PRINTED: 10/02/2017

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	7 001112011011		.,	A. BUILDIN	IG		
		495144		B. WING_		09/2	1/2017
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DDRESS, CITY, STATE, ZIP CODE			
PETERSI	BURG HEALTHCARE	CENTER		URG, VA 2	OULEVARD 3805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
F 000	An unannounced M survey, and Virginia conducted 9-18-17 Corrections are req CFR Part 483 Fede requirements and V for the Licensure of complaint was investigated of the time of the consisted of 20 curr (Residents #1 through record reviews the facility strength record that the review the facility strength record record reviews (Employees (Employees (Employees that the review the facility strength record record record reviews the facility strength record record reviews the facility strength record record reviews (Employees (Employees that the review the facility strength record record reviews (Residents #1 through record reviews (Resid	firginia Rules and Re Nursing Facilities. Ostigated during the su 120 certified bed facilities survey. The survey rent Resident reviews gh #19 and #23) and sidents #20 through # of compliance with the sure requirements: met as evidenced by: view and employee r aff failed to ensure 1 ee #14) had a criming the Virginia State Pot the criminal backgrouthird party screening	ection was bstantial with 42 gulations one arvey. We sample of 3 closed \$22). ecord of 24 al record olice. und check	F 000	This plan of correction is p executed because it is required provisions of state and fed because Petersburg Health admits or denies the validicallegations and citations list of this Statement of Deficient CommuniCare-Petersburg maintains that the alleged not jeopardize the health a residents, nor is of such chour capability to render admits a regulations, the facility will take the actions set for following plan of corrections COV 32.1- 126.01 (A) 1. Employee #14 had a crim background check complete 09/19/2017. 2. Current employees were ensure they have a correct background check complete Resources/ designee on 09.	uired by the leral law and no care Center ty of the sted on the pagencies. Healthcare Cendeficiencies do and safety of the aracter as to line equate care. ith all federal aty has taken or the in the incenderal and the inc	res nter e nit
	The findings include				3. Administrator/ designee Resources/ designee on pro	educated Huma	
Employee #14 was hired on 6/27/17. The background check was completed by a third party screening service. The results from the screening service document that the criminal history search was performed for Petersburg City, Hopewell City, and the "Eastern District of VA". On 9/21/17, the				of Virginia background chec 10/03/2017.			

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State of \	√irginia						
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ND PLAN O	F CORRECTION	IDENTIFICATION TO	1111111111	A. BUILDI	NG		
		495144		B. WING		09/21/2017	
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE			
PETERSI	BURG HEALTHCARE	CENTER	287 EAST PETERSBI		OULEVARD 23805	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETE	
F 001	third party screenin Virginia State Polic complete the crimin stated that the third The HR Manager presearch conducted dated 9/19/17. The documented. The Administrator and that 12:00 p.m. The facility policy to Exploitation Policy'	(HR) Manager state ag company did not use criminal database anal background check diparty used their own provided a criminal bawith the Virginia State are were no identifial issue was reviewed Director of Nursing of the "Abuse, Neglect" was reviewed. The	se the to k. She in search, ackground e Police ble issues with the in 9/21/17 and section	F 001	4. A Virginia background check conducted on a weekly basis ensure correct Virginia backgroundleted by the Human Resources/designee on new hassurance/ Performance Importante to ensure complianced for further monitoring functions.	for 12 weeks to round check is nires. Results to the Quality rovement nce and the	
	titled "Screening" read "2. A criminal background check will be completed to meet state requirements" and "d. Criminal State Background Checks". The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Resident Rights 12 VAC 5-371-220 (H). Please Cross Reference to F-157 notification. Freedom from Abuse, Neglect, and Exploitation. 12 VAC 5-371-110 (B.1-3) Cross Reference to F-225 Freedom from Abuse, Neglect, and Exploitation. 12 VAC 5-371-110 (B.1-3) Cross Reference to		the s for the deference bloitation. ence to bloitation.		Resident Rights 12 VAC 5-371-220 (H). Please reference to F-157 notification Freedom from Abuse, Negleon 12 VAC 5-371-110 (B1-3) Crost F-225. Freedome from Abuse, Negleon 12 VAC 5-371-110 (B.1-3) Crost Production (B.1-3)	et, Exploitation. ess reference to ect, Exploitation.	
	Resident Rights 12 VAC 5-371-140	F-226 Resident Rights 12 VAC 5-371-140(D)(15)(d). Please			F-226.		

STATE FORM

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Resident Rights

on sheet 2 of 5

12 VAC 5-371-140(D)(15)(d). Please Cross Reference to F-241.

PRINTED: 10/02/2017

FORM APPROVED State of Virginia (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 09/21/2017 B. WING. 495144 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) Resident Assessment F 001 Continued From Page 2 F 001 12 VAC 5-371-250 (B.2) Cross Reference to F-Cross-Reference to F-241. 274. Resident Assessment 12 VAC 5-371-250 (B.2) Cross Reference to Comprehensive Person Centered Care F-274 Planning. 12VAC 5-371-250 (C) Cross Reference to F-Comprehensive Person Centered Care Planning 12 VAC 5-371-250 (C) Cross Reference to F-280 280. Comprehensive Person Centered Care Planning Comprehensive Person Centered Care 12 VAC 5-371-200 (B)(1)(ii). Please Cross-Reference to F-281. **Planning** 12 VAC 5-371-200 (B)(1)(ii). Please Cross-Quality of Life/Quality of Care 12 VAC 5-371-220 (A)&(B). Please Reference to F-281 Cross-Reference to F-309. (Harm level deficiency) Quality of Life/ Quality of Care 12 VAC 5-371-220n(A)&(B). Please Cross-Quality of Care 12 VAC 5-371-220 Cross Reference to F-315 Reference to F-309 (Harm Level deficiency) Quality of Care 12 VAC 5-371-220 (A/B/D). Please Quality of Care Cross-Reference to F-323. (Harm level 12 VAC-371-220 Cross Reference to F- 315 deficiency) **Pharmacy Services** Quality of Care 12 VAC 5-371-220 (B). Please Cross-Reference to F-329. 12VAC 5-371-220 (A/B/D). Please Cross reference to F - 323. (Harm level deficiency) **Pharmacy Services** 12 VAC 5-371-220(B) Cross Reference to F-333

STATE FORM

Pharmacy Services

Physician Services

Pharmacy Services

12 VAC 5-371-180 Cross Reference to F-334

12 VAC 5-371-240(F) Cross Reference to F-387

12 VAC 5-371-300(A, B) Cross Reference to

333. 296V11

Pharmacy Services

Reference to F-329.

Pharmacy Services

12 VAC 5-371-220 (B). Please Cross

12 VAC 5-371-220 (B) Cross Reference to F-

If continuation sheet 3 of 5

PRINTED: 10/02/2017 FORM APPROVED

State of Virginia (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 09/21/2017 B WING 495144 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) Pharmacy Services F 001 F 001 Continued From Page 3 12 VAC 5-371-180 Cross Reference to F-334. F-425 **Physician Services** Infection Control 12 VAC 5-371-240(F) Cross Reference to F-12 VAC 5-371-180 (A) Cross-Reference to F-441. 386. Quality Assurance and Process Improvement 12 VAC 5 - 371 - 190 Cross Refernce to F-518 **Pharmacy Services** Resident Rights 12 VAC 5-371-300(A, B) Cross Reference to 12 VAC - 371 - 150 F425. Based on the Code of Virginia, facility document review, and staff interview, the facility staff failed to complete sex offender registry checks on all Infection Control admissions prior to admission, and further failed 12 VAC 5-371-180 (A) Cross Reference to Fto inform Residents upon admission how to access the sex offender registry. The facility 441. could provide no policies on sex offender requirements related to protections of the facility Quality Assurance and Process Improvement population with regard to sex offenders and Virginia state law. 12 VAC 5-371-190 Cross Reference to F-518. The findings included: 12 VAC 371 150 (g) On 9-18-17 upon entrance to the facility at 2:00 1. Facility did not notify residents how or p.m., the Administrator was asked to provide where to obtain Virginia sex offender (within 24 hours)evidence that the facility was registry information for current residents. receiving automatic sex offender notifications from the Virginia State Police, and also to provide proof They were notified on or by 10/10/2017. that registry checks were conducted on all those Sex offender registry was checked for admitted to care, and asked how the facility made current residents on 07/20/2017. admitted Residents aware of the sex offender registry, and how to access it. 2. Current residents were notified of how and where to access the Virginia sex On 9-19-17 the administrator gave proof of offender registry by the Admissions receiving automatic alerts of new sex offenders registered in the area from the Virginia state Director/ designee by phone or letter by police, however, stated they had not been 10/09/2017. Current residents were completing background checks for sex offender checked against the Virginia Sex Offender status of admissions, and had just started this 7-20-17. The Administrator further stated they registry on 10/03/2017. had not been educating new admissions and or

PRINTED: 10/02/2017 FORM APPROVED

State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 09/21/2017 B. WING 495144 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) 3. The administrator educated the F 001 F 001 Continued From Page 4 Admissions Director/ designee how and their responsible parties of how to access the where to access the Virginia sex offender registry, and stated she had no policies with registry on 10/03/2017. regard to these protections. The facility abuse policies were reviewed, and made no mention of 4. A weekly audit of new admissions will be these protections. conducted by the Admissions Director/ designee to ensure new residents know how The facility administrator and Director of Nursing were made aware of the deficient practice at the to access the Virginia sex offender registry end of day debriefings on 9-19-17, 9-20-17, and times twelve weeks and new admissions will 9-21-17. No further information was provided by be checked against the Virginia Sex Offender the facility. Registry. Results from audits will be forwarded to the Quality Assurance Meeting to ensure compliance and the needfor further monitoring for three (3) months. 11/03/2017

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

PRINTED: 10/02/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING_		09	/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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	
	survey was conduct Substantial Correct compliance with 42 Term Care required investigated during. The census in this 106 at the time of the consisted of 20 curres (Residents #1 throus record reviews (Residents	Medicare/Medicaid standard ted 9-18-17 through 9-21-17. ions are required for CFR Part 483 Federal Longments. One complaint was the survey. 120 certified bed facility was the survey. The survey sample tent Resident reviews gh #19 and #23) and 3 closed sidents #20 through #22). FY OF CHANGES (ROOM, ETC) of Changes. mediately inform the resident; dent's physician; and notify, or her authority, the resident men there is- oliving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or	F 00	Federal Tags F 157	t 0440. orts for the ere reviewed obysician on cated on cication of xraor before expension of the complete of	to ay	
		ED/SLIDDI IED DEDDESENTATIVE'S SIGN		months.	11	/03/2017	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495144	B. WING			0	9/21/2017
	PROVIDER OR SUPPLIER SBURG HEALTHCARE	CENTER		287	ET ADDRESS, CITY, STATE, ZII EAST SOUTH BOULEVARD ERSBURG, VA 23805	CODE	9
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	(D) A decision to tra resident from the fa §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatis available and prophysician. (iii) The facility must resident and the resident (e)(10) of this section (iv) The facility must update the address phone number of the This REQUIREMEN by: Based on staff interreview, and clinical resident and clinical resident and the resident and th	ensfer or discharge the acility as specified in obtification under paragraph (g) in, the facility must ensure that ation specified in §483.15(c)(2) wided upon request to the sident representative, if any, on or roommate assignment and assignment assignment as specified in paragraph in. The cord and periodically (mailing and email) and a resident representative(s). The is not met as evidenced wiew, facility documentation ecord review, the facility staffer (Resident # 2) in a survey into the obtaining derivative and injury secovered.	F 18	57			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORI	D: 10/02/2017 M APPROVED D. 0938-0391
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495144	B. WING_		00	9/21/2017
	PROVIDER OR SUPPLIER SBURG HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	1 08	012 1120 11
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	Continued From page	ge 2	F 15	7		-
	to the facility on 3/2/included but were no Depressive Disorder Symptoms, Pseudol Pacemaker, Anemia thrombosis. Resident #2's most uset) with an ARD (as	par old female, was admitted 2012. Her diagnoses of limited to: Major or with severe Psychotic oulbar Affect, Cardiac or, Acute embolism and recent MDS (minimum data assessment reference date) of as a Quarterly assessment.		*		
	She was coded as h memory deficits, sev She was also coded assistance of one pe activities of daily livir transfers. For transf needing total assista	aving short and long term vere cognitive impairments. as needing extensive to total erson to perform all of her ag with the exception of ers, she was coded as nce of two staff members. lways incontinent of bowel				
	On 9/19/2017 at 8:45 record was reviewed	5, Resident # 2's clinical				
	Review of Resident # nursing note entries:	‡ 2's clinical record revealed				
	CNA (Certified Nursing Res. (Resident) right land grading and proupon assessment representing to hard fouch, bruising to hard hand. Res. pulls away performed, right hand	5 p.m.) "Called to room by ang Assistant) Stated hand was swollen and Res. otecting her right hand. s. noted alert and verbally d at wrist area warm to and forearm edema to y when assessment I elevated on pillow res. hysician notified orders				

received continue to observe."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495144	B. WING		00	09/21/2017		
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, 2 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	ZIP CODE	72172017		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	at 17:30 order giver (immediately). Call p.m.) No attendant 24703467. Attendar arrival 21:30 (9:30 p attendant to arrive in monitor and refer." "8/10/2017 01:00 (1 (wheelchair) @ (at) wrist and hand monhand purple discolor moved without diffic 8/10/2017 02:15 (2: X-ray of right lower a 8/10/2017 04:40 (4:4 x-ray show spiral frasome displacement. is osteopenia. Dr. was send to the ER (Eme The Physician order 5:30 p.m. and the Mccompleted until 8/10/attendant at facility." documentation that the delay in obtaining Physician was notifie which revealed a spir 8/10/2017 at 4:40 a.r. for X-ray was received in jury.	30 p.m.) Mobile X ray called an Claim # 24702593 Stat to Mobile X-ray @ 19:05 (7:05 at facility. New claim ticket and the to call facility no time of o.m.), call from mobile x-ray an 2 1/2 hours. Will continue to consider the beginning of shift, right intered, swelling remain to top ration noted, right hand and ulty, no discomfort noted. 15 a.m.) Mobile X-ray in to do farm. 10 a.m.) X-ray report back, cture of distal third ulna with No wrist FX (fracture), there are notified, order given to be regency Room)." 10 a.m. order given to be regency Room. 11 and the X-ray was not for the X-ray was not for the results of the X-ray ray ray fracture of the ulna on the Physician was notified of the results of the X-ray ray fracture of the ulna on the Industry of the world of the results of the X-ray ray fracture of the ulna on the Industry of the world of the results of the X-ray ray ray fracture of the ulna on the Industry of the world of the results of the X-ray ray fracture of the ulna on the Industry of the world of the results of the X-ray ray fracture of the ulna on the Industry of the world of the results of the X-ray ray fracture of the ulna on the Industry of the world of the Industry of Indus	F 18	57				
I	During the end of day	y debriefing on 9/21/2017,				1		

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	G	COMPLETED	
		495144	B. WING		09/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG			PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 157	Continued From pa the DON, Administ were informed of the No further informat	rator and Corporate consultant e findings.	F 157	7	
F 225 SS=E	483.12(a)(3)(4)(c)(1) ALLEGATIONS/INI 483.12(a) The facili (3) Not employ or of who- (i) Have been found exploitation, misappy mistreatment by a city of the control of the	ty must- therwise engage individuals I guilty of abuse, neglect, propriation of property, or court of law; Ingentered into the State concerning abuse, neglect, atment of residents or their property; or ary action in effect against his license by a state licensure a finding of abuse, neglect, atment of residents or resident property. Interest enurse aide registry or any knowledge it has of any knowledge it has of any knowledge it has of a licenses for service as a facility staff. Illegations of abuse, neglect, reatment, the facility must:	F 225	1. Resident #2's investigation was reinvestigated on 10/09/2017. References interviewed on 09/20/2017. Resident #7's investigation was reported on 06/20/2017. Resident investigation was reported on 06/20/2017. September 2017 were reviewed to a timely completion, thorough investigand timely reporting to reporting agroccurred by DON/Administrator/ defon 10/05/2017. 3. Facility staff will be educated on the to immediately report incidents/ sus abuse to supervisor by Administrated designee on or before 11/03/2017. 4. Facility reported incidents will be reviewed timely and reported as the per abuse policy. Results from audit forwarded to the Quality Assurance, Performance Improvement Committee insure compliance and the need for monitoring for three (3) months.	ation was #8's 8/2017. ensure gations, gencies esignee the need spicion of or/ ey occur s will be / tee to
		lleged violations involving loitation or mistreatment,			11/03/2017

DEPAR CENTE	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 10/02/2017 M APPROVED D: 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3) DA	ATE SURVEY OMPLETED
		495144	B. WING		00	0/24/2047
	PROVIDER OR SUPPLIER SBURG HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP COE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	DE TOS	9/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BF	(X5) COMPLETION DATE
	including injuries of misappropriation of reported immediatel after the allegation is cause the allegation serious bodily injury, the events that caus abuse and do not rethe administrator of tofficials (including to adult protective servifor jurisdiction in long accordance with Starprocedures. (2) Have evidence the thoroughly investigated (3) Prevent further precedures investigation, or mistre investigation, or mistre investigation is in procedure and to with State law, including Agency, within 5 work if the alleged violation corrective action must his REQUIREMENT by: Based on resident interview, the facility starinvestigate and report	unknown source and resident property, are y, but not later than 2 hours is made, if the events that involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ces where state law provides geterm care facilities) in the law through established at all alleged violations are ed. Intential abuse, neglect, eatment while the gress. In of all investigations to the redesignated other officials in accordance and to the State Survey sting days of the incident, and its verified appropriate to the taken. It is not met as evidenced therefore, and clinical record failed to thoroughly injuries of unknown origin 4 residents (Residents #4.	F 22	25		

residents.

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 Continued From page 6 F 225 1. For Resident #4, the facility staff failed to interview her cognitively intact roommate (Resident #1) who witnessed the fall involving an improper transfer by staff, that resulted in a leg fracture. 2. For Resident # 2, the facility staff failed to thoroughly investigate and failed to report to the State agency timely of an injury of unknown origin involving a spiral fracture of the ulna. "The ulna is one of two bones that give structure to the forearm. ... It ioins with the humerus on its larger end to make the elbow joint, and joins with the carpal bones of the hand at its smaller end. Together with the radius, the ulna enables the wrist joint to rotate. Ulna Bone Anatomy, Diagram & Function | Body Maps - Healthline www.healthline.com/human-body-maps/ulna-bon 3. For Resident #7, the facility staff failed to report to the facility administration about a significant (insulin) medication error timely. They further failed to report the escalating situation (hospitalization) to the State agency timely, within the allotted time frame, of a serious injury caused by the error. 4. For Resident #8, the facility staff failed to report

unknown origin.

The Findings included:

to the state agency timely, of a fracture of

Resident #4 was an 88 year old who was

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/02/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 | Continued From page 7 F 225 admitted to the facility on 2/22/06. Resident #4's diagnoses included Proximal Tibia Displaced Metaphyseal and Impacted Plateau Fractures (crushed bone), Muscle Weakness-Generalized, Age-Related Osteoporosis, Schizophrenia. Psychotic Disorder, Hypertension, and Alzheimer's Disease

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/7/17, coded Resident #4 as having a Brief Interview of Mental Status Score of 7 - indicating severely impaired cognition. For transfers, she was coded as requiring the extensive physical assistance of two persons. In the area of functional limitation in range of motion, she was coded as having lower extremity impairment on both sides. Her mobility device was a manual wheelchair.

On 9/19/17 a review was conducted of facility documentation, revealing Resident #4's Care Plan, which read, "Initiated 3/9/10. Revised 7/18/17. I am at risk for and have had an actual fall related to: Cognitive impairment with decreased safety awareness. I am easily distracted and have poor insight/judgement. I am incontinent and I am dependent for ADLs (Activities of Daily Living). Assist resident with all transfers." The Care Plan had not been revised to include the requirement of the extensive physical assistance of two persons for transfers.

On 9/19/17 at 8:30 A.M., an observation was conducted of Resident #4, who was in her bed. When asked about how her leg was feeling, Resident #4 smiled and appeared to be confused. Suddenly, her roommate who was identified and put into the sample as Resident #1, made an

Event ID: KO0Q11

		E & MEDICAID SERVICES			FOR	M APPROVE D. 0938-039	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/SU		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER SBURG HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	ODE	09/21/2017	
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	unsolicited stateme aides named Caroly herself and dropped her in her wheelchahands and fell on the went to the hospital leg brace on, and half." Resident #1's Status Score was 1 impairment. Resident #4's clinicated following x-ray report Findings: Four views tibia displaced metaplateau fractures, ar severe tricompartment osteophytes and los On 9/19/17 a review conducted, revealing on 6/29/17. It read, "Resident assessment fracture. Documents 6/25/17. Investigation facility follow-up read 25, 2017, (CNAA - Cordinated transferred (Resident wheelchair." Accordinated transferred (Resident wheelchair." Accordinated transferred (Resident transferred	ant. She said, "One of the yn (CNA A) came in here by dispersion the floor while putting hir. She slipped out of her he floor. She broke her leg and here said it on for a month and a lad it on cognitive lad record contained the fit, "6/28/17 10:23 A.M. It is of the left knee. Proximal physeal and impacted the partially obscured by the ental osteoarthritis with large is of joint space. Effusion. In facility documentation was a Facility Reported Incident linjury of Unknown Origin. In the revealed left tibia plateau reveal resident had a fall on the pending." On 7/3/17, the lad, "Upon investigation, June dertified Nursing Assistant) the floor in the report, only one coted the transfer instead of lad in law resident body in the lad in law resident body in the sident butt was on the floor in the sident but was on th	F 22				

extended. Resident left leg was under her butt." This incident occurred during the day shift at 7:50

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 10/02/201	
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	OULD BE	(X5) COMPLETION DATE	
	A.M. The clinical record of Nursing Progress N Resident resting in Is lung fields clear, no noted. No dizzy spel position, call bell in rhours." For the next there was no further continuous shifts). On 6/28/17 the Nurs Vital signs 99.2-90-2 noted with edema to bruising present to lo (complains of) pain v CNA to dress her. Re Tylenol Tabs 2 PO (b made aware STAT x knee (left lower leg). It to the hospital at 7:00 facility at 6:45 P.M. N medication, use of kneed with the progress not called report. No surgestimate in the strength of the surgestimate in the sur	contained the following ote, "6/25/17/ 10:51 P.M. Ded, respirations unlabored, coughing or congestion Is noted. Bed in lowest reach. Staff monitoring Q 2 three days, until 6/28/17 post-fall monitoring (7 sing Progress Note read, "2-138/86-96%. Resident left knee and lower leg ower leg. Resident C/O when touched, will not allow resident medicated for pain by mouth) for left leg pain. DR ray of left FIB TIB and left 'Resident #4 was admitted D.A.M. and returned to the	F 22	5			
		.M., an interview was					

The Director of Nursing, who had conducted the investigation, was present. When asked why she transferred Resident #4 without the assistance of another staff member, CNAA stated, "The way I was trained the person demonstrated that the resident needed only 1 person for transfers.

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 225 Continued From page 10 F 225 When CNA A was informed that Resident #1 witnessed the fall, she admitted that Resident #1 was in the room, but said that "the curtain was pulled." There was no documentation that the curtain had been pulled. When the Director of Nursing was asked why Resident #1 wasn't interviewed regarding the fall, she stated. "Because I didn't know that she was in the room and I didn't ask." On 9/19/17 at 5:00 P.M. the facility Administrator (Administration A) was notified of the findings. On 9/20/17 the Administrator submitted following (name of facility) Plan of Correction: "Findings: Facility failed to properly investigate two injuries of unknown origins. The facility failed to interview all potential witnesses. Resident: (#4) Fell on 6/25/17, and on 6/28/17 diagnosed with a left knee fracture. Resident: (#2) Diagnosed with a fracture of unknown origin.

were being performed."

100% of residents with hi risk for injuries related to falls were reviewed to ensure proper transfers

The Plan of Correction also stated that all facility residents were assessed for proper transfer techniques and initiated on 9/19/17. Nursing staff were in-serviced. In addition, CNAA had been suspended pending investigation, and had subsequently resigned. The Plan also stated that all department heads were in-serviced on the proper way to complete an investigation.

2. For Resident # 2, the facility staff failed to thoroughly investigate and failed to report to the State agency timely of an injury of unknown origin

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 11 F 225 involving a spiral fracture of the ulna. Resident #2, a female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis. Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. On 9/19/2017, Resident # 2's clinical record was reviewed. Review of the Nurse's Notes revealed entries: "8/9/2017 17:15 (5:15 p.m.) "Called to room by CNA (Certified Nursing Assistant) _____. Stated Res.(Resident) right hand was swollen and Res. was guarding and protecting her right hand.

received continue to observe."

Upon assessment res. noted alert and verbally responsive, right hand at wrist area warm to touch, bruising to hand and forearm edema to hand. Res. pulls away when assessment performed, right hand elevated on pillow res. medicated for pain. Physician notified orders

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 225 | Continued From page 12 F 225 8/9/2017 17:30 (5:30 p.m.) Mobile X ray called at 17:30 order given. Claim # 24702593 Stat. Call to Mobile X-ray @ 19:05 (7:05 p.m.) No attendant at facility. New claim ticket 24703467. Attendant due to call facility no time of arrival 21:30 (9:30 p.m.), call from mobile x-ray attendant to arrive in 2 1/2 hours. Will continue to monitor and refer." "8/10/2017 01:00 (1:00 a.m.) Res up in w/c (wheelchair) @ (at) the beginning of shift, right wrist and hand monitored, swelling remain to top hand purple discoloration noted, right hand moved without difficulty, no discomfort noted. 8/10/2017 02:15 (2:15 a.m.) Mobile X-ray in to do X-ray of right lower arm. 8/10/2017 04:40 (4:40 a.m.) X-ray report back. x-ray show spiral fracture of distal third ulna with some displacement. No wrist FX (fracture), there is osteopenia. Dr. was notified, order given to send to the ER (Emergency Room). 8/10/2017 05:18 (5:18 a.m.) Resident out to hospital via ambulance." Documentation revealed that on 8/9/2017 at 5:30 p.m., the clinician ordered an X-ray of Resident

Room at 5:18 a.m.

2's right hand. The X-ray was obtained 8/10/2017 at 2:15 a.m. and Resident #2 was determined to have a "spiral fracture of the distal third of the ulna." The physician ordered for Resident #2 to be evaluated by the hospital Emergency Room. Resident # 2 was transported to the Emergency

Review of the X-ray from the hospital: X-ray of Resident #2's right forearm and right

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/02/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 225 Continued From page 13 F 225 wrist obtained 8/10/2017, read by the radiologist 8/10/2017 at 4:22 a.m. revealed results: Forearm AP and LAT, Right "Findings: There is fracture of the distal third of the ulna with mild displacement. The radius is intact. There is osteopenia. Radial head is normal. Conclusion: Spiral type fracture of the distal third of the ulna with some displacement. Soft tissue swelling." Wrist AP and LAT, Right: Comparison: 9/2/2016 Results Findings: There is no fracture of the wrist. There is osteopenia. The radiocarpal joint space is normal. There is spiral fracture of the distal third of the ulna with some displacement. Conclusion: No fracture of the wrist itself. There is fracture of the distal third of the ulna with displacement." Review of the Emergency Room Documentation revealed Resident # 2 was seen by the ER physician at 5:42 a.m. The ER notes on page 7 of 12 under History of Present Illness stated "Patient had fallen earlier in the evening." Also stated "there x-ray showed a right ulnar fracture. She does have some wrist swelling without any obvious fracture seen on her x-ray." The Physical examination results on page 8 of 12 included statements under Musculoskeletal: "Right upper extremity with deformity midshaft. Significant

bruising and swelling at the hand and wrist., not normal ROM (Range of Motion), not normal strength." A Sugar Tong splint was placed by the

The facility began an investigation into Resident # 2's injury of unknown origin, her fractured ulna.

ER technician on the right side.

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 10/02/2017 MAPPROVED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		0/L 1/20 11
PETERS	BURG HEALTHCARE	CENTER		287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
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	Review of the invest handwritten note by who worked 8/8/201 witness statements, Nursing and each si of the typed witness occurrence as 8/10/CNA G and CNA H) and one was signed actual date of discov 8/9/2017. Further restatements revealed the LPNs who worke 8/8/2017 on 3-11 shi statements from CN. Assistants) who work 8/8/2017 on 11-7 shi There was no Witnes (Licensed Practical N shift on 8/9/2017, the injury and no witr Licensed Practical N the injury on 3-11 shi There was a handwri witness statement from Resident # 2 on 8/8/2 note revealed the narlisted and it was not oreported discoloration stated she assessed see anything other the	RN (Registered Nurse) A 7 on 11-7 shift and 5 typed typed by the Director of gned by the witnesses. Each statements listed the date of 2017, four (CNAA, CNAF, were signed on 8/11/2017 by CNA-I on 8/14/2017. The very of the injury was view of the witness no witness statements from ed 8/8/2017 on 7-3 shift, ft, 8/9/2017 on 7-3 shift, ft. There were no witness As (Certified Nursing ked 8/8/17 on 3-11 shift, and ft ess statement from the LPN lurse) who worked on 7-3 e shift prior to discovery of ness statement from urse (LPN D) who assessed ft on 8/9/2017. tten note presented as a om RN A who worked with 2017 11-7 shift. Review of the me of the resident was not dated. RN A stated the CNA on the right hand. RN A the right hand and did not	F 22	25		

round the CNA report a discoloration. I assessed the right hand and did not see anything, just the discoloration. hand moved without difficulties. no

		AND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/02/201 M APPROVEI	
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	72112011	
PETERS	BURG HEALTHCARE	CENTER		287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
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F 225	s/s (signs and sympthat time. Resident There was no docur of the concern report assessment of the relinical record. There	otoms) of discomfort noted at did not get up on 11-7 shift." mentation in the nurses notes rted by the CNA and no ight hand was found in the e was no Witness statement -7 shift on 8/8/17 who	F 22	5			
	stated an investigatiorigin had been concurable to substantia there were no staten initially assessed the other staff members Resident # 2, the DC nurses' note. The DC nurses' note.	nducted with the DON who on of the injury of unknown ducted and the facility was te abuse. When asked why nents from the LPN who e right arm on 8/9/2017 and assigned to work with DN stated the LPN wrote a DN was asked to provide all e investigation of the injury of					
	DON were informed thoroughly investigat origin and interview a The Administrator stareported to the State 2 hours of discovery. stated a thorough invocempleted at the time injury of unknown original investigation.	m., the administrator and of the failure of the staff to e the injury of unknown all potential witnesses. ated Serious Injuries must be Agency within no more than The Administrator also restigation should have been e of the discovery of the gin and that another					

Review of the Investigation Planning Tool revealed documentation on Page 2 Under "Other

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	D: 10/02/2017 MAPPROVED
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NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER				287	EET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD FERSBURG, VA 23805	,	0/21/2017
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	Potentially Affected residents who may a Abuse QIS (Quality the interview able resobservation on nonattach documentation attach, skin sweep a do you feel safe" attach a safe resident five answers of n/a ("out" was written nexthere was no answer and there were two census for Wing 1. written on two of the and no response writthat hall. There was a hall. The Census shempty beds but one shandwritten in one rototal census of 57 resident and 9 empty beds on 8/9/2017. 40 resident as discharged, 2 were was listed as "n/a". If for 5 residents on Will Review of the Facility the State Agency on a was faxed in the State 5:32 PM by the previoof the Intake Informatical construction.	Residents (identify any nave been affected, use the Indicator Survey)questions for esidents and do a skin interview able residents to on)": In-service on abuse attach, Abuse question "ask ach. Review of the Midnight 1/9/2017 Attachment revealed sponses to the Question: Do ed of the residents on Wing 1. Iters of "yes" written next to onto on Wing 1. There were not applicable) and the word at to one resident's name. For written for 28 residents. The response of "n/a" was 3 residents on the 300 hall then for the other resident on one empty bed on the 300 lowed 56 occupied beds, 4 resident's name had been from on Wing 1, indicating a sidents on Wing 1 and the of the control of the Census on the replied yes, 3 were listed the in the hospital and one of the was no answer listed.	F 2	25			

the State Agency on 8/10/2017 at 8:29 AM.

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		AND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 10/02/2017 MAPPROVED
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	DDE	0/21/2017
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Review of the clinic unknown origin was 5:15 PM. Review of the Faciliand Exploitation on 5/1/2017 revealed sthis policy, immedia soon as possible, but after the alleged incomposition bodily injury is discompositional and other allegations. Origin: an injury should of unknown origin work conditions are metal not observed by any definition for Injury of missing from the doubter definitions conseclusion." The copt the surveyors only in and 3 of 23). The tothere were 23 pages on 9/20/2017, the Aof Correction with find properly investigate origins. The facility of witnesses. The planes of residents with falls were reviewed to were being performed was presented after a thorough investigate. On 9/20/2017 during the facility Administration.	al record revealed the injury of a discovered on 8/9/2017 at ty Policy on Abuse, Neglect Page 2 of 23, Effective tatements "For the purpose of tely is to be interpreted "as ut no more than two hours ident of abuse or serious vered and within 24 hours for 'Under "Injury of Unknown uld be classified as an injury hen both of the following a) the source of the injury was person. ** The rest of the of Unknown Origin was cument. On the next page tinued with "involuntary by of the Abuse policy given to included 3 pages (pages 1, 2 per of the document stated as to the policy. Idministered presented a Plantage of the injuries of unknown failed to interview all potential in included statement that 100 pigh risk for injuries related to one ensure proper transfers ad." The plan of correction the survey team discovered	F 225			

again stated Serious Injuries must be reported to

PRINTED: 10/02/2017

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FOR	M APPROVED D. 0938-039
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NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER				287 E	T ADDRESS, CITY, STATE, ZIP CODI AST SOUTH BOULEVARD RSBURG, VA 23805		72172011
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F 225	the State Agency widiscovery. The Admithorough investigatic completed at the tininjury of unknown or investigation was cultivated. No further information. 3. For Resident #7, to the facility adminical (insulin) medication failed to report the election (hospitalization) to the allotted time frame by the error. Resident #7 was addictional facility adminical facility adminical facility adminical facility adminical facility adminical facility. Resident #7 was addictional facility adminical facility adm	ithin no more than 2 hours of inistrator also stated a on should have been he of the discovery of the rigin and that another arrently being conducted. In was provided. Ithe facility staff failed to report stration about a significant error timely. They further inscalating situation he State agency timely, within he, of a serious injury caused mitted to the facility on ses that included; Diabetes, ase, Hypertension, ares, hyponatremia, gout, disease, history of urinary bry of clostridium difficile, asure ulcer with infection, and seesment reference date) of a significant change ent #7 was coded as having	F 22	25			

On 9-19-17 a thorough review of the resident's clinical record was conducted. Nursing progress

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 10/02/201 ⁻ M APPROVED D. 0938-039 ⁻
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	_10s	0/21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE
	notes were reviewer 6-20-17 at 12:55 p.r "cold/clammy/diaphe The note goes on to received a subcutanther left upper arm. nursing note describblood sugar reading doctor order the blood after the glucagon gp.m. (12:55), and at blood sugar was 158 documented as 138 the Resident was set the emergency room hypoglycemia, and fanursing notes that the 116 milligrams/deciliant Review of hospital errevealed that EMS (ambulance reported administered oral gluafter administration, was now 78, at the tireview of the hospitate p.m., on 6-20-17 the again dropped to 46, gone up to 79, after in 10% 1000 ml (millilite 5% 1000 ml to includ potassium chloride wadmitted to the hospit	d and revealed that on m. the Resident was pretic with blood sugar of 31." say that the Resident recous injection of Glucagon in On 6-20-17 at 3:03 p.m. a resident had a of 34 at 2:00 p.m., as the od sugar recheck in 1 hour riven at approximately 1:00 3:00 p.m. the Resident's	F 22			

Interviews were conducted on 9-19-17, and 9-20-17 with the Administrator and Director of Nursing (DON) with regard to this situation. They

facility.

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495144 B WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 225 Continued From page 20 F 225 stated that the Resident had received 18 units of regular rapid acting (Humalog) insulin at 9:00 a.m., on 6-20-17, instead of the (Humulin N) Isophane long acting insulin, which was ordered to be given at that time. Prior to the administration of the wrong insulin, the Resident's blood sugar at 6:00 a.m., was 82. Review of physician's orders and the Medication Administration Record (MAR) revealed that the Resident was ordered to have, and receiving the following 2 types of insulin: 1. Humulin (N) inject 18 units subcutaneously every 12 hours for diabetes at 9:00 a.m., and 9:00 p.m. 2. Humalog (lispro) inject as per sliding scale every 6 hours; at 12 midnight, 6:00 a.m., 12:00 noon, 6:00 p.m. if blood sugar 351 to 400 give 20 units subcutaneously. if 401 to 450 give 25 units. if 451 to 500 give 30 units. if 501 to 502 give 35 units and call doctor. If blood sugar less than 60 or greater than 501 call doctor. The Administrator and DON went on to say that the nurse who had given the wrong insulin had not realized the error until another nurse saw the Resident and asked what the medication nurse had given to the Resident. The medication nurse

the time of survey.

showed the second nurse the vial of regular insulin and the second nurse reported the error. The nurse who made the error was terminated. At the time of the incident, the administrator was not the same individual acting as administrator at

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evidence of re-training.

acting) insulin was finally decreased, and administration time changed on 7-1-17, 5 days after the Resident returned, and the Regular humalog sliding scale insulin was continued as before. No re-education of staff was included in the investigation packet reviewed by surveyors, and was not provided by administration as

In conclusion, the investigation, reporting, and education for this incident were not completed as required by federal mandate. The Administrator and DON (Director of Nursing) were made aware of the deficient practices at the end of day debriefs on 9-19-17, 9-20-17, and 9-21-17. No further information was presented by the facility.

4. For Resident #8, the facility staff failed to report to the state agency timely, of a fracture of

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serious injury occurred.

Tuesday 6-27-17 at 1:21 p.m. the Resident's"MD (doctor) was made aware of swelling to right hand. Order received to obtain a two viewed x-ray of Resident's right hand." The notes go on to say the Resident was guarding the hand because of pain, and exhibited facial grimacing as well. No description was given as to how the

The X-ray was completed and resulted on 6-27-17 and signed by the Radiologist at 2:43 p.m. on that day. The diagnosis was "Acute fracture of the fourth metacarpal probably in satisfactory position." This revealed a fractured

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	1 00/2 1/2011		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)					
F 225	hand (broken bone The facility did not runknown origin to the Wednesday 6-28-11 been within 2 hours fracture. The 5 day investigation was not agency until 7-5-17 late. In conclusion, the renot completed as resulting the Administrator at the deficient practic on 9-19-17, 9-20-17 information was present as 12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and present property, (2) Establish policies investigate any such (3) Include training as \$483.95, 483.95 (c) Abuse, neglect, as a such control of the such property, (4) Establish policies investigate any such property, (5) Establish policies investigate any such property, (6) Abuse, neglect, as a such property, (7) Establish policies investigate any such property, (8) Include training as \$483.95,	in the hand). report the injury (fracture) of the state agency until 7, and the report should have to of the identification of the rollow up report of the state (7 busines's days), and also reporting for this incident was required by federal mandate. Ind DON were made aware of the at the end of day debriefs 7, and 9-21-17. No further sented by the facility. 3.95(c)(1)-(3): INT ABUSE/NEGLECT, ETC report of the end of the control of the	F 226	F 226 1. Resident #2's investigation was reinvestigated on 10/09/2017. Resroommate was interviewed on 09/3 Resident #7's investigation was rep 06/20/2017. Resident #8's investig reported on 06/28/2017. 2. Facility reported incidents from September 2017 were reviewed to timely completion, thorough invest and timely reporting to reporting agoccurred by DON/Administrator/ do on 10/05/2017.	20/2017. Ported on sation was ensure igations, gencies		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
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F 226	Continued From page 24 requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed for 4 residents		F 226	3. Facility staff will be educated to immediately report incident abuse to supervisor by Adminis designee on or before 11/03/2. 4. Facility reported incidents we reviewed timely and reported apper abuse policy. Results from a forwarded to the Quality Assur Performance Improvement Contensure compliance and the need monitoring for three (3) month.	ents/ suspicion of ninistrator/ 3/2017. s will be ed as they occur om audits will be ssurance/ Committee to need for further			
	policies. 1. For Resident #4, operationalize abus The facility staff was suspend and thorou involved in an improleg fracture. 2. For Resident # 2 operationalize the ainvestigation and tirunknown origin. 3. For Resident #7, operationalize (put invegard to investigationalize)	the facility staff failed to e policies in a timely manner. ited almost three months to aghly investigate a CNA oper transfer, that resulted in a the facility staff failed to buse policies regarding nely reporting of injuries of the facility staff failed to nto practice) their policies in ing, educating, and timely as of serious injury concerning						

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On 9/19/17 a review was conducted of facility documentation, revealing Resident #4's Care Plan, which read, "Initiated 3/9/10. Revised 7/18/17. I am at risk for and have had an actual

distracted and have poor insight/judgement. I am

fall related to: Cognitive impairment with decreased safety awareness. I am easily

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
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(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	incontinent and I ar (Activities of Daily L transfers." The Car include the requirer assistance of two p On 9/19/17 a 8:30 A conducted of Resid When asked about Resident #4 smiled Suddenly, her room put into the sample unsolicited statemeraides named Caroly herself and dropped her in her wheelcha hands and fell on the went to the hospital leg brace on, and half." Resident #1's Status Score was 14 impairment. Resident #4's clinicated following x-ray report Findings: Four views tibia displaced metated plateau fractures, ar severe tricompartment osteophytes and loss. On 9/19/17 a review conducted, revealing on 6/29/17. It read, "	n dependent for ADLs Living). Assist resident with all e Plan had not been revised to ment of the extensive physical ersons for transfers. A.M., an observation was ent #4, who was in her bed. how her leg was feeling, and appeared to be confused. mate who was identified and as Resident #1, made an nt. She said, "One of the on (CNAA) came in here by I her on the floor while putting ir. She slipped out of her e floor. She broke her leg and She came back here with a ad it on for a month and a Brief Interview of Mental I, indicating no cognitive al record contained the ct, "6/28/17 10:23 A.M. s of the left knee. Proximal physeal and impacted e partially obscured by ental osteoarthritis with large s of joint space. Effusion. of facility documentation was a Facility Reported Incident Injury of Unknown Origin. Intervealed left tibia plateau	F 226			
	6/25/17. Investigation facility follow-up read	reveal resident had a fall on pending." On 7/3/17, the l, "Upon investigation, June certified Nursing Assistant)				

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The clinical record contained the following Nursing Progress Note, "6/25/17/ 10:51 P.M. Resident resting in bed, respirations unlabored, lung fields clear, no coughing or congestion noted. No dizzy spells noted. Bed in lowest position, call bell in reach. Staff monitoring Q 2 hours." For the next three days, until 6/28/17 there was no further post-fall monitoring (7 continuous shifts).

CNA A's signed statement (dated 6/25/17) read, "I set her down in the chair. I walked away. I heard a noise. I turned around I saw resident body in front of wheelchair Resident butt was on the floor

in between the leg rest. The leg rest was extended. Resident left leg was under her butt." This incident occurred during the day shift a 7:50

A.M.

On 6/28/17 the Nursing Progress Note read, "Vital signs 99.2-90-22-138/86-96%. Resident noted with edema to left knee and lower leg bruising present to lower leg. Resident C/O (complains of) pain when touched, will not allow CNA to dress her. Resident medicated for pain Tylenol Tabs 2 PO (by mouth) for left leg pain. DR made aware STAT x-ray of left FIB TIB and left knee (left lower leg)." Resident #4 was admitted to the hospital at 7:00 A.M. and returned to the facility at 6:45 P.M. New orders for pain medication, use of knee immobilizer, and no weight bearing to left leg were given by the resident's MD at the facility. The nursing Progress noted read, "SRMC (hospital) called report. No

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON		(X3) DATE SURVEY COMPLETED		
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	surgery indicated a extensive. Keep kr On 9/19/17 at 4:05 conducted with CN The Director of Nuinvestigation, was pransferred Reside another staff members was trained the perresident needed on When CNA A was in witnessed the fall, swas in the room, but pulled." There was curtain had been pulled." There was curtain had	P.M., an interview was AA in the conference room. rsing, who had conducted the present. When asked why she at #4 without the assistance of per, CNAA stated, "The way I rson demonstrated that the aly 1 person for transfers. Informed that Resident #1 she admitted that Resident #1 she admitted that Resident #1 at said that "the curtain was no documentation that the alled. When the Director of why Resident #1 wasn't and that she was in the room. P.M. the facility Administrator was notified of the findings. On strator submitted following Correction; alled to properly investigate own origins. The facility failed antial witnesses. On 6/25/17, and on 6/28/17 fit knee fracture. Resident: (#2) facture of unknown origin.	F 2	26				

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transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM 495144		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495144	B. WING				9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		0/21/201/	
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F 226	Review of Resident nursing note entries "8/9/2017 17:15 (5:'CNA (Certified Nurs Res.(Resident) right was guarding and p Upon assessment responsive, right hat touch, bruising to ha hand. Res. pulls awaperformed, right har medicated for pain. received continue to	# 2's clinical record revealed :: 15 p.m.) "Called to room by ing Assistant) Stated t hand was swollen and Res. rotecting her right hand. es. noted alert and verbally nd at wrist area warm to and and forearm edema to ay when assessment nd elevated on pillow res. Physician notified orders	F 2	226				
	p.m., the clinician or 2's right hand. The at 2:15 a.m. and at 4 showing Resident #2"spiral fracture of the physician was notified #2 to be evaluated be Room. Resident #2 Emergency Room at The facility began are of unknown origin, he investigation revistatements from the on 7-3 shift, 8/8/2017 or witness statements fits 8/8/17 on 3-11 shift, The handwritten notes statement from RN Assertion 12.	dered an X-ray of Resident # X-ray was obtained 8/10/2017 4:40 a.m., the report returned 2 was determined to have a e distal third of the ulna." The ed and ordered for Resident by the hospital Emergency was transported to the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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F 226	of "On Tuesday nig On the last round last	ght, I worked with the resident. ne CNA report a discoloration. thand and did not see iscoloration. hand moved no s/s (signs and symptoms of that time. Resident did not	F 2					
	interviewed by the s Director of Nursing a the facility conference remembered taking 8/9/2017 during the put Resident # 2 to I herself. CNA F state any problems or swe when she last saw h trained to transfer R because of her size, was small and could	2 p.m., the CNA F was urveyor in the presence of the and three other surveyors in ce room. CNA F stated she care of Resident # 2 on day shift. CNA F stated she ced at the end of the shift by d Resident # 2 did not have elling noted on her right arm er. CNA F stated she was esident # 2 using one person CNA F stated Resident # 2 be transferred by one						

STATEMENT OF DEFICIENCIES (X1) PROVAINT IDENT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CTION	(X3) DATE SURVEY COMPLETED	
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	coded Resident # to transfer. CNA F was written on the stated she had tak was trained to transfer. CNA F was written on the stated she had tak was trained to transfer. Review of the Clinic unknown origin was 5:15 PM. Review of from the State Age Nursing contacted at 8:29 AM via tele Review of the Facilithe State Agency of was faxed in the State Agency of was faxed in the State Agency of was faxed in the State Agency of the Injury of unknown or there was no document was not a substained a fall investigation did incomplete the State Agency of the Injuries, falls, occurred in the time identification of the investigation was not failed to interview a facility notified the State Interview and facility no	2 has needing 2 staff persons stated she did not know what CNA Kardex. CNA F again en care of Resident# 2 and sfer the resident by herself. Cal record revealed the injury of s discovered on 8/9/2017 at of the Intake Information Formacy showed the Director of the State Agency on 8/10/2017	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495144	B. WING_		05	9/21/2017		
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, 2 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	ZIP CODE	72 112011		
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	origin, interview all to report timely to the of Nursing stated the the side rails because Resident # 2 might rail. The Director of # 2 liked to bang her The Administrator be reported to the Sthan 2 hours of disciplated at the time injury of unknown of investigation was convestigation was also documentation statis (right). Seen by orth hurt with side railing cast was place, now Review of the nurse revealed was no documentation the side history of banging her Review of the Invest revealed documentation and the side history of banging her Review of the Invest revealed documentation and the side history of banging her Review of the Invest revealed documentation and the side history of banging her Review of the Invest revealed documentation and the side observation on non-attach documentation and the side of the side o	potential witnesses and failed the State Agency. The Director are staff immediately removed see it was thought that have caught her arm in the Nursing also stated Resident or arms on the rails too. stated Serious Injuries must state Agency within no more covery. The Administrator also expecting ation should have been the of the discovery of the rigin and that another currently being conducted. In's progress note dated presented and revealed and revealed ing "pt had ulnar shaft fracture opedics. No fall. Pt likely got a Seen by Orthopedics, soft or railing removed." S' notes, and care plan cumentation of side rails locumentation of use of rails if Resident # 2 had a	F 22					

AND PLAN OF CORRECTION I IDENTIFICATION NUMBER: I			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING	·	00)/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		112112011
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	do you feel safe" at Census Report for a documentation of re You Feel Safe? ask There were five ans and the word "out" resident's name. The occupied beds, 4 ername had been hard, indicating a total wing 1. There was residents. The docu you feel safe? being 2 revealed there we empty beds on Wing 8/9/2017. 40 resider as discharged, 2 we was listed as "n/a" On Page 4 revealed interview with Staff (place on her bed an On August 9, 2017 7 (Resident name) in lin place and she put shift CNA no in place and up how off and lying in her b struck her right ulna. Residosteopenia. Side rail time. The facility corand oriented residen found. Skin sweeps negative findings. Ba	tach. Review of the Midnight B/9/2017 Attachment revealed esponses to the Question: Do ed of the residents on Wing 1. Swers of n/a (not applicable) was written next to one de Census showed 56 mpty beds but one resident's adwritten in one room on Wing census of 57 residents on mo answer written for 28 mentation of the question, Do grasked of residents on Wing re 51 occupied beds and 9 graph 20 on the Census on the replied yes, 3 were listed are in the hospital and one statements: "Base on Resident # 2) had side railed an order for Geri sleeves. Y-3 shift CNAplace ther bed with the Geri sleeves her side rails up. On 3-11 ted Resident name side rails ever her Geri sleeves were ed. (Resident # 2) may have on the half side rail which e displace oblique fracture to dent # 2 x-ray reveal s have been removed at this inducted interviews with alert ts-no negative findings were were performed with no ase on the interview of staff, sician progress note we are	F 2	26		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495144	B. WING_		09	9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	SOUTH BOULEVARD URG, VA 23805 PROVIDER'S PLAN OF CORRECTION		
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	On 9/20/2017, the second administration and same day during the Review of the Faciliand Exploitation on 5/1/2017 revealed set this policy, immediates soon as possible, beafter the alleged included bodily injury is discolar and injury should be set the allegations. Origin: an injury should be surveyed by any definition for Injury of unknown origin we conditions are met: not observed by any definition for Injury of missing from the do other definitions conseclusion." The copy the surveyors only in and 3 of 23). The tothere were 23 pages pages were not present the facility Administration were informed of the again stated Serious the State Agency will discovery. The Admit thorough investigation completed at the timinjury of unknown or	survey team was informed that ded by the facility subsequently resigned on that	F 22				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495144	B. WING			00	/21/2017	
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F 226		page 36 ation was provided.	F 2	226				
	operationalize (puregard to investigate reporting to agend incident of an insufficient #7 was a 6-22-16 with diagration chronic kidney dischaperipheral vasculatract infections, his	7, the facility staff failed to it into practice) their policies in ating, educating, and timely cies of serious injury concerning ulin medication error. admitted to the facility on noses that included; Diabetes, ease, Hypertension, zures, hyponatremia, gout, ar disease, history of urinary story of clostridium difficile, ressure ulcer with infection, and						
	dermatitis. Resident #7's mosset) with an ARD (7-3-17 was coded assessment. Resmemory loss, and Resident #7 was cassistance to total staff members for living), and always Foley urinary cather on 9-19-17 a thoroclinical record was notes were review 6-20-17 at 12:55 p "cold/clammy/diap On 6-20-17 at 5:25 to the hospital via 9 (ER) for evaluation	st recent MDS (minimum data assessment reference date) of as a significant change ident #7 was coded as having severe cognitive loss. oded as requiring extensive dependence on one to two all ADL's (activities of daily incontinent of bowel with a eter for bladder elimination. Dugh review of the resident's conducted. Nursing progress ed and revealed that on .m. the Resident was horetic with blood sugar of 31." 5 p.m., the Resident was sent 911 to the emergency room of hypoglycemia, and facility in the nursing notes that the						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495144	B. WING			0	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		287	EET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD 'ERSBURG, VA 23805		0/21/2017
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	Review of hospital of revealed that EMS (ambulance reported administered oral glafter administration, was now 78, at the review of the hospitap.m., on 6-20-17 the again dropped to 46 gone up to 79, after 10% 1000 ml (millilif 5% 1000 ml to inclupotassium chloride vadmitted to the hospuntil 6-26-17, when a facility. Interviews were congular rapid acting (DON) with stated that the Resideregular rapid acting (a.m., on 6-20-17, insisophane long acting to be given at that tir The Administrator ar the nurse who had gnot realized the error Resident and asked had given to the Resident and the second insulin and the second resident and resid	diter at the time of transfer. Emergency room records (emergency medical services) If to the hospital that they ucagon to the Resident, and the Resident's blood sugar time of transfer. Further al record revealed that at 7:16 Resident's blood sugar had is, and by 11:00 p.m. it had intravenous (IV) Dextrose ters) was given and Dextrose de sodium chloride and was given. The Resident was bital and remained for 7 days, she was returned to the ducted on 9-19-17, and ministrator and Director of regard to this situation. They dent had received 18 units of (Humalog) insulin at 9:00 stead of the (Humulin N) g insulin, which was ordered	F 2	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING			9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STATE 287 EAST SOUTH BOULEVA PETERSBURG, VA 23805	E, ZIP CODE RD	5/2 1/201/	
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F 226	Facility policy was a current standards a in the documents. The previous Admin Reported Incident Wednesday 6-21-1 Tuesday 6-27-17. It was admitted to the for hypoglycemia, a have occurred (with the same day. The have occurred no labusiness day. The realization that the sthe error were reins returned from the hacting) insulin was for the documents.	reviewed, and revealed that all and requirements were in place histrator sent a "Facility (FRI) to the state agency on 7, and a follow up report on Both were late. The Resident hospital on Tuesday 6-20-17 and the initial report should ain 2 hours of hospitalization) follow up 5 day report should atter than 6-26-17, the 5th investigation showed no same orders which produced tituted when the Resident ospital. The Humulin N (long inally decreased, and	F 2	226			
	after the Resident rehumalog sliding scabefore. No re-educate investigation parand was not provide evidence of re-training. The Administrator at the deficient practice on 9-19-17, 9-20-17 information was presented. For Resident #8, toperationalize (put in regard to investigation.)	nd DON were made aware of es at the end of day debriefs, and 9-21-17. No further sented by the facility. the facility staff failed to no practice) their policies in ng, educating, and timely s of serious injury of a					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		7120 T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 226	Continued From pa	ge 39	F 2	26			
	10-19-07 with diagn psychosis, Hyperter cholesterol, anemia congestive heart fail Alzheimer disease, infections. Resident #8's most set) with an ARD (as 7-6-17 was coded as assessment. Residememory loss, and se Resident #8 was cod assistance to total distaff members for al living), with the excerequired set up for h Resident was coded bowel and bladder e On 9-19-17 a thorou clinical record was conotes were reviewed Tuesday 6-27-17 at (doctor) was made a hand. Order receive x-ray of Resident's rito say the Resident where the serious injury occurred the X-ray was comp 6-27-17 and signed to p.m. on that day. The X-ray was comp 6-27-17 and signed to p.m. on that day.	gh review of the resident's onducted. Nursing progress and revealed that on 1:21 p.m. the Resident's"MD ware of swelling to right d to obtain a two viewed ght hand." The notes go on was guarding the hand I exhibited facial grimacing on was given as to how the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
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F 241 SS=D	hand (broken bone The facility did not runknown origin to the Wednesday 6-28-1 been within 2 hours fracture by federal I report of investigating state agency until 7 also late. The Administrator at the deficient practice on 9-19-17, 9-20-17 information was presented as a second of the deficient practice on 9-19-17, 9-20-17 information was presented as a second of the deficient practice on 9-19-17, 9-20-17 information was presented as a second of the deficient practice on 9-19-17, 9-20-17 information was presented as a second of the deficient of the deficient of the region of the re	n." This revealed a fractured in the hand). report the injury (fracture) of the state agency until 7, and the report should have of the identification of the aw. The 5 day follow up on was not submitted to the -5-17 (7 business days), and and DON were made aware of the at the end of day debriefs 7, and 9-21-17. No further esented by the facility. TY AND RESPECT OF the treat and care for each the rand in an environment that note or enhancement of his or cognizing each resident's cility must protect and of the resident. IT is not met as evidenced interview, w, and in the course of a tion, the facility staff failed to iving experience for 1 resident e survey sample of 23 clined to honor toileting, and equests.	F 241		nce/ incident esident and nsure they	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
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F 241	Resident #23 was a admitted to the faci diagnoses included Diarrhea, Overactiv Joint, and Muscle V The Minimum Data Assessment with an of 7/27/17, coded R Interview of Mental intact cognition and ability. Resident #23 extensive assistance She was coded as lower extremities, a incontinent of bowe required a wheelcha assistance of 1 person On 9/21/17 at 10:42 the Surveyor, Admin (Administrator/Executed (ED)/Administration (DON Administration (DON Administration (DON Administration (DON Administration (ED)/Administration (Took Administration (Took Adm	a 77 year old who was lity on 7/23/16. Resident #23's Irritable Bowel Syndrome with the Bladder, Pain in Unspecified Weakness-Generalized. Set, which was an Annual of Assessment Reference Date desident #23 as having a Brief Status Score of 15, indicating independent decision-making as was coded as requiring the se of 1 person for transfers. In a naving an impairment of both and as being frequently and bladder. Resident #23 air with the physical son for locomotion.	F 24	care by UM/ designee on 10/03/2 Current residents kardexs' were used 10/04/2017 by UM/designee. 3. Staff will be educated on resider and dignity when providing incompared to iletting by ADON/ designed before 11/03/2017. 4. A weekly audit of 5 residents were completed by UM/designee of CN performing incontinent care times weeks to ensure dignified inconting to ileting is being provided. Results audits will be forwarded to the Quantity Assurance/ Performance Improver Committee to ensure compliance aneed for further monitoring for the months.	ent rights tinent e on or ill be As s twelve ent care/ i from hality ment and the	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
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CH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
r, which I can //17 a Group //18 a Group //18 a Group //18 a Group //18 a review //18 a review //18 a review //19 a review //18 a review //19 at 12:49 //18 at 12:49 //18 at 12:49 //19 at 12:49 //18 at 12:49 //19	o Interview was conducted with the residents stated that the of providing them with on a consistent basis. It was conducted of Resident d. Resident #23's Care Plan pairment. Toileting and transfer ed. Pain Management. S. P.M., the facility sitted the following written d. In regards to (Resident #23) at 10:42 A.M. Facility sighly investigate concerns for aght in regards to 2 staff MPREHENSIVE ASSESS NT CHANGE days after the facility ald have determined, that gnificant change in the formental condition. (For the facility are intervention by staff or by the facility are disease-related clinical as an impact on more than dent's health status, and inary review or revision of the		F 274 1. Resident #2 had significant change completed on 10/03/2017. Resident a significant change MDS complete 10/02/2017. 2. Current residents with an ARD be September 1 st through September Section G of the ADLs were audited ensure any significant changes were	nt #3 had d on etween 20 th 201 I to e	17
	SUMMARY STACH DEFICIENCY ULATORY OR LE DEFICIENCY ULATORY OR LE DEFICIENCY ULATORY OR LE DEFICIENCY ULATORY OR LE DEFICE DE DEFICIENCY OR LE DEFICIENCE DE D	A95144 OR SUPPLIER EALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) THE BY THE WAY OF THE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) THE BY THE WAY OF THE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) THE BY THE WAY OF	A BUILDING 495144 B. WING CR SUPPLIER EALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PRECEDED BY FULL CULATORY OR LSC IDENTIFYING INFORMATION) THE DEFINITION OF THE PRECEDED BY FULL CULATORY OR LSC IDENTIFYING INFORMATION) THE DEFINITION OF THE PRECEDED BY FULL CULATORY OR LSC IDENTIFYING INFORMATION) THE DEFINITION OF THE PRECEDED BY FULL CULATORY OR LSC IDENTIFYING INFORMATION) THE PREFIX TAG THE PREFIX TAG F 241 F 241	A BUILDING 495144 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES CHICKNEY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULE (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) F 241 F 2	A BUILDING A SUPPLIER #495144 BASTREET ADDRESS, CITY, STATE, ZIP CODE #287 EAST SOUTH BOULEVARD #287 PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 241 F 244 Resident #2 had significant change MDS SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED OF TO THE APPROPRIATE DEFICIENCY) F 241 F 242 F 241 F 244 R Resident #2 had significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03/2017. Resident #3 ha a significant change MDS Completed on 10/03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	E CENTER		STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
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F 274	Based on staff in and facility docum failed to complete status assessment determination of a Residents (Reside sample of 23 residents (Reside sample of 23 residents). For Resident #2 assess the Reside condition after the transferring, dress declined from extetotally dependent August 2017. 2. Resident #3, habetween April and mobility, transfer, hygiene, and bath failed to complete the improved actividentified. Findings included: 1. For Resident #2 assess the Reside condition after the transferring, dress declined from extetotally dependent of August 2017. Resident #2, a fen on 3/2/2012. Her not limited to: Majosevere Psychotics.	terview, clinical record review tentation review, the facility staff a SCSA (significant change in at) within 14 days after a change in status for 2 tents #2 and # 3) in the survey dents. 2, the facility staff failed to ent for a significant change in Resident's functional status in sing, and toileting changed and ensively dependent on staff to on staff between May and ad significant improvements July 2017 in the areas of bed locomotion, toilet use, personal ing however, the facility staff a significant change MDS after vities of daily living (ADL's) were	F 274	3. MDS coordinators will be Administrator/ designee of for significant MDS changed 4. A weekly audit of section (that have been completed be conducted to ensure signare captured in regards to weeks by the MDS coordin Results from audits will be Quality Assurance/ Perform Improvement Committee to compliance and the need form onitoring for three (3) more signature.	on requirements es. on G of the MDS d that week) will gnificant change ADLs times twel ator/ designee. forwarded to the nance o ensure or further onths.	l es lve

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		287	REET ADDRESS, CITY, STATE, ZIP COD 7 EAST SOUTH BOULEVARD TERSBURG, VA 23805	E	03/21/2017
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	embolism and thron Resident #2's most set) with an ARD (at 8/3/2017 was coded She was unable to It for mental status (B cognitive impairment extensive to total as perform all of her ac exception of transfer coded as needing to members. She was of bowel and bladded. The most recent MD was compared to the Assessment with an changes experience these two assessment. The 5/5/2017 Quarter Resident #2 was cod assistance in (ADL's transferring, dressing Resident was coded bowel and bladder. The 8-3-17 Quarterly Resident #2 was codimpairment. The Redependent on staff foliving, with transferring The Resident was codincontinent of bowel and Review of these doci	recent MDS (minimum data ssessment reference date) of das a Quarterly assessment. De coded with a Brief interview IMS), indicating severe at. She was coded as needing sistance of one person to ctivities of daily living with the rs. For transfers, she was otal assistance of two staff acoded as always incontinent etc. 20 With an ARD of 8/3/2017 aprevious Quarterly ARD of 5/5/2017. The day Resident # 2 between ents follow below: 21 Previous Quarterly assessment revealed ded as requiring extensive and toileting. The as always incontinent of assessment revealed ded with no cognitive sident was coded as totally or (ADL's) activities of daily for (ADL's) activities of daily and toileting, and toileting. The sident was coded as totally or (ADL's) activities of daily and bladder. The company of t	F 2	74			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING	4		00	9/21/2017
	PROVIDER OR SUPPLIER			287 EAST S	RESS, CITY, STATE, ZIP CO OUTH BOULEVARD JRG, VA 23805		012112011
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	continued through without a significate completed. Guidance was professident Assessm V 3.0, May 2013, p. Significant Change (Comprehensive) A0310A= 04 14th determination that status occurred (decalendar days) Z0400B=14th cale that significant change courred (determination that significant change that significant change correction would be Medicare & Medicare	the 8/3/2017 MDS assessment int change assessment being vided in "Long Term Care itent Instrument User's Manual 2.2-15: In Status (SCSA) Calendar day after significant change in resident's etermination date + 14 Indar day after determination inge in resident's status itention date + 14 calendar 2:00 PM, RN (Registered sible for MDS documentation in de aware of the need for a assessment. She stated a esent to CMS (Centers for	F 2	74			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495144	B. WING				09/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		287	EET ADDRESS, CITY, STATE, ZIP CODI EAST SOUTH BOULEVARD FERSBURG, VA 23805		00/E1/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
F 274	the improved activitidentified. Resident #3 was adwith the diagnoses kidney disease stage chronic pain, hypertidisease with left sid. The most recent Minguarterly assessme Reference Date (AF coded Resident #3 required limited assimobility, transfers, of and bathing. On 9/18/17 at 2:25 probserved sitting in a watching television. conversational. Resident interview the needed but he does. On 9/19/17 at 10:00 record was reviewed annual MDS with an quarterly MDS with an quarterly MDS with a G-Functional Status. Activities of Daily Liv Self-Performance as	ies of daily living (ADL's) were limitted to the facility on 4/4/16 of, but not limited to, chronic le III, diabetes mellitus, ension, and cerebrovascular ed weakness. Inimum Data Set (MDS) was a nt with an Assessment RD) of 8/2/17. The MDS with no cognitive impairment; istance from staff for bed liressing, toileting, hygiene, D.m., Resident #3 was wheelchair, in his room He was alert and sident #3 stated during at the staff help him when "a lot by myself." a.m. Resident #3's clinical d. The review revealed an ARD of 4/11/17 and a an ARD of 7/12/17. Section coded section G0110 ring (ADL) Assistance is follows:	F 2	274	DEFICIENCY)		
	from staff), Transfer=3, Locomotion on and o Dressing=3, Toilet use=3,	ensive assistance required					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495144	B. WING		00	9/21/2017
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		0/Z1/ZV }
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	staff), Transfer=2, Locomotion on and Dressing=3, Toilet use=2, Personal hygiene= Bathing=2, Section H Bladder Continence=0 (Alw As guided by the M Change MDS incluing improvement in 2 of Section G and Section G	and Bowel-Bowel ways incontinent). mited assistance required from d off unit=1 (Supervision), 2, and Bowel-Bowel ways continent). MDS manual, a Significant des a change of decline or or more areas which include stion H. p.m. and 2:45 p.m. an lucted with the MDS nurse, A (RN-A). The question of why e MDS wasn't done was asked areas of change were was not the staff member who	F 27	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		09/	21/2017
	PROVIDER OR SUPPLIE		2	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
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F 274 F 280 SS=D	provided by the fa 483.10(c)(2)(i-ii,iv) PARTICIPATE PL 483.10 (c)(2) The right to and implementati plan of care, including the right be included in the request meetings revisions to the policy of the right to participate of the right to reincluded in the plan (v) The right to reincluded in the plan (v) The right to seright to sign after of care. (c)(3) The facility right to participate shall support the replanning process (i) Facilitate the in resident representations.	acility staff. (v)(3),483.21(b)(2) RIGHT TO ANNING CARE-REVISE CP participate in the development on of his or her person-centered iding but not limited to: rticipate in the planning process, to identify individuals or roles to a planning process, the right to and the right to request erson-centered plan of care. Inticipate in establishing the and outcomes of care, the type, by, and duration of care, and any ted to the effectiveness of the effectiveness of the significant changes to the plan Shall inform the resident of the in his or her treatment and resident in this right. The must— Inclusion of the resident and/or		F 280 Careplan Revision 1. Resident #4 careplan was revisinclude extensive physical assist persons on 09/20/2017 by Unit designee. Resident #2's careplan revised to ensure her falls from A September 2017 were in carepla 10/09/2017 by Unit Manager/ de 2. Current resident's careplans wereviewed to ensure physical assistfalls (from September 2017) have updated in their careplans on 10 UM/ designee. 3. Licensed nursing staff will be excareplan revision by DON/ Design before 11/03/2017. 4. Weekly audits of residents' care be completed to ensure revisions physical assistance and falls have completed times twelve by the Unit Manager/ DON/ Designee. Result audits will be forwarded to the Quassurance/ Performance Improve Committee to ensure compliance need for further monitoring for the months.	of two Manager/ n was August & n esignee. vere stance and e been /09/2017 ducated of nee on or eplans will for been nit ts from uality ment and the iree (3)	l by
	strengths and nee					

		H AND HUMAN SERVICES				D: 10/02/201 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	O. 0938-039° ATE SURVEY DMPLETED
		495144	B. WING			NO4 100 17
	ME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805					9/21/2017
(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 DATE
F 280		age 49 resident's personal and	F 28	0		
	cultural preference	s in developing goals of care.				
	483.21 (b) Comprehensive	Care Plans				
	(2) A comprehensiv	ve care plan must be-				
	(i) Developed within the comprehensive	n 7 days after completion of assessment.				
	(ii) Prepared by an i	interdisciplinary team, that imited to				
	(A) The attending p	hysician.				
	(B) A registered nur resident.	se with responsibility for the				
	(C) A nurse aide wit resident.	h responsibility for the				
	(D) A member of foo	od and nutrition services staff.				
	the resident and the An explanation musi medical record if the and their resident re	acticable, the participation of resident's representative(s). the included in a resident's participation of the resident presentative is determined the development of the				
	(F) Other appropriate disciplines as detern or as requested by the	e staff or professionals in nined by the resident's needs he resident.				
	(iii) Reviewed and re	vised by the interdisciplinary				

PRINTED: 10/02/2017

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 280 Continued From page 50 F 280 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed, for 2 residents (Residents #4, #2) in the survey sample of 23 residents, to review and revise the care plan. 1. For Resident #4, the facility staff failed to update the care plan to include the requirement for the extensive physical assistance of two staff persons for transfers. 2. For Resident #2, the facility staff failed to revise the care plan after each fall or incident. The Findings included:

Alzheimer's Disease.

Resident #4 was an 88 year old who was admitted to the facility on 2/22/06. Resident #4's diagnoses included Proximal Tibia Displaced Metaphyseal and Impacted Plateau Fractures (crushed bone), Muscle Weakness-Generalized, Age-Related Osteoporosis, Schizophrenia, Psychotic Disorder, Hypertension, and

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 6/7/17, coded Resident #4 as having a Brief Interview of Mental Status Score of 7 - indicating severely impaired cognition. For transfers, she was coded as requiring the extensive physical assistance of two persons. In the area of functional limitation in range of motion, she was coded as having lower extremity impairment on

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED. A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 51 F 280 both sides. Her mobility device was a manual wheelchair. On 9/19/17 a review was conducted of facility documentation, revealing Resident #4's Care Plan, which read, "Initiated 3/9/10. Revised 7/18/17. I am at risk for and have had an actual fall related to: Cognitive impairment with decreased safety awareness. I am easily distracted and have poor insight/judgement. I am incontinent and I am dependent for ADLs (Activities of Daily Living). Assist resident with all transfers." The Care Plan had not been revised to include the requirement of the extensive physical assistance of two persons for transfers. On 9/19/17 a 8:30 A.M., an observation was conducted of Resident #4, who was in her bed. When asked about how her leg was feeling. Resident #4 smiled and appeared to be confused. Suddenly, her roommate who was identified and put into the sample as Resident #1, made an unsolicited statement. She said, "One of the aides named Carolyn (CNAA) came in here by herself and dropped her on the floor while putting her in her wheelchair. She slipped out of her hands and fell on the floor. She broke her leg and went to the hospital. She came back here with a leg brace on, and had it on for a month and a half." Resident #1's Brief Interview of Mental

impairment.

Status Score was 14, indicating no cognitive

Resident #4's clinical record contained the following x-ray report, "6/28/17 10:23 A.M. Findings: Four views of the left knee. Proximal tibia displaced metaphyseal and impacted plateau fractures, are partially obscured by severe tricompartmental osteoarthritis with large

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE			287 EAS	NDDRESS, CITY, STATE, ZIP CO T SOUTH BOULEVARD BBURG, VA 23805		72 1720 T7	
(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 COR (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 280	On 9/19/17 a revie conducted, reveal on 6/29/17. It read Resident assessm fracture. Documer 6/25/17. Investiga facility follow-up re 25, 2017, (CNAA transferred (Resid wheelchair." Accorstaff member contwo. CNAA's signed state the down in the anoise. I turned a front of wheelchair in between the legextended. Resident This incident occur. A.M. The clinical record Nursing Progress Resident resting in lung fields clear, noted. No dizzy sposition, call bell in hours." For the next there was no further continuous shifts). On 6/28/17 the NuVital signs 99.2-90 noted with edema bruising present to	loss of joint space. Effusion. Lew of facility documentation was ing a Facility Reported Incident III, "Injury of Unknown Origin. In the revealed left tibia plateau into revealed left tibia plateau into reveal resident had a fall on tion pending." On 7/3/17, the lead, "Upon investigation, June - Certified Nursing Assistant) lent #4) from the bed to the reding to the report, only one iducted the transfer instead of letter in the reding to the resident body in it in Resident butt was on the floor or rest. The leg rest was inteleft leg was under her butt." It is left leg was under her butt. It is red during the day shift a 7:50 contained the following Note, "6/25/17/ 10:51 P.M. In bed, respirations unlabored, to coughing or congestion ells noted. Bed in lowest in reach. Staff monitoring Q 2 ket three days, until 6/28/17 ter post-fall monitoring (7) cursing Progress Note read, "-22-138/86-96%. Resident to left knee and lower leg. Iower leg. Resident C/O or when touched will not allow the progress of the read in th	F 2	80				

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 280 Continued From page 53 F 280 CNA to dress her. Resident medicated for pain Tylenol Tabs 2 PO (by mouth) for left leg pain. DR (Doctor) made aware STAT x-ray of left FIB TIB and left knee (left lower leg)." Resident #4 was admitted to the hospital at 7:00 A.M. and returned to the facility at 6:45 P.M. New orders for pain medication, use of knee immobilizer, and no weight bearing to left leg were given by the resident's MD (medical doctor) at the facility. The nursing Progress noted read, "SRMC (hospital) called report. No surgery indicated at this time because its to extensive. Keep knee immobilizer in place." On 9/19/17 at 4:05 P.M., an interview was conducted with CNAA in the conference room. The Director of Nursing, who had conducted the investigation, was present. When asked why she transferred Resident #4 without the assistance of another staff member, CNA A stated, "The way I was trained the person demonstrated that the resident needed only 1 person for transfers. When CNAA was informed that Resident #1 witnessed the fall, she admitted that Resident #1 was in the room, but said that "the curtain was pulled." There was no documentation that the curtain had been pulled. When the Director of Nursing was asked why Resident #1 wasn't interviewed regarding the fall, she stated, "Because I didn't know that she was in the room and I didn't ask."

The Director of Nursing was also asked why Resident #4's Care Plan had not been updated. She stated that she didn't have an answer.

On 9/19/17 at 5:00 P.M. the facility Administrator (Administration A) was notified of the findings. On 9/20/17 the Administrator submitted following

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZI 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	two injuries of unkn to interview all pote Resident: (#4) Fell diagnosed wit a left Diagnosed with a fr 100% of residents was to falls were review were being perform. The Plan of Correct residents were asset techniques and initia were in-serviced. In suspended pending subsequently resign updating the resider manner. The facility Administ that read, "No policy 2. For Resident #2, revise the care plan Resident #2, a fema on 3/2/2012. Her diagnost illimited to: Major severe Psychotic Sy Affect, Cardiac Pace embolism and throm Resident #2's most illimited to: Mesident #2's most illimited to	rection; ailed to properly investigate flown origins. The facility failed intial witnesses. on 6/25/17, and on 6/28/17 knee fracture. Resident: (#2) acture of unknown origin. with hi risk for injuries related ed to ensure proper transfers ed." ion also stated that all facility essed for proper transfer addition, CNA A had been investigation, and had ned. The Plan did not address ints' Care Plans in a timely trator submitted a written note on careplan revisions." the facility staff failed to after each fall or incident. ale, was admitted to the facility agnoses included but were Depressive Disorder with reptoms, Pseudobulbar emaker, Anemia, Acute	F 28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		05	9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, 287 EAST SOUTH BOULEVAR PETERSBURG, VA 23805	, ZIP CODE	72172017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	8/3/2017 was coded She was coded as memory deficits, see She was also coded assistance of one pactivities of daily livit transfers. For transneeding total assist She was coded as and bladder. 7 incidents were do regarding falls. Door Resident # 2 had 3 Unknown Origin on 3/28/2017 and 7/9/2 (8/23/2017, 8/28/20) were no new interveafter 4 of the falls. 3/13/2017 12:45 p.n staff attempting to reobserved lying on the dietary person. No allowestigation conductives the resident # 2 slid from reached out for the intervel No apparent injury. Review of the Fall Intervel Resident # 2 slid out cause was listed as and recommendation W/C".	d as a Quarterly assessment. having short and long term evere cognitive impairments. d as needing extensive to total terson to perform all of her ing with the exception of offers, she was coded as ance of two staff members. always incontinent of bowel cumented in the Nurses Notes cumentation revealed falls prior to the Injury of 8/9/2017 (3/13/2017, 2017) and 3 falls since 17 and 9/9/2017). There entions listed on the care plan inFall from wheelchair with edirect from door. Resident the floor on her right side per apparent injury. RP notified. In the wheelchair when she rail. She did not hit her head. Care plan was not revised. Investigation and Post Fall revealed documentation that it of the wheelchair. Possible "posture in W/C (wheelchair)" in was listed as "Dumping intervention listed on the care	F 24	80			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG		(X3) DATE SURVE COMPLETED	
		495144	B. WING			09	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCAR			287 EAST SOUTH	ET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD ERSBURG, VA 23805 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	RRECTIVE ACTION SHOU ERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
	3/28/2017 at 11:57 the floor in front of bruise. Physician a care plan noted. If all documented the it is not written on the intervention. 8/28/2017 10:20 a. Witnessed fall: Responsed by PT (Pulling on bar on example of the pulling of the	a.m. Resident observed on her wheelchair. Left upper arm nd RP notified. No revision of Nurses notes written after the e bed was in a low position, but he care plan as an m. Location: Hallway. Sident observed on floor on I of Wing One exit door. In the care plan as an mysical Therapy) Resident was kit door and slipped from chair. The aken: for injuries-slight redness to no broken skin, PTA (Physical stated resident did not hit ct, to redness bumps or ains intact to right hand, cap mormal limits.) Purple/yellowish or to fall. ROM WNL to upper less. Resident two person assist ir. Physician notified a.m., RP notified 8/28/2017 at	F 2	80	BEI IOIENCT)		
		fracture." No revision of		-			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING			9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARI			STREET ADDRESS, CITY 287 EAST SOUTH BO PETERSBURG, VA	Y, STATE, ZIP CODE ULEVARD	9/2 1/2017	
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F 280	Continued From pa	age 57	F 2	80			
	list of Falls/ Incider September 2017 a place after each incam, a list was preas Fall without injury/9/2017. One incident "Found on Fof Unknown Origin listed. The Direct were the only incident aware. There was a on 3/13/2017 and 3 to the surveyor. The included handwritter listed on the care purpose.	rsing was asked to provide a hts from March 2017 to long with interventions put in cident. On 9/21/2017 at 8:15 sented with 3 incidents listed ry on 8/23/2017, 8/28/2017 and dent dated 7/9/2017 was listed loor incidents". And the Injury Incident on 8/9/2017 was or of Nursing stated those ents or falls of which she was no documentation of the falls 8/28/2017 on the list presented e list provided by the DON en interventions that were not lan.					
	8/11/2017 after the areas were added to Bone Fracture, Acut wrist and ADL (Activinclude many intervarm splint, check can gently when moving body alignment, supand immobilize part. The only other new related to falls since 7/12/2017- Therapy	revisions to the care plan					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495144	B. WING_		09/	/21/2017	
	NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 281	no documentation side rails or half side is no evidence of wimplemented, if the During the end of othe facility Administration were made aware. No further informated 483.21(b)(3)(i) SEF PROFESSIONAL SEF PROFESS	of the care plan also revealed of the intervention of use of de rails for Resident # 2. There when the use of side rails was ere was an order or consent. day debriefing on 9/20/2017, trator and Director of Nursing of the findings. tion was provided. RVICES PROVIDED MEET STANDARDS sive Care Plans ded or arranged by the facility, comprehensive care plan, all standards of quality. NT is not met as evidenced interview, staff interview, ion review, clinical record course of a complaint acility failed to follow the ards of practice for 5 residents is, #2, #14, and #6) in the 23 residents. the facility staff failed to n ordered dressing changes.	F 28		was clarified on (2017 . MARS and TARs y are now being 's orders on rders were		
	document the admi	inistration of two medications,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495144	B. WING		09/	21/2017		
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
F 281	Tablet 100 MG. 3. For Resident # 2, ensure medications administered per ph 4. For Resident #14 clarify a physician's Depakote after an omedication was recorders for and was (milligrams) and De day from 2/22/17 to 5. for Resident #6, to a fall alarm per physicon 1:00 p.m. on 9-19. The Findings included 1. Resident #1 was admitted to the facil diagnoses included Bypass Graft, Prese (LVAD Unit), Arterio Native Coronary Art Diabetes Mellitus Ty Generalized, Difficu Both Hands, Major I Hemoglobinuria, and The Minimum Data Assessment with and	the facility staff failed to and treatments were hysician's orders. 4, the facility staff failed to order for the medication order to increase the eived. Resident #14 had receiving Depakote 125 mg pakote 250 mg two times a 9/21/17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17. The facility staff failed to apply sician's orders from 9:00 a.m., 0-17.	F 281	2. Current residents POSs were a September 2017 by UM/ designer 10/05/2017. 3. License nurses will be educated documentation, and clarification needed on physician orders by DON/designee on or before 11/04. Weekly audits times 12 will be on eMARs/ eTARs by UM/designer proper documentation has been if needed. Results from audits with forwarded to the Quality Assurant Performance Improvement Commensure compliance and the need monitoring for three (3) months.	d on prop when 3/2017. complete ee to ensu completed ill be ice/ nittee to for furthe	er d ire d		
	Interview of Mental at that she was cognition independent in decisions.	Status Score of 14, indicating						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		ATE SURVEY DMPLETED	
		495144	B. WING			9/21/2017	
NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ('S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	documentation, revisubmitted to the off 1/25/17. The compliant of the compliant of the conducted of Residuasked if she had an received at the facilithey are supposed They never check if be changed every of the bandage attack on her left side was along with the nurse not been changed p. 9/18/17. On 9/19/17 a review #1's clinical record. 2017, the dressing I having been changed of April 2017, the documented as hav 4/13/17, 4/28/17, 4/2 month of May 2017, documented as hav thru 5/14/17. There dressing changes for the complete of the compl	w was conducted of facility realing a complaint which was fice of Long Term Care on laint alleged that Resident #1's nage around it and that the changed daily. A.M. an observation was lent #1 in her room. When my concerns about the care she lity, Resident #1 responded, do to check my heart machine. This bandage is supposed to lay. They don't." They don't." They don't." They don't." They was conducted of Resident During the month of February had only been documented as led from 2/23/17 thru 2/27/17. March 2017, the dressing levery day. During the month ressing had only been ing been changed on 29/17, and 4/30/17. During the the dressing had only been ing been changed from 5/2/17 was no documentation of or June thru September 2017.	F 2	81			
	dressing changes for On 9/19/17 the Direct Administration B) was	or June thru September 2017.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		nc	0/21/2017	
	PROVIDER OR SUPPLIEI BURG HEALTHCAR			STREET ADDRESS, CITY, STATE, 287 EAST SOUTH BOULEVAR PETERSBURG, VA 23805	ZIP CODE	72172017	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	"It's important to cit isn't causing any came in and did at and take care of it." The DON submitter training summary Advance Heart Fa Assist Device, Ste Resident #1 had be 1/1/17, but the facifor the care of her facility staff did not for the care of the surveyor's request obtained a copy of for the device on 9 instructions for the Ventricular Assist Sis extremely import the percutaneous I clean and dry at all technique any time touch or handle the the exit site for sign redness, swelling, smell. IMMEDIATE contact person if the Resident #1's clinic following note from called on 1/18/17 to from (Resident #1) She was brought of assessment. The gibe saturated with the sidner of the saturated with the same same of the saturated with the same of the sa	posed to be changed daily, and ged since 9/17/17. She stated, hange it daily to make sure that y type of infection. (name) Clinic in inservice on how to clean it	F 28	81			

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING_	<u> </u>	COMPLETED	
		495144	B. WING		no	21/2017
PETERSBURG HEALTHCARE CENTER		28	REET ADDRESS, CITY, STATE, ZIP COI 7 EAST SOUTH BOULEVARD TERSBURG, VA 23805	DE OS	2112011	
(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)	OULD BE	(X5) COMPLETI DATE
	Continued From page 62 and a scanty amount of serosanguinous drainage was expressed with palpation of the surrounding tissue. Admitted due to suspected drieline infection. "The hospital subsequently identified the infection as MSRA (Methicillin-resistant Staphylococcus Aureus). Resident #1 was hospitalized from 1/19/17 thru 2/21/17. On 9/21/17 at 2:16 P.M. a review was conducted of the facility's Infection Control Program. The DON stated, "sterile technique should have been implemented during (Resident #1's name) dressing changes, including pulling the curtain, putting on a mask, gloves, setting up a sterile field, and cleaning the site. This training was done on 8/31/17. I don't know why it wasn't done on a daily basis. It should have been done on a daily basis since we were trained in August. It is important to keep infection from the drive line." The facility did not have a written policy on sterile technique for dressing changes. On 9/21/17 the facility Administrator (Administration A) was informed of the findings. No further information was received.		F 281			
	document the admir during August 2017. (Administration B) s Lippincott as a nursi Resident #16 was a admitted to the facili	the facility staff failed to nistration of two medications. The Director of Nursing tated that the facility utilizes ng standard reference. 182 year old who was ty on 1/24/17. Resident #16's Cerebrovascular Disease,				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495144	B. WING		n	9/21/2017		
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STAT 287 EAST SOUTH BOULEY. PETERSBURG, VA 2380	TE, ZIP CODE ARD	72 1720 17		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE		
	The Minimum Data Assessment with a of 7/3/17, coded Reinterview of Mental that he was indepeability. He was also extensive physical for transfers, having both legs, and requived Ministration Record Administration Record Administration Record The following medicas having been administration Tablet 30 Gout. 9:00 P.M. Docusate Sodium Todaily for Constipation at 4:00 P.M. On 9/20/17 at approximaterview was conducted as a description of the solid content of the solid co	a Set, which was a Quarterly in Assessment Reference Date esident #16 as having a Brief Status Score of 13, indication indent in decision making coded as requiring the assistance of two staff persons in the functional limitation of iring a wheelchair for mobility. If was conducted of Resident It, revealing the Medication ord (MAR) for August 2017. Eations were not documented inistered per signed If MG by mouth once daily for 8/29/17, and 8/30/17 at Itablet 100 MG by mouth once in 8/29/17, and 8/30/17 at Itablet 100 MG by mouth	F 28	31				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING			9/21/2017	
NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, 287 EAST SOUTH BOULEVAR PETERSBURG, VA 23805	ZIP CODE	5/2 1/20 11	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 281	it was withheld and applicable)." Guidance is given "Safe Medication A General" 10/02/20 administered in the (Electronic Medical a medication was reason why, any ir notification, and the interventions." On 9/20/17 at apple Administrator was further information 3. For Resident #2 ensure medication administered per per Resident #2, a 91 sto the facility on 3/2 included but were repressive Disorde Symptoms, Pseudo Pacemaker, Anem thrombosis. Resident #2's most set) with an ARD (a 8/3/2017 was code She was coded as	from Lippincott Solutions, Administration Practices, 15. "Document all medications e patient's MAR or EMAR ation Administration Record). If all administered, document the aterventions taken, practitioner e patient's response to roximately 4:45 P.M. the facility informed of the findings. No was received. 2, the facility staff failed to and treatments were hysician's orders. year old female, was admitted 2/2012. Her diagnoses not limited to: Major er with severe Psychotic obulbar Affect, Cardiac ia, Acute embolism and assessment reference date) of d as a Quarterly assessment, having short and long term	F 2				
	She was also code assistance of one pactivities of daily liv	evere cognitive impairments. d as needing extensive to total person to perform all of her ing with the exception of sfers, she was coded as					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING	;		09/21/2017	
NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER				STREET ADDRESS, CITY, STAT 287 EAST SOUTH BOULEV, PETERSBURG, VA 23805	ARD	03/21/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD E TO THE APPROPRI	SE COMPLETION	
	needing total assis She was coded as and bladder. On 9/19/2017 at 8: record was conducted was condu	stance of two staff members. always incontinent of bowel 45 AM, review of the clinical cted. ication Administration Record 2017 revealed missing medications: Ins one tablet by mouth every of AM reams one tablet by mouth every of AM reams one tablet by mouth at 9 AM reams one tablet by mouth 17 at 9 AM reams one tablet by mouth 17 at 9 AM reams one tablet by mouth 17 at 9 AM reams one tablet by mouth 17 at 9 AM reams one tablet by mouth every of AM reams one tablet by mouth at 2 at 8 PM reams one tablet by mouth at 3 at 8 PM reams one tablet by mouth at 3 at 8 PM reams one tablet by mouth at 3 at 8 PM reams one tablet by mouth at 3 at 8 PM reams one tablet by mouth at 3 at 8 PM reams one tablet by mouth at 3 at 8 PM reams one tablet by mouth at 3 at 8 at 12 at 8 at 12	F 2	281			

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** DEFICIENCY) Continued From page 66 F 281 skin protectant. Missing on 8/12/2017 night shift, 8/18/2017 evening shift Bilateral Geri-Sleeves to arms every day every shift may remove for hygiene every shift. Missing on 8/12/2017 night shift, 8/18/2017 evening shift Check placement of pressure reducing wheelchair cushion every shift for Pressure relief. Missing on 8/12/2017 night shift, 8/18/2017 evening shift Review of the Treatment Administration Record (TAR) for September 2017 revealed missing documentation of: Barrier Cream to buttocks and peri-area every shift and as necessary after each incontinent episodes, may keep at bedside every shift for skin protectant. Missing on 9/4/2017 evening shift, 9/8/2017 evening shift Bilateral floor mats at bedside while in bed every shift for fall. Missing on 9/4/2017 evening shift. 9/8/2017 evening shift Bilateral Geri-Sleeves to arms every day every

evening shift

shift may remove for hygiene every shift Missing on 9/4/2017 evening shift, 9/8/2017 evening shift

wheelchair cushion every shift for Pressure relief. Missing on 9/4/2017 evening shift, 9/8/2017

Check placement of pressure reducing

shift, 9/8/2017 evening shift

Turn and repositioned every 2 hours and as needed every shift Missing on 9/4/2017 evening

On 9/20/2017 at 4:45 PM, an interview was conducted with the Director of Nursing who stated

that nurses were expected to administer medications and treatments as ordered by the physician and document on the MAR and TAR at the time of administration. The DON stated the facility's profession guidance was provided by

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495144	B. WING		00	/21/2017
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		72 1720 17
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	administration of merovided by "Lipping administering a mediately on the immediately on the immediately on the On 9/20/2017 at apthe end of day deb Director of Nursing missing documentations and transport of the provided and to manually writhere was no explain documentation on a survey. The DON presente Administration Policy is to provide a providing monitoring received and administration Procedure I. Administration Procedure: 1. Administration Procedure: 1. Administration Procedure: 1. Administration Procedure Medication of the provided and administration Procedure Procedure: 1. Administration Procedure:	ing standards for the nedication and treatments is neott", which stated "After edication or treatment, record it appropriate record form." Oproximately 5:00 PM during riefing, the Administrator and (DON) were informed of the ation of administration of eatments for Resident # 2. The cility had some computer 7 and 8/30/2017 and nurses ite on MARs and TARs but nation for missing the other dates found during the other dates found during the other dates found Revised 4/20/2017 revealed der Policy The purpose of this guidance for the process for g that all medications are instered in a timely manner. The paredness will be administered as withheld it was withheld it was withheld.	F 281			

	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		ATE SURVEY DMPLETED
		495144	B. WING			00	9/21/2017
	OF PROVIDER OR SUPPLIE			28	REET ADDRESS, CITY, STATE, ZIP CODE 7 EAST SOUTH BOULEVARD ETERSBURG, VA 23805	1 08	5/21/2017
(X4) PREF TAG	IX (EACH DEFICIENCE	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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 2	81 Continued From p	age 68	F2	281			
		orders were evident for the reatments not documented as nistered.					
	During the end of the DON, Adminis were informed of t	day debriefing on 9/21/2017, trator and Corporate consultant he findings.					
	No further informa	tion was provided.				• ,	
	clarify a physician's Depakote after an medication was re- orders for and was	14, the facility staff failed to sorder for the medication order to increase the ceived. Resident #14 had receiving Depakote 125 mg epakote 250 mg two times a po 9/21/17.					
		admitted to the facility on agnoses of, but not limited to, ion, and anxiety.					
	quarterly assessme Reference Date (A coded Resident #1 cognition; required	inimum Data Set (MDS) was a ent with an Assessment RD) of 6/28/17. The MDS 4 with moderately impaired extensive assistance from dressing, toileting, and					
	sitting in a wheelch and conversational was great and state for church services	n. Resident #14 was observed air in her room. She was alert . Resident #14 stated lunch ed her sister will be coming in that day. Resident #14 did pative behaviors or symptoms				•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495144	B. WING			0.	9/21/2017	
	PROVIDER OR SUPPLIE			287	REET ADDRESS, CITY, STATE, ZIP CODE ' EAST SOUTH BOULEVARD TERSBURG, VA 23805	, ,	5/21/201/	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 281	record was review physician's orders 1/9/17 Depakote S Release 125 mg C times a day relater and 2/22/17 Depakote Give 1 tablet by m Major Depressive Both the 125 mg a and signed as adn Administration Reconstruction of Nursing Depakote orders, and physician note On 9/21/17 at 9:30 the MAR were review Practical Nurse-LP medications to Resthe Registered Nurse-	D p.m. Resident #14's clinical red. The review revealed which included: Sprinkles Capsule Delayed Give 1 capsule by mouth two d to Major Depressive Disorder Tablet Delayed Release 250 mg outh two times a day related to Disorder. and 250 mg orders were listed inistered on the Medication cord (MAR) from 2/22/17 until m. the Administrator and g were informed of the The pharmacy review sheet	F 2	81				
	and empty medica Resident #14 recei mg of Depakote. I and RN-B that whe increased to 250 m discontinued. Clar wanted both orders	tion package which revealed ved both the 125 mg and 250 t was discussed with LPN-B en the medication was not ification whether the physician or not was requested.						

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
PETERSURG HEALTHCARE CENTER SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS OUT HOULD EVAND PETERSBURG, VA 23805			495144	B. WING _		no	1/21/2017	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 281 Continued From page 70 the doctor and he discontinued the 125 mg of Depakote. When asked what should have been done, RN-B stated "nursing and pharmacy should have clarified it." Facility policy titled "Medication Administration" with a reviewed date of 4/20/17 included: "II. Safety Precautions: a. Observed the "five rights" for administration it. the right time iii. the right method of administration" "III. Basic Safety in Administration i. Read labels multiple times comparing to MAR 1. Review original physician order if discrepancy a. Do not provide if discrepancies continue" On 9/21/17 at 1:05 p.m. the Administrator and Director of Nursing were informed of the failure to clarify the Depakote orders. 5. For Resident #6, the facility staff failed to apply a physician ordered fall alarm from 9:00 a.m. to 1:00 p.m. on 9-19-17. Resident #6 was admitted to the facility on 3-30-16, with the diagnoses including, Huntington's disease, hypertension, seizures, dementia, depression, and anemia.			CENTER		287 EAST SOUTH BOULEVARD		12011	
the doctor and he discontinued the 125 mg of Depakote. When asked what should have been done, RN-B stated "nursing and pharmacy should have clarified it." Facility policy titled "Medication Administration" with a reviewed date of 4/20/17 included: "	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETION DATE	
		the doctor and he d Depakote. When a done, RN-B stated ' have clarified it." Facility policy titled ' with a reviewed date "II. Safety Precau a. Observed the 'fiv i. the right resid ii. the right time iii. the right med iv. the right med iv. the right med v. the right med v. the right med liIII. Basic Safety i a. Medication i. Read labels m MAR 1. Review origind discrepancy a. Do not provid continue" On 9/21/17 at 1:05 p Director of Nursing v clarify the Depakote 5. For Resident #6, a physician ordered if 1:00 p.m. on 9-19-17 Resident #6 was adm 3-30-16, with the diag Huntington's disease dementia, depression	iscontinued the 125 mg of sked what should have been hursing and pharmacy should "Medication Administration" of 4/20/17 included: tions: re rights" for administration ent dicine on administration" In Administration multiple times comparing to hal physician order if the if discrepancies or informed of the failure to orders. The facility staff failed to apply fall alarm from 9:00 a.m. to intend to the facility on gnoses including; hypertension, seizures, n, and anemia.	F 28				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495144	B. WING		00	/21/2017
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZII 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		72 1120 11
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	quarterly assessm Reference Date (A coded Resident #6 cognition, and requ from staff for all ac On 9-19-17, beginn of the Resident we Resident #6 was o with a scoop mattre sides of the bed, a and wedges on top Resident positionin alert, non-verbal, a side of the bed alm occasion the Resid bed, with her legs o the Resident's butte bed. A staff memb the room and repos On 9-19-17 Reside reviewed. The revi which included: 12-5-16 "personal to No bed alarm was a hours on 9-19-17 u observation. Surve 2:00 p.m., and a be Resident at that tim The Resident's care included the bed ala "Fall Risk".	ent with an Assessment ARD) of 6-22-17. The MDS is with severely impaired ulring extensive assistance extivities of daily living. Ining at 9:00 a.m. observations are completed up until 1:00 p.m. is been added foot board on the bed, and under the mattress for a g. The Resident was awake, and kicking her legs over the lost continuously. On one lent was halfway out of the completely out of the bed, and ocks were on the edge of the er followed the surveyor into sitioned the Resident. Int #6's clinical record was ew revealed physician's orders applied to the Resident for 4 antil after the 1:00 p.m. and alarm was in place on the element of the facility at a dalarm was reviewed and arm in the interventions for	F 2	81		
		led "Treatment Administration"				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495144	B. WING _		09/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 281	"It is the policy of th	ge 72 is facility to provide resident meets the psychosocial,	F 28 ⁻		
	physical and emotion the residents. "The provide guidance for	onal needs and concerns of purpose of this policy is to or the process for providing reatments are received and			
	"Lippincott" as the f standards. Both me administration polic	of Nursing (DON) stated acility reference for nursing edication and treatment ies from the facility followed ver, staff did not follow the irsing standard.			
	day debriefs, the Ad Nursing were inform apply the fall alarm	7, and 9-21-17 at the end of aministrator and Director of ned of the failure of staff to as ordered to Resident #6 for The facility provided no			
		PROVIDE CARE/SERVICES ELL BEING	F 309	F 309 1. Resident # 10's nurse responsible	
	applies to all care a residents. Each res facility must provide services to attain or practicable physical well-being, consiste	e indamental principle that and services provided to facility sident must receive and the athe necessary care and maintain the highest mental, and psychosocial and with the resident's essment and plan of care.		documenting Levemir insulin on 09 was disciplined. 2. Residents receiving insulin will be for the month of September 2017 k designee to ensure documentation On 10/09/2017. Any failure to docinsulins were addressed by the nurmanagers.	e audited by UM/ occurred. ument
		are fundamental principle that ent and care provided to		3. Licensed nurses will be educated documenting administration of inst DON/designee on or before 11/03/	ulin by

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY MPLETED
		495144	B. WING		09/	/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCAR		2	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	facility residents. E assessment of a right tresidents receace accordance with practice, the composite plan, and the but not limited to the tresidents with provided to reside consistent with protine comprehensive and the residents. (I) Dialysis. The faresidents who require plan, and the preferences, consiste of practice, the concare plan, and the preferences. This REQUIREME by: Based on staff intreview, and clinicate failed to ensure the for 1 Resident (Residents). For Resident # 10 document the adme 9/3/2017 as ordered.	Based on the comprehensive resident, the facility must ensure resident, the facility must ensure resident, the facility must ensure residents and standards of prehensive person-centered residents' choices, including the following: Inent. Inent.	F 309	4. A weekly audit of residents reinsulin will be reviewed weekly weeks by the DON/designee to proper documentation and foll Results from audits will be forw Quality Assurance/ Performant Improvement Committee to excompliance and the need for from monitoring for three (3) months	times twelf ensure ow through varded to the ce insure urther hs.	ո.
		cility on 12/2/2008. Resident				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		495144	B. WING _		09	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	#10's diagnoses ind Contracture Left hip Disorder, Hypertens Disorder, and Macure Resident #10's mosset) with an ARD (a 8/3/2017 was coded She was coded as for Memory Status) severe cognitive im coded as needing one person to perfoliving with the excepshe was coded as rup only. She was code	cluded Diabetes Mellitus, o, Contracture right hip, Bipolar sion, Major Depressive ular Degeneration. Set recent MDS (minimum data assessment reference date) of das an Annual assessment. Thaving a BIMS (Brief Interview Score of 8/15 indicating pairment. She was also extensive to total assistance of form all of her activities of daily oftion of eating. For eating, needing supervision and set coded as always incontinent of was conducted of Resident der 2017 revealed missing the medication:	F 309			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495144	B. WING			09	/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		28	TREET ADDRESS, CITY, STATE, ZIP CODE 87 EAST SOUTH BOULEVARD ETERSBURG, VA 23805		
(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 APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
SS=D	medications and trephysician and docur the time of administ facility's profession Lippincott. Guidance for nursin administration of me provided by "Lippinco administering a mediamediately on the There were valid phrollowing medication the Medication Administered. On 9/20/17 at 5:10 F (Administration A), at (DON-Administration A), at (DON-Administration A) findings. The DON shave administered to the Medication Administration findings. The DON shave administered to the Medication Administration findings. The DON shave administered to the Medication A) and the Medication A) are continented to find the Medication A). (b) Incontinence. (c) Incontinence. (d) The facility must continent of bladder receives services and continence unless hor becomes such that to maintain.	g standards for the edication and treatments is cott", which stated "After dication or treatment, record it appropriate record form." ysician orders for the hat was not documented on inistration Record (MAR), or ress Notes as having been a condition of the edication of the edication or treatment, record it appropriate record form." P.M. the facility Administrator and Director of Nursing edicated that the nurses should the medication as ordered. On was received. CATHETER, PREVENT UTI,	F 31		F 315 1. Resident #23 had a bowel and be screener completed on 09/25/201 Resident #23's kardex was update 09/25/2017 to include how to per incontinence care for resident.	.7. d on	
	110 TOTACINO 001	p. s. romano accoccinioni, tric					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495144	B. WING		09/21/2017
		ATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805 PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	
F 315	facility must ensure (i) A resident who e indwelling catheter resident's clinical c catheterization was (ii) A resident who e indwelling catheter is assessed for rem as possible unless demonstrates that e and (iii) A resident who receives appropriat prevent urinary trac continence to the e (3) For a resident w on the resident's co facility must ensure incontinent of bowe treatment and servi bowel function as p This REQUIREMEN by: Based on resident clinical record revie complaint investiga provide toileting ass (Resident #23) in th residents.	enters the facility without an is not catheterized unless the condition demonstrates that necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary is incontinent of bladder e treatment and services to at infections and to restore extent possible. with fecal incontinence, based emprehensive assessment, the that a resident who is all receives appropriate ces to restore as much normal cossible. NT is not met as evidenced interview, w, and in the course of a tion, the facility staff failed to sistance for 1 resident the survey sample of 23 clined to honor toileting is.	F 315	2. Current residents had a bowel a bladder screener completed on 16 Current residents' kardexs were usensure how to care for incontiner included on kardex on 10/05/201 were completed by Unit Manager 3. Nursing staff will be educated a complete a bowel and bladder screeners to update resident kardexs, a use the resident kardex by DON/door before 11/03/2017. 4. A weekly audit of new admissions' be bladder screeners to ensure completed on new admissions' be bladder screeners to ensure complete forwarded to the Quality Assur Performance Improvement Commensure compliance and the need formationing for three (3) months.	pdated to pdated and pdated to pdat

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495144	B. WING_		09	9/21/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	admitted to the fact diagnoses included Diarrhea, Overactive Joint, and Muscle V. The Minimum Data Assessment with a of 7/27/17, coded F. Interview of Mental intact cognition and ability. Resident #2 extensive assistant She was coded as lower extremities, a incontinent of bower equired a wheelch assistance of 1 per On 9/21/17 at 10:42 the Surveyor, Admi (Administrator/Exec (ED)/Administration (DON Administration (DON Administration (DON Administration verbally abused by that her evening shassistant 3-11 P.M. respect, and that he changed. Resident be angry with her a incontinence care a stated that her day her and refused to in They make me put stand up. My legs hanswer the call bell wheelchair and run	a 77 year old who was ility on 7/23/16. Resident #23's described by the Bladder, Pain in Unspecified Weakness-Generalized. A Set, which was an Annual in Assessment Reference Date Resident #23 as having a Brief Status Score of 15, indicating described independent decision-making 3 was coded as requiring the coe of 1 person for transfers. Thaving an impairment of both and as being frequently and bladder. Resident #23 air with the physical son for locomotion. A.M., Resident #23 stated to inistrator cutive Director (A), and Director of Nursing (A), and Director o	F 31	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING		COMPLETED		
		495144	B. WING		09	/21/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
PETERS	BURG HEALTHCARE	CENTER		287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	Continued From pa	nge 78	F 3	15		
	8 residents. Two of facility staff were no	o Interview was conducted with the residents stated that the of providing them with on a consistent basis.				
	#23's clinical record read, "Self-care im	w was conducted of Resident d. Resident #23's Care Plan pairment. Toileting and transfer led. Pain Management. lee pain.				
	statement: "9/21/17 interview on 9/21/1 ED/DON will thorou	5 P.M., the facility litted the following written 7. In regards to (Resident #23) 7 at 10:42 A.M. Facility lighly investigate concerns for light in regards to 2 staff				
F 323 SS=G		1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 3	23 F 323 1. Resident #2 was assessed for		
_	(d) Accidents. The facility must en	sure that -		needed for proper transfer ted 09/26/2017 by Therapy/design	nee. Reside	nt
		vironment remains as free rds as is possible; and		#4 was assessed for assistance proper transfer technique on Therapy/ designee. Resident	09/20/2017	by
		eceives adequate supervision ices to prevent accidents.		reapplied on 09/19/2017. 2. Residents with alarms orde		
	appropriate alternation bed rail. If a bed or must ensure correct	e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and drails, including but not limited ments.		reviewed for effectiveness of on or by 10/10/2017 by DON/ Current residents requiring tw for transfers were assessed for transfer technique by Um/des	designee. vo person as or proper	
				10/05/2017		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		09/	21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	from bed rails prior (2) Review the risks the resident or resident or resident or resident or resident formed consent p (3) Ensure that the appropriate for the inthis REQUIREMENT by: Based on staff intereview and clinical resident to provide the for a transfer, insteas for 2 residents (Residents for 2 residents (Resident facility staff failed to resident facility staff failed to	dent for risk of entrapment to installation. and benefits of bed rails with dent representative and obtain rior to installation. bed's dimensions are resident's size and weight. IT is not met as evidenced review, facility documentation ecord review, the facility staff assistance of 2 staff persons ad using one person transfer ident # 2 and # 4) resulting in ent (Resident # 4) who fracture of the leg. And the apply a bed alarm for one facility staff failed to ace of two staff persons for a neelchair to bed. the facility staff failed to ace of 2 staff persons for a d to the wheelchair, resulting of the leg. the facility staff failed to apply sician's orders from 9:00 a.m., 0-17.	F 323	3. Nursing staff will be inservice usage and application by DON/ Nursing staff will be educated of 11/03/2017 on all residents' reperson assist during transfers to DON/designee. 4. A weekly audit of alarms will completed to ensure in place be Manager/designee times twelve weekly audit of residents require person assistance during transfer completed times twelve by ADO Results from audits will be forwed Quality Assurance/ Performance Improvement Committee to ensure in place be a supplied to the province of the province o	designee. on or by equiring two by I be y Unit e weeks. A ing two ers will be DN/designee arded to the sure ther	o -

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 80 F 323 instead using a one person transfer from the wheelchair to bed. Resident #2, a 91-year-old female, was admitted to the facility on 3/2/2012. Her diagnoses included but were not limited to: Major Depressive Disorder with severe Psychotic Symptoms, Pseudobulbar Affect, Cardiac Pacemaker, Anemia, Acute embolism and thrombosis Resident #2's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/3/2017 was coded as a Quarterly assessment. She was coded as having short and long term memory deficits, severe cognitive impairments. She was also coded as needing extensive to total assistance of one person to perform all of her activities of daily living with the exception of transfers. For transfers, she was coded as needing total assistance of two staff members. She was coded as always incontinent of bowel and bladder. On 9/19/2017, Resident # 2's clinical record was reviewed. Review of the Nurse's Notes revealed entries: "8/9/2017 17:15 (5:15 p.m.) "Called to room by CNA (Certified Nursing Assistant) _____. Stated Res.(Resident) right hand was swollen and Res. was guarding and protecting her right hand. Upon assessment res. noted alert and verbally responsive, right hand at wrist area warm to

touch, bruising to hand and forearm edema to hand. Res. pulls away when assessment performed, right hand elevated on pillow res. medicated for pain. Physician notified orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY		
	495144	B. WING		00	V24/2047		
PETERSBURG HEALTHCARE CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCES			STREET ADDRESS, CITY, STATE, Z 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	IP CODE	09/21/2017 CODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
p.m., the clinician or 2's right hand. The at 2:15 a.m. and Rehave a "spiral fractualina." The facility began are of unknown origin, howestigation was under the injury and unated the injury and inj	ealed that on 8/9/2017 at 5:30 redered an X-ray of Resident #X-ray was obtained 8/10/2017 sident #2 was determined to re of the distal third of the injury er fractured ulna. The lable to determine the cause lable to substantiate abuse. It igation revealed a statement fed nursing assistant) (CNA sident #2 during the 7-3 shift IADL (Activities of Daily but the day who stated she laries during her shift. Is statement from CNA F Nursing and signed by the red in motice anything. I got her up air for breakfast. She rolled at chair. About 2:20 I put her it her side rails up and pull red DON stated the CNAs ch Resident that provides leds. The facility staff was	F3	923				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED
		495144	B. WING		0	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	person extensive as On 9/19/2017 at 4:0 interviewed by the so Director of Nursing the facility conferen remembered taking 8/9/2017 during the put Resident # 2 to herself. CNA F state any problems or sw when she last saw h trained to transfer R because of her size was small and could person. CNA F state coded Resident # 2 to transfer. CNA F s was written on the C stated she had take was trained to transform. On 9/19/2017 at 4:1 in the hallway near to conducted with CNA Unit 1 and was familistated it required 2 pc. The CNA Kardex for book designated for stated they did not k for Resident # 2 was On 9/19/2017 at 4:15 conducted with the total conducted with the tota	ssist for bed mobility. 22 p.m., the CNA F was surveyor in the presence of the and three other surveyors in ce room. CNA F stated she care of Resident # 2 on day shift. CNA F stated she bed at the end of the shift by ed Resident # 2 did not have elling noted on her right arm her. CNA F stated she was resident # 2 using one person. CNA F stated Resident # 2 did not know the MDS has needing 2 staff persons stated she did not know what CNA Kardex. CNA F again in care of Resident# 2 and fer the resident by herself. 10 p.m., CNA B was observed Unit 1. An interview was a who stated she worked on liar with Resident # 2. CNA B beople to transfer Resident #	F3	123		

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER.		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING			9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STATE, 287 EAST SOUTH BOULEVAR PETERSBURG, VA 23805	ZIP 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 X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	The investigation in transferred Reside to bed by herself. On 9/19/2017 at 5 DON were informe perform a two persinstead using a one end of day debriefin Administrator was interviewed earlier and Director of Nur Resident # 2 by her during her orientation 9/20/2017 at 4 conducted with the CNA F told her that technique to transfer The DON was asked MDS dated 8/3/201 requiring total assist transfers. The DON the MDS. On 9/21/2017 at ap copies of the CNA F copies were labeled 9/18/2017. One for right of the form "Trof the CNA Kardex with a print date of 9 generated by the copersonal hygiene/or bathing, dressing, requires 2 assist for the web address of at the bottom of the	ndicated the CNA had nt #2 from her wheelchair back p.m., the administrator and d of the failure of the staff to on transfer for Resident #2, e person transfer. During the ng on 9/19/2017, the facility informed that CNA F was that day and told the surveyors sing that she transferred rself as she had been shown on by another CNA. b.m., an interview was Director of Nursing who stated she used a "Stand and Pivot" er Resident # 2 by herself. ed if she was aware that the 7 coded Resident # 2 as t of two staff persons for N stated she did see that on proximately 1:00 p.m., three Kardex were presented. Two	F 3.	23			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495144	B. WING		. 0	9/21/2017		
	PETERSBURG HEALTHCARE CENTER			STREET ADDRESS, CITY, STAT 287 EAST SOUTH BOULEV. PETERSBURG, VA 2380	TE, ZIP CODE ARD			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	CROSS-REFERENCED	ACTION SHOULD BE	(X5) COMPLETION DATE		
F 323	Kardex had been up of survey. Facility stit. The DON presented 9/21/2017 at 9 a.m. stated during her interest stated that she stated assist" for Resident by the DON. During the end of dathe facility administr of the failure of the states.	navailable during the first days taff stated they could not find d a handwritten note on that was dated 9/20/2017 and terview with CNA F, she and Pivot with one person # 2 and the note was signed ay debriefing on 9/21/2017, ator and DON were informed staff to perform a two person t #2, instead using a one	F 3	323				
	provide the assistand transfer from the bed in a fall and fracture Resident #4 was an admitted to the facilit	the facility staff failed to ce of 2 staff persons for a d to the wheelchair, resulting of the left leg, which is harm. 88 year old who was by on 2/22/06. Resident #4's						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION UNG		(X3) DATE SURVEY COMPLETED		
		495144	B. WING		_	9/21/2017		
	PETERSBURG HEALTHCARE CENTER			STREET ADDRESS, CITY, ST 287 EAST SOUTH BOULE PETERSBURG, VA 238	ATE, ZIP CODE EVARD	P 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 CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
	Metaphyseal and li (crushed bone), Mage-Related Osteon Psychotic Disorder Alzheimer's Disease The Minimum Data Assessment with a of 6/7/17, coded Relaterview of Mental severely impaired owas coded as requivered assistance of two pfunctional limitation coded as having lower both sides. Her mowheelchair. On 9/19/17 a review documentation, reversely limitation coded as having lower both sides. Her mowheelchair. On 9/19/17 a review documentation, reversely limitation coded as having lower both sides. Her mowheelchair. On 9/19/17 a review documentation, reversely limitation for limitation coded as having lower both sides. Her mowheelchair. On 9/19/17 a review documentation, reversely limitation for limi	impacted Plateau Fractures uscle Weakness-Generalized, oporosis, Schizophrenia, Hypertension, and ie. Set, which was a Quarterly in Assessment Reference Date esident #4 as having a Brief Status Score of 7 - indicating cognition. For transfers, she iring the extensive physical ersons. In the area of in range of motion, she was wer extremity impairment on bility device was a manual was conducted of facility ealing Resident #4's Care initiated 3/9/10. Revised k for and have had an actual itive impairment with wareness. I am easily poor insight/judgement. I am dependent for ADLs iving). Assist resident with all the Plan had not been revised to nent of the extensive physical	F 3	23				

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495144	B. WING_		09	9/21/2017	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
(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 THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
	herself and dropped her in her wheelch hands and fell on the and went to the howith a leg brace or a half." Resident # Status Score was impairment. She wadequate vision and Resident #4's clinic following x-ray report indings: Four view tibia displaced met plateau fractures, a severe tricompartmy osteophytes and loo On 9/19/17 a review conducted, revealing on 6/29/17. It read, Resident assessment fracture. Document 6/25/17. Investigatif facility follow-up reading fracture. The second wheelchair." According the second fracture of the second from the anoise. I turned are front of wheelchair in between the leg extended. Resident and the second front of wheelchair in between the leg extended. Resident	ed her on the floor while putting air. She slipped out of her he floor. She broke her leg spital. She came back here n, and had it on for a month and 1's Brief Interview of Mental 14, indicating no cognitive has also coded as having	F 32	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		00	9/21/2017	
NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, Z 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	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 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	The clinical record Nursing Progress Resident resting ir lung fields clear, noted. No dizzy sposition, call bell in hours." For the nethere was no furth continuous shifts). On 6/28/17 the Novital signs 99.2-90 noted with edema bruising present to (complains of) pair CNA to dress her. Tylenol Tabs 2 PO (doctor) made award left knee (left if admitted to the host to the facility at 6:4 medication, use of weight bearing to learn the read, "SRMC surgery indicated a extensive. Keep known of the precious of Nurinvestigation, was part to the staff members another staff members was trained the per resident needed on When CNAA was in the staff members of the precious of the conducted of the per resident needed on When CNAA was in the per resident needed on the conducted with CNAA was in the conducted with CNAA was in the conducted of the per resident needed on the conducted with CNAA was in the conducted with conducted with conducted with conducted with conducted with CNAA was in the conducted with conduc	d contained the following Note, "6/25/17/ 10:51 P.M. h bed, respirations unlabored, ho coughing or congestion hells noted. Bed in lowest h reach. Staff monitoring Q 2 ext three days, until 6/28/17 her post-fall monitoring (7	F 33	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495144	5144 B. WING			9/21/2017
	PETERSBURG HEALTHCARE CENTER (VA) ID SLIMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZI 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	P CODE	3/2 1/20 1/
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	was in the room, but pulled." There was curtain had been pure Nursing was asked interviewed regarding." Because I didn't kn and I didn't ask." On 9/19/17 at 5:00 (Administration A) with 9/20/17 the Administration Petersburg Plan of "Findings: Facility fattwo injuries of unknote interview all potent interview all interview all potent interview all interview all potent interview all po	at said that "the curtain was no documentation that the ulled. When the Director of why Resident #1 wasn't ng the fall, she stated, now that she was in the room P.M. the facility Administrator was notified of the findings. On strator submitted following Correction; ailed to properly investigate own origins. The facility failed attal witnesses. On 6/25/17, and on 6/28/17 knee fracture. Resident: (#2) acture of unknown origin.	F 33	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495144	B. WING		no	9/21/2017		
	PROVIDER OR SUPPLIER BURG HEALTHCAR			STREET ADDRESS, CITY, STAT 287 EAST SOUTH BOULEVA PETERSBURG, VA 23805	E, ZIP CODE ARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE. CROSS-REFERENCED DEFICI	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETION DATE		
F 323	on 1/24/17. Reside Cerebrovascular Description, unsponding the Minimum Data Assessment with a of 7/3/17, coded Resident of Mental that he was independent of the Minimum Data Assessment with a of 7/3/17, coded Resident of Mental that he was independent of Mental that he was inde	ent #16's diagnoses included bisease, Gout, and ecified. a Set, which was a Quarterly in Assessment Reference Date esident #16 as having a Brief Status Score of 13, indicating indent in decision making o coded as requiring the assistance of two staff persons g functional limitation of both a wheelchair for mobility. and Director of Nursing were urveyor confirmed the with Resident #16, who was resident #16 stated that CNA D transfer him by herself from lichair. The Administrator later D had received disciplinary ag an improper transfer after	F 32	23				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495144	B. WING			no)/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				
(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 APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	3. For Resident #6, and a fall risk, the faphysician ordered fa 1:00 p.m. on 9-19-1 Resident #6 was ad 3-30-16, with the dia Huntington's diseas dementia, depression the most recent Mir quarterly assessment (AR coded Resident #6 vognition, and require from staff for all action 9-19-17, beginni	a Resident with a fall history, acility staff failed to apply a all alarm from 9:00 a.m. to 7. mitted to the facility on agnoses including; e, hypertension, seizures, on, and anemia. nimum Data Set (MDS) was a not with an Assessment (MDS) with severely impaired ring extensive assistance	F3	323				
		served laying in a low bed						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND ADDED.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495144	B. WING			0	9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			0/2 1/2011	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	with a scoop mattre sides of the bed, a pand wedges on top Resident positioning alert, non-verbal, and side of the bed almodoccasion the Reside bed, with her legs conthe Resident's button bed. A staff member the room and reposition of the reviewed. The reviewed. The reviewed. The reviewed included: 12-5-16 "personal bed No bed alarm was always on 9-19-17 unobservation. Survey 2:00 p.m., and a bed Resident at that time. The Resident's care included the bed alar "Fall Risk". The facility policy title was reviewed, and residents. "The provide guidance for provide guidance for sidents."	ss, pads on the floor of both badded foot board on the bed, of and under the mattress for g. The Resident was awake, ad kicking her legs over the best continuously. On one ent was halfway out of the bed, and cks were on the edge of the er followed the surveyor into itioned the Resident. It #6's clinical record was aw revealed physician's orders are returned to the facility at a lalarm was in place on the edge. It alarm was in place on the edge of the facility at a lalarm was in place on the edge. It alarm the interventions for the edge of the facility to provide resident every shift." The policy is to the facility to provide resident every shift in the interventions for edge of the following: It alarm the interventions for every shift in the intervention of the edge of the e	F 3	23				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495144	B. WING		09/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(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 APPROPRICIENCY)	D BE COMPLETION	
F 329	"Lippincott" as the fistandards. Both madministration policition the standard. On 9-19-17, 9-20-1 day debriefs, the Advising were informapply the fall alarm 9-19-17. This omis accident precursor provided no further 483.45(d)(e)(1)-(2) FROM UNNECESS 483.45(d) Unnecessary drugs drug when used— (1) In excessive dost therapy); or (2) For excessive dost therapy); or (3) Without adequate (4) Without adequate (5) In the presence which indicate the discontinued; or	r of Nursing (DON) stated racility reference for nursing edication and treatment ries from the facility followed 7, and 9-21-17 at the end of diministrator and Director of ned of the failure of staff to to Resident #6 for 4 hours on sion presented a hazard, and for Resident #6. The facility information. DRUG REGIMEN IS FREE SARY DRUGS sary Drugs-General. g regimen must be free from An unnecessary drug is any see (including duplicate drug	F 329	F 329 1. Resident # 14's Depakote dosage clarified by the physician on 09/21, 2. Current residents' on Depakote reviewed for adequate dosing on 10/05/2017 by DON/ Designee. 3. Licensed nurses will be educated verifying increases or decreases in order changes by DON/ Designee of 11/03/2017. 4. A weekly audit of Depakote ord performed to ensure Depakote incompand/ or decreases are proper transithe DON/ Designee times twelve. from audits will be forwarded to the Assurance/ Performance Improve Committee to ensure compliance need for further monitoring for the company of the property o	/2017. were d on Depakote on or by ers will be creases scribed by Results he Quality ment and the cree (3)	
	(4) Without adequate(5) In the presence which indicate the discontinued; or(6) Any combination	te indications for its use; or of adverse consequences lose should be reduced or as of the reasons stated in		4. A weekly audit of Depakote ord performed to ensure Depakote income and/ or decreases are proper transthe DON/ Designee times twelve. from audits will be forwarded to the Assurance/ Performance Improve Committee to ensure compliance	creases scribed by Results he Quality ment and the	

	OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		495144	B. WING_		0.5	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCAR			STREET ADDRESS, CITY, STATE, ZIP CO 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	483.45(e) Psychot Based on a comprresident, the facilit (1) Residents who drugs are not giver medication is necessional record; (2) Residents who gradual dose reductional record; (2) Residents who gradual dose reductions, unless an effort to discont This REQUIREME by: Based on observational record review, the sone (Resident #14) sample, was free fire Resident #14 receismedication Depaktor of depression) from When the physician the original order for (milligrams) had not mg was ordered, the 125 mg order. The findings include Resident #14 was a 8/19/11 with the diadementia, depression.	ropic Drugs. rehensive assessment of a y must ensure that have not used psychotropic in these drugs unless the ressary to treat a specific resed and documented in the use psychotropic drugs receive retions, and behavioral ress clinically contraindicated, in reference of the service of t	F 32			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495144	B. WING _	01	09	9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCAR			STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		72 1720 17	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY 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 E APPROPRIATE	(X5) COMPLETION DATE	
F 329	coded Resident #' cognition; required staff for transfers, hygiene.	age 94 ARD) of 6/28/17. The MDS 14 with moderately impaired I extensive assistance from dressing, toileting, and m. Resident #14 was observed	F 32	29			
	sitting in a wheelch and conversationa was great and stat for church services	nair in her room. She was alert il. Resident #14 stated lunch ed her sister will be coming in s that day. Resident #14 did gative behaviors or symptoms					
		p.m. Resident #14's clinical ed. The review revealed which included:					
	Release 125 mg G	prinkles Capsule Delayed ive 1 capsule by mouth two I to Major Depressive Disorder		=			
		Tablet Delayed Release 250 mg buth two times a day related to Disorder.					
	and signed as adm	nd 250 mg orders were listed inistered on the Medication ord (MAR) twice daily from 7.					
	Director of Nursing	n. the Administrator and were informed of the The pharmacy review sheet s were requested.					
		a.m. the Depakote orders on					

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING

09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VÁ 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG TAG** CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 329 Continued From page 95 F 329 Practical Nurse-LPN-B) who administered the medications to Resident #14 that morning with the Registered Nurse Unit Manager (RN-B) present. LPN-B showed surveyor the opened and empty medication package which revealed Resident #14 received both the 125 mg and 250 mg of Depakote. It was discussed with LPN-B and RN-B that when the medication was increased to 250 mg that the 150 mg was not discontinued. Clarification whether the physician wanted both orders or not was requested. On 9/21/17 at 11:00 a.m., RN-B stated she called the doctor and he discontinued the 125 mg of Depakote. When asked what should have been done, RN-B stated "nursing and pharmacy should have clarified it." Facility policy titled "Medication Administration" with a reviewed date of 4/20/17 included: "...II. Safety Precautions: a. Observed the "five rights" for administration i. the right resident ii. the right time iii. the right medicine iv. the right dose v. the right method of administration..." "...III. Basic Safety in Administration a. Medication i. Read labels multiple times comparing to MAR 1. Review original physician order if discrepancy a. Do not provide if discrepancies continue..." Physician notes that were reviewed did not have

documented evidence that Resident #14 was to receive both 125 mg and 250 mg of Depakote. A

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	l , ,		ONSTRUCTION		MPLETED
		495144	B. WING			09/	/21/2017
	PROVIDER OR SUPPLIEF			287	ET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD ERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Valproic Acid level levels of Depakote laboratory result d the record which v	age 96 (a blood test to monitor the circulating in the blood) ated 7/11/17 was observed in was within normal range. Included a Valproic Acid level	F 3.	29			
	Review Summary' progress notes fro not have any medidocumented. Pharmacy note da	rmacy "Medication Regimen de and "Pharmacy Review" m 2/23/17 through 9/12/17 did cation irregularities ted 1/24/17 included: ng BID" (BID=twice a day)					
F 333 SS=G	"Behavior noted Depakote 250 mg On 9/21/17 at 1:05 Director of Nursing clarify the Depakot unnecessary medi 483.45(f)(2) RESID SIGNIFICANT ME 483.45(f) Medication The facility must e (f)(2) Residents are medication errors. This REQUIREME by: Based on staff into	p.m. the Administrator and were informed of the failure to be orders which resulted in cation administration. DENTS FREE OF D ERRORS on Errors.	F 3:	1. cl.i Re 2. re cc	333 Resident #14's Depakote orders arified by the physician on 09/21 esident #7 was hospitalized on 00 Current residents' on insulin we eviewed for September 2017 to exprect medicine and amount of mas given on 10/05/2017 on 10/00 current residents receiving Depakeviewed for correct dosing 10/05,001/ designee.	1/2017. 6/20/20 ere ensure nedicine 6/2017. ote were	e

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495144	B. WING		09/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
F 333	failed to ensure two (Residents #7 and in the survey samp medication errors. error resulted in had 1. For Resident #7 the wrong insuling chospitalized for 7 dd 2. Resident #14 resthe medication Dept treatment of depres 9/21/17. When the 9/21/17 that the oring (milligrams) had 250 mg was ordered the 125 mg order. The findings includ Resident #7 was as 6-22-16 with diagnochronic kidney dise hyperkalemia, seize peripheral vascular tract infections, his history of sacral predermatitis. Resident #7's most set) with an ARD (as each of the survey of sacral predermatitis.	Resident #14) of 23 residents ale, were free from significant Resident #7's medication arm. The facility staff administered ausing the Resident to be ays. Received two different doses of the physician was notified on a ginal order for Depakote 125 do not discontinued at the time and, the physician discontinued at the time and the physician discontinued at the physician discontinued	F 333	3. Licensed nurses will be educated proper Depakote dosing by verification the physician whether it is an incomposition of the physician whether it is an incomposition of the physician whether it is an incomposition of the physician and transcription of the physician of the phy	ying with crease or n process by 2017. Depakote ure right nedicines y for twelve esignee. yarded to the se sure
	memory loss, and s #7 was coded as re	dent #7 was coded as having severe cognitive loss. Resident equiring extensive assistance on one to two staff members			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		0.0	9/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STATE, Z 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	P CODE	312 1120 11	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HÈ APPROPRIATE	(X5) COMPLETION DATE	
	for all ADL's (activiti incontinent of bowe for bladder eliminated on 9-19-17 at thoroclinical record was notes were reviewed on 6-20-17 at 12:50 "cold/clammy/diaph 31." The note goes received a subcutainher left upper arm to the Resident had a 2:00 p.m., as the dorecheck in 1 hour at approximately 1:00 LPN F documented sugar was 158, and her as 138 milligram on 6-20-17 at 5:25 to the hospital via 90 (ER) for evaluation of 3p-11p shift nurse, at in the nursing notes sugar was 116 at the not agree with the hospital erevealed that EMS (ambulance reported administered oral gligafter administration,	ties of daily living), and always	F 3:	33			

STATEMENT OF DEFICIENCIES (X1) PROVIDERS IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495144	B. WING		00	/21/2017
	PROVIDER OR SUPPLIE		2	TREET ADDRESS, CITY, STATE, Z 87 EAST SOUTH BOULEVARD ETERSBURG, VA 23805		12112011
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT 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 DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	Further review of that 7:16 p.m., on 6-sugar had again dit had gone up to 7 Dextrose 10% 100 and potassium chlismas admitted to the days, until 6-26-17 evening, to the factories were considered by the factories of the factories were considered by the factories of the factories	the hospital record revealed that 20-17, the Resident's blood ropped to 46, and by 11:00 p.m. 79, after intravenous (IV) 10 ml (milliliters) was given and 10 ml to include sodium chloride oride was given. The Resident e hospital and remained for 7, when she was returned in the ility. Inducted on 9-19-17, and deministrator and Director of the regard to this situation. They sident had received 18 units of 18 (Humalog) insulin at 9:00 instead of the (Humulin N) ing insulin, which was ordered time. Prior to the 19 wrong insulin, the Resident's 10 a.m., was 82. In's orders and the Medication ord (MAR) revealed that the red to have, and was receiving, is of insulin; If acting insulin, inject 18 units the red to have, and was receiving, is of insulin; If acting insulin, inject 18 units the red to have, and was receiving, and 19 p.m. If acting insulin, inject as the p.m. If a 400 give 20 units To units,	F 333			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				ATE SURVEY DMPLETED
		495144	B. WING			00	9/21/2017
	PROVIDER OR SUPPLIER	E CENTER		287	EET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD FERSBURG, VA 23805		3/2 1/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 333	If blood sugar less call doctor. The Administrator the nurse (LPN F) insulin had not rea nurse (RN B), stun Resident #7's room Resident, and ask had given to the R(LPN F) went to the (RN B) the vial of r the series of event statement. The nuterminated, and untime of the incident same individual actime of survey, and could only answer former Administrate. The Resident's car revealed intervention medications as ord with changes in consigns or symptoms sugar symptoms of mental status, lethal	and DON went on to state that who had given the wrong lized the error until another at lunch time, saw the ed what medication (LPN F) esident. The medication nurse e medication cart, and showed egular insulin. RN B validated is as correct in a written arse who made the error was eavailable for interview. At the ting as administrator was not the liso the current Administrator as to the information left by the	F3	333			
	Resident was in sep.m. blood sugar rerevealed a critical lease. The facility medical reviewed, and reverse.	ion management policy was aled that all current standards					
	and requirements watching that policy follows	vere in place for medication n the documents. An excerpt					

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		495144	B. WING		09	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CO 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 333	"The facility policy of Administration" with included: "II. Safety Precata a. Observed the "fix ithe right resision. The right me iv. the right medication administration in the right medication administration. To provide the six rights medication administration in medication administration	entitled "Medication in a review date of 4-20-17 utions: ive rights" for administration dent edicine it in Administration in Administration multiple times comparing to inal physician order if de if discrepancies or Professional standards, an Nurses Association's distandards of Nursing ich apply to the activity of tration and treatment prevent medication errors, of medications. Many an be linked, in some way, to adhering to the six rights of tration include the following: edication see ent ute	F 33	33	21	
		documentation." 7, "A medication order is				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORI	D: 10/02/2017 M APPROVED D. 0938-0391
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED
		495144	B. WING_		00	9/21/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP C			72 1120 11			
PETERS	BURG HEALTHCARE	CENTER		287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 333	required for every madminister to a client receive an order, co orders with the med (MAR/TAR) when the ordered. Verify mediate MARs are writted clients transfer from care setting to another.	redication or treatment you tRegardless of how you mpare the prescriber's written ication administration record e medication is initially lication information whenever en or distributed or when one nursing unit or health ier. Once you determine that ient's MAR is accurate, use npare, prepare and	F 33	3		
	Reported Incident" (I Wednesday 6-21-17 Tuesday 6-27-17 in I medication error. Bowas admitted to the for hypoglycemia, an have occurred (within the same day. The f	strator sent a "Facility FRI) to the state agency on , and a follow up report on regard to the serious of the were late. The Resident hospital on Tuesday 6-20-17 of the initial report should in 2 hours of hospitalization) follow up 5 day report should er than 6-26-17, the 5th				
	same orders which p reinstituted when the hospital. The Humul decreased, and adm to avoid confusion in after the Resident rei	owed no realization that the roduced the error were Resident returned from the in N (long acting) insulin was inistration time was changed the orders on 7-1-17, 5 days turned, and the Regular insulin was continued as				

No re-education of staff was included in the investigation packet reviewed by surveyors, and was not provided by administration as evidence of

re-training. Other instances of issues were found

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI, IDENTIFICATION NUMBER		A. BUILDI	FIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED	
	495144	B. WING		09	9/21/2017	
NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIF 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		1,201	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 IE APPROPRIATE	(X5) COMPLETION DATE	
insulin within the fact documented in other within this survey streport. In conclusion, the irreducation, for this irrequired by federal Administrator and Enharm level deficient regard to insulin additional debriefs on 9-20-17 information was present the medication Department of depres 9/21/17. When the 9/21/17 that the origing (milligrams) had 250 mg was ordered the 125 mg order. Resident #14 was an 8/19/11 with the diagramentia, depressional The most recent Mirreguarterly assessment Reference Date (AR coded Resident #14 cognition; required entared in the survey strength of the survey strength in the survey st	with regard to administration of cility, and those are er deficiencies, contained catement of deficiencies (SOD) investigation, reporting, and incident were not completed as mandate. The current DON were made aware of the practice for this Resident with ministration at the end of day and 9-21-17. No further esented by the facility. Decived two different doses of akote (ordered for the sion) from 2/22/17 through physician was notified on physician was notified on inal order for Depakote 125 and discontinued at the time di, the physician discontinued disconti	F 33	33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		00	0/21/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		1/2 1/2011	
(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 TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	On 9/20/17 at 1 p.r sitting in a wheelch and conversational was great and state for church services not display and neg of depression. On 9/20/17 at 2:30 record was reviewed physician's orders with the 125 mg Gi times a day related and 2/22/17 Depakote Times a day related and 2/22/17 Depakote Times a day related and Both the 125 mg and and signed as admit Administration Record 2/22/17 until 9/21/11 On 9/20/17 at 4 p.m Director of Nursing Depakote orders. To and physician notes on 9/21/17 at 9:30 at the MAR were reviewed practical Nurse-LPN medications to Resi the Registered Nurse present. LPN-B should empty medications to and empty medications.	m. Resident #14 was observed pair in her room. She was alert alert in her room. She was alert resident #14 stated lunch and her sister will be coming in that day. Resident #14 did pative behaviors or symptoms p.m. Resident #14's clinical and. The review revealed which included: prinkles Capsule Delayed are 1 capsule by mouth two to Major Depressive Disorder ablet Delayed Release 250 mg auth two times a day related to disorder. and 250 mg orders were listed anistered on the Medication ord (MAR) twice daily from 7. a. the Administrator and were informed of the The pharmacy review sheet	F 3:	33			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495144	B. WING			00	9/21/2017	
	PROVIDER OR SUPPLIE			287	EET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD FERSBURG, VA 23805	1 00	312 1120 T	
PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	к	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	mg of Depakote. and RN-B that wh increased to 250 r discontinued. Cla wanted both order On 9/21/17 at 11:0 the doctor and he Depakote. When done, RN-B stated have clarified it." Facility policy titled with a reviewed da "II. Safety Preca a. Observed the " i. the right res ii. the right me iv. the right me iv. the right me "III. Basic Safety a. Medication i. Read labels MAR 1. Review orig discrepancy a. Do not prov continue" Physician notes the documented evider receive both 125 m Valproic Acid level levels of Depakote laboratory result da the record which we	It was discussed with LPN-B en the medication was mg that the 150 mg was not rification whether the physician is or not was requested. Of a.m., RN-B stated she called discontinued the 125 mg of asked what should have been it "nursing and pharmacy should it "Medication Administration" and the of 4/20/17 included: autions: five rights" for administration ident the electron identical included in the	F3	33				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495144	B. WING		09/21/2017		
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE COMPLETION		
F 333	Review of the phart Review Summary"	macy "Medication Regimen and "Pharmacy Review"	F 333				
	progress notes from 2/23/17 through 9/12/17 did not have any medication irregularities documented. On 9/21/17 at 1:05 p.m. the Administrator and Director of Nursing were informed of the failure to clarify the Depakote orders which resulted in unnecessary medication administration and significant medication error. No further						
	information was pro 483.80(d)(1)(2) INF PNEUMOCOCCAL	ovided by the facility staff. LUENZA AND IMMUNIZATIONS	F 334	F 334 1. Resident #3 was offered a pneum			
	(1) Influenza. The fa	nd pneumococcal immunizations The facility must develop policies s to ensure that- ing the influenza immunization,		on 10/02/2017, but refused because resident stated he had within the past 5 years. Resident #3 received the pneumovaccine on 12/22/2015. 2. Current residents were audited to ensure a pneumovaccine was offered to them by the UM/ designee on 09/24/2017. Current residents that accepted the pneumovaccine			
	each resident or the receives education	e resident's representative regarding the benefits and s of the immunization;					
	immunization Octob annually, unless the contraindicated or the immunized during the	Each resident is offered an influenza munization October 1 through March 31 inually, unless the immunization is medically intraindicated or the resident has already been munized during this time period;		will receive the pneumovaccine. Current residents that declined will have documentation in the medical chart as to why.			
	has the opportunity	the resident's representative to refuse immunization; and		Licensed nurses will be educated offering and documenting receiving declining pneumovaccine by			
		nedical record includes indicates, at a minimum, the		ADON/Designee on or before 11/0	3/2017.		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		09/	21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCAR SUMMARY ST			STREET ADDRESS, CITY, STATE, ZIP COD 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805 PROVIDER'S PLAN OF CORRE	DE	(X5)	
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F 334	was provided educe and potential side immunization; and (B) That the reside immunization or di immunization due refusal. (2) Pneumococcal develop policies and develop policies and potential side immunization, eac representative recebenefits and potentimmunization; (ii) Each resident is immunization, unle medically contrained already been immunization immunization. (iii) The resident of has the opportunity (iv) The resident's documentation that following: (A) That the reside was provided educe and potential side immunization; and	ent or resident's representative cation regarding the benefits effects of influenza ent either received the influenza d not receive the influenza to medical contraindications or disease. The facility must end procedures to ensure that the pneumococcal h resident or the resident's eives education regarding the etial side effects of the	F 334	4. A weekly audit will be performance and documented on response and the quality Assured to	they are egarding the eeks by the udits will be trance/ommittee to eed for furthers.		

PRINTED: 10/02/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 108 F 334 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced bv: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one (Resident #3) of 23 residents in the survey sample, to offer and/or evaluate the need for the pneumococcal (pneumonia) vaccine. Resident #3's clinical record had documented that he was not eligible to receive and also that he previously received the pneumococcal vaccine however, the facility staff failed to determine the date he received the vaccine or document the reason he was not eligible to receive it. The findings included: Resident #3 was admitted to the facility on 4/4/16 with the diagnoses of, but not limited to, chronic kidney disease stage III, diabetes mellitus. chronic pain, hypertension, and cerebrovascular disease with left sided weakness. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 8/2/17. The MDS

conversational.

and bathing.

coded Resident #3 with no cognitive impairment; required limited assistance from staff for bed mobility, transfers, dressing, toileting, hygiene,

On 9/18/17 at 2:25 p.m., Resident #3 was observed sitting in a wheelchair, in his room watching television. He was alert and

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		495144	B. WING _		05	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(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 ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 334	On 9/19/17 at 10:0 record was reviewed comparison MDS' to 7/12/17 Section O Procedures, and P Vaccine, was documented and A.0=No, Educate and Education and Indian resident and Indian res	O a.m. Resident #3's clinical ed. The review revealed on with an ARD of 4/11/17 and Special Treatments, rograms-O0300 Pneumonia mented as A.1=Yes, the coccal vaccination is up to 3.1.=Not eligible-medical ctively. O a.m. the MDS nurse, A (RN-A) was asked why the e was ineligible "could be within 5 years but didn't have a on." At 2:45 p.m. RN-A //Discharge/Transfer Forms" discharging hospital with a of 4/15/16 at 11:31 a.m. which le Given: NO umococcal Vaccine (sic) Not sly immunized" p.m. the Administrator and were informed of Resident #3 intation of when the cine was administered or e was "not eligible." The	F 33			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495144	B. WING			0!	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		287 EA	ADDRESS, CITY, STATE, ZIP COD ST SOUTH BOULEVARD SBURG, VA 23805	E	172017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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
	as received on 9/23 1 with no date given "Not Eligible." Facility policy titled " Vaccine" with a revieincluded: "Policy:The purpose of thi and notify residents effort to reduce the scertain types of pnet recommends that in years old be vaccina pneumonia, and in phave chronic lung dis (chronic obstructive who smoke cigarette and other conditions resistance to infection provided with educate pneumonia and will be vaccine upon admission Procedure: "B. Residents in the pneumococcal pneumonia and will be vaccine upon admission Procedure: "B. Residents in the pneumococcal pneu	/16 and the Pneumovax Dose and "Consent Status" as Resident Pneumococcal awed date of 4/20/17 Is policy is to educate staff and responsible parties in an aseverity and episodes of amonia. The CDC dividuals over the age of 65 ated against pneumococcal articular, those who also seases such as COPD pulmonary disease), those as, those who have diabetes that may lower their an. Residents will be a cion regarding pneumococcal articular of the pneumococcal articular of the pneumococcal articular of the pneumococcal and the pneumococcal articular of the pneumococcal articular of the pneumococcal and the pneumococcal articular of the pneumococcal and the pneumococcal articular of the pneumococcal and	F 33	34			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495144	B. WING _		09	/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
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F 386 F 386 SS=D	483.30(b)(1)-(3) PF CARE/NOTES/OR (b) Physician Visits The physician mus (1) Review the resignation of the physician mus (2) Write, sign, and visit; and (3) Sign and date as influenza and pneuble administered perior policy after an asset This REQUIREMED by: Based on staff intereview and clinical failed to ensure Phyrecertification were (Resident # 10) in a residents. For Resident # 10, ensure Physicians signed timely. Resphysician between resulting in 77 days orders. The findings include Resident #10 was a admitted to the facil #10's diagnoses include Resident #10 was a admitted to the facil #10's diagnoses included.	dent's total program of care, ins and treatments, at each ragraph (c) of this section; date progress notes at each ll orders with the exception of mococcal vaccines, which may rephysician-approved facility essment for contraindications. NT is not met as evidenced erview, facility documentation record review, the facility staff ysician orders for signed timely for one resident a survey sample of 23 the facility staff failed to orders for recertification were ident # 10 was not seen by the 6/14/2017 and 8/30/2017 between signed recertification	F 386 F 386	F 386 1. Resident # 10's physician or were signed by a physician on 2. Current residents' physician were audited to ensure timely 10/05/2017 by Medical Records. Medical Records/ designee educated by Administrator on frames/ timely physician visits 10/11/2017. 4. A weekly audit of physician for timely visits will be comple weeks to ensure compliance be Record/ designee. Results from the forwarded to the Quality As Performance Improvement Composition of the ensure compliance and the nemonitoring for three (3) month.	08/30/2017. order sheet visits on ds/ designee. will be proper time on order sheets ted for 12 y the Medica m audits will ssurance/ mmittee to ed for furthe	s	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATIÓN NUMBER:		PLE CONSTRUCTION G		MPLETED
		495144	B. WING _		0!	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
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F 386	Resident #10's mos set) with an ARD (a 8/3/2017 was coded She was coded as I for Memory Status) severe cognitive im coded as needing e one person to perfoliving with the excepshe was coded as rup only. She was coded and bladder. On 9/20/17 at 8:45 of Resident #10's clin recently signed Phy Report" form was don 8/30/2017 to recently signed Phy Report for the previous Summary Report for 6/14/2017. On 9/20/2017 at 4:4 Director of Nursing signed Physicians Colinical record was cone prior was dated days between signal	sion, Major Depressive lar Degeneration. It recent MDS (minimum data ssessment reference date) of das an Annual assessment. In aving a BIMS (Brief Interview Score of 8/15 indicating pairment. She was also extensive to total assistance of rm all of her activities of daily obtion of eating. For eating, needing supervision and set oded as always incontinent of AM, a review was conducted inical record. Review of ical record revealed the most sicians "Order Summary ated as having been signed apitulate and reinstitute the on, and treatment orders. A Resident # 10's clinical record asly signed Physician's Order rm was dated as signed on 5.5 PM, the Administrator and were informed that the last Orders Sheet noted in the dated on 8/30/2017 and the on 6/14/2017, resulting in 77 tures. The Director of Nursing tated the physicians should are every 60 days.	F 38			
						1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495144	B. WING			09/	21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE SUMMARY STA	CENTER TEMENT OF DEFICIENCIES	ID	28	TREET ADDRESS, CITY, STATE, ZIP CODE 87 EAST SOUTH BOULEVARD ETERSBURG, VA 23805 PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 425 F 425 SS=E	483.45(a)(b)(1) PH/ACCURATE PROC (a) Procedures. Af pharmaceutical sent that assure the accudispensing, and adribiologicals) to meet (b) Service Consultatemploy or obtain the pharmacist who (1) Provides consultatemploy or obtain the pharmacist who (1) Provides consultatemploy or obtain the pharmacist who (1) Provides consultatemploy. Based on observation of pharmathis REQUIREMENTO by: Based on observation record review, the fact and report medication (Resident #14) of 23 sample The pharmacy did in facility staff that Residifferent doses of the (ordered for the treat 2/22/17 through 9/2) was notified on 9/21 Depakote 125 mg (rediscontinued at the fiphysician discontinued Resident #14 was a facility and facility staff that Resident #14 was a facility staff that Resident #14 wa	ARMACEUTICAL SVC - EDURES, RPH acility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. ation. The facility must e services of a licensed ation on all aspects of the cy services in the facility; IT is not met as evidenced and, staff interview, and clinical acility staff failed to identify on irregularity for one a residents in the survey act identify and report to the sident #14 received two e medication Depakote atment of depression) from 1/17. When the physician //17 that the original order for milligrams) had not time 250 mg was ordered, the led the 125 mg order. ad: dmitted to the facility on gnoses of, but not limited to,	F 4 F 4	25	1. Resident #14's Depakote dosage clarified on 09/21/2017. 2. Current residents' on Depakote reviewed to ensure orders are transcorrectly on 10/05/2017 by DON/ II 3. Licensed nurses will be educated transcription of medications related Depakote dosing by DON/ Designed 11/03/2017. 4. A weekly audit of residents recent Depakote will be performed to ensure proper transcription has occurred DON/ Designee times twelve week from audits will be forwarded to the Assurance/ Performance Improvem Committee to ensure compliance and need for further monitoring for the months.	were scribed Designed I on d to e on or iving sure by the es. Result ne Qualit nent and the ee (3)	e. by ts

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495144	B. WING		05	9/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, 2 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	ZIP CODE	72172017
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	The most recent Mi quarterly assessme Reference Date (AF coded Resident #14 cognition; required staff for transfers, dhygiene. On 9/20/17 at 1 p.m sitting in a wheelcha and conversational. was great and state for church services not display and negro of depression. On 9/20/17 at 2:30 precord was reviewed physician's orders where the services of the services of depression. On 9/20/17 at 2:30 precord was reviewed physician's orders where the services of depression. On 9/20/17 at 2:30 precord was reviewed physician's orders where the services of the s	nimum Data Set (MDS) was a ent with an Assessment RD) of 6/28/17. The MDS with moderately impaired extensive assistance from ressing, toileting, and a. Resident #14 was observed air in her room. She was alert Resident #14 stated lunch dher sister will be coming in that day. Resident #14 did ative behaviors or symptoms b.m. Resident #14's clinical did. The review revealed which included: rinkles Capsule Delayed we 1 capsule by mouth two to Major Depressive Disorder ablet Delayed Release 250 mg with two times a day related to isorder. d 250 mg orders were listed histered on the Medication rd (MAR) twice daily from the Administrator and were informed of the he pharmacy review sheet	F 4:	25		

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		495144	B. WING _		0!	9/21/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	On 9/21/17 at 9:30 the MAR were rev Practical Nurse-LF medications to Re the Registered Nu present. LPN-B si and empty medica Resident #14 rece mg of Depakote. In and RN-B that who increased to 250 m discontinued. Clar wanted both order. On 9/21/17 at 11:0 the doctor and he doctor	a.m. the Depakote orders on iewed with the nurse (Licensed PN-B) who administered the sident #14 that morning with rse Unit Manager (RN-B) mowed surveyor the opened tion package which revealed ived both the 125 mg and 250 it was discussed with LPN-B en the medication was not rification whether the physician is or not was requested. O a.m., RN-B stated she called discontinued the 125 mg of asked what should have been "nursing and pharmacy should" "Medication Administration" te of 4/20/17 included: utions: ive rights" for administration ident electione see thood of administration"	F 42			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495144	495144 B. WING		00	0/21/2017	
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIF 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		112 112 V 11	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 425	documented evider receive both 125 m Valproic Acid level (levels of Depakote laboratory result dathe record which was Physician orders indevery 6 months. Review of the pharm Review Summary a progress notes from not have any medic documented.	nce that Resident #14 was to g and 250 mg of Depakote. A a blood test to monitor the circulating in the blood) ted 7/11/17 was observed in as within normal range. cluded a Valproic Acid level macy "Medication Regimen and "Pharmacy Review" a 2/23/17 through 9/12/17 did ation irregularities	F 42	25			
F 441	included: "This patient with a irregularities noted a The most recent Phaincluded lab "Notes" irregularities listed. On 9/21/17 at 1:05 p Director of Nursing with pharmacy review medication irregularity was provided by the	ed 3/21/17 and 4/24/17 no recommendations or at this time" armacy review dated 9/12/17 but no recommendations or but no recommendations or c.m. the Administrator and were informed of the failure of ws to identify and report the ity. No further information	F 441				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495144	B. WING _		09/21/2017	,
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
F 441 SS=D	(a) Infection prevent The facility must es and control program a minimum, the follo (1) A system for preinvestigating, and communicable disevolunteers, visitors, providing services arrangement based conducted accordinaccepted national simplementation is F (2) Written standard for the program, whilmited to: (i) A system of surveyossible communic before they can spreadility; (ii) When and to whom communicable disereported; (iii) Standard and trate be followed to predict the program and the communicable disereported; (iv) When and how resident; including the	tion and control program. Itablish an infection prevention in (IPCP) that must include, at owing elements: Eventing, identifying, reporting, controlling infections and asses for all residents, staff, and other individuals under a contractual upon the facility assessmenting to §483.70(e) and following tandards (facility assessment Phase 2); Ids, policies, and procedures inch must include, but are not eillance designed to identify able diseases or infections ead to other persons in the om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; isolation should be used for a	F 44	1 Resident #1's sterile dressing chawere initiated on 09/20/2017. 2. Current residents with the LVAD were reviewed to ensure a sterile of change was completed as ordered Manager/designee on 10/04/2017. 3. Licensed nursing staff will be instantially be in	device Iressing by Unit erviced on DON/ LVAD ewed to being kly times e. Results e Quality ent nd the	17

AND PLAN OF CORRECTION IDENTIFICAT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495144 B			00	09/21/2017	
	VIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, Z 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	IP CODE	72 1120 11	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
de inv (B) lea cir (v) mu dis col (vi) by (4) und act (e) pro spro (f) and pro Thi by: Ba fac rev inve (Re res pro	volved, and) A requirement the st restrictive posicumstances. The circumstance ust prohibit employeese or infected intact with residentact will transmit. The hand hygient staff involved in contract will transmit. A system for recider the facility's liftions taken by the Linens. Personrocess, and transporces, and transporced of infection. Annual review. The staff involved in the contract will transport the facility documentation in the contract will be stigation, the face stigation, the face stigation, the face stigation, to impleming the contract will be stigated.	e infectious agent or organism hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct ats or their food, if direct the disease; and he procedures to be followed direct resident contact. ording incidents identified PCP and the corrective e facility. hel must handle, store, ort linens so as to prevent the The facility will conduct an IPCP and update their	F4	41		•	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495144	B. WING		00	9/21/2017	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, S 287 EAST SOUTH BOUL PETERSBURG, VA 23	STATE, ZIP CODE LEVARD	72 1/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 441	The Findings included Resident #1 was to the facility on 1 included Presence Presence of Hear Arteriosclerotic Hear Arteriosclerotic Hear Artery without Ang Type 1, Muscle W Difficulty Walking, Major Depressive Hyperlipidemia. The Minimum Dat Assessment with of 8/14/17, coded Interview of Mentathat she was cognindependent in decoded as having a On 9/18/17 a revied ocumentation, resubmitted to the of 1/25/17. The comp LVAD unit had drabandages were not on 9/19/17 at 8:45 conducted of Residusked if she had a received at the factory are supposed They are supposed They never check be changed every.	a 61 year old who was admitted /1/17. Resident #1's diagnoses of Artocoronary Bypass Graft, the Assist Device (LVAD Unit), eart Disease of Native Coronary Jina Pectoris, Diabetes Mellitus eakness - Generalized, Contractures of Both Hands, Disorder, Hemoglobinuria, and a Set, which was a Quarterly an Assessment Reference Date Resident #1 as having a Brief of Status Score of 14, indicating itively intact and was cision-making. She was also dequate vision and hearing. Bew was conducted of facility evealing a complaint which was effice of Long Term Care on colaint alleged that Resident #1's image around it and that the effication of the conduction of the conduction of the conduction was dent #1 in her room. When any concerns about the care she ility, Resident #1 responded, and to check my heart machine. It. This bandage is supposed to	F 4				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUIL		(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
				B. WING			9/21/2017
	PROVIDER OR SUPPLIER	CENTER		287	REET ADDRESS, CITY, STATE, ZIP CO EAST SOUTH BOULEVARD TERSBURG, VA 23805		72 1720 ()
(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 DATE
F 441	Continued From pa	age 120	F4	41			
	9/18/17.	oer physician's order on					
	#1's clinical record. 2017, the dressing having been change During the month of had been changed of April 2017, the documented as have 4/13/17, 4/28/17, 4/month of May 2017 documented as have thru 5/14/17. There dressing changes from 9/19/17 the Direct Administration B) we will a dressing was supported by the month of May 2017 documented as have thru 5/14/17. There dressing changes from 9/19/17 the Direct Administration B) we will a dressing was supported by the month of the month	was conducted of Resident During the month of February had only been documented as ed from 2/23/17 thru 2/27/17. If March 2017, the dressing every day. During the month ressing had only been ring been changed on 29/17, and 4/30/17. During the the dressing had only been ring been changed from 5/2/17 was no documentation of or June thru September 2017. In cotor of Nursing (DON as asked to observe Resident DON confirmed that the esed to be changed daily, and disince 9/17/17. She stated, ange it daily to make sure that type of infection. (name) Clinic inservice on how to clean it					
	training summary en Advance Heart Failu Assist Device, Steril Resident #1 had be 1/1/17, but the facilition for the care of her differ the care of the A surveyor's request cobtained a copy of the Advance of the A surveyor's request cobtained a copy of the Advance of the A surveyor's request cobtained a copy of the Advance of the A surveyor's request cobtained a copy of the Advance of the Advan	a signature sheet and ntitled, "8/31/17. (name) ure Center - Left Ventricular e Dressing Change." en admitted to the facility by staff did not obtain training evice until 8/31/17. The nave any written instructions essistive device. After the on 9/18/17, the facility ne manufacturer's instructions 20/17. The manufacturer's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495144	B. WING			00	/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		287	REET ADDRESS, CITY, STATE, ZIP CODE ' EAST SOUTH BOULEVARD TERSBURG, VA 23805	1 03	72 1720 17
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 441	Ventricular Assist Stis extremely imports the percutaneous le clean and dry at all it technique any time touch or handle the the exit site for signs redness, swelling, dismell. IMMEDIATEL contact person if the Resident #1's clinical following note from totalled on 1/18/17 to from (Resident #1) his She was brought on assessment. The gase be saturated with this surrounding the dried and a scanty amount was expressed with tissue. Admitted due infection." The hospital infection as MSR Staphylococcus Aure hospitalized from 1/1 On 9/21/17 at 2:16 Pof the facility's Infection.	Heartmate 2 LVAS (Left ystem) on Page 108 read, "It and to keep the exit site where ad goes through your skin times. Follow aseptic you change the bandage or exit site. IMPORTANT! Watch so infection, such as rainage, bleeding, or a bad Y tell your doctor or hospital are are any signs of infection." All record contained the she hospital, "1/19/17. Her son report drainage and pain his mother's drieline exit site. on 1/19/17 for a wound auge dressing was noted to ck, tan drainage. The skin line exit site was macerated, to f serosanguinous drainage palpation of the surrounding to suspected drieline tal subsequently identified RA (Methicillin-resistant eus). Resident #1 was	F	41			
	implemented during changes, including p a mask, gloves, setti cleaning the site. Thi 8/31/17. I don't know basis. It should have since we were trained	Resident #1's dressing ulling the curtain, putting on ng up a sterile field, and s training was done on why it wasn't done on a daily been done on a daily basis d in August. It is important to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495144	B. WING		09/21/2017	
NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CENTER			S 2			
(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 APPROPROFICIENCY)	D BE COMPLÉTIC	N
F 441 F 518 SS=D	Continued From page 122 not have a written policy on sterile technique for dressing changes. On 9/21/17 the facility Administrator (Administration A) was informed of the findings. No further information was received. 483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing F 518 1. Staff members in question with inserviced on facility emergency preparedness (related to general electrical outlets, and hurrican electrical outlets, and hurrican electrical outlets, and hurrican electrical outlets, and hurrican electrical electrical outlets.		F 518 1. Staff members in question were inserviced on facility emergency preparedness (related to generate electrical outlets, and hurricanes/tornadoes) plans by 11/03/2017 by	ors,		
	by: Based on staff interest ensure that employeemergency proceded. Three employees of outlets to use while three employees of emergency proceded. The findings included Registered Nurse Ensurement She was interviewed When asked which used while the generated she did not be the interview. RN Enterview. RN Enter	lid not know which electrical the generator was running. lid not know the hurricane ures.		ED/designee. 2. Staff will be educated on emergore preparedness (related to generate electrical outlets, and hurricanes/tornadoes) by ED/designee. 3. Current staff will be educated emergency preparedness on or be 11/03/2017 by the ED/ Designee. orientation will include facility empreparedness information. 4. Weekly facility orientation will reviewed to ensure facility emergore preparedness is included by Admidesignee. Results from audits will forwarded to the Quality Assurant Performance Improvement Commensure compliance and the need monitoring for three (3) months.	ors, on facility efore Facility nergency be gency inistrator/ Il be nce/ mittee to for further	17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION: (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED	
		495144				0.0	/21/2017
	PROVIDER OR SUPPLIER BURG HEALTHCARE	CENTER		287 EAST	DDRESS, CITY, STATE, ZIP (SOUTH BOULEVARD BURG, VA 23805	CODE	1/2 1/20 1/
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	to be plugged in if the Wing 1. RN B states residents that require the other wing. Certified Nursing Assinterviewed on 9/20, which electrical outlegenerator was running know. She was ask question at the condition, CNA C was extreme weather situstion, CNA C was extreme weather situstion on either situstion on either situstion on either situstions on either resident either situations on extreme was running. CNA Extraining on extreme whurricanes or tornadowas not sure what to situation. The Maintenance Direction of the situation.	the red outlets were only on and she would move the red use of the red outlets to red use of the red outlets were to be used while the red outlets were to be rator was running. In a saked if she had training on uations such as hurricanes or stated that she had not had uation. Sistant D (CNA D) was 17 during the afternoon, she had training on extreme uch as hurricanes or stated that the residents red that the residents ooms. Sistant E (CNA E) was 17 at 3:50 p.m When asked the she had that the e used while the generator was asked if she had weather situations such as red. CNA E stated that she do during either weather	F 5	18			
		. He was asked which					

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES				RM APPROVE 10. 0938-039
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
495144		B. WING			09/21/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	7372 1720 17
PETERS	BURG HEALTHCARE	CENTER		287 EAST SOUTH BOULEVA PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 518	running. The Main outlets worked whil It was reviewed with that staff who were emergency proceduoutlets to use. The issues regarding	tenance Director stated that all e the generator was running. In the Maintenance Director interviewed regarding tures did not know which and emergency procedures the Administrator and Director	F 5	DEFICIE		
		*				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/02/2017

FORM APPROVED