100 cognition for makin 108 was coded as staff member for ac "Section H Bladder Appliances" coded	ost recent MDS (minimum ant change assessment with ent reference date) of 05/07/18, 08 as scoring a 5 (five) on the nental status (BIMS) of a score being severely impaired of g daily decisions. Resident # being totally dependent of one ctivities of daily living. In and Bowel" under "H0100 Resident # 108 as "A. (including suprapubic ostromy)."					

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

Event ID: 5S1P11

Facility ID: VA0088

If continuation sheet Page 214 of 223

JUN 18 2018
VDH/OLC

	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		TE SURVEY MPLETEO
		495240	B. WING		05	5/25/2018
	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES BY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		SHOULO BE	(X5) COMPLETION DATE
F 880	Resident # 108's in conducted. Reside CNA (certified nurse of plastic disposable cabinet in resident opened the room of for wipes and trasist the same gloves under the same gloves, resident # 108 to removed gloves, resident # 108 to removed gloves, resident # 108 to removed gloves, resident # 108 to removed gloves, resident # 108 to removed gloves, resident # 108 to removed gloves, resident # 108. CNA #8 the the plastic trash be right side, cleaned placed the soiled what is a fitted the brief to Resident # 108's padjust the height of lowest position, the gathered up the traopened the privace hands. Resident # was observed attandirectly on the floor On 05/24/18 at 8:3 conducted with CN incontinence care on 05/23/18. Whe infection control privace in the control privace on 05/23/18. Whe infection control privace in the	If p.m., an observation of incontinence care was ent # 108 was lying in bed. Sing assistant) # 8 put on a pair pole gloves, she then opened the is room gathering supplies, door and asked staff in the hall in bags. CNA # 8 while wearing sed the bed remote to adjust the appropriate height, etrieved a box of wipes brought her staff member, put on eves, removed the resident's resident # 108 was observed to movement. Wearing the same end wipes to clean Resident in placed the soiled wipes into ag, rolled the resident onto his Resident #108's bottom, and wipes and brief into the plastic in rolled Resident #108 onto right clean brief under resident, and resident # 108. While still gloves CNA # 8 adjusted willows, used the bed remote to find the bed by lowering it to the en removed her gloves, ash bag and dirty linen bag, y curtain and then washed her #108's catheter collection bag ched to the side of bed resting				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495240	B. WING	j	(05/25/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 3900 PLANK ROAD FREDERICKSBURG, N			
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION OATE	
F 880	stated, "I wash my items for care. Will gloves put them in and trash and take there are linen and then wash my han the procedure for y gloves, CNA # 8 st and after you take being informed of 05/23/18, CNA # 8 should have chang throughout the procare. When asked to de catheter collection collection bag should catheter collection (Resident #108) is bed and didn't real cadministrative state administrator and were made aware. No further informatical References: (1) A type of move	hands, put on gloves, gather nen I'm finished take off the trash bag tie up the bags linen at them to the shower room, I trash bins in the shower room, I trash bins in the shower room, I do the shower room, I trash bins in the shower room, I do the shower room, I trash bins in the shower room, I trash bins in the shower room, I trash bins in the shower room, I trash bins in the shower room, I trash bins in the shower of them off each time." After the observation conducted on recalled and agreed that she ged her gloves several times cess of providing incontinence scribe the positioning of a bag, CNA # 8 stated, "The ald not be on the floor, he a fall risk and I lowered the ize the bag was on the floor. Droximately 5:55 p.m. ASM ff member) # 1, the ASM # 2, director of nursing	F &	880			
	https://www.nlm.ni sease.html. (2) A swallowing di obtained from the	h.gov/medlineplus/parkinsonsdi sorder. This information was					

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

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
		495240	B. WING		05	/25/2018	
	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP C 3900 PLANK ROAD FREDERICKSBURG, VA 22407	00E		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL .SC IOENTIFYING INFORMATION)	IO PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE	(X5) COMPLETION DATE	
F 880	Continued From pa	age 216	F 8	80		i	
	obtained from the	ostate. This information was website: n.gov/medlineplus/enlargedpro					
	blue, unhappy, mis Most of us feel this short periods. Clin disorder in which for or frustration interf	y be described as feeling sad, erable, or down in the dumps. way at one time or another for ical depression is a mood eelings of sadness, loss, anger, ere with everyday life for weeks mation was obtained from the					
	https://medlineplus	.gov/ency/article/003213.htm.	:			: : : :	
	blood vessels. It in capillaries that carr Arteries can become called atherosclero vessels and block Weakened blood vestained from the vestal to blood the contained from the vessels.	rstem is the body's network of cludes the arteries, veins and by blood to and from the heart. The thick and stiff, a problem sis. Blood clots can clog blood flow to the heart or brain. The essels can burst, causing body.) This information was website: n.gov/medlineplus/vasculardise					
	disease. The most disease is narrowir arteries, the blood the heart itself. Thi disease and happe major reason peop kinds of heart prob in the heart, or the cause heart failure	y different forms of heart common cause of heart ag or blockage of the coronary vessels that supply blood to is is called coronary artery as slowly over time. It's the le have heart attacks. Other lems may happen to the valves heart may not pump well and . Some people are born with is information was obtained					

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

Event IO: 5S1P11

Facility IO: VA0088

If continuation sheet Page 217 of 223

JUN 18 2018
VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		49524 0	B. WING		05/25/2018	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZI 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLÉTI HE APPROPRIATE OATE	
	2. The facility sta hands in between Resident #11, #99 Resident #11 was 2/5/15 and readm diagnoses that incend stage renal diagnoses that incend stage renal diagnoses that incend stage renal diagnoses that incend stage renal diagnoses that incend stage renal diagnoses that incend stage renal diagnoses that incend stage renal diagnoses that incend assessment with assessment with adate) of 2/27/18. being cognitively incended in the stage of the	s.gov/heartdiseases.html. ff failed to wash or sanitize their administering medications to	•	380		
	3/1/18 with diagnoral limited to muscle blood pressure an #99's most recent assessment was with an ARD (asse 5/3/18. Resident cognitively intact idecisions scoring Resident #15 was 4/6/16 and readm that included but victure left shoulder, I heart failure, and most recent MDS	admitted to the facility on oses that included but were not weakness, atrial fibrillation, high ad diabetes mellitus. Resident MDS (minimum data set) a 14 day scheduled assessment essment reference date) of #99 was coded as being in the ability to make daily 13 out of 15 on the BIMS. admitted to the facility on itted on 4/27/17 with diagnoses were not limited to COPD in pulmonary disease), pain in ow back pain, diabetes mellitus, hypothyroidism. Resident #15's (minimum data set) an annual assessment with an				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		, ,		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495240	B. WING			05/	25/2018	
	NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFY(NG INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE	
	Resident #15 was intact in the ability	ontinued From page 218 esident #15 was coded as being cognitively tact in the ability to make daily decisions scoring 5 out of 15 on the BIMS. In 5/23/18 at 5:00 p.m., medication dministration observation was conducted with PN (licensed practical nurse) # 1. At 5:05 p.m., PN #1 applied gloves and started preparing redications for Resident #11. The following redications were prepared:		880				
	administration obs LPN (licensed pra LPN #1 applied gl medications for R						: : :	
	1) Renegal Tablet 2) Vitamin C 500							
	LPN #1 placed the medication in applesauce and then administered the medicine to Resident #11. LPN #1 then walked out of Resident #11's room, took off her gloves, and signed off that the medications were given on the eMAR (electronic medication administration record).							
		#1 applied gloves and started owing medication for Resident		:				
	3) Metformin 500	mg tablet		-				
:	to the administrati #99. LPN #1 rem administration of t	nitize or wash her hands prior on of Metformin to Resident oved her gloves after the the Metformin and began to on for the next resident,					:	
:		#1 applied gloves and wing medication for Resident					;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495240	B. WING	3	05	/25/2018
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION OATE
	LPN #1 opened the took out the insulir of Humalog and acreated that 15. LP LPN #1 did not ware and after the admit On 5/24/18 12:15 conducted with LP When asked how during medication would wash or sar giving medication stated that gloves injections such as would still wash he gloves during medication stated that gloves during medication stated that gloves injections such as would still wash he gloves during medication after gloves are reconducted with LP maintain infection LPN #4 stated that her hands before a given. LPN #4 stated	e container to the insulin and a vial. LPN #1 drew up 8 units dministered the medication to N #1 then removed her gloves. sh or sanitize her hands before nistration of Humalog. p.m., an interview was N (licensed practical nurse) #2. to maintain infection control pass, LPN #2 stated that she litize her hands in-between to each resident. LPN #2 should also be worn for insulin. When asked if she er hands if she were wearing ication pass, LPN #2 stated always be washed or sanitized		880		
	interview. On 5/24/18 at 3:19 staff member) #1,	p.m., ASM (administrative the administrator and ASM #2,				
	of the above conce	of Nursing) were made aware erns.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
•		495240	B. WING			05	5/25/2018
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3900 PLANK ROAD FREDERICKSBURG, VA 22407				
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 880	The facility policy Administration Gepart, the following and water and gloadministration of the parenteral, enteral medications. Har water again after a resident contact. A used in place of state nursing regular No further information (1) Renegal- is incomphosphorus in particles (CKD) on https://dailymed.nm?setid=5e3012011 (2) Vitamin C, also water-soluble vital some foods, added dietary supplement obtained from The https://ods.od.nih. Professional/ (3) Metformin is used that are caused by such as type two obtained from The obtained from The such as type two obtained from The obtained from The such as type two obtained from The obtained from The obtained from The obtained from The form The form The form The form The obtained from The obtained from The obtained from The form	titled, "Medication ineral guidelines," documents in a "Hands are washed with soap ves are applied before opical, ophthalmic, otic, I, rectal, and vaginal ads are washed with soap and administration and with any Antimicrobial sanitizer may be oap and water as allowed per alations and facility policy." Ation was presented prior to exit. Sicated for the control of serum itents with chronic kidney dialysis. Im. nih.gov/dailymed/drugInfo.cf b-f2bf-43a0-86b2-44ae996dc68 O known as L-ascorbic acid, is a min that is naturally present in a dot others, and available as a nit. This information was a National Institutes of Health. gov/factsheets/VitaminC-Health sed to treat high blood sugar y a type of diabetes mellitus diabetes. This information was a National Institutes of Health. Im.nih.gov/pubmedhealth/PMH		380			
		insulin analog indicated to control in adults and children itus. When given					

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495240	B. WING	3	05	5/ 25/201 8
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CO 3900 PLANK ROAD FREDERICKSBURG, VA 22407		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 880	subcutaneously, Fonset of action an than regular huma obtained from The https://dailymed.n	rage 221 HUMALOG has a more rapid d a shorter duration of action an insulin. This information was a National Institutes of Health at lm.nih.gov/dailymed/drugInfo.cf 5-86b8-4926-b8c3-b42133ca7a	F	880		
	of a vial of insulin syringe needle for Resident #15 was 4/6/16 and readm that included but with the left shoulder, I heart failure, and most recent MDS assessment was a ARD (assessment #15 was intact in the ability 15 out of 15 on the On 5/23/18 at 5:00 administration obs	admitted to the facility on litted on 4/27/17 with diagnoses were not limited to COPD re pulmonary disease), pain in low back pain, diabetes mellitus, hypothyroidism. Resident #15's (minimum data set) an annual assessment with an a reference date) of 2/27/18. coded as being cognitively to make daily decisions scoring a BIMS.				
	LPN #1 applied gl medication for Re 1) Humalog 8 unit LPN #1 opened th took out the insulinew vial. LPN #1	ctical nurse) # 1. At 5:29 p.m., oves and prepared the following sident #15: s sliding scale insulin. e container to the insulin and n vial. The insulin vial was not a did not sanitize the top of the ng the insulin needle. LPN #1				

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

Event ID:5S1P11

Facility ID: VA0088

If continuation sheet Page 222 of 223

RECEIVED
JUN 18 2018
VDH/OLC

AD PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DA	(X3) DATE SURVEY COMPLETED		
		495240	B. WING			E/2E/2040	
NAME OF PROVIDER OR SUPPLIER FREDERICKSBURG HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP 3900 PLANK ROAD FREDERICKSBURG, VA 2240	CODE	05/25/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	On 5/24/18 at 12:58 conducted with LPN would maintain infectionsulin, LPN #4 state have a new bottle of top with an alcohol so needle. LPN #4 state maintain infection con 5/24/18, LPN #1 interview. On 5/24/18 at 3:19 p staff member) #1, the DON (Director of of the above concerns The facility policy title Administration: Injection address the above concerns the facility policy title Administration: Injection address the above concerns the facility policy title Administration: Injection address the above concerns the facility policy title Administration: Injection address the above concerns the facility policy title Administration information address the above concerns the facility policy title Administration information. The facility policy title Administration information and a plant of action action and a plant of action and a plant of action action action action ac	umalog and administered the ent #15. p.m., an interview was #4. When asked how she ction control while drawing up ed that if the resident did not insulin, she would wipe the wap before inserting the ed that this was done to introl. could not be reached for an	F 88	30			
<u> </u>	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·				i	