DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

PRINTED: 05/12/2016

FORM APPROVED

495143

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

04/21/2016

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

GOLDEN LIVINGCENTER- MARTINSVLLE

1607 SPRUCE STREET MARTINSVILLE, VA 24112

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 4/19/16 through 4/21/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 142 certified bed facility was 120 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through Resident #21) and 3 closed record reviews (Resident #22, Resident #24 and Resident #24).

F 151

483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS SS=E - FREE OF REPRISAL

> The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

This REQUIREMENT is not met as evidenced

Based on resident and staff interview, it was determined the facility staff failed to facilitate voting rights for facility residents.

Findings:

On 4/20/16 at 3:30 PM a member of the survey team met with seven alert and oriented members of the facility resident council. During this meeting the residents discussed their voting rights.

F 000

Disclaimer:

Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws.

F 151

1. Resident #13 is registered to vote and have consented to vote in the November 2016 election.

- 2. All residents registered to vote have the potential to be affected, 100% audit of all residents registered to vote will be completed by Activities Director/ Designee. Consent forms to vote to be completed with each resident that is alert and oriented and registered to vote.
- 3. Department Heads inserviced by **Executive Director regarding** resident's right to vote. Will attend Resident Council as requested monthly to ensure residents

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

TITLE

(X6) DATE

Apy 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 HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE COMF	SURVEY PLETED
		495143	B. WING		04/2	21/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER- MA	ARTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
	The residents said for elections, but fo March 1st, 2016, "Saccommodations were accommodations were they had wanted to Tuesday primary-afacility staff had maprovide an absente as Resident #13, and S-VII. On 4/21/16 at 10:30 DON and activities finding. The activity made plans for the elections-but she had a plan to depend a pla	they usually went to the polls of the recent primary held super Tuesday," no were made for them to go vote. Tuesday, "no were made for them to go vote. Tuesday, "no were made for them to go vote. Tuesday, "no were made for them to go vote. Tuesday, "no were made for them to go vote. Tuesday, "no would have gone if the de plans to take them or e ballot. They were identified and Residents S-I, S-VI, and "D'AM the facility administrator, director were informed of the director said she usually residents to vote in general and not facilitated voting imary election. She said she lo so. D(4) PERSONAL ENTIALITY OF RECORDS are right to personal privacy and so or her personal and clinical cludes accommodations, written and telephone ersonal care, visits, and and resident groups, but this efacility to provide a private lent. In paragraph (e)(3) of this it may approve or refuse the and clinical records to any	F 1	have completed consent for vote. 4. Results of audit will be bromonthly QAPI for review a recommendations implemed as indicated. 1. Shower curtains placed in all shower rooms in the facility. 2. All staff inserviced on maint privacy for residents while share being given. Staff are to a sign on the outside of the shower in use. Staff are to ensure shower in use. Staff are to ensure shower in use and public giving showers. 3. Maintenance/designee to audit rooms weekly to ensure shower in place.	l aining howers place hower es are nower bulled	

Event ID: RZRX11

Facility ID: VA0159

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VDH/OLC

If continuation sheet Page 2 of 85

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

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PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

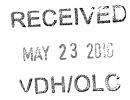
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		495143	B. WING_		04/	21/2016
	PROVIDER OR SUPPLIER	RTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	<u> </u>	2.1120.10
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F 164	and clinical records resident is transferr institution; or record. The facility must ke contained in the resident form or storage release is required healthcare institution contract; or the resident facility. This REQUIREMENT by: Based on observation interview it was detected by the same of the facility resident.	to refuse release of personal does not apply when the ed to another health care direlease is required by law. ep confidential all information sident's records, regardless of methods, except when by transfer to another n; law; third party payment dent. AT is not met as evidenced ion, and resident and staff ermined the facility staff failed or facility residents while is units. PM a member of the survey n alert and oriented members nt council. During this meeting seed their privacy issues in the	F 16	Audits to occur weekly x 4 we then monthly x 3 months. Dhe to interview 3 residents weekled then monthly x 3 months to exprivacy is maintained during a 4. Results of audit will be broug Quality Assurance Performar Improvement (QAPI) for reverecommendations implement indicated.	IS/design y x 4 we have a showers. that to have iew and	eks,
	Resident #13 said t shower room and "p out." The resident s to the hallway and s	here was no curtain in the beople keep walking in and aid she was exposed naked the could see people outside can see in and see us."				
	the shower and had was a man, he just	ne surveyor she had been in I people walk in on her. "One walked right in and stood girl giving me a shower."	THE CONTRACTOR OF THE CONTRACT			

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 3 of 85



DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

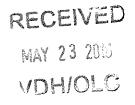
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		DNSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		······································	04/21/2016
	PROVIDER OR SUPPLIEF			1607	ET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET ITINSVILLE, VA 24112	1 07/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	had a shower at the the door two times. The surveyor check did not observe are privacy to resident stalls could be view doors were opene. On 4/21/16 at 10:3 and DON were infradministrator said all the shower room 483.10(n) RESIDE DRUGS IF DEEM! An individual reside the interdisciplinare §483.20(d)(2)(ii), in practice is safe. This REQUIREMED by: Based on observating interview, and clinificated to assess a self-administration survey sample (Resident#16 was 3/14/13 with diagnals).	replained the very first time she he facility, the staff had opened is to the hallway. Coked the three shower units and my curtains at all to provide its while using the facility. All the swed from the hallway when the end. 30 AM the facility administrator, formed of the finding. The intervention they had put shower curtains in ms. ENT SELF-ADMINISTER Item the may self-administer drugs if my team, as defined by the mas determined that this ENT is not met as evidenced ation, staff interview, resident ical record review, facility staff resident for safe medication in for 1 of 24 residents in the	F 1	76 1.		leted and cord. nted. lucted on residents heir room elf- mpleted. ith the ications
	resident was asse	eranoid schizophrenia. The ssed without signs of delirium, avior issues and scored 15/15				

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 4 of 85



DEPARTMENT OF HEALTH AND HUMAN SERVICES

mare -	PRINTED: 05/12/2010
	FORM APPROVED
Secret Secretary	OMB NO. 0938-039

CENTE	RS FOR MEDICARE	& MEDICAID ERVICES					. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495143	B. WING			04	/21/2016
NAME OF I	PROVIDER OR SUPPLIER		k a 	ST	REET ADDRESS, CITY, STATE, ZIP CODE		= 1,40 10
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			07 SPRUCE STREET ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Quarterly Minimum 2/5/16. During medication p 9:15 AM, the survey nurse enter Reside morning medication ordered was DuoNe application inhale or respiratory failure, gawake. When the swith the medication the nebulizer to self treatment. She state could wait for the reso she used one of room. The surveyor when she used one said she did not. The was unaware that the treatments available. The resident's compoself medication admit (date initiated 4/1/18 care planned for settreatments. The surveyor report of nursing on 4/20/17 The DON reported that been assessed nebulizer treatments some education, that to self-administer the	ge 4 w for Mental Status on the Data Set assessment dated coass observation on 4/20/16 at yor observed the medication in #16's room to administer in One of the medications is solution 0.5-2.5 mg/3 ML 1 rally every 4 hours related to give every 4 hours while surveyor entered the room nurse, the resident was using radminister a nebulizer ited that she didn't feel she ingularly scheduled treatment, the treatments she kept in her asked if she told nursing staff of those treatments. She is medication nurse said she is e medication nurse said she is e medication nurse said she is eresident had nebulizer in for self-administration. Orehensive care plan included ininistration- combivent inhaler in the form of the director of during a summary meeting. On 4/21/16 that the resident for self-administration of sand determined that, after at it was safe for the resident medication, but that the red her supply of DuoNebs and	F	4.	. New admissions will be asset the ability to self administer DNS/designee will audit 10 tweek x 4 weeks, then month to ensure medications are no beside without orders and set administration assessment. Results of audit will be brough monthly Quality Assurance I Improvement (QAPI) meeting and recommendations implet as indicated.	medication rooms a ly x 3 medication the state of the sta	ions. onths

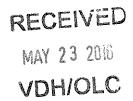
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declined to do so at that time.

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 5 of 85



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

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495143	B. WING_		04/21/2016
	(EACH DEFICIENC)	ARTINSVLLE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO TH	ORRECTION (X5) ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 176		age 5 inistrator were notified that this ncern at a summary meeting	F 17	76)
	483.15(c)(6) LISTE GRIEVANCE/RECO When a resident or must listen to the vigrievances and recoand families concer		F 24	 All Resident Counci Minutes pulled from months to ensure res were addressed and residents are now be snacks. 100% Audit of the R 	the last six sident's concerns resolved. All sing offered HS
	by: Based on observatinterviews and residetermined the faciviews and act upon recommendations or respond to those grameeting. Findings:	NT is not met as evidenced tion, resident and staff dent council minutes, it was lity staff failed to listen to the a the grievances and of residents in the council and rievances in a resident council		Heads respond to commanner. Department on resident council of the concerns in a time staff inserviced on eare offered HS snack	were addressed and Council Department sure that Department oncerns in a timely at Heads inserviced concerns and addressing nely manner. All nsuring all residents ks.
	team met with seve of the facility reside the residents discus and suggestions the council to the admir One recurring companinutes September March 2016) was the their nighttime snac	PM a member of the survey en alert and oriented members ent council. During this meeting essed their various complaints ey had made as a resident enistrative staff. plaint (reviewed in the council or 2015 and January, and the residents were not getting ex. Further review of the icated no one from the		3. Executive Director of resident council condimonthly x 6 months, 6 months assuring the are being addressed off on all Resident C DNS or designee to a from each unit each monthly x 3 months.	cerns/minutes , then quarterly x nat all concerns timely. ED to sign Council Minutes. audit 5 residents week x 4 weeks, then

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 6 of 85

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		AND HUMA ERVICES & MEDICALD SERVICES				PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING			04/21/2016
	PROVIDER OR SUPPLIER LIVINGCENTER- MA SUMMARY STA	ARTINSVLLE	ID	10	TREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET MARTINSVILLE, VA 24112 PROVIDER'S PLAN OF CORRECT	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 244	residents within the Residents #13, 15, complained that onl offered snacks and them either. S-3 told the surveyont. If I do, it's because S-I said the last two diabetics got one. "It they sometimes just That's not enough to in the middle of the with some good pro-	had ever responded to the council venue. S-I, S-5, S-6 and S-7 all ly the diabetic residents were half the timethey didn't get or, "I might get one, but might use I asked for it." I weeksit was sketchy if the I am a very brittle diabetic and thand me animal crackers! o keep me from bottoming out nightI need a solid snack stein in it."	F	244	DNS or designee to audit from each unit each week then monthly x 3 months resident's HS snacks bein 4. Results of audit will be b Quality Assurance Perfor Improvement (QAPI) me and recommendations.	x x 4 weeks, inquiring about g offered. rought to mance
200	had not addressed them at any of their On 4/20/16 the surv observe the nightly diabetic snacks wer	ted the administrative staff or discussed the issue with meetings. veyor remained in the facility to snack run. At 8:00 PM the re delivered to the resident tray. At 8:10 PM the facility				
:	CNAs picked up the	e diabetic snacks and neir respective destinations				

would like anything.

The two CNAs followed never stopped and asked anyone else if they would like something. Several diabetic snacks were delivered to rooms with two residents. The diabetic resident got a snack--but the other resident was not asked if he, or she

On 4/20/16 at 8:20 PM CNA III was asked if every resident got a nightly snack. She stated, "No, we

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 7 of 85

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MAY 23 2016

DEPARTMENT OF HEALTH AND HUMAN ERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495143	B. WING_		04/:	21/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 252	there for us. Every night." At 8:20 PM the fact were informed the diabetic did not get observed to have and a large (unopanimal crackers at the council and had fact council and had fact concerns during at the administrator who were standed that. She snacks had to be 483.15(h)(1) SAFE/CLEAN/COENVIRONMENT The facility must promfortable and had the resident to use to the extent possible. This REQUIREMED by: Based on observatification of the comfortable and had the resident to use to the extent possible.	cility DON and administrator residents that were not a snack. Every unit was a full (unopened) loaf of bread ened) jar of peanut butter, and some ice cream. 30 AM the DON and further informed that they had be concerns of the resident illed to respond to the council's council meeting. 31 told the survey team she did upposed to respond to council ught the dietary department had said she did not realize the offered. 32 MFORTABLE/HOMELIKE 33 rovide a safe, clean, omelike environment, allowing a his or her personal belongings	F 24		tely. oms or y curtain deep vas ent # 8 in ains put r Digeste	up	

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Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 8 of 85

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DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICA SERVICES

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TATEMENT OF DEFICIENCIES (X IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		495143	B. WING		04/21/2016		
	PROVIDER OR SUPPLIEI			STREET ADDRESS, CITY, STATE, ZIF 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
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F 252	The findings included in the surveyors entered tour the surveyors odor throughout the prevalent on the Non 04/19/16 at apsurveyor entered tourit. When entering surveyor observed the room. The shood of feces and observed a cigare substance approximates approximate surveyor observed manager in the half into the shower roconcerns were should be account manager. The surveyor them the North unit. The wash cloths in the throughout. On 04/20/16 at apsurveyors entered unit. During this of observed a bathin pushed into a show stretcher the surveyors entered and an empty medical surveyors entered and an empty entered	ents #7, #6, and #8). ded. approximately 1:30 p.m. the the facility. During the initial were able to smell a pervasive refacility. The odors were more forth and South units. proximately 2:50 p.m. the shower room on the South refacility in the shower room the facility linen in ower room had a very strong urine. The surveyor also the butt in the floor and a brown imately the size of quarter in the brown substance resembled registrictly the size of the line housekeeping account allway and asked them to step om with the surveyor. The ared with the housekeeping	F 2	Nursing staff inserved shower rooms are keeping staff chemicals in the shower rooms are the shop or anywhere expended and taking when the trash can and the shop of the shop or anywhere expended and taking when the trash can are seach week xeeping cleaned, rocleaned, non-skid non-sk	tept clean and ry shower. Finserviced on leaving ower room/beauty else in the facility ing out the trash is overflowing. med on all shower 1 month, then s to ensure shower rooms resident rooms are being nats in rooms no chemicals are left ower curtains are		

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 9 of 85

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MAY 23 2010

	TMENT OF HEALTH RS FOR MEDICARE	AND HUMA ERVICES			j j	FORM	: 05/12/2016 APPROVED : 0938-0391	
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DA1	E SURVEY MPLETED	
		495143	B. WING			0.4	/21/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	121/2010	
GOLDEN	I LIVINGCENTER- MA		1607 SPRUCE STREET MARTINSVILLE, VA 24112					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION L PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE		
F 252	Continued From pa		F 2	252				
	as several empty m	is a glove in the floor, as well edication cups, debris was ut and the trashcan was flowing.						
	housekeeping acco North unit shower re	roximately 2:25 p.m. the unt manager was shown the pom. When asked about ces he stated there was a 5:00 p.m. and the ed until 3:00 p.m.						
	(certified nursing as the odor in the Sout verbalized to the sur	roximately 3:05 p.m. CNA sistant) #1 was asked about h unit shower room and rveyor that yes it did smell in id it always seemed to have be.						
	approximately 3:30 orientated Resident	as held on 04/20/16 at p.m. Seven alert and s of the facility attended this en Residents in group stated ous.						
	None of the shower shower curtains.	rooms in the facility included						
		staff were notified of the above g with the survey team on mately 5:05 p.m.		men and mental and the second statement of the second seco				
or control or	No further information	on regarding these issues		11 0000 1 0000 1 0000 1 000 1				

conference.

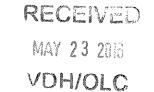
was provided to the survey team prior to the exit

2. For Resident #7 the facility staff failed to ensure a clean, comfortable and homelike environment. Resident #7 's privacy was dirty

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 10 of 85



		AND HUM SERVICES				FORM	D: 05/12/2016 M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
		495143	B. WING	·		04	I/21/2016
NAME OF I	PROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIP COD		72172010
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE	1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	SHOULD BE COMPLÉTION	
F 252	Continued From pa	qe 10	. F2	252			1
) areas with a brownish	. • •	.02			
	Resident #7 was a	67 year old female who was		*			1
		on 9/22/15 and readmitted on					!
		diagnoses included, but were					:
		entia without behaviors,					
	• • •	ar, affective mood disorder,	:	:			:
	anxiety, hypertensic	nt Minimum Data Set (MDS)					
		in the clinical record was a		:			
		essment with an Assessment					
		RD) of 2/22/16. The facility		İ			
		sident #7 had a Cognitive					
		13. The facility staff also					İ
		t #7 required set up (0/1) to		:			
	Living (ADL).	2/2) with Activities of Daily	:	1			
		16 at 3:10 p.m. the surveyor		1			:
		#7's room. The surveyor					
		dent #7's privacy curtain was					
		vo (2) areas with a brownish					;
		as approximately 4 cm round. approximately 10 cm's long					
	and 4 cm's wide.	approximately to cit's long					i
:		16 at 8 a.m. the surveyor					
		#7 lying in bed and sleeping.					
		ved that Resident #7's privacy					
		rty and soiled with a brownish		1			
:	debris in two (2) are			1			:
		16 at 5:05 p.m. the survey		\$			
		dministrator (Adm), Director					
		Assistant Director of Nursing					
		Compliance Nurse (CCN)		•			
		dent (AVP). The surveyor					
		trative Team (AT) that cy curtain was dirty and soiled					*

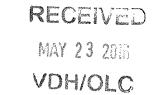
with a brownish debris.

No additional information was provided prior to exiting the facility as to why the facility staff

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 11 of 85



DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES						FOR	D: 05/12/2016 M APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY DMPLETED
		495143	B. WING			0	4/21/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER- MA	RTINSVLLE		160	EET ADDRESS, CITY, STATE, ZIP CODI 7 SPRUCE STREET RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 252	homelike environmed 3. For Resident #6 a clean, comfortable Resident #6 was act with diagnoses include heart failure, hypert stroke, seizure discopain. The resident interview for mental minimum data set a 3/9/16 and was ass delirium, psychosis, While interviewing the surveyor observed was petals on the filter than the dried rose petals on the filter dried rose petals on the filte	ean, comfortable and ent for Resident #7. If, facility staff failed to provide e, homelike environment. Imitted to the facility on 7/9/15 ading coronary artery disease, ension, diabetes mellitus, rder, asthma, and chronic scored 15/15 on the brief status on the quarterly essessment (MDS) dated essed without symptoms of	F	252			
	Resident #8 was ad 10/24/05 with diagn mellitus, heart failur vascular disease, dand bipolar disorder	facility maintenance staff comfortable, homelike interior. mitted to the facility on oses including diabetes e, hypertension, peripheral ementia, anxiety, depression,					

for mental status and was assessed without

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 12 of 85

PRINTED: 05/12/2016

RECEIVED MAY 23 2010 VDH/OLC

PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMAN RERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICALD JERVICES 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 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE** MARTINSVILLE, VA 24112 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 TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 252 Continued From page 12 F 252 symptoms of delirium, psychosis, or behavior disorder on the minimum data set assessment dated 1/29/16. On 4/19/16 at approximately 3 PM, the surveyor observed the resident in the room. The resident's bedside rug was stained and covered with loose brown material. On 4:21 PM at approximately 11 AM, the resident's rug was observed to be stained and covered with loose debris. There was a sticky spot on the floor near the sink and a floor mop pad was lying on the floor near the sticky substance. The resident stated that the rug "could use a good vacuum". The administrator and director of nursing were notified of the concern during a summary meeting on 4/21/16. Missing/broken tiles on the North, 6/2/2016F 253 483.15(h)(2) HOUSEKEEPING & F 253 South, and Patio shower rooms were SS=E MAINTENANCE SERVICES repaired. Capital Request completed The facility must provide housekeeping and and approved for vinyl rub rails for 3 maintenance services necessary to maintain a shower rooms and 1 downstairs closet. sanitary, orderly, and comfortable interior. Resident #6, #8, and #11's sinks all

This REQUIREMENT is not met as evidenced

Based on observation, Resident interview, staff interview, and facility document review, the facility staff failed to provide maintenance services on 3 of 3 units and for 3 of 24 Residents. Residents #6, #8, and #11.

The findings included.

repaired.

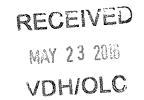
Executive Director inserviced Department Head staff on putting all broken, rusty, dripping sinks in to Building Engines for repairs to be completed. 100% Audit completed on all sinks in the building.

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 13 of 85



		AND HUM SERVICES & MEDICAL SERVICES			PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495143	B. WING		04/21/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(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 APPF DEFICIENCY)	ULD BE COMPLETION
F 253	Patio units were observed in the South unit. V room the surveyor of the unit. Upon entering surveyor observed in commode had 4 dainward. On 04/19/16 at approximately observed in commode had 4 dainward. On 04/19/16 at approximately observed in the surveyor was amount of tile missis missing tile on the vicabinet. After exiting the South of the surveyor walked to and upon entering the surveyor observed in the surveyor	ge 13 as on the North, South, and served to have cracked and/or roximately 1:30 p.m. the e shower room/beauty shop when entering this shower observed 1 cracked tile. Toximately 1:45 p.m. the e shower room on the patio this shower room the that the wall next to the maged tiles that were pushed roximately 2:50 p.m. the e shower room on the South as able to observe a large and in front of the tub and wall underneath a hanging with unit shower room the North unit shower room the missing tile in the first shower in the second shower stall.	F 25	All sinks that were identicated by Maintenance 3. Maintenance Director/ Deaudit all sinks and showe the facility once a week withen monthly x 3 months are no cracked tiles or russinks. 4. Results of audit will be be monthly Quality Assuran Improvement (QAPI) Meand recommendations immindicated.	Staff. esignee to r rooms in 4 weeks, to ensure there sted, leaking rought to ce Performance seting for review
	missing/broken tiles survey team on 04/2 p.m.	staff were notified of the during a meeting with the 20/16 at approximately 5:05			
\$ 	provided the survey	ference the facility staff or with a copy of a letter dated or vinyl rub rails for 3 shower			· ·

rooms and 1 downstairs closet.

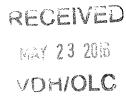
	IMENI OF HEALIH	& MEDICAL SERVICES			()		
			T				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		
		495143	B. WING			BE COMPLE	21/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER- MA	RTINSVI I F			07 SPRUCE STREET		
				M	ARTINSVILLE, VA 24112		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 253	Continued From pa	ge 14	F 2	53			
	•	irector was shown all of the		-			
	missing and broken	tiles during a walkthrough of					
		surveyor on 04/21/16 at		1			:
1		a.m. The maintenance were going to replace the	:				
	missing tiles with a		:				:
i		on regarding this issue was					:
	provided to the surv conference.	rey team prior to the exit	:				
:		i, facility maintenance staff	:				:
		comfortable, homelike interior.	1				:
		mitted to the facility on 7/9/15		1			ŝ.
		iding coronary artery disease, ension, diabetes mellitus,		1			
:		rder, asthma, and chronic		1			:
:	pain. The resident s	scored 15/15 on the brief					
		status on the quarterly		:			
:		ssessment (MDS) dated essed without symptoms of		1			:
	delirium, psychosis,			:			
		he resident on 4/29/16, the					
		hat the sink in the resident's . There was a steady stream					
		M on 4/21/16, and the					
		e to turn off the water or					
;	reduce the flow to a	drip.		-			
	The director of nurs	ing and administrator were					· -
		ern during a summary meeting					
÷	3 For Resident #8	facility maintenance staff		:			
		comfortable, homelike interior					:
1	_						•

Resident #8 was admitted to the facility on

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 15 of 85



PRINTED: 05/12/2016

PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMA** **SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAL 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 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE MARTINSVILLE, VA 24112** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 253 Continued From page 15 F 253 10/24/05 with diagnoses including diabetes mellitus, heart failure, hypertension facility maintenance staff failed to provide a comfortable, homelike interior, peripheral vascular disease, dementia, anxiety, depression. and bipolar disorder. The resident scored 12/15 on the brief interview for mental status and was assessed without symptoms of delirium, psychosis, or behavior disorder on the minimum data set assessment dated 1/29/16. On 4:21 PM at approximately 11 AM, the resident's faucet was observed to be dripping water. The surveyor was unable to turn off the water. The administrator and director of nursing were notified of the concern during a summary meeting on 4/21/16.

disease, anxiety, hip fracture, and sarcoidosis of the lung. The resident scored 15/15 on the brief interview for mental status on the quarterly minimum data set assessment (MDS) dated 3/9/16 and was assessed without symptoms of delirium, psychosis, or behavior issues.

 For Resident #11, facility maintenance staff failed to provide a comfortable, homelike interior.

Resident #11 was admitted to the facility on 12/30/15 with diagnoses including peripheral vascular disease, gastroesophageal reflux

On 4:21 PM at approximately 11 AM, the resident's faucet was observed to be rusty and dripping water. The surveyor was unable to turn

off the water.

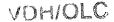
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 16 of 85





		AND HUMA SERVICES & MEDICAL SERVICES			FORM	0: 05/12/2016 1APPROVED 0: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495143	B. WING		N4	/21/2016
NAME OF	PROVIDER OR SUPPLIER	***************************************		STREET ADDRESS, CITY, STATE, ZIP CO		, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE	į į	1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 253	The director of nurs notified of the conce on 4/20/16.	ing and administrator were ern during a summary meeting	F 253			C/2/2016
	a comprehensive, a reproducible assess functional capacity. A facility must make assessment of a resident assessment by the State. The aleast the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b Physical functioning Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of si	nduct initially and periodically ccurate, standardized sment of each resident's a comprehensive sident's needs, using the at instrument (RAI) specified ssessment must include at emographic information; patterns; eing; and structural problems; and health conditions; all status;	F 272	 CAA's for all residents in reviewed and any identification addressed. All residents had the potentificated by deficient practors. Re-education was provided Clinical Assessment and Specialist on 4/29/2016 recompletion of CAA's and worksheet. An audit of 10 assessments will be computed by DNS/designee monthly accompliance. Results of audit will be be monthly Quality Assurar Improvement (QAPI) Meand recommendations in indicated. 	ential to be etice. ed by the Reimbursen egarding the CAA 0% of compoleted by the 3 months to prought to nee Performeeting for reservice.	ment rehensive e ensure ance

areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.

	TMENT OF HEALTH RS FOR MEDICARE	I AND HUMA SERVICES			PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495143	B. WING		04/21/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOLDEN	N LIVINGCENTER- MA	RTINSVLLE	1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 272	Continued From pa	ge 17	F 272	2			
	:						
:	by:	NT is not met as evidenced erview and clinical record			·		
	failed to ensure con Assessment Summ Residents in the sai	mined that the facility staff mplete and accurate Care Area nary (CAA ' S) for 12 of 24 imple survey, Resident #7, 1, #1, #2, #14, #5, #9 and #10.			:		
	The Findings Includ 1. For Resident #7	led: 7 the facility staff failed to			:		
	Assessment Summ Minimum Data Set (nd accurate Care Area nary (CAA'S) on an Admission (MDS) assessment with an					
	Resident #7 was a 6 originally admitted of	ence Date (ARD) of 9/28/15. 67 year old female who was on 9/22/15 and readmitted on			:		
	not limited to: deme	g diagnoses included, but were entia without behaviors, ar, affective mood disorder,					
	anxiety, hypertension The most current M						
	Quarterly MDS asse Reference Date (AF	essment with an Assessment RD) of 2/22/16. The facility					
	Summary Score of	sident #7 had a Cognitive 13. The facility staff also at #7 required set up (0/1) to					
		2/2) with Activities of Daily					

Living (ADL).

On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced an Admission MDS assessment with an ARD of 9/28/16. The facility

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 18 of 85



DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

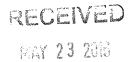
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495143	B. WING		1 ()4/21/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
COLDEN	I LIVINGCENTER- MA	DTINEW (E		1607 SPRUCE STREET			
GULDEN	LIVINGCENTER- MA	RINSVLLE		MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 272	Continued From pa	ge 18	F 2	72			
	staff coded that Res	sident #7 had a Cognitive					
		10. The facility staff also	1				
		t #7 required set up	:				
		limited assistance (2/2) with					
		/. Care Area Assessment	1				
		Resident #7 triggered for	-				
		L Functional/Rehabilitation					
	Potential, Falls, Nut						
		use. In the column titled,					
		of CAA documentation," the				:	
		ented "CAA WS (worksheet)	:			1	
) The instruction's documented	2				
		e facility staff were to	-				
		ertinent information related to					
		ound regarding the care plan	7 E	The second secon		:	
	decision making. T		-	- Comment		:	
	documented that th	e CAA documentation should	:	Company of the Compan		:	
	include information	on the complicating factors,		SAMPLE STATE OF THE			
	risks, and any refer	rals for the resident for the				:	
	care area.						
	On April 20, 2016 at	t 8:15 a.m. the surveyor					
	notified the Unit Ma	nager (UM), who was a				į	
	Registered Nurse, t	hat Resident #7's CAA's on					
	the Admission MDS	assessment with the ARD of					
		plete and inaccurate. The					
	surveyor reviewed t			:		:	
		e UM. The surveyor notified	!				
:		cific location of supporting	1	: 1			
:		arding the care plan decision					
		ocumented in the column		1			
	•	Date of CAA documentation.		: \$		V 19 19	
		d the UM that the CAA'S were		•			
	incomplete and inac						
:		t 11:20 a.m. the surveyor					
		urse, who was a RN, that					
		s associated with the					
		h the ARD of 9/28/15 were					
:		ccurate. The surveyor notified the facility staff had				; ;	

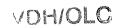
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Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 19 of 85





DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING_	,	n/	1/21/2016
	PROVIDER OR SUPPLIEF			STREET ADDRESS, GITY, STATE, ZIP COU 1607 SPRUCE STREET MARTINSVILLE, VA 24112		IL IIZU IV
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 272	Continued From p	age 19	F 27	72		:
	documented that to completed on 10/2 MDS Nurse that the supporting documed decision making put The MDS Nurse so already told her the supporting document that she could worksheet was co On April 20, 2016 met with the Admin Nursing (DON), As (ADON), Corporate and Area Vice Prenotified the Admin Resident #7's CAP assessment dated in accurate. No additional inforexiting the facility and the supporting the suppor	the CAA worksheet was 2/15. The surveyor notified the ne specific location of entation in the care plan rocess had to be documented. tated that another surveyor had at the specific location of entation had to be documented in not document that the CAA				
	Resident #7. 2. For Resident and ensure complete and Assessment Summan Data Service Assessment Referment Programment Programm	#12 the facility staff failed to and accurate Care Area mary (CAA'S) on an Annual t (MDS) assessment with an rence Date (ARD) of 10/2/15. a 66 year old female who was on 10/15/14 and readmitted on a diagnoses included, but were gestive heart failure, chronic hary disease, paralysis agitans,				

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 20 of 85



DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAR SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			04	/21/2016
NAME OF	PROVIDER OR SUPPLIEF	₹		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	1 0-1	_ 1/2010
GOLDEN	I LIVINGCENTER- M	ARTINSVLLE			SPRUCE STREET		
				MAF	RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 272	Continued From p	age 20	F 2	72			
	-	The facility staff coded that		—			
		a Cognitive Summary Score of		1			
		aff also coded that Resident					:
		ed (2/2) to total nursing care		:			
		aily Living (ADL's).					·
		at 3:15 p.m. the surveyor					
		t #12's clinical record. Review					
		rd produced an Annual MDS		:			
		an ARD of 10/2/15. The facility					j
		esident #12 had a Cognitive					
		f 15. The facility staff also					
		nt #12 was independent after					
		uiring total nursing care (4/2)					
		tion V. Care Area Assessment					
		Resident #12 triggered for					
		ehabilitation Potential, Urinary		3			
		od State, Falls, Nutritional		:			
		otropic Drug Use. In the					j
		cation and Date of CAA					
		ne facility staff documented					
		eet) dated 10/7/15." (sic) The					
		nented in Section V that the					
		o document where pertinent					
		to the CAA could be found					
	regarding the care	plan decision making. The					
		ocumented that the CAA					
	documentation she	ould include information on the					
	complicating facto	rs, risks, and any referrals for					
:	the resident for the	e care area.					
	On April 20, 2016	at 10:25 a.m. the surveyor		:			
		anager (UM), who was a		į			
2		that Resident #12's CAA's on) 			
		ssessment with the ARD of					
		mplete and inaccurate. The		}			
		the Annual MDS assessment		-			. [
3		surveyor notified the UM that		Í			
-		n of supporting documentation					
		plan decision making had to		1			
4	be documented in	the column titled, Location and					

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 21 of 85



DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	5 . 3			FORM	D: 05/12/2016 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DA	TE SURVEY
	495143	B. WING		04	1/21/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		NA 1/2-01-0
GOLDEN LIVINGCENTER- MA	ARTINSVLLE	l l	1607 SPRUCE STREET MARTINSVILLE, VA 24112		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272 Continued From pa	age 21	F 272	2		
notified the UM that and inaccurate. On April 20, 2016 at notified the MDS Not Resident #12's CAV MDS with the ARD and inaccurate. The Nurse that the facility the CAA worksheet The surveyor notifies specific location of the care plan decist documented. The Note of the care plan decist documented and the surveyor had alread location of supportified documented and the that the CAA works On April 20, 2016 at met with the Adminical Nursing (DON), Assequence (ADON), Corporate and Area Vice Presentified the Adminical Resident #12's CAV assessment dated inaccurate. No additional informexiting the facility at the ensure complete Resident #12. 3. Facility staff failed.	nentation. The surveyor it the CAA'S were incomplete at 11:20 a.m. the surveyor urse, who was a RN, that A's associated with the Annual of 10/2/15 were incomplete ne surveyor notified the MDS ity staff had documented that it was completed on 10/7/15. The did he MDS Nurse that the supporting documentation in ion making process had to be MDS Nurse stated that another dy told her that the specific ng documentation had to be nat she could not document wheet was completed. It 5:05 p.m. the survey team istrator (Adm), Director of sistant Director of Nursing Compliance Nurse (CCN) sident (AVP). The surveyor strative Team (AT) that A's on the Annual MDS 10/2/15 were incomplete and mation was provided prior to s to why the facility staff failed and accurate CAA's for ed to complete an accurate resessment) summary for		RECEIVE MAY 23 201	D 6	

reviewed on 4/20/16 at 9:30 AM.

Resident # 3 was admitted to the facility on 12/16/14. The diagnoses included Schizophrenia,

anxiety, depression, and seizure disorder.

VDH/OLC

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

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		TE SURVEY MPLETED
		495143	B. WING		04	/21/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER- MA	RTINSVLLE		STREET ADDRESS, CITY, STATE, ZIF 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 272	The resident's signidata set) assessmeresident with severe Resident #3 require (activities of daily live The MDS contained 6/30/15. The location of the CAA docuincomplete for local summarized materion This information was administrator on 4/2 additional info was 4. Facility staff fair CAA (Care Area As Resident #4. The reviewed on 4/20/10 Resident #4 was a 12/16/14. The diagratementia, hyperten The resident's annuassessment dated	ificant change MDS (minimum ant dated 6/25/15 coded the ely impaired cognitive function. ed staff assistance for all ADL. ving.) If CAAs signed and dated on and date section (Section mentation was observed to be tion and dates of the al. Its shared with the DON and 21/16 at 10:30 AM. No provided. Ited to complete an accurate sessment) summary for esident's clinical record was 6 at 9:30 AM. Idmitted to the facility on noses included Schizophrenia, sion, anxiety and depression. Ital MDS (minimum data set) 112/10/15 coded the resident	F 272			
	required staff assist daily living.) The MDS contained 12/10/15. The locat V) of the CAA docu	gnitive function. Resident #4 cance for all ADL (activities of discount of all ADL) (activities of discount of and dated and dated discount of and dates of the all.		MAY	CEIVED 7 2 3 2016 H/OLC	

This information was shared with the DON and

		AND HUM SERVICES & MEDICAL SERVICES			PRINTED: 05/12/2016 FORM APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495143	B. WING		04/21/2016
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD	
GOLDEN	LIVINGCENTER- MA	RTINSVLLE		1607 SPRUCE STREET MARTINSVILLE, VA 24112	
(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 X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLÉTION
F 272	5. For Resident #6 document the sourcarea assessment (0	21/16 at 10:30 AM. No provided. facility staff failed to be of information in the care	F 2	72	
	with diagnoses incluheart failure, hypert stroke, seizure disopain. The resident interview for mental minimum data set a	iding coronary artery disease, ension, diabetes mellitus, order, asthma, and chronic scored 15/15 on the brief status on the quarterly ssessment (MDS) dated essed without symptoms of			TOPONOMICA CONTRACTOR
	surveyor noted that admission assessm document the source the CAA. The CAA "Location and Date WS (worksheet) dat worksheets contain pertaining to the trig	d review on 4/20/16, the the CAA summary on the ent dated 7/16/15 did not e of the information used in summary documents under of CAA documentation" CAA ded 7/21/15. The CAA a summary of information gered areas, but do not es of that information.			
n (1) control on the control of the	she had not been ta individual items of ir The director of nurs notified of the conce	19/16, the MDS nurse stated ught to list the sources of aformation. Ing and administrator were are during a summary meeting		REC	EIVED
THE PROPERTY OF THE PROPERTY O		, facility staff failed to e of information in the care AA) summary.		MAY	2 3 2016 1/OLC

PRINTED: 05/12/2016

		AND HUMAN ERVICES				FORI	D: 05/12/2016 M APPROVED D. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		495143	B. WING			0,	4/21/2016
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	MATIZUTU
GOLDEN	N LIVINGCENTER- MA	ARTINSVLLE			7 SPRUCE STREET RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ige 24	F 2	72			
	12/30/15 with diagn vascular disease, g disease, anxiety, hi the lung. The resid interview for mental minimum data set a 3/9/16 and was ass	admitted to the facility on noses including peripheral pastroesophageal reflux ip fracture, and sarcoidosis of dent scored 15/15 on the brief all status on the quarterly assessment (MDS) dated sessed without symptoms of a or behavior issues.					
	surveyor noted that admission assessm document the source the CAA. The CAA "Location and Date WS (worksheet) day worksheets contain pertaining to the trig	rd review on 4/20/16, the the CAA summary on the nent dated 1/6/15 did not ce of the information used in a summary documents under of CAA documentation" CAA ated 1/13/16. The CAA as a summary of information ggered areas, but do not ces of that information.	•				
		1/19/16, the MDS nurse stated aught to list the sources of nformation.					
The section of the se	notified of the conce on 4/20/16. 7. For Resident #1, include the location section V (care area summary) of the Re MDS (minimum date	the facility staff failed to of the CAA documentation in a assessment (CAA) esidents significant change ta set) assessment with an reference date) of 06/22/15.			RECEIN	√ED	
	ARD (assessment r	elerence date) of 06/22/15.			MAY 23	2016	

Resident #1 was admitted to the facility 10/19/13.

Diagnoses included, but were not limited to, history of urinary tract infections, hyperkalemia,

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 25 of 85

VOH/OLC

	INENT OF REALTH RS FOR MEDICARE	& MEDICAID SERVICES				FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DAT	. 0938-0391 E SURVEY MPLETED
		495143	B. WING	·		04	/21/2016
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			7 SPRUCE STREET RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 272	Continued From pa chronic pain, osteod disease, and anxiet	arthritis, cerebrovascular	F 2	272			
	significant change in with an ARD of 06/2 out of a possible 15 section V read in pa and Date of CAA Do	e patterns) of the Resident in status MDS assessment 12/15 scored the Resident 12 points. The directions under art "3. Indicate in the Location ocumentation column where to the CAA can be found"					
	CAA documentation documented CAA V documented the da The actual location(abeled "Location and Date of " the facility staff had /S (worksheet) and had tes of 06/25/15 and 06/29/15. s) regarding the not been documented.	The state of the s				To a view and analysis and a view
	(registered nurse) # asked about the mis reviewing section V	roximately 10:15 a.m. RN 2 (MDS coordinator) was ssing documentation. After RN #2 verbalized to surveyor ormation was missing.					
:	This information wa administrative team 5:05 p.m.	s shared with the on 04/20/16 at approximately					
		nation regarding this issue was ey team prior to the exit	Commence of a first of the commence of a first of a fir	¥			
	include the location section V (care area summary) of the Re (minimum data set)	the facility staff failed to of the CAA documentation in a assessment (CAA) sidents annual MDS assessment with an ARD nce date) of 03/14/16.	Company of the Control of the Contro				The state of the s

DEPARTMENT OF HEALTH AND HUM SERVICES

PRINTED: 05/12/2016

PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMAN **TRVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SÉRVICES 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 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE MARTINSVILLE, VA 24112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ŧΠ (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 272 Continued From page 26 F 272 Resident #2 was admitted to the facility 03/08/16. Diagnoses included, but were not limited to. hypertension, dementia, hypokalemia, insomnia, and depressive disorder. Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD of 03/14/16 scored the Resident 15 out of a possible 15 points. The directions under section V read in part "3. Indicate in the Location and Date of CAA Documentation column where information related to the CAA can be found..." Under the column labeled "Location and Date of CAA documentation" the facility staff had documented CAA WS (worksheet) and had documented the dates of 03/14/16 and 03/22/16. The actual location(s) regarding the documentation had not been documented. On 04/20/16 at approximately 10:15 a.m. RN (registered nurse) #2 (MDS coordinator) was

onference.

9 For Resident #14, the facility staff failed to

administrative team on 04/20/16 at approximately

No additional information regarding this issue was provided to the survey team prior to the exit

asked about the missing documentation. After reviewing section V RN #2 verbalized to surveyor that the required information was missing.

This information was shared with the

 For Resident #14, the facility staff failed to include the location of the CAA documentation in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment with RECEIVED

MAY 23 2016

VDH/OLC

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

5:05 p.m.

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 27 of 85

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MAY 23 2010

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		AND HUMAN ERVICES 8 MEDICAID SERVICES					FORM.	05/12/2016 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	U	(X3) DATE	0938-0391 E SURVEY PLETED
		495143	B. WING_				04/:	21/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE	, ZIP CODE		M 17
GOLDEN	N LIVINGCENTER- MA	ARTINSVLLE			7 SPRUCE STREET			
	<u> </u>			MA	RTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 272	Continued From pa	age 27	F 27	779				
	· ·	ent reference date) of 09/15/15.	1	·I fa				
	11/30/12. Diagnose limited to, Alzheime	admitted to the facility es included, but were not er's disease, generalized pain, idism, and glaucoma.					; ; ;	
	significant change in with an ARD of 09/1 out of a possible 15 section V read in pa and Date of CAA Do	e patterns) of the Residents in status MDS assessment 15/15 scored the Resident 0 5 points. The directions under art "3. Indicate in the Location ocumentation column where to the CAA can be found"						
:	CAA documentation documented CAA V documented the da The actual location(abeled "Location and Date of n" the facility staff had VS (worksheet) and had ates of 09/17/15 and 09/18/15. (s) regarding the I not been documented.						
:	(registered nurse) # asked about the mis reviewing section V	proximately 10:15 a.m. RN #2 (MDS coordinator) was issing documentation. After / RN #2 verbalized to surveyor formation was missing.					:	
•	This information wa administrative team 5:05 p.m.	as shared with the n on 04/20/16 at approximately	The country of the state of the					:
m m i i i i i i i i i i i i i i i i i i		nation regarding this issue was vey team prior to the exit	To compare with the common party of the common					

10. For Resident #5 the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) assessment.

Resident #5 was admitted to the facility on

DEPARTMENT OF HEALTH AND HUMA **SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICARD 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 495143 B. WING 04/21/2016

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE MARTINSVILLE, VA 24112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 272 Continued From page 28 F 272 09/07/12. Diagnoses included but not limited to atrial fibrillation, hypertension, gastroesophageal reflux disease, hyperlipidemia, arthritis, fracture, dementia, anxiety, depression, cataracts, delirium and anorexia. The most recent comprehensive MDS (minimum data set) with and ARD (assessment reference date) of 03/04/16 coded the Resident as 6 of 15 in Section C, cognitive patterns. Section V. Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was "CAAWS (worksheet) dated 03/10/16". The MDS coordinator was interviewed on 04/20/16 at approximately 1020. She stated " That 's just how I do them ". The administrative staff was informed of the findings during a meeting on 04/20/16 at approximately 1710. No further information was provided prior to exit. 11. For Resident #9 the facility staff failed to ensure an accurate comprehensive MDS assessment. Resident #9 was admitted to the facility on 07/28/10 and readmitted on 12/12/15. Diagnoses included but not limited to congestive heart failure, hypertension, dementia, anxiety, depression, psychotic disorder, schizophrenia, atrial fibrillation, gastroesophageal reflux disease, arthritis and cataracts. The most recent comprehensive MDS with an ARD of 04/09/15 coded the Resident as 15 out of

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

15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation

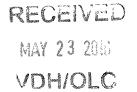
was " CAA WS dated 04/15/15 ".

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 29 of 85

PRINTED: 05/12/2016



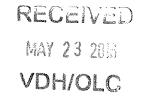
		AND HUMA ERVICES			FORM	D: 05/12/2016 M APPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
		495143	B. WING		n/	1/21/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE		1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		N SHOULD BE	(X5) COMPLETION DATE
:	That 's just how I d The administrative s findings during a me approximately 1710 No further informat 12. For Resident #1 ensure an accurate assessment. Resident #10 was a 11/03/14. Diagnose anemia, hypertensic hyperkalemia, main bipolar disorder, chi disease, respiratory gastroesophageal r renal disease. The most recent co ARD of 10/19/15 co in Section C, cognit Area Assessment (0 reviewed. The facili date and location of determine the care was "CAA WS dat The MDS coordinat	tor was interviewed on imately 1020. She stated " lo them ". staff was informed of the eeting on 04/20/16 at 0. tion was provided prior to exit. 10 the facility staff failed to comprehensive MDS admitted to the facility on is included but not limited to on, hypotension, nutrition, anxiety, depression, ronic obstructive pulmonary of failure, dysphagia, reflux disorder and end stage amprehensive MDS with an oded the Resident as 15 of 15 tive patterns. Section V, Care CAA) Summary was also ty staff had not identified the f the CAA information used to plan. The only documentation ed 10/22/15". For was interviewed on mately 1020. She stated "	F 2	272		
	findings during a me approximately 1710 No further informat 483.20(d)(3), 483.1	tion was provided prior to exit.	F 2	280		

The resident has the right, unless adjudged incompetent or otherwise found to be

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 30 of 85



	TMENT OF HEALTH	AND HUMAN RVICES & MEDICAID SERVICES			FORM	05/12/2016 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATI	E SURVEY IPLETED
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GOLDEN	N LIVINGCENTER- MA			1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	participate in planni changes in care and A comprehensive care within 7 days after the comprehensive associated in a register for the resident, and disciplines as determined in the resident, the resident, the resident in t	r the laws of the State, to ing care and treatment or	F 280	and updated to reflect a care plant for all triggers identificated with the need to proceed to care. 2. A 100% audit will be completed current residents most recent coassessment to ensure that a care has been generated for all triggen CAA's that have been identified the need to proceed to care plants. Re-education was provided by Clinical Assessment and Reim Specialist on 4/29/2016 regard.	lan fied re plan. ed of all compreh re plan gering ed with an. y the libursem	l nensive nent npletion
	by: Based on staff inter review the facility sta (comprehensive car 24 Residents, Residents, Residents, Residents) The findings included The facility staff fails pressure. Resident #2 was ad Diagnoses included	ed. ed to develop a CCP for dmitted to the facility 03/08/16. d, but were not limited to, entia, hypokalemia, insomnia,		of CAA's and the CAA works the care plan decision. An aud of Comprehensive Assessment and care plans will be complete DNS/designee monthly and submitted to QAPI for review 4. Results of audit will be brough monthly Quality Assurance Per Improvement (QAPI) meeting review and recommendations implemented as indicated.	t Trigge ted by th x 3 mon to erforman	ors he nths.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with

	TMENT OF HEALTH	AND HUMA SERVICES & MEDICAL SERVICES				FORM	0: 05/12/2016 MAPPROVED 0: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495143	B. WING			04	/21/2016
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			7 SPRUCE STREET ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL! CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 31	· F2	280			
		nt reference date) of 03/14/16					
		t 15 out of a possible 15					
		ladder/bowel) was coded to					
	indicate the Resider	nt was occasionally . Section M (skin conditions)	:				
		ite the Resident did not have	:				
	•	but had a pressure reducing					
		Section V (care area					
		summary) had triggered for					
		e ulcer and the facility staff ney would develop a CCP for	:				
:	A review of the curre reference to pressu	ent CCP did not include any re.		***************************************			,
	surveyor and RN (re the Residents MDS	roximately 10:15 a.m. the egistered nurse) #2 reviewed and CCP. After reviewing the zed to the surveyor that she t.					
	This information wa administrative team 5:05 p.m.	s shared with the on 04/20/16 at approximately					
		nation regarding this issue was ey team prior to the exit		the way and the desirable or many by a children or both			
F 281 SS=E		VICES PROVIDED MEET TANDARDS	F2	281			
		ed or arranged by the facility on all standards of quality.		And the second district of the second			
	This REQUIREMEN	IT is not met as evidenced		Colombia de Constante de Colombia de Colombia de Colombia de Colombia de Colombia de Colombia de Colombia de C			· : :

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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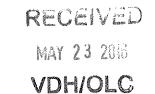
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		495143	B. WING	i		04	/21/2016
	PROVIDER OR SUPPLIER N LIVINGCENTER- M	-		160	REET ADDRESS, CITY, STATE, ZIP COD D7 SPRUCE STREET ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 281	staff interview, and staff failed to 1- for for administration of 24 residents in the 17 and 2- failed when preparing multiple of 1. Resident #17 when preparing multiple of 1. Resident #17 when preparing multiple of 1. Resident #17 when the 10/14/15 with diag disease, hypertens hypotension, renal encephalopathy, to the admission min assessment dated 6/15 on the brief and was assessed as hon a 10 point scale of 15 on the brief and was assessed as hon a 10 point scale of 15 on the brief and was assessed as hon a 10 point scale of 15 on the brief and was assessed as hon a 10 point scale of 15 on the brief and was assessed as hon a 10 point scale of 15 on	t interview, family interview, I clinical record review, facility low standard nursing practice of controlled substances for 1 the survey sample (Resident to follow standard precautions edication for administration. Tas admitted to the facility on noses including coronary artery sion, orthostatic failure, metabolic by back pain, and hip pain. On imum data set (MDS) 10/21/15, the resident scored assessment for mental status as without signs of delirium, avior disorder. The resident naving frequent pain at a level 8 between that the pharmacy ing for pain medication which of receiving. The resident quently asked for pain as told she could not have pain the she had medication hours. The resident's son reported for the Resident's son reported or the month. The medication with month.	F2		 Resident #17 has had ar date pain assessment and care was reviewed and rindicated. All residents on a pain reprogram will have an upassessment and plan of reviewed and revised as All PRN Narcotic admirts the last 30 days will be to the Medication Admirecord and identified cobe addressed as indicated. DNS/Designee will provide be addressed Nurses with exergarding the Pain Mana Guidelines, Medication Guidelines, and required DNS/Designee will reviwith pain management rein clinical start-up and iconcerns will be address indicated. DNS/Designee weekly random audit of administrations and the documentation including pain management program 	d plan of revised as management to date part of the care will be indicated. Inistration incerns will be ducation agement Administration agement Administration document we resident ew resident sed as the will do at 10 narcotic required greview of the review of the control of t	ation tation. tts
	administration reco	ords for March and April 2016		The second secon			

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 33 of 85



	TMENT OF HEALTH	AND HUMAN RVICES & MEDICAID RVICES			FORM): 05/12/2016 1 APPROVED 0. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DAT	re survey MPLETED
	!	495143	B. WING		04/	/21/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		(A 1) =
GOLDEN	N LIVINGCENTER- MA	ARTINSVLLE		1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE
to the state of th	times per day Marcl = 68 pills), then cha hydrocodone-acetar day March 18 through pills). The March March 2016. The Aresident received so hydrocodone-acetar day as ordered until 4/21/16. The April March 2016. The April Marceived hydrocodone-acetar day as ordered until 4/21/16. The April March 2016 at 5:50 AM and surveyor requested the resident for March 18 at 19 phydrocodone-acetar covered 4/15/16 throdates, the narcotic swas signed out for the 4/15 at 20 AM, 1 PM 4/16 at 20 AM, 1 PM 4/18 at 30 AM, 1 PM 4/19 at 30 AM, 1 PM 4/20 at	ch 1 through March 17 (17 X 4 anged to aminophen 7.5-325 4 times per ugh March 31 (14 X 4 = 56 IAR indicated that aminophen 5-325 as needed /16/16 was not administered in April 2016 MAR indicated the cheduled aminophen 7.5-325 4 times per il the surveyor's review on MAR indicated the resident one-acetaminophen 7.5-325 on d 4/16 at 6:20 AM. The I the narcotic sign out logs from the resident one-sheet for 7.5-325 and one for 5-325. For aminophen 7.5-325, the sheet rough 4/20/16. For those sheet indicated medication the resident: PM, 9 PM 5 PM, 5 PM, 9 PM 4, 18:30 PM 4, 5 PM, 8 PM M Destance Accountability sheet or ended on 4/20 at 12 PM	F 281	4. Results of audit will be broug monthly Quality Assurance I Improvement (QAPI) meetin review and recommendations implemented as indicated.	Perform	nance

The PRN Controlled Substance Accountability Sheet for hydrocodone-acetaminophen 5-325

		I AND HUM SERVICES 8 MEDICARD SERVICES				FOR	D: 05/12/2016 M APPROVED O. 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
···		495143	B. WING_			₀	4/21/2016
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP COI		712
GOLDEN	N LIVINGCENTER- MA				7 SPRUCE STREET RTINSVILLE, VA 24112		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	ige 34	; F 28	81			
	\$	esident had received 14	:	i			
1		of pain medication between MAR documented only 2					
111 1000	doses. No nurse's	notes documented) ;			
1000	administration of un	nscheduled pain medication		:			
\$ 1	except for the 4/12	and 4/17 doses.	ē				
k stranger	employs a pharmac	edication cards, the facility ceutical single dose dispenser.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
:	hydrocodone-aceta	minophen 7.5-325 was		1			:
The second secon	(3 doses), 4/5 (3 do	system on 4/3 (2 doses), 4/4 oses), 4/6 (3 doses), 4/7 (4 es), 4/11 (6 doses), 4/13 (4 ees).	- **** - **** - **** - ****************		•		
:		O AM, the surveyor intervieweding unit manager about the	A LI VININA MARA EN IL C.				
	resident's complaint	t that nurses will not give her	and the second				: :
		en she asks for it. The nurse lication was ordered every 4	- may 11 to called 1 to	* ***			:
	hours. When the do	octor ordered the higher dose	Table Balletin Str.				:
:		7.5-325), she made the prior I she hoped the resident) >				:
	wouldn't need to use	e it. The nurse said the					
		s that she could have a PRN		ì			
:	much".	, but "we try not to give her too	**************************************				
:		ssed withholding ordered pain	AVARBITA V. 1001				
		director of nursing on 4/21/16	als addition	1			
:	at approximately 12 and Alixa machine r	2:15 PM. The narcotic sheets requisition reports		and the second			
	documenting that fe	ewer doses of scheduled pain dered and documented were	and the state of t				; ; ;

signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did

not receive medication when requested. The

	/e-	AND HUMA SERVICES			O	FOR	D: 05/12/2016 M APPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		495143	B. WING_			0,	4/21/2016
	PROVIDER OR SUPPLIER N LIVINGCENTER- MA			160	REET ADDRESS, CITY, STATE, ZIP COD 07 SPRUCE STREET ARTINSVILLE, VA 24112	E	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 281	reconciling medicat the supply on hand. The facility policy fo states in: Administra Medications, section return to cart, replace multi-dose and dose administration in the substance sign out section "M. When a (PRN) medication, or giving, observe for mand record [on the February or supplementary of the supplementary of th	d to have no mechanism for tion administration records with . or medication administration ration Procedures For All on" J. After administration, ce the medication container (if es remain), and document e MAR or TAR, and controlled record, if indicated." and administering an 'as needed' document the reason for medication actions/reactions	F 28	311			
	were not being addr medication was not documented were re administrator, direct members of the adr meeting on 4/21/16. 2. On 4/20/16 at 5:8 the medication nurs medication cart draw	55 PM, the surveyor observed se on the north wing at the wing insulin into a syringe.		** ** New to complete the complete two considerations and an immunity of the an			
EMPARTONS STATES		greet the surveyor and the the needle cap for the syringe					

held between the nurse's teeth. The director of nursing was not in her office, so the surveyor reported the incident to the administrator.

On 4/21/16 at 8 AM, the director of nursing reported that the registered nurse had been educated not to put needle caps in her mouth and provided an Employee Education record as

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 36 of 85



		AND HUM SERVICES				FORM	: 05/12/2016 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	E SURVEY IPLETED
		495143	B. WING		Marie and the second se	04/	21/2016
NAME OF	PROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 0-11	21/2010
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE	l.		SPRUCE STREET TINSVILLE, VA 24112		
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281	Continued From pa evidence.	ge 36	F 281				
F 309 SS=E	made aware of the discovered.	nd director of nursing were concerns as they were CARE/SERVICES FOR	F 309	1.	date pain assessment and pl care was reviewed and revis	an of	6/2/2016
:	provide the necessa or maintain the high mental, and psycho	receive and the facility must ary care and services to attain est practicable physical, social well-being, in e comprehensive assessment		2.	program will have an up to assessment and plan of care reviewed and revised as ind All PRN Narcotic administr	date pa will be icated. ation ir	in :
	This REQUIREMENT is not met as evidenced by: Based on resident interview, family interview, staff interview, and clinical record review, facility staff failed to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain for 1 of 24 residents in the survey sample (Resident #17). Resident #17 was admitted to the facility on 10/14/15 with diagnoses including coronary artery disease, hypertension, orthostatic hypotension, renal failure, metabolic encephalopathy, low back pain, and hip pain. On the admission minimum data set (MDS) assessment dated 10/21/15, the resident scored 6/15 on the brief assessment for mental status and was assessed as without signs of delirium, psychosis, or behavior disorder. The resident was assessed as having frequent pain at a level 8 on a 10 point scale.			3.	the last 30 days will be reco to the Medication Administ record and identified concer be addressed as indicated. DNS/Designee will provide Licensed Nurses with educa regarding the Pain Manager Guidelines, Medication Adr Guidelines, and required do DNS/Designee will review with pain management need in clinical start-up and ident concerns will be addressed a indicated. DNS/Designee w weekly random audit of 10 a administrations and the requ	the the tion nent ninistracument s daily ified as ill do a narcotic	ation. ts

DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

<u> </u>	10 I ON MILDIOAINE	A MILDIUAID SERVICES				<u>UVI DIVIC</u>	<u>. บรรช-บรร เ</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
		495143	B. WING			04/	/21/2016
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GOI DEN	I LIVINGCENTER- MA	RTINSVI I E		160	7 SPRUCE STREET		
OCLUL!	EDVINGOE/ETER- NO			MA	RTINSVILLE, VA 24112		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 37	F;	309	documentation including rev	iew of	he
	During a family inte	rview on 4/21/16, the		4.	Results of audit will be broug	tht to	:
		rted that the pharmacy	,		monthly Quality Assurance F	~	ance
	appeared to be billi	ng for pain medication which		:	Improvement (QAPI) meetin		·
		t receiving. The resident	:		review and recommendations	_	
	: ·	uently asked for pain	2	1		Ė	:
		s told she could not have pain			implemented as indicated.		:
		e she had medication hours. The resident's son		1			
		or the resident's pharmacy bill					
		ne resident had been billed for					
		The Resident's son reported		1			
		order had been changed to	:				
	Norco 7.5/325 early	in the month.					
		ew of the medication rds for March and April 2016					
	revealed the reside						
		minophen 5-325 (Norco) 4					
		h 1 through March 17 (17 X 4					
	= 68 pills), then cha	inged to minophen 7.5-325 4 times per					
		gh March 31 (14 X 4 = 56	1				
	pills). The March M.						
	•	aminophen 5-325 as needed		1			
		16/16 was not administered in	The section of the se	:			
		pril 2016 MAR indicated the		ĺ			:
	resident received so						
		minophen 7.5-325 4 times per					
		I the surveyor's review on MAR indicated the resident		į			
		me-acetaminophen 7.5-325 on	1				
		d 4/16 at 6:20 AM. The	· :				
		the narcotic sign out logs fro		1			
		ch and April 2016. Facility					
:	staff provided only		į.				
	hydrocodone-anan	7.5-325 and one for	1				

hydrocodone-apap 5-325. For

hydrocodone-acetaminophen 7.5-325, the sheet

		AND HUN SERVICES				FOR	D: 05/12/2016 MAPPROVED
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	O. 0938-0391 ATE SURVEY DMPLETED
		495143	B. WING			n	4/21/2016
	PROVIDER OR SUPPLIER	RTINSVLLE		1607	EET ADDRESS, CITY, STATE, ZIP CODE 7 SPRUCE STREET RTINSVILLE, VA 24112		7/2 1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	covered 4/15/16 thr dates, the narcotic was signed out for 4/15 8:30 AM, 1 4/16 8 AM, 12:44/17 9 AM, 1 PN 4/18 9 AM, 1 PN 4/19 8 AM, 1 PN 4/20 8 AM, 12 PThe Controlled Subgiven to the surveyowith 10 pills remain. The surveyor's interthere were 7 pills re on 4/21/16 (implying	rough 4/20/16. For those sheet indicated medication the resident: PM, 9 PM 5 PM, 5 PM, 9 PM 1, 5 PM, 9 PM 1, 18:30 PM 1, 5 PM, 8 PM M stance Accountability sheet or ended on 4/20 at 12 PM		309:			
	Sheet for hydrocode indicated that the resunscheduled doses 3/18 and 4/20. The doses. No nurse's administration of unexcept for the 4/12. In addition to the memploys a pharmac During the period for hydrocodone-aceta withdrawn form the (3 doses), 4/5 (3 doses)	edication cards, the facility reutical single dose dispenser. om 4/1/16 through 4/21/16, minophen 7.5-325 was system on 4/3 (2 doses), 4/4 (ses), 4/6 (3 doses), 4/7 (4 s), 4/11 (6 doses), 4/13 (4					
	the resident's nursir	AM, the surveyor interviewed ng unit manager about the t that nurses will not give her					

pain medication when she asks for it. The nurse

PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICARS 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 _ 495143 **B. WING** 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE** MARTINSVILLE, VA 24112 (X4) ID 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 309 Continued From page 39 F 309 stated that the medication was ordered every 4 hours. When the doctor ordered the higher dose (hydrocodone-apap 7.5-325), she made the prior dose PRN, but said she hoped the resident wouldn't need to use it. The nurse said the resident's order was that she could have a PRN dose every 4 hours, but "we try not to give her too much". The surveyor discussed withholding ordered pain medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did not receive medication when requested. The pharmacy appeared to have no mechanism for reconciling medication administration records with the supply on hand. The concern that the resident's reports of pain were not being addressed and the resident's pain medication was not properly controlled or documented were reported to the facility administrator, director of nursing, and other members of the administrative staff at a summary meeting on 4/21/16. F 312 483.25(a)(3) ADL CARE PROVIDED FOR F 312 6/2/2016 SS=D DEPENDENT RESIDENTS

and oral hygiene.

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal

DEPARTMENT OF HEALTH AND HUMA SERVICES					F		: 05/12/2016 APPROVED
CENTER	RS FOR MEDICARE	& MEDICALD SERVICES	OMB NO. 0938				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING COMPLET				
		495143	B. WING	***************************************		04/	/21/2016
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	LININGCENTED MA	DTIMEN/I I E		1607	SPRUCE STREET		
GOLDEN	LIVINGCENTER- MA	KINSVLLE		MAF	RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	Account to the second s	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 40	F 312))			6/2/2016
		90 .0			Resident #12 had fingernails	+=i	
				1.		umme	u
	This REQUIREMEN	IT is not met as evidenced		_	and cleaned 4/20/2016.		
	by:			2.	100% audit to be completed of		
		ion, staff interview and clinical			resident's fingernails by 5/27/	2016.	
	record review it was	determined that the facility		į	Nursing staff inserviced to en	sure	
		e Activities of Daily Living			nails are cleaned and trimmed		
		endent resident for 1 of 24					
į		mple survey, Resident #12.		_	residents designated shower of		į.
		e facility staff failed to provide		٤.	DNS or designee to audit 10	residen	t's
	nail care.			i i	nails each week x 4 weeks,		}
2	The Findings Includ			1	then monthly x 3 months.		:
		66 year old female who was n 10/15/14 and readmitted on		4.	Results of Audit will be brou	to the	1
		diagnoses included, but were					
		estive heart failure, chronic		1	monthly Quality Assurance P		ance
:		ary disease, paralysis agitans,			Improvement (QAPI) meeting		:
:	hypertension, pneur			2	review and recommendations		
		od disorder, anxiety and			implemented as indicated.		•
	depression.				-		•
	The most current M	inimum Data Set (MDS)					
	located in the clinical	al record was a Quarterly MDS					•
		Assessment Reference Date					
3		he facility staff coded that					
		Cognitive Summary Score of		-			•
		f also coded that Resident					
		(2/2) to total nursing care					
	with Activities of Dai			5			
		3:15 p.m. the surveyor					v .
		#12 sitting in her wheelchair in		41.01			7 3
		#12 was dressed in street or observed that Resident					:
		vere painted a greenish color		3			•
		finger nails were dirty with a					

brownish debris.

On April 20, 2016 at 10:05 a.m. the surveyor observed Resident #12 sitting at the nurses' station in her wheelchair. Resident #12 was dressed in street clothing. The surveyor

	ΓΜΕΝΤ OF HEALTH RS FOR MEDICARE	AND HUN SERVICES			FOF	ED: 05/12/2016 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) E	DATE SURVEY COMPLETED
		495143	B. WING			04/21/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE		1607 SPRUCE STREET MARTINSVILLE, VA 24112	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 41	F 312	·		
		dent #12 's finger nails were	1 312			
		color. The surveyor also				
		dent #12 's finger nails and		1		
		ith a brownish debris. The	*	•		
		that the Unit Manager, who				÷
		lurse (RN), at the nurses ' or informed the UM that	:	*		
		ger nails and were dirty. The	:			:
		ident #12 refused care				:
		she would see if Resident				
		staff to provide nail care.	:			1
		ident #12 if the facility staff				:
	could provide nail c " Yes. "	are and Resident #12 stated,				•
	On April 20, 2016 at	t 5:05 p.m. the survey team				
		strator (Adm), Director of	1			
		sistant Director of Nursing	N. C.			
		Compliance Nurse (CCN)				
		ident (AVP). The surveyor trative Team (AT) that				
1		gers and finger nails were dirty	A Paris de la Pari			
9		oris. The surveyor notified the				
		taff failed to provide nail care		·		
	to Resident #12.					r
1		nation was provided prior to				:
STATE OF THE STATE		s to why the facility staff failed to a dependent Resident,		·		
1	Resident #12.	to a dependent Nesident,	£	1 1		
F 323	483.25(h) FREE OF	ACCIDENT	F 323	3		6/2/2016
	HAZARDS/SUPER			, and the control of		0/2/2010
100 H	The facility must en	sure that the resident	The state of the s	Topographic and the state of th		

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prevent accidents.

environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 42 of 85



DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		495143	B. WING _			04/21/2016
	PROVIDER OR SUPPLIER			1607	EET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET RTINSVILLE, VA 24112	I OHIZITZO 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 323	by: Based on observar document review, to maintain a hazard for units. The South units. The South units. The South units. The South units. The South units in the Sou	NT is not met as evidenced tion, staff interview, and facility he facility staff failed to ree environment on 1 of 3 hit. ed. If the facility on 04/19/16 at p.m. the surveyor entered the ty shop on the South unit. The Upon entering this room the artially used spray bottle of label on this bottle read "Keep dren." The surveyor gave this digester to LPN # 10. ested from the facility the fety data sheet) related to the MSDS sheet included the n. Hazard Identification-may irritation avoid contact with the on 04/20/16 at approximately gh of the facility with the or on 04/21/16 at a.m. the maintenance director	F 32	2.	Bottle of odor digester immed removed from shower room/b shop on South Wing. Shower beauty shop immediately shut locked. 100% audit of all rooms in the completed to ensure that there chemicals left unattended in fa 100% of shower room/beauty to ensure doors are locked. Housekeeping/maintenance/de check shower rooms and beau a week x 4 weeks, then once a months to ensure the doors are and there are no chemicals left Results of audit will be brough monthly Quality Assurance Pel Improvement (QAPI) meeting and recommendations implemindicated.	eauty room/ and e facility were no acility. shop doors esignee to ty shop once month x 3 e locked t unattended. ht to erformance t for review
:	provided to the survicenterence.	ey leam prior to the exit		1		;

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 43 of 85



DEPARTMENT OF HEALTH AND HUN N SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

OTATEMEN	TOP OFFICIENCIES	TWO PROVIDENCES	T		OIVID INC). 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495143	B. WING			/21/2016	
	PROVIDER OR SUPPLIER N LIVINGCENTER- MA			STREET ADDRESS, CITY, STATE, ZIP 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTIO	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 329 SS=E	Each resident's drugunnecessary drugs drug when used in eduplicate therapy); without adequate mindications for its usadverse consequents should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs utherapy is necessar as diagnosed and drecord; and resident drugs receive gradubehavioral intervent	ig regimen must be free from i. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F 3	1. Resident #7, #12, #15, #18, #9, and #10 behave reviewed and placed in Care. 2. All residents on psychomereviewed and behavior placed in Point Click Concerning staff to address with monitoring side effective Inserviced licensed number behavior monitoring for Order by order reports the each day in clinical start psychotropic medication logs can be initiated. Note that the readmissions to be checked in the initiated of indicated. 3. DNS/designee to audit the weekly x 4 weeks, and the constant and provide the residents to answer.	rior logs were Point Click Point Click propic medicate monitoring logs are for licenses each shift alore fects each shift sing staff on r side effects. To be reviewed t up to check for so that behave lew admissions executed in daily mayior logs to behavior logs hen monthly x	gs d ng t. For vior s and	
The state of the s	by: Based on staff inter review it was determ failed to ensure that sample survey were medications, Reside #18, #9 and #10.			on 15 residents to ensur are present for each dru that there are no omission	g class and		

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 44 of 85



PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMA **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 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE MARTINSVILLE, VA 24112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 329 Continued From page 44 F 329 4. Results of audit will be brought to 1. For Resident #7 the facility staff failed to monthly Quality Assurance Performance monitor psychotropic drug use to include: specific behavior, interventions, side effects and Improvement (OAPI) Meeting for effectiveness. Resident #7 was receiving review and recommendations Quetiapine Fumarate (Seroquel) 50mg, a psychotropic medication, every evening at implemented as indicated. bedtime. Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors, hypokalemia, Bipolar, affective mood disorder. anxiety, hypertension and pain. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL). On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced physician orders for

"QUEtiapine Fumarate Tablet (Seroquel) 50mg Give 1 tablet by mouth at bedtime related to UNSPECIFIED MOOD [AFFECTIVE] DISORDER (F39)." (sic) The order originated on 12/11/15. Continued review of the clinical record produced the April Medication Administration Record (MAR's). The April MAR's documented that the facility staff were administering the Seroquel every evening as ordered by the physician. Continued review of the clinical record produced the Behavioral Monitoring Sheet for April 2016. Review of the April 2016 Behavioral Monitoring Sheet failed to document specific behavior, interventions, side effects and effectiveness on

DEPARTMENT OF HEALTH AND HUMA ERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495143	B. WING_		1 0	04/21/2016		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 1607 SPRUCE STREET MARTINSVILLE, VA 24112				
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 329	Continued From p	age 45	F 32	99				
	the 7-3 shift on 4/1 4/6/16, 4/7/16, 4/16/14, 4/15/16, 4/15/16, 4/17/16, 4/18/16. On April 20, 2016 a notified the Unit Markegistered Nurse, Seroquel, a psyche evening. The survestacility staff had not specific behavior, if effectiveness of the surveyor reviewed with the UM. The specific physician a surveyor then revies Behavioral Monitor surveyor pointed of monitor the psychologomet with the Admir Nursing (DON), As (ADON), Corporate and Area Vice Presentified the Adminificacility staff failed to psychotropic drug specific behavior, if effectiveness. No additional information of the psychologometric surveyor that Resunnecessary mediato monitor for specific behavior of the surveyor pointed the Adminificacility staff failed to psychotropic drug specific behavior, if effectiveness.	/16, 4/2/16, 4/3/16, 4/5/16, 0/16, 4/11/16, 4/12/16, 4/13/16, 4/16/16 and on the 3/11 shift on 1/16, 4/12/16, 4/13/16, 4/15/16, and on the 11-7 shift on at 8:15 a.m. the surveyor anager (UM), who was a that Resident #7 was receiving otropic medication, every eyor notified the UM that the at monitored Resident #7 for nterventions, side effects and a Seroquel drug use. The Resident #7's clinical record surveyor pointed out the order for the Seroquel. The ewed the April MAR's and April ring Sheet with the UM. The ut that the facility staff failed to						
	use.	12 the facility staff failed to				:		

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 46 of 85



DEPARTMENT OF HEALTH AND HUN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495143	B. WING			04/	21/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER- MA	RTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP 1607 SPRUCE STREET MARTINSVILLE, VA 24112	CODE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
behavior, interventice effectiveness. Reseffectiveness. Reserviveness and revening at bedtime. Resident #12 was a originally admitted of 11/24/15. Admitting not limited to: congeobstructive pulmonal hypertension, pneur hypothyroidism, modepression. The most current Mocated in the clinical assessment with an (ARD) of 3/22/15. Resident #12 had a 14. The facility staff #12 required limited with Activities of Dairon April 19, 2016 at reviewed Resident #10 orders dated 12/1/1 but were not limited (Risperidone) Giverelated to UNSPECTO A SUBSTANCE CONDITION (F29) of The order originated Continued review of the April Medication (MAR's). The April facility staff were adordered by the phys Further review of the April 2016 Behavior	ic drug use to include: specific ons, side effects and esident #12 was receiving osychotropic medication, every a 66 year old female who was on 10/15/14 and readmitted on diagnoses included, but were estive heart failure, chronic ary disease, paralysis agitans, monia, dyspnea, od disorder, anxiety and linimum Data Set (MDS) al record was a Quarterly MDS a Assessment Reference Date The facility staff coded that Cognitive Summary Score of also coded that Resident (2/2) to total nursing care lily Living (ADL's). to 3:15 p.m. the surveyor #12's clinical record. Review of produced signed physician produced signed physician produced signed physician orders included, to: "RisperDal Tablet on 11/15/15. If the clinical record produced Administration Records MAR's documented that the liministering the Risperdal as	F 3				

	TMENT OF HEALTH	I AND HUN I SERVICES			FORM): 05/12/2016 MAPPROVED): 0938-0391		
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED		
		495143	B. WING		04	l/21/2016		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12-1		
GOLDEN	N LIVINGCENTER- MA	RTINSVLLE	1607 SPRUCE STREET MARTINSVILLE, VA 24112					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE		
F 329	Continued From pa	ige 47	F 32					
	use on the 7-3 shift 4/7/16, 4/10/16, 4/1 4/15/16, 4/16/16, 4/ on the 3-11 shift on 4/12/16, 4/13/16, 4/ on the 11-7 shift on On April 20, 2016 at notified the Unit Ma	eness for the Risperdal drug t on 4/3/16, 4/5/16, 4/6/16, 11/16, and 4/12/16, 4/13/16, 17/16, 4/18/16, 4/19/16 and 14/7/16, 4/8/16, 4/11/16, 1/15/16, 4/16/16, 4/17/16 and 14/4/16 and 4/18/16. 11 10:25 a.m. the surveyor anager (UM), who was a that Resident #12 was	on the contract of the contrac					
	receiving Risperdal, every evening. The the facility staff had for specific behavior and effectiveness or surveyor reviewed F with the UM. The surveyor then review Behavioral Monitoris surveyor pointed ou	I, a psychotropic medication, e surveyor notified the UM that I not monitored Resident #12 or, interventions, side effects of the Risperdal drug use. The Resident #12's clinical record surveyor pointed out the order for the Risperdal. The wed the April MAR's and April ing Sheet with the UM. The ut that the facility staff failed to						
***************************************	met with the Admini Nursing (DON), Ass (ADON), Corporate and Area Vice Presi notified the Adminis facility staff failed to psychotropic drug u	tropic drug use. It 5:05 p.m. the survey team istrator (Adm), Director of sistant Director of Nursing Compliance Nurse (CCN) ident (AVP). The surveyor strative Team (AT) that the monitor Resident #12 for use, Risperdal, to include interventions, side effects and						

No additional information was provided prior to exiting the facility as to why the facility staff failed

unnecessary medications. The facility staff failed to monitor for specific behavior, interventions, side effects and effectiveness of the Risperdal

to ensure that Resident #12 was free of

	TMENT OF HEALTH	I AND HUM SERVICES				FORM	D: 05/12/2016 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '		E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495143	B. WING	<u>; </u>		04	/21/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	IZ IIZU IV
GOLDEN	I LIVINGCENTER- MA	ARTINSVLLE		ı	007 SPRUCE STREET ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 329	Continued From pa	₃ge 48	F:	329			:
	use.			4			
		15 the facility staff failed to		1			
		pic drug use to include: specific		;			
		ions, side effects and					
	·	esident #15 was receiving pic medication, every evening			•		: :
:	at bedtime.	pic medication, every evening	1	*			•
:	· ·	a 72 year old female who was					
		4. Admitting diagnoses	1				:
		not limited to: pneumonia,					:
	chronic pain, edem	a, cataract vitreous					
		t failure, Bipolar, hypertension,					
		orbid obesity, kidney failure					:
	and Schizophrenia.						
		Minimum Data Set (MDS)					:
!		d in the clinical record was a					
:		essment with an Assessment RD) of 3/18/16. The facility					
		sident #15 had a Cognitive					
		15. The facility staff also					
:		nt #15 required extensive					
		total nursing care (4/2) with	:				
:	Activities of Daily Li	iving (ADL).					
:		at 9:10 a.m. the surveyor					
:		#15's clinical record. Review					
		d produced Physician Order	1				
		hysician orders included but					
		" Abilify Tablet 10 MG e 1 tablet by mouth at bedtime	· ·				
	related to BOPLOA						
		11.9)." (sic) The order	1				
	originated on 3/23/1		*				\$ - 20 - 10
		of the clinical record produced	1	!			:
		ication Administration Records	Top statement	:			: :
:		f the April 2016 MAR's	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	:			
	documented that the		1	:			1
į		bilify as ordered by the	į	1			
[ed review of the clinical record	1 8 8 5	:) E
	produced the April 2	2016Behavioral Monthly Flow 🕴	<i>i</i>				

	DEPARTMENT OF HEALTH AND HUM SERVICES					FOR	D: 05/12/2016 RM APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>OMB NO. 0938-0391</u>		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495143	B. WING		MARKALL III.	0	4/21/2016	
NAME OF F	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·		
GOLDEN	LIVINGCENTER- MA	RTINSVLLE			1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE	
F 329	Continued From pa	ae 49	Eq	329				
, 020,	· ·	_)Z3	•			
:		the Behavioral Monitoring						
:		document specific behavior,	-		· C			
:		effects and effectiveness for The Behavioral Monitoring						
		locument specific behavior,						
		effects and effectiveness on						
		16 and on the 3-11 shift on			1			
	•	1-7 shift on 4/2/16, 4/4/16 and						
:	4/19/16.							
		t 9:50 a.m. the surveyor			1			
		nager (UM), who was a			1			
		RN), that Resident #15 was						
	receiving Abilify, a p	sychotropic medication every					•	
	evening. The surve	eyor notified the UM that the						
		monitored Resident #15 for						
		terventions, side effects and						
		Abilify drug use. The surveyor	7.000.000.000.000.000.000.000.000.000.0					
		#15's clinical record with the					;	
		pointed out the specific					:	
		the Abilify. The surveyor then						
		MAR's and April Behavioral	-				;	
		ith the UM. The surveyor						
	•	facility staff failed to monitor						
	the psychotropic dru	t 11:45 a.m. the survey team	1					
-		istrator (Adm) and Director of	5				;	
		e surveyor notified the						
		n (AT) that the facility staff	- Marine				1	
		sident #15 for psychotropic						
		include specific behavior,						
:		effects and effectiveness.	C PARTITION OF THE PART		1			
		nation was provided prior to	**************************************				:	
	exiting the facility as	s to why the facility staff failed	B100-000				· :	
		dent #15 was free of					:	
		ations. The facility staff failed					:	
		fic behavior, interventions,						
		ectiveness of the Abilify use.	-		!		}	
:		22 the facility staff failed to						
	monitor psychotropi	ic drug use to include: specific	# · · · · · · · · · · · · · · · · · · ·				:	

		AND HUN SERVICES & MEDICAL SERVICES				FOI	ED: 05/12/2016 RM APPROVED IO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) E	OATE SURVEY COMPLETED
		495143	B. WING _			TT WETT THE THE THE THE THE THE THE THE THE	04/21/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CO	· · · · · · · · · · · · · · · · · · ·	
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			7 SPRUCE STREET RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 329	Continued From pa	ge 50	F 32	.g			
		ons, side effects and	1 02	.0			:
		esident #22 was receiving					
		tropic medication, every					
	evening at bedtime						
		a 63 year old male who was					
		3 and was discharged on					
		agnoses included, but were					:
		monia, obesity, Bipolar,		:			
		pulmonary disease and	•				
	respiratory failure.						
		linimum Data Set (MDS)					
		d in the clinical record was a		٠			
		DS assessment with an					
		ence Date (ARD) of 3/3/16.					
		ded that Resident #22 had a Score of 15. The facility staff					
		sident #22 was independent	:				
		Activities of Daily Living.					
		t 8:10 a.m. the surveyor					
		#22's closed clinical record.					
	Review of the close	d clinical record produced					
	Physician Order Sh	eets (POS's). Physician					
	orders included but	were not limited to:		V.			
		ate Tablet 100mg (Seroquel)	•	:			
		uth at bedtime related to					
		ER, CURRENT EPISODE		:			•
		DERATE (F31.21)." (sic)		:			
		f the closed clinical record		:			:
	produced the March	1 2016 Medication ords (MAR's) Review of the		1			
	: AUDUNISITATION KEC(HUS UVIAR ST REVIEW OF THE		1			

the Seroquel drug use.

March 2016 MAR's documented that the facility staff were administering the Seroquel as ordered by the physician. Continued review of the closed clinical record failed to produce any behavioral

interventions, side effects and effectiveness for

On April 21, 2016 at 9:50 a.m. the surveyor notified the Unit Manager (UM), who was a

monitoring to include specific behavior,

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

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495143	B. WING		0.	4/21/2016	
	PROVIDER OR SUPPLIER N LIVINGCENTER- M			STREET ADDRESS, CITY, STATE, ZIP 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(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 329	Registered Nurse received Seroquei The surveyor notif closed clinical received havioral monitors and the surveyor revieclinical record with to locate any behas 2016 related to the On April 22, 2016 met with the Admin Nursing (DON). The Administrative Teafailed to monitor Resided to monitor Resided to monitor Resident and enurse that Resunnecessary medito monitor for special effects and enurse. 5. For Resident #2 provide evidence of Resident was curred epression, loraze for insomnia. Resident #2 was a Diagnoses include hypertension, demand depressive dis Section C (cognitivation and MDS (minitation ARD (assessmiscored the Reside	(RN), that Resident #22 had during his stay at the facility, ied the UM that review of the ord failed to produce any ring for the Seroquel drug use. Ewed Resident #22's closed the UM. The UM was unable evioral monitoring for March is Seroquel drug use. At 11:45 a.m. the survey team instrator (Adm) and Director of the surveyor notified the im (AT) that the facility staff resident #22 for psychotropic is, to include specific behavior, effects and effectiveness. In mation was provided prior to as to why the facility staff failed ident #22 was free of cations. The facility staff failed cific behavior, interventions, if ectiveness of the Seroquel is, the facility staff failed to of adequate monitoring. The ently receiving paxil for pam for anxiety, and trazodone idmitted to the facility 03/08/16. In the during the facility of the facility	F 32				

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 52 of 85



		AND HUM SERVICES						05/12/2016 APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAN SERVICES						0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILT		CONSTRUCTION			E SURVEY PLETED	
		495143	B. WING	~			04/	21/2016	
NAME OF F	PROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP COD	<u>_</u>	140	£ 1/2010	
GOLDEN	LIVINGCENTER- MA	RTINSVLLE	1607 SPRUCE STREET MARTINSVILLE, VA 24112						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDE	3E	(X5) COMPLETION DATE	
F 329	Resident #2's CCP included the focus a complications associated Anti-Depressant me included, but were reffects and report to Anti-anxiety/Hypnotiside effects and rep Antidepressant-Sed as ordered by physieffectiveness" The Residents curre 0.5 mg give 1 tablet related to anxiety distablet by mouth one depressive disorder trazodone give 75 m related to insomnia. these medications he POS (physician order (date of admit). A review of the Residentian recort the medications had orders. The "BEHAVIOR Moused by the facility a contained no data frincomplete for April	chaviors) was coded to not did not have any behaviors. (comprehensive care plan) area "Potential for drug related ciated with use of psychotropic to: Anti-Anxiety medication, edication." Interventions not limited to, monitor for side o physician: ic medicationsMonitor for cort to physician: lationProvide Medications cian and evaluate for ent orders included lorazepam by mouth three times a day sorder, paxil 40 mg give 1 time a day related to major single episode, and ng by mouth at bedtime The start date for all three of nad been documented on the er summary) as 03/08/16 idents MAR's (medication of the day for April 2016 indicated if been administered per ONTHLY FLOW SHEET" and dated April 2016 om April 1-April 8 and was 15, 16, 19, and 20. Someone	F	329					
:		of for April 3 on the night shift. een crossed out with an X.							

DEPARTMENT OF HEALTH AND HUMA PERVICES CENTERS FOR MEDICARE & MEDICAL ERVICES

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PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495143	B. WING			04	1/21/2016	
	PROVIDER OR SUPPLIER			160	REET ADDRESS, CITY, STATE, ZIP CODE 17 SPRUCE STREET ARTINSVILLE, VA 24112	1 0-	72.172010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	‹	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	Continued From p	age 53	· F3	29				
		as shared with the mon 04/20/16 at approximately		TO THE RESERVE TO THE PROPERTY OF THE PROPERTY			4	
		mation regarding this issue was vey team prior to the exit		beautiful control control on another con-				
	provide evidence on Resident was current	4, the facility staff failed to of adequate monitoring. The ently receiving escitalopram or depression and xanax for						
	11/30/12. Diagnos limited to, Alzheim	admitted to the facility es included, but were not er's disease, generalized pain, ective disorder, hypothyroidism,		to the control of the				
	significant change set) assessment w reference date) of 0 out of a possible	re patterns) of the Residents in status MDS (minimum data rith an ARD (assessment 09/15/15 scored the Resident 15 points. Section E oded to indicate the Resident ehaviors.						
	included the focus complications assomedications relate Anti-Depressant." were not limited to report to physician medicationsMon to physician: Antido	P (comprehensive care plan) area "Potential for drug related ociated with use of psychotropic d to: Anti-Anxiety medication, Interventions included, but, monitor for side effects and : Anti-anxiety/Hypnotic itor for side effects and report epressant-SedationProvide lered by physician and veness"						

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 54 of 85



DEPART	MENT OF HEALTH	AND HUM SERVICES					J: 05/12/2016 MAPPROVED
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
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NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODI		ME HAVIV
GOLDEN	LIVINGCENTER- MA	RTINSVLLE			07 SPRUCE STREET ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 329	Continued From page	ge 54	F	329			
	mouth one time a didisorder and xanax times a day for anxievery 4 hours as near A review of the Resiadministration recort the medications had orders. The as need documented as beir 1723 (5:23 p.m.). The "BEHAVIOR Moused by the facility a contained incomplet 4, 15, 19, and 20. This information was administrative team 5:05 p.m. No additional inform provided to the surve conference. 7. For Resident #18 provide evidence of Resident was currer anxiety and citalopra Resident #18 was made facility 12/11/12. Dia	te 20 mg give 1 tablet by lay related to depressive tablet 0.5 mg by mouth two lety and 1 tablet by mouth leeded for anxiety. lidents MAR's (medication rds) for April 2016 indicated d been administered per ded xanax had been ng administered on April 8 at he staff had documented an ONTHLY FLOW SHEET" and dated April 2016 te monitoring data for April 1,					

	TMENT OF HEALTH	AND HUM SERVICES & MEDICAID SERVICES			O	FOR	D: 05/12/2016 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495143	B. WING	·		n	4/21/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER- MA	RTINSVLLE		16	REET ADDRESS, CITY, STATE, ZIP CODE 07 SPRUCE STREET ARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	Section C (cognitive significant change in set) assessment with reference date) of 0 15 out of a possible (behaviors) was condid not have any between the focus are complications assomedications related antidepressant medications related antidepressant medications assomedications related antidepressant medications assomedications related antidepressant medications.	e patterns) of the Residents in status MDS (minimum data th an ARD (assessment 9/18/15 scored the Resident 15 points. Section E ded to indicate the Resident haviors. (comprehensive care plan) area "Potential for drug related ciated with use of psychotropic to: Anti-Anxiety medication, lication." Interventions not limited to, monitor for side physician: ic medicationsMonitor for	F	329			
	The Residents curre 20 mg by mouth one depressive disorder three times a day for as needed. The "BEHAVIOR Mused by the facility a contained incomplet 4, 6, 15, 19, 20, and This information wa						
		ation regarding this issue was ey team prior to the exit	TOTAL THE STATE OF				

DEPARTMENT OF HEALTH AND HUM SERVICES	
CENTERS FOR MEDICARE & MEDICATO SERVICES	

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING			04/21/2016	
	PROVIDER OR SUPPLIER	ARTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 329	provide evidence of antipsychotic medical Resident #9 was according to a not part included but not limited failure, hypertension depression, psychotatrial fibrillation, gast arthritis and cataract The most recent M coded the Resident cognitive patterns. Resident's CCP (conceviewed and contain part "I sometimes hyelling, cursing, hitt care and resisting of food is poisoned at related complication psychotropic medical psychotro	the facility staff failed to f adequate of monitoring of the cation fluphenazine. Idmitted to the facility on nitted on 12/12/15. Diagnoses lited to congestive heart in, dementia, anxiety, stic disorder, schizophrenia, stroesophageal reflux disease, cts. DS with an ARD of 03/09/16 is as 9 out of 15 in Section C, This is a quarterly MDS. The emprehensive care plan) was sined care plans which read in leave behaviors which include ing, throwing items, refusing care. She also believes the times" and "Potential for drug ins associated with the use of	F3	329			
	"fluphenazine 2.5m	g Give 2.5mg by mouth two to schizoaffective disorder,		:			
	for April 2016 was r sheet was coded for	Behavior Monthly Flow Sheet" eviewed on 04/20/16. The flow rethe monitoring of "false inations/paranoia/delusion".					

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 57 of 85



	INENT OF HEALTH RS FOR MEDICARE	& MEDICAID SERVICES			FORM	M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA	D. 0938-0391 TE SURVEY MPLETED
		495143	B. WING		04	I/21/2016
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GOLDE	N LIVINGCENTER- MA	RTINSVLLE	į į	607 SPRUCE STREET MARTINSVILLE, VA 24112		
(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 APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	sheet. Surveyor sp regarding the incom at approximately 15 explanation as to w The concern of the brought to the attenduring a meeting or 1705. No further information.	e blank spaces on the flow oke with the unit manager aplete flow sheet on 04/20/16 i30 and she could offer no hy it was not complete. incomplete flow sheets was tion of the administrative staff in 04/20/16 at approximately on was provided prior to exit. It the facility staff failed to adequate of monitoring of the	F 329		,	
	Resident #10 was a 11/03/14. Diagnose anemia, hypertensic hyperkalemia, maln bipolar disorder, chidisease, respiratory gastroesophageal renal disease. The most recent MI coded the Resident cognitive patterns. reviewed and conta part "I sometimes h not asking for assis Often saying no one never ask for any herelated complication psychotropic medic Anti-psychotic media	dmitted to the facility on s included but not limited to on, hypotension, utrition, anxiety, depression, ronic obstructive pulmonary failure, dysphagia, eflux disorder and end stage OS with an ARD of 10/19/15 as 15 of 15 in Section C, The Resident's CCP was ined care plans which read in ave behaviors which include: tance when needed form staff. e is helping me even Hough I elp" and ""Potential for drug as associated with use of				

ordered by physician and evaluate for

DEPARTMENT OF HEALTH AND HUM SERVICES

	TMENT OF HEALTH	AND HUM SERVICES			PRINTED: 05/12/20 FORM APPROVE	ΕD
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	91
		495143	B. WING_		04/21/2016	
	PROVIDER OR SUPPLIER I LIVINGCENTER- MA	RTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
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F 329	effectiveness". Resident #10's clini 04/20/16. It contain summary for April 2 "Seroquel tablet 25 times a day related The Resident 's " If for April 2016 was risheet was coded for compulsive, and movere multiple blank Surveyor spoke with the incomplete flow approximately 1530 explanation as to with the concern of the brought to the attention of the strength of the concern of the brought to the attention of the concern of the brought to the attention of the concern	cal record was reviewed on ed a physician's order 016 which read in part mg give 50mg by mouth two to bipolar disorder". Behavior Monthly Flow Sheet" eviewed on 04/20/16. The flow r the monitoring of "anxiety, ultiple med complaints". There spaces on the flow sheet. In the unit manager regarding sheet on 04/20/16 at and she could offer no hy it was not complete. incomplete flow sheets was tion of the administrative staff in 04/20/16 at approximately	F 32	29		
F 363 SS=D	483.35(c) MENUS I ADVANCE/FOLLOV Menus must meet the residents in accordadietary allowances of Board of the Nation Academy of Science and be followed. This REQUIREMENT by:	on was provided prior to exit. MEET RES NEEDS/PREP IN VED he nutritional needs of ance with the recommended of the Food and Nutrition al Research Council, National es; be prepared in advance; IT is not met as evidenced ion, staff interview, clinical	F 36	1. Resident #4 interviewed. have prune juice disconting plan and tray card update #3 meal plan updated to poatmeal and/or cold cerea updated by Registered Discorrect portion for all diese	nued. Care d. Resident provide al. Menus letician for	16

	MENT OF HEALTH	₹					FORM.	05/12/2016 APPROVED
		& MEDICAID SERVICES						0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII			NSTRUCTION		E SURVEY PLETED
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NAME OF F	PROVIDER OR SUPPLIER					TADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	LIVINGCENTER- MA	RTINSVLLE				PRUCE STREET INSVILLE, VA 24112		:
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F 363	determined the facil dietitian approved in individual tray card (Residents #3 and 4). Findings: 1. Facility staff failed her dietitian approved card. The clinical reat 10:00 AM. Resident #4 was ad 6/28/11. The diagnod constipation, chronineuralgia. The latest MDS (middated 3/2/16 coded cognitive function. Sfacility staff for all the living)—with a set-up. The latest CCP (corupdated 4/14/16 incomplete the interventions to as orderedObtain preferencesProv. Resident #4's physical on 2/26/16 to monitor.	acility document review, it was lity staff failed to ensure nenus were complete per for 2 of 24 residents. 4.) d to provide Resident #4 with ed food, as stated on the tray cord was reviewed on 4/20/16 mitted to the facility on uses included dementia, compain, insomnia and compain, insomnia and minum data set) assessment, the resident with unimpaired the required the assistance of the ADLs (activities of daily only to eat.	F 36		3.	100% audit completed of resi preferences. Inservice to be completed by with all dining staff regarding resident preferences. Weekly to be conducted 5 x a week x to ensure compliance. Results of Audit will be broumonthly Quality Assurance I Improvement (QAPI) meeting review and recommendations implemented as indicated.	DSM audits week aght to Perform	(S
	#4's breakfast tray i	AM CNA I set up Resident n her bedroom. Once set-up surveyor reviewed the tray		A THE CASE OF THE				

card for the contents of the meal.

	TMENT OF HEALTH	AND HUM SERVICES				FORM	0: 05/12/2016 MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) DA). 0938-0391 TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		//Z 1/ZU10
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F 363	Continued From pa	ge 60	F;	363			
	prune juice on her to did not contain these never get my prune have a problem with On 4/21/16 at 8:30 was interviewed abselections. She said approved by a dietil the tray cards shoul "No, they're not get get." On 4/21/16 at 10:30 administrator were 2. Facility staff failed the menu selections.	upposed to receive 4 oz of tray and 6 oz of water. The tray se items. Resident #4 stated, "I juice, it's for constipation. I h that." AM, the DM (dietary manager) out the diets and tray card di the corporate menu was tian and all food selections on Id be served to the resident. Iting what they're supposed to D AM the facility DON and informed of these findings. Add to provide Resident #3 with a listed on his tray card.					
	4/20/16 at 9:30 AM. Resident #3 was ad diagnoses included blindness seizure di chronic obstructive The resident's lates the resident with se The resident was conursing staff for all to the following focus, food/beverage intak blindness." The staff	Imitted on 12/16/11. His anxiety, depression, isorder, schizophrenia, and pulmonary disease. t MDS, dated 1/29/16 coded vere cognitive impairment. ompletely dependent on the ADLs.					

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	IDENTIFICATION NUMBER:		NG		ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER I LIVINGCENTER- MA	RTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	<u> </u>	72 1720 10
(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
	included the diet or Mechanical soft tex bowls at all meals. I On 4/20//16 at 8:15 CNA II assisting Re II was feeding the recouldn't feed himse. The tray card was a breakfast tray. The waffles, coffee and and water were not two waffles served i In addition, the tray CEREAL." The resident and at the will the mand at the will At no time did CNA	ers, signed and dated 4/12/16, der, "No salt packet diet. ture. Patient to receive food in Large portions." AM the surveyor observed sident #3 with breakfast. CNA esident, as he was blind and lif. ompared to the foods on the tray card contained oatmeal, 3 water. The oatmeal, coffee on the tray. There were only instead of three. card said, "NO COLD dent had a cup of Frosted the tray. He seemed to enjoy	F 36	53		
	the resident's tray til said the corporate in dietitian and all food should be served to getting what they're On 4/21/16 at 10:30 administrator were i	AM the facility DON and nformed of these findings.	F 36	36		
JJ J						

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 62 of 85



PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUM/ BERVICES **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 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE** MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 366 : Continued From page 62 F 366 1. Resident #4's food preferences 5/31/2016 Each resident receives and the facility provides have been updated. substitutes offered of similar nutritive value to 2. 100% audit to be completed on resident food residents who refuse food served. preferences. 3. Dietary Manager/designee to complete This REQUIREMENT is not met as evidenced inservices with staff regarding resident Based on observation, staff and resident food preferences. Weekly audits x 4 interview and clinical record review it was weeks will be completed in random determined the facility staff failed to provide a food substitute of a similar nutritive value for one dining areas to determine if residents that was declined for 1 of 24 residents (Resident are being offered substitutes. All #4.) food preferences will be updated Findings: quarterly with resident's scheduled Facility staff failed to provide Resident #4 with a MDS assessments. substitute selection for a food she said she didn't 4. Results of Audit will be brought to like. The clinical record was reviewed on 4/20/16 monthly Quality Assurance Performance at 10:00 AM. Improvement (QAPI) meeting for Resident #4 was admitted to the facility on review and recommendations 6/28/11. The diagnoses included dementia, constipation, chronic pain, insomnia and implemented as indicated. neuralgia. The latest MDS (minimum data set) assessment, dated 3/2/16 coded the resident with unimpaired cognitive function. She required the assistance of facility staff for all the ADLs (activities of daily living)--with a set-up only to eat.

The latest CCP (comprehensive care plan) updated 4/14/16 included the problem,

preferences.....Provide food substitutes.

"Inadequate oral/food intake due to dementia."
The interventions to nursing staff included, "Diet as ordered....Obtain and update food/beverage

DEPARTMENT OF HEALTH AND HUM	SERVICES
CENTERS FOR MEDICARE & MEDICARD	SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3		E SURVEY PLETED
		495143	B. WING		04/:	21/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER- MA	RTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 386	on 2/26/16 to monit The resident was of On 4/20/16 at 8:45 #4's breakfast tray it tray set-up, CNA I be patty on the resident "I don't eat sausage the patty whole on tray go get the resident selection. (When as surveyor she liked to the contract of the contract of the contract of the contract of the contract of the contract of the contract of this section; write notes at each visit; a with the exception of polysaccharide vaccadministered per pholicy after an asset	cian ordered weekly weights or the resident for weight loss. In an unrestricted, regular diet. AM CNA I set up Resident in her bedroom. During the regan to cut up a sausage it's plate. The resident stated, it's plate. The resident stated, it's plate. She did not offer to another breakfast meat sked, the resident told the plate. She did not offer to another breakfast meat sked, the resident told the plate. AM, the DM (dietary manager) CNA I had failed to offer mate selection when the edid not like sausage. The A should have asked her what ad of the sausage. AM the facility DON and informed of these findings. AN VISITS - REVIEW DERS review the resident's total studing medications and visit required by paragraph (c), sign, and date progress and sign and date all orders influenza and pneumococcal	F 386	1. Obtained Physician Progress resident #7. 2. 100% audit completed of eac record performed to ensure the medical record contained the to date Physician Progress Noresident.	h medica nat each most up	

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 64 of 85



PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMA BERVICES 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 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE** MARTINSVILLE, VA 24112 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION

F 386 | Continued From page 64

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Based on staff interview and clinical record review, it was determine that the facility staff failed to ensure timely Physician Progress Notes for 1 of 24 Residents in the sample survey. Resident #7.

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

Resident #7 went from 10/2/15 until 2/18/16 without having Physician Progress Notes written. The Findings Included:

Resident #7 was a 67 year old female who was originally admitted on 9/22/15 and readmitted on 12/11/15. Admitting diagnoses included, but were not limited to: dementia without behaviors. hypokalemia. Bipolar, affective mood disorder. anxiety, hypertension and pain.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 2/22/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #7 required set up (0/1) to limited assistance (2/2) with Activities of Daily Living (ADL).

On April 19, 2016 at 3:15 p.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced the latest Physician Progress Notes dated 10/2/15. Additional review of the clinical record failed to produce any additional Physician Progress Notes since 10/2/15.

On April 20, 2016 at 8:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse, that Resident #7's clinical record did not produce and Physician Progress Notes since 10/2/15. The surveyor reviewed the clinical record with the UM. The UM was unable to locate any additional Physician Progress Notes. The UM stated she would ask Medical

F 386

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TAG

3. A running log was created to effectively monitor Physician Visits by resident and date of the last physician visit. Medical records to give proper notification of upcoming required visits to the physician's office via fax, as well as upcoming scheduled need for a resident's visit by physician. An audit of 5 random charts a week to be completed by Medical Records Coordinator x 4 weeks, then once a month x 3 months to ensure physician compliance with progress notes.

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

DATE

4. Results of audit will be brought to monthly Quality Assurance Performance Improvement (QAPI) Meeting for review and recommendations.

DEPART	MENT OF HEALTH	AND HUM SERVICES): 05/12/2016 AAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Name of the state). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495143	B. WING			n/a	/21/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		72 112010
GOLDEN	LIVINGCENTER- MA	RTINSVLLE			607 SPRUCE STREET MARTINSVILLE, VA 24112		
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F 386	Continued From pa	ge 65	F 3	86	· Constitution		
		any Physician Progress Notes led or that had been thinned					
,		t 9 a.m. the Medical Records		1			:
	clerk approached th	ne surveyor and stated that		:			
:	Progress Notes.	y additional Physician		1			
:	•	t 9:05 a.m. the Corporate					:
		(CCN) approached the		:			
		ned the surveyor that the system was not capturing the					
		Notes that were being done					
	electronically. The	CCN stated that they had					
		or that supplied the electronic					
	system and that the problem.	y were working to correct the					
		t 11 a.m. the UM hand		:			
	delivered two (2) Ph	ysician Progress Notes. The					
		Notes were dated 2/18/16		:			
		urveyor pointed out to the UM illid not have any Physician					
		over 4 months from 10/2/15					
	through 2/18/16.	0101 1 11011110 110111 10121 10		:	:		
		t 5:05 p.m. the survey team		:			
		strator (Adm), Director of					
		Sistant Director of Nursing		:	:		:
		Compliance Nurse (CCN) dent (AVP). The surveyor		:			1
		trative Team (AT) that					
		have timely physician		- 1			ĺ
		e surveyor notified the AT that		,			
		cian Progress Notes were		1	7 14 7		
	dated 10/2/15 and 2						<u> </u>
		ation was provided prior to		į			
:		s to why the facility staff failed sysician Progress Notes for		İ			
	Resident #7.	yaidian Frogress Notes for		:			
E 425	483 60(a) (b) DHAD	MACELITICAL SVC	E 1	ne.			:

	TMENT OF HEALTH	AND HUMA ERVICES & MEDICAID SERVICES				PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		ISTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING			04/21/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COL	
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			PRUCE STREET INSVILLE, VA 24112	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 AP DEFICIENCY)	HOULD BE COMPLETION
	drugs and biological them under an agree §483.75(h) of this punlicensed personn law permits, but onlisupervision of a lice. A facility must provide (including procedur acquiring, receiving administering of all the needs of each receiving administering of all the needs of each receiving all aspects of the services in the facility must entail aspects of the services in	EDURES, RPH povide routine and emergency als to its residents, or obtain the ement described in art. The facility may permit all to administer drugs if State by under the general ensed nurse. de pharmaceutical services that assure the accurate and drugs and biologicals) to meet drugs and biologicals to meet esident.	F 425	2.	Resident #17 has had a date pain assessment a care was reviewed and indicated. All residents on a pain program will have an u assessment and plan of reviewed and revised a All PRN Narcotic adm the last 30 days will be to the Medication Adm record and identified c be addressed as indicated DNS/Designee will produced in the Pain Marcotic adm the last 30 days will be addressed as indicated by the medication Adm record and identified control of the Medication Adm regarding the Pain Marcotic Buidelines, Medication Guidelines, and required DNS/Designee will reviewed and required DNS/Designee will reviewed and required DNS/Designee will reviewed and required by the pain Marcotic Buidelines, and required by the pain Marcotic Buidelines, and required by the pain Marcotic Buildelines, nd the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Marcotic Buildelines and the pain Buildelines and the pain Buildelines and the pain Buildelines and the pain Buildelines and the pain Buildelines and the pain Buildelines and the pain Buildelines and the pain Bui	management up to date pain f care will be as indicated. ainistration in e reconciled ainistration oncerns will ted. by ide the education nagement n Administration ed documentation.
: : :	Based on resident staff interview, and pharmacy and facili	interview, family interview, clinical record review, ty staff failed to account for d and supplied to the facility to	4		with pain management in clinical start-up and concerns will be addre	identified

prevent or manage pain for 1 of 24 residents in

10/14/15 with diagnoses including coronary artery

encephalopathy, low back pain, and hip pain. On

Resident #17 was admitted to the facility on

the admission minimum data set (MDS)

the survey sample (Resident #17).

disease, hypertension, orthostatic hypotension, renal failure, metabolic

indicated. DNS/Designee will do a

weekly random audit of 10 narcotic

documentation including review of the

administrations and the required

pain management program.

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

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		495143	B. WING			04/	21/2016
	PROVIDER OR SUPPLIER N LIVINGCENTER- MA			16	TREET ADDRESS, CITY, STATE, ZIP CODE 607 SPRUCE STREET IARTINSVILLE, VA 24112		E 1160 1 V
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	assessment dated 6/15 on the brief as and was assessed psychosis, or behavious assessed as hon a 10 point scale. During a family interesident's son report appeared to be billing the resident was not stated that she frequedication and was medication because scheduled every 4 leshowed the surveyof for March 2016. The 120 Norco 5/325. That the resident's on Norco 7.5/325 early Clinical record reviet administration record administration record revealed the resident hydrocodone-aceta times per day March 2016. The Anydrocodone-aceta day March 18 throupills). The March M. hydrocodone-aceta for pain, ordered 1/1/1/16. The April 1/1/16. The	10/21/15, the resident scored assessment for mental status as without signs of delirium, woor disorder. The resident naving frequent pain at a level 8 and the price of the president makes of the president of the price of the president of the price of t	F 4	125	4. Results of audit will be broug monthly Quality Assurance P Improvement (QAPI) meeting review and recommendations implemented as indicated.	erformag g for	ance

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 68 of 85



	TMENT OF HEALTH	AND HUMA SERVICES & MEDICAID SERVICES				FOR	D: 05/12/2016 M APPROVED
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DA	O. 0938-0391 ATE SURVEY DMPLETED
		495143	B. WING	à		0,	4/21/2016
NAME OF F	PROVIDER OR SUPPLIER	<u></u>	<u></u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		7/21/2010
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			7 SPRUCE STREET RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	·IX	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 425	Continued From pa	ıge 68	F	425			:
		I the narcotic sign out logs fro					
		rch and April 2016. Facility	:				:
	staff provided only of	one sheet for 7.5-325 and one for	:				:
:	hydrocodone-apap		:				1
4		minophen 7.5-325, the sheet					
1	covered 4/15/16 thr	rough 4/20/16. For those					i
		sheet indicated medication					:
:	was signed out for t						· :
	4/15 8:30 AM, 1 4/16 8 AM, 12:4	PM, 9 PM 5 PM, 5 PM, 9 PM					•
		5 PM, 5 PM 1, 5 PM, 9 PM		V.			:
	-	<i>I</i> I, 18:30 PM	:				
	4/19 8 AM, 1 PM	1, 5 PM, 8 PM	:				:
	4/20 8 AM, 12 P						
:		ostance Accountability sheet					:
	given to the surveyor with 10 pills remain	or ended on 4/20 at 12 PM		ţ.			•
		rview notes indicated that	1				:
		emaining on the card at 12 PM					
	on 4/21/16 (implying	g that the final 2 doses on 4/20	oh Affadank				
:		1 had been signed out).	1				:
	The DDM Controlle	1.0 Sections Assessmentalities					:
:		d Substance Accountability one-acetaminophen 5-325					•
		esident had received 14	1				•
		s of pain medication between	1		•		÷
1	3/18 and 4/20. The	MAR documented only 2	and the second				
5	doses. No nurse's		100				
		nscheduled pain medication	1000				
	except for the 4/12	and 4/17 doses.					* * *
	In addition to the m	edication cards, the facility) V
		ceutical single dose dispenser.	date of the				
	During the period fr	rom 4/1/16 through 4/21/16,	and the many				
:		minophen 7.5-325 was	m providence of the control of the c				1
		system on 4/3 (2 doses), 4/4	in our Address of the				; ;
:		oses), 4/6 (3 doses), 4/7 (4 es), 4/11 (6 doses), 4/13 (4	de to monomo y's skin kan	AT 2 11 10 10 10 10 10 10 10 10 10 10 10 10			

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

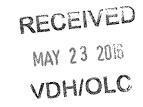
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING		ŀ	04/2	1/2016
	PROVIDER OR SUPPLIER	ARTINSVLLE		STREET ADDRESS, CITY, STATE, ZIP CO 1607 SPRUCE STREET MARTINSVILLE, VA 24112	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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 B	E ATE	(X5) COMPLETION DATE
F 425	the resident's nurs resident's complain pain medication wi stated that the medhours. When the concern that the were administrator, direct of the concern that the were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was no documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator, direct of the medication was not documented were administrator.	O AM, the surveyor interviewed ing unit manager about the nt that nurses will not give her hen she asks for it. The nurse dication was ordered every 4 doctor ordered the higher dose p 7.5-325), she made the prior d she hoped the resident se it. The nurse said the as that she could have a PRN s, but "we try not to give her too ussed withholding ordered pain a director of nursing on 4/21/16 2:15 PM. The narcotic sheets requisition reports sewer doses of scheduled pain dered and documented were resident and that more than were signed out of the PRN esident complained that she did ation when requested. The did to have no mechanism for tion administration records with	F 42	25			
	meeting on 4/21/16	S. RIDORS HAVE FIRMLY	F 46	88			

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 70 of 85



		AND HUMA SERVICES				FORM	05/12/2016 APPROVED
STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATI	0938-0391 E SURVEY PLETED
		495143	B. WING _			04/:	21/2016
NAME OF I	PROVIDER OR SUPPLIER		·	STI	REET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			07 SPRUCE STREET ARTINSVILLE, VA 24112		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 468	Continued From pa The facility must eq secured handrails o	uip corridors with firmly	F 46		Handrail beside the elevator of South unit and handrail outsid room 136 repaired. 100% Audit of all handrails in	e of	6/2/2016
	by: Based on observat	NT is not met as evidenced tion and staff interview, the ensure handrails were firmly inits (South unit).	:		facility checked to ensure ther no loose or cracked handrails. 3. Maintenance Director and Ma Assistant educated on repairin	intenan	ce
	surveyor observed to elevator on the Sou	ed. roximately 3:05 p.m. the that the handrail beside the ith unit was loose and cracked tside of room 136 was loose.		report of the second of the se	loose or cracked handrails in to Maintenance Director/Designed audit handrails once a week x then monthly x 3 months to en are no loose or broken handrai	ee to 4 week sure the	s, ere
	5:05 p.m.	on 04/20/16 at approximately		2	facility. Any broken or loose had will be repaired at that time. 4. Results of audit will be brough	nt to	
	maintenance directe	a.m. the loose and cracked		The state of the s	monthly Quality Assurance Pe Improvement (QAPI) meeting and recommendations implem as indicated.	for rev	
_	provided to the surv conference.	nation regarding this issue was vey team prior to the exit		PRESENTATION AND AND AND AND AND AND AND AND AND AN			
F 502 SS=D	services to meet the	IISTRATION ovide or obtain laboratory e needs of its residents. The e for the quality and timeliness	F 50	2			6/2/2016

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	NO FUR MEDICARE	& MEDICAID SERVICES			C	<u>MB NO</u>	<u>. 0938-</u> 0391	
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495143	B. WING_			04/	21/2016	
NAME OF I	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE			
GO! DEN	I LIVINGCENTER- MA	APTINSVI I E		160	7 SPRUCE STREET			
OCCUPE!	TEITHOOLITIEN AD	WITHOU FILE		MA	ARTINSVILLE, VA 24112			
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F 502	by: Based on staff intereview the facility stordered lab for 2 of and #1. The findings included 1. For Resident #9 was accordered lab for 2 of a physician's order Resident #9 was accordered but not liming failure, hypertension depression, psycholatrial fibrillation, gas arthritis and cataract The most recent MI coded the Resident cognitive patterns. Resident #9's clinical ordered dated 03/02 C/S (urinalysis with surveyor could not be surveyor could not be test in the clinical remanager if she could and she could not. The concern of the brought to the attenduring a meeting or 1705. No further informatical for the concern of the brought to the attenduring a meeting or 1705.	erview and clinical record taff failed to obtain a physician 24 Residents, Resident's #9 led: the facility staff failed to obtain urinalysis. Imitted to the facility on nitted on 12/12/15. Diagnoses lited to congestive heart in, dementia, anxiety, stroesophageal reflux disease, ets. DS with an ARD of 03/09/16 as 9 out of 15 in Section C, This is a quarterly MDS. all record was reviewed on ed a signed physician's 2/16 which read in part "U/A c culture and sensitivity)". The locate the results of this lab ecord. Surveyor asked the unit lid locate the results of the test missing lab results was ation of the administrative staff in 04/20/16 at approximately on was provided prior to exit.	F 50		 Resident #9's urine was not of as ordered. Resident's MD maware of missed lab. There was new orders. 100% audit resident's lab orded the last 3 months conducted. audit of all residents labs for last 3 months completed to enabs were collected as ordered Licensed Nurses educated on ensuring labs ordered by the are placed on the the lab requito be drawn. Lab audits to be conducted by designee once a week x 4 we then monthly x 3. Results of audit will be broug Quality Assurance Performant Improvement (QAPI) meeting review and recommendations implemented as indicated. 	lers for 100% the nsure d. n physici phisitions beks, eks, eght to nce ng for	an	
		04/20/16 at approximately	!					
:	1705.	,						
:		on was provided prior to exit. the facility staff failed to		,			:	

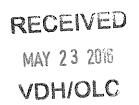
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obtain the lab tests CBC (complete blood count),

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 72 of 85



PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMAN **ERVICES** 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 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE MARTINSVILLE, VA 24112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION DATE 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 DEFICIENCY) F 502 Continued From page 72 F 502 CMP (comprehensive metabolic panel), and ESR (erythrocyte sedimentation rate). Resident #1 was admitted to the facility 10/19/13. Diagnoses included, but were not limited to. history of urinary tract infections, hyperkalemia. chronic pain, osteoarthritis, cerebrovascular disease, and anxiety disorder. Section C (cognitive patterns) of the Resident significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/22/15 scored the Resident 12 out of a possible 15 points indicating the Resident was cognitively intact. The clinical record included a physicians order dated 03/22/16 for a CBC, CMP, and ESR on 03/23/2016. During the clinical record review the surveyor was unable to locate any results for these lab tests. On 04/20/16 at 10:10 a.m. the surveyor asked RN (registered nurse) #1 about the missing lab results. On 04/20/16 at 10:55 a.m. RN #1 verbalized to the surveyor that the lab tests had not been completed, the physician had been notified, and the labs would be obtained today. This information was shared with the administrative team on 04/20/16 at approximately 5:05 p.m.

conference.

No additional information regarding this issue was provided to the survey team prior to the exit

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN			(X3) DATE SURVEY COMPLETED			
		495143	B. WING			04	/21/2016
	PROVIDER OR SUPPLIER N LIVINGCENTER- MA			1607	EET ADDRESS, CITY, STATE, ZIP CODE SPRUCE STREET RTINSVILLE, VA 24112	<u> </u>	2112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 508	other diagnostic seresidents. The facing quality and timeline the property of	rovide or obtain radiology and ervices to meet the needs of its ility is responsible for the ess of the services. NT is not met as evidenced erview and clinical record radiology test in the sample survey, ded: e facility staff failed to obtain a CT of the head ordered on 67 year old female who was on 9/22/15 and readmitted on g diagnoses included, but were entia without behaviors, ar, affective mood disorder,	F 508	 2. 3. 	Resident #7 CT failed to be conducted timely. Copy place medical record. Resident's Medical record. Resident's Medical record timely. Resident CT scan, no concerns identify 100% audit of residents in the months completed to ensure ordered by MD were completed in the medical chart. Scheduler educated to notify when delays in scheduling of diagnostics occur. Audit to be conducted by DN designee weekly x 4 weeks, to monthly x 3 months to ensure ordered were completed and in the medical record. Results of audit will be brough monthly Quality Assurance F	MD ng CT nt receiving ied. e last 3 diagnosted and ED/DN S IS or then e diagnosted placed	stics I NS ostics
	Reference Date (AF staff coded that Resident coded that Resident limited assistance (X Living (ADL). On April 19, 2016 at reviewed Resident for the clinical record	RD) of 2/22/16. The facility sident #7 had a Cognitive 13. The facility staff also at #7 required set up (0/1) to (2/2) with Activities of Daily at 3:15 p.m. the surveyor #7 's clinical record. Review d produced a physician order the head dated 2/22/16.		AND THE STATE OF T	Improvement (QAPI) meetin and recommendations impler as indicated.	_	

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Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 74 of 85



	TMENT OF HEALTH	AND HUM SERVICES				FORM	: 05/12/2016 I APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495143	B. WING			04/	/21/2016
NAME OF F	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			607 SPRUCE STREET ARTINSVILLE, VA 24112		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 508	Continued From pa	ige 74	F 5	508			,
		of the clinical record failed to		,00			
		of the physician ordered CT					
	of the head.	or the projection.					
	On April 20, 2016 at	t 8:15 a.m. the surveyor					
	notified the Unit Ma	nager (UM), who was a					
		that Resident #7 had a	:	:			
		a CT of the head dated		1			,
:		eyor reviewed the clinical	:				ļ
		. The surveyor pointed out the					
		e CT of the head. The		:			
		eviewed the clinical record in he results of the CT of the					
:		s unable to locate the results of		1			:
		ed head CT. The UM stated	AMBRITAN AND AND AND AND AND AND AND AND AND A				
		ck with the facility Scheduler to					
		head had been done as					
:	ordered by the phys	-		;			
	Within a few minute	es the UM and facility					
		hed the surveyor. The					
		livered several documents and			·		
		faxed to the radiology vender		:			
:		to obtain a CT of the head.		:			
		ed that she never heard back					
	from the radiology v						
		t 5:05 p.m. the survey team istrator (Adm), Director of					
		sistant Director of Nursing		1			
		Compliance Nurse (CCN)		!			
		ident (AVP). The surveyor					
		strative Team (AT) that	Tarket and the same of the sam	İ			
		physician order to obtain a CT	C TO THE CONTRACT OF THE CONTR				:
:		1/16. The surveyor notified the					;
		ne head was not obtained as	Trada to We				1
	ordered by the phys						
		nation was provided prior to	r. Commen				: {
!		s to why the facility staff failed ian ordered CT of the head for	MAN BRANCH VACURATION I Dec				

Resident #7.

DEPARTMENT OF HEALTH AND HUMA SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495143	B. WING		04/21/2016
	PROVIDER OR SUPPLIER I LIVINGCENTER- MA		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1607 SPRUCE STREET MARTINSVILLE, VA 24112	1 04/2/1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 513	The facility must file record signed and cother diagnostic ser This REQUIREMENT by: Based on staff intereview, it was deterfailed to ensure that ordered radiology to clinical record for 1 survey, Resident #7 The Findings Include For Resident #7 the that the results of a the head obtained of the clinical record. Resident #7 was a coriginally admitted to: demethypokalemia, Bipola anxiety, hypertensic The most current Massessment located Quarterly MDS assered Counterly MDS assered C	RAY/DIAGNOSTIC REPORT //DATED e in the resident's clinical dated reports of x-ray and rvices. AT is not met as evidenced rview and clinical record mine that the facility staff to the results of a physician est was contained in the of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 24 Residents in the sample of 37 year old female who was on 9/22/15 and readmitted on a diagnoses included, but were intia without behaviors, ar, affective mood disorder,	F 513	F 513 This deficiency has been corrected. 1. Resident #7's CT scan obtain and placed in resident's med record. MD made aware of delay in obtaining the CT sc ordered timely. 2. 100% audit of the past 3 more completed of current resident ensure diagnostics ordered we completed and placed in the medical chart. 3. Audit to be conducted by DI designee to occur weekly x 4 then monthly x 3 months to diagnostics ordered were contained and placed in the medical restimely. 4. Results of audit will be broughted and recomment (QAPI) meeting and recommendations implemas indicated.	ned ical the an inths its to vere NS/ 4 weeks, ensure impleted cords ght to Performance g for review
		produced a physician order			i

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			E SURVEY MPLETED				
		495143	B. WING			04.	/21/2016
NAME OF I	PROVIDER OR SUPPLIER		1	ŞTR	EET ADDRESS, CITY, STATE, ZIP CODE		
COLDEN	I I IVINICACINTED MA	DTIMOVA I F		160	7 SPRUCE STREET		
GULDEN	I LIVINGCENTER- MA	ARTIMSVLLE .		MA	RTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 513	Continued From pa	age 76	F 5	13			
	to obtain a CT of th	e head on 4/11/16.					•
		of the clinical record failed to					
		of the physician ordered CT	1				
	of the head.	,					:
		it 8:15 a.m. the surveyor	İ	i			
		anager (UM), who was a	-				:
		that Resident #7 had a					:
		obtain a CT of the head dated					
	on 4/11/16. The sui	veyor notified the UM that the					
	results of the physic	cian ordered CT scan of the		1			
	head could not be I	ocated in the clinical record.					i
	The surveyor review	wed the clinical record with the					
,		pointed out the specific order	1				
		the head dated 4/11/16. The					
		ontinued to review of the					
		e UM was unable to locate the					1
		cian ordered Ct of the head for					İ
:		tated that she knew the CT of					:
		done. The UM stated she					:
	would see what she						
		es the UM approached the					
:		delivered the results of the		:			
		CT of the head obtained on		}			1
		yor asked were the UM had		Ì			
		The UM stated the radiology		1			
3		he results over to her.		1			
		t 5:05 p.m. the survey team		1			
		istrator (Adm), Director of sistant Director of Nursing		-			
,		Compliance Nurse (CCN)		\$ }			
1		ident (AVP). The surveyor					•
5		strative Team (AT) that			•		
		physician order to obtain a CT		1			:
		/16. The surveyor notified the	1	:			±
		of the physician ordered CT of					
		contained in the clinical record.					
1		ed the AT that the UM had		\$			
	-	logy vender and the vender		1			:
	had faxed the resul		1	:			·

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 77 of 85 RECEIVED

MAY 23 2016

PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUM SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICARD 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 _ 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE MARTINSVILLE, VA 24112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 513 | Continued From page 77 F 513 No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that the results of the physician ordered CT of the head obtained on 4/11/16 was contained in the clinical record for Resident #7. F 514 483.75(I)(1) RES F 514 F 514 This deficiency has been 6/2/2016 SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIB corrected. Resident #15's medical record The facility must maintain clinical records on each corrected. Resident #16 had self resident in accordance with accepted professional administration assessment completed standards and practices that are complete: accurately documented; readily accessible; and 4/20/2016. Resident #17 has had systematically organized. an up to date pain assessment and plan of care was reviewed and The clinical record must contain sufficient information to identify the resident; a record of the revised as indicated. resident's assessments; the plan of care and 2. All nursing staff educated services provided; the results of any preadmission screening conducted by the State: on putting the correct resident's and progress notes. information in resident's medical records. All residents on a pain This REQUIREMENT is not met as evidenced management program will have an by: up to date pain assessment and plan Based on staff interview and clinical record review, it was determined that the facility staff of care will be reviewed and revised failed to ensure a complete and accurate clinical as indicated. All PRN Narcotic record for 4 of 24 Residents in the sample survey. Resident #15, Resident #16, Resident #17 and administration in the last 30 days Resident #18. will be reconciled to the Medication The Findings Included: For Resident #15 the facility staff had Administration record and identified

Sheet's in the record.

co-mingled another residents Physician Order

Resident #15 was a 72 year old female who was admitted on 7/24/14. Admitting diagnoses included, but were not limited to: pneumonia.

concerns will be addressed as indicated.

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICAR	E & MEDICAN SERVICES				MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495143	B. WING			04/21/2016
NAME OF PROVIDER OR SUPPLIEF		·*	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	0.72172010
GOLDEN LIVINGCENTER- M	ARTINSVLLE			507 SPRUCE STREET	
			M	ARTINSVILLE, VA 24112	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE COMPLETION
degeneration, hea hypothyroidism, mand Schizophrenia The most current assessment locate Quarterly MDS as Reference Date (Astaff coded that Reside assistance (3/2) to Activities of Daily I On April 21, 2016 reviewed Resident of the clinical reco Order Sheets (PO was admitted on 1 included, but were enlarged prostate, diabetes mellitus a On April 21, 2016 notified the Unit M Registered Nurse POS's were co-mi record. The surve with the UM. The residents POS's in On April 22, 2016 met with the Admin Nursing (DON). T Administrative Tea POS's were locate record. No additional infor exiting the facility a	na, cataract vitreous rt failure, Bipolar, hypertension, orbid obesity, kidney failure dinimum Data Set (MDS) rd in the clinical record was a ressment with an Assessment rRD) of 3/18/16. The facility resident #15 had a Cognitive rf 15. The facility staff also rt #15 required extensive rtotal nursing care (4/2) with riving (ADL). reat 9:10 a.m. the surveyor rf 15's clinical record. Review rd produced the Physician resident who real produced the Physician resident who real produced the pain, real produced to: leg pain, real produced,	F 5		100% audit of all rooms cond 4/20/2016 to ensure no other have medications present in the without an MD order and a sea administration assessment con 100% audit of all residents where ability to self administer medical completed and care plans upded accordingly. 100% audit of emedical record in the facility to ensure there was no comministration in any resident's record. 3. Medical records completed in with Nursing Staff, Therapy I and Department Heads regard filing order in Medical record DNS/Designee will provide the Nurses with education regard Management Guidelines, Medical record Guidelines, Medical record Guidelines, and documentation. DNS/Designeresidents with pain management in clinical start-up and identification will do a weekly random audit administrations and the requirement of the requi	residents heir room off- mpleted. ith the ications ated ach completed ngled medical service Department, ling the proper s. he Licensed ing the Pain dication and required be will review eent needs daily ied concerns l. DNS/Designee t of 10 narcotic

for Resident #15.

2. For Resident #16, facility staff failed to

including review of the pain management

DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICARE SERVICES

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICATO SERVICES			Section of the sectio	OMB NO. 0938-03	91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	-
		495143	B. WING			04/21/2016	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE			607 SPRUCE STREET MARTINSVILLE, VA 24112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTIC)N
F 514	medication. Resident#16 was as 3/14/13 with diagnor failure, lichen scleron neuropathy, and paresident was assess psychosis, or behavior the Brief Intervie Quarterly Minimum 2/5/16. During medication psychosis, or behavior the Brief Intervie Quarterly Minimum 2/5/16. During medication psychosis enter Resider morning medication ordered was DuoNe application inhale or respiratory failure, grawake. When the swith the medication the nebulizer to self-treatment. She state could wait for the reso she used one of room. The surveyor when she used one said she did not. The was unaware that the treatments available. The resident's composed free initiated 4/1/15 was as a self-medication and (date initiated 4/1/15).	ge 79 self-administration of dmitted to the facility on ses including respiratory sis atrophius, peripheral ranoid schizophrenia. The sed without signs of delirium, rior issues and scored 15/15 w for Mental Status on the Data Set assessment dated pass observation on 4/20/16 at ror observed the medication at #16's room to administer one of the medications be solution 0.5-2.5 mg/3 ML 1 rally every 4 hours related to ive every 4 hours while surveyor entered the room nurse, the resident was using administer a nebulizer ed that she didn't feel she gularly scheduled treatment, the treatments she kept in her asked if she told nursing staff of those treatments. She we medication nurse said she we resident had nebulizer of for self-administration. Orehensive care plan included anistration- combivent inhaler of administration of nebulizer fadministration of nebulizer	F	514	program. New admissions for the ability to self adminimedications. DNS/designeer rooms a week x 4 weeks, the 3 months to ensure medicate beside without orders and seadministration assessment. In clinical start up, DNS or review orders for self-adminimed are plan will be initiated. 4. Results of audit will be bromonthly Quality Assurance Improvement (QAPI) meet review and recommendation implemented as indicated.	ster will audit 10 en monthly x ions are not left at elf- Each morning designee to nistration and ught to Performance ing for	

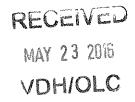
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The surveyor reported the concern to the director

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 80 of 85



		AND HUM SERVICES & MEDICAL SERVICES			FOR	D: 05/12/2016 M APPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DA	TE SURVEY
		495143	B. WING _		04	1/21/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	······································	
GOLDEN	LIVINGCENTER- MA	RTINSVLLE		1607 SPRUCE STREET MARTINSVILLE, VA 24112		
(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 APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	-	F 51	14		
	The DON reported	6 during a summary meeting. on 4/21/16 that the resident for self-administration of				
	nebulizer treatment	s and determined that, after at it was safe for the resident				
		ne medication, but that the		:		:
	resident had returned declined to do so at	ed her supply of DuoNebs and that time.				:
		nistrator were notified that this ncern at a summary meeting				
		, staff failed to document the cations ordered to prevent or				
; ; ;	10/14/15 with diagn disease, hypertensi					
:	hypotension, renal fa	allure, metabolic v back pain, and hip pain. On :				
:	the admission minir	num data set (MDS)		•		:
		10/21/15, the resident scored sessment for mental status				
	and was assessed	as without signs of delirium,				•
		vior disorder. The resident aving frequent pain at a level 8	Total additional and the second			
:	During a family inte	rview on 4/21/16, the				:
		ted that the pharmacy				į
:		ng for pain medication which treceiving. The resident		•		:

stated that she frequently asked for pain medication and was told she could not have pain

medication because she had medication scheduled every 4 hours. The resident's son showed the surveyor the resident's pharmacy bill

		AND HUMAN FRVICES & MEDICAID FRVICES			(I C	FORM): 05/12/2016 1APPROVED): 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTIO	N N	(X3) DA	TE SURVEY MPLETED
		495143	B. WING			04	/21/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS	S, CITY, STATE, ZIP CO		/Z 1/ZV 1U
GOLDEN	I LIVINGCENTER- MA	RTINSVLLE	1	1607 SPRUCE ST MARTINSVILLE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	IDER'S PLAN OF CORF ORRECTIVE ACTION S FERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 81	F 514	† ·			
		e resident had been billed for					1
		he Resident's son reported	•	•			:
		rder had been changed to		\$ •			:
	Norco 7.5/325 early	in the month.	•	:			
	Clinical record revis	w of the medication		•			:
		rds for March and April 2016	:				:
	revealed the reside	of received		•			
		minophen 5-325 (Norco) 4					1
		n 1 through March 17 (17 X 4					:
	= 68 pills), then cha						
		minophen 7.5-325 4 times per	\$				
		gh March 31 (14 X 4 = 56					
	pills). The March M.			:			
:	hydrocodone -aceta	minophen 5-325 as needed	37				1
1	for pain, ordered 1/2	16/16 was not administered in					
	March 2016. The A	pril 2016 MAR indicated the					:
:	resident received so						•
		minophen 7.5-325 4 times per	-				
		the surveyor's review on					:
	4/21/16. The April N	MAR indicated the resident					:
	received hydrocodo	ne-acetaminophen 7.5-325 on					
		14/16 at 6:20 AM. The					
	surveyor requested	the narcotic sign out logs fro					1
	the resident for Man	ch and April 2016. Facility					•
	staff provided only of hydrocodone-apap						:
	hydrocodone-apap (
1		minophen 7.5-325, the sheet					•
		ough 4/20/16. For those					:
i .		heet indicated medication					v
1	was signed out for the			:			
8	4/15 8:30 AM, 1 I			· :			
:	•	PM, 5 PM, 9 PM		• •			<i>i</i> 1
		· · · · · · · · · · · · · · · · · · ·					1

9 AM, 1 PM, 5 PM, 9 PM

The Controlled Substance Accountability sheet

9 AM, 1 PM, 18:30 PM 8 AM, 1 PM, 5 PM, 8 PM 8 AM, 12 PM

4/16 4/17

4/18

4/19 4/20

DEPARTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDICARY SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

PRINTED: 05/12/2016 FORM APPROVED OMB NO. 0938-0391

OF CORRECTION	IDENTIFICATION NUMBER:	i''	ING		DATE SURVEY COMPLETED
	495143	B. WING			04/21/2016
PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C 1607 SPRUCE STREET MARTINSVILLE, VA 24112		NAME OF STREET
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
medication with the at approximately 12 and Alixa machine documenting that for medication than ordinary signed out for the redocumented given supply, while the renot receive medical pharmacy appearer reconciling medication medication was not documented were readministrator, direct members of the admeeting on 4/21/164. For Resident #18 an allergy to eggs at the POS (physician order for the flu vacant limited to, chroring and Alimited hine and Alixa machine and Al	e director of nursing on 4/21/16 2:15 PM. The narcotic sheets requisition reports fewer doses of scheduled pain rdered and documented were resident and that more than were signed out of the PRN esident complained that she did ation when requested. The ed to have no mechanism for ation administration records with d. the resident's reports of pain dressed and the resident's pain at properly controlled or reported to the facility ctor of nursing, and other fiministrative staff at a summary d. 8, the clinical record included and the flu vaccine. However, an order summary) included an occine. most recently admitted to the lagnoses included, but were nic lymphoid leukemia,	The second state of the se	14		
Section C (cognitive significant change is set) assessment with reference date) of C 15 out of a possible treatments, proceduced to indicate the flu vaccine in the fa	re patterns) of the Residents in status MDS (minimum data ith an ARD (assessment 09/18/15 scored the Resident e 15 points. Section O (special jures, and programs) was ne Resident did not receive the acility as they were not	THE THE THE THE THE THE THE THE THE THE			
N	Continued From particular departments of the admeeting on 4/21/16 4. For Resident #18 an allergy to eggs a the POS (physician order for the flu vaccine) assessment wireference date) of 0 15 out of a possible treatments, procedicoded to indicate the flu vaccine in the fate of the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccine in the flu vaccin	A95143 PROVIDER OR SUPPLIER I LIVINGCENTER- MARTINSVLLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 83 medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did not receive medication when requested. The pharmacy appeared to have no mechanism for	PROVIDER OR SUPPLIER I LIVINGCENTER- MARTINSVLLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 83 medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident and that more than documented given were signed out of the PRN supply, while the resident complained that she did not receive medication when requested. The pharmacy appeared to have no mechanism for reconciling medication administration records with the supply on hand. The concern that the resident's reports of pain were not being addressed and the resident's pain medication was not properly controlled or documented were reported to the facility administrator, director of nursing, and other members of the administrative staff at a summary meeting on 4/21/16. 4. For Resident #18, the clinical record included an allergy to eggs and the flu vaccine. However, the POS (physician order summary) included an order for the flu vaccine. Resident #18 was most recently admitted to the facility 12/11/12. Diagnoses included, but were not limited to, chronic lymphoid leukemia, shortness of breath, pain, and constipation. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/15 scored the Resident 15 out of a possible 15 points. Section O (special treatments, procedures, and programs) was coded to indicate the Resident did not receive the flu vaccine in the facility as they were not	## STREET ADDRESS, CITY, STATE, ZIP C ## LIVINGCENTER- MARTINSVLLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 83 Page 20	PROVIDER OR SUPPLIER INTROCENTER- MARTINSVILE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LISC IDENTIFYING INFORMATION) Continued From page 83 medication with the director of nursing on 4/21/16 at approximately 12:15 PM. The narcotic sheets and Alixa machine requisition reports documenting that fewer doses of scheduled pain medication than ordered and documented were signed out for the resident complained that she did not receive medication when requested. The pharmacy appeared to have no mechanism for reconciling medication administration records with the supply on hand. The concern that the resident's reports of pain were not being addressed and the resident's pain medication was not properly controlled or documented were reported to the facility administrator, director of nursing, and other members of the administrative staff at a summary meeting on 4/21/16. 4. For Resident #18, the clinical record included an allergy to eggs and the flu vaccine. However, the POS (physician order summary) included an order for the flu vaccine. Resident #18 was most recently admitted to the facility 1/21/11/12. Diagnoses included, but were not limited to, chronic lymphoid leukemia, shortness of breath, pain, and constipation. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/15 scored the Resident significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/15 scored the Resident significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/15 scored the Resident significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/18/15 scored the Resident to the facility as they were not

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Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 84 of 85



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PRINTED: 05/12/2016 DEPARTMENT OF HEALTH AND HUMAN FORM APPROVED CENTERS FOR MEDICARE & MEDICAID JERVICES 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 _ 495143 B. WING 04/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1607 SPRUCE STREET GOLDEN LIVINGCENTER- MARTINSVLLE MARTINSVILLE, VA 24112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 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 DATE DEFICIENCY) F 514 Continued From page 84 F 514 The front cover of Resident #18's clinical record included the Resident allergies. These included the flu vaccine and eggs. The face sheet in the clinical record also included the allergies eggs and influenza vaccine. The current physician orders included the order "Annual Influenza vaccine q. (every) October... " The order date was documented as 10/06/15. The surveyor was unable to find evidence in the clinical record that the Resident had actually received the flu vaccine. The administrator and DON (director of nursing) were notified of the conflicting information regarding the Residents allergy status on 04/21/16 at 11:55 a.m. the DON verbalized to the survey team that she would take care of it. No further information regarding this issue was provided to the survey team prior to the exit conference.

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

Event ID: RZRX11

Facility ID: VA0159

If continuation sheet Page 85 of 85



MAY 23 2016

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

TITLE

(X6) DATE

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	care planning. 12 VAC 5-371-250 (Reference to F-272 12 VAC 5-371-200. care planning. 12 VAC 5-371-200 (F-281 12 VAC 5-371-220 (to F-309. 12 VAC 5-371-220 (to F-312. 12 VAC 5-371-370 (12 VAC 5-371-370 (Resident assessment (B-1) Cross Reference Quality of Care. (A THRU G) Cross re	ent and note to reference ent. to F-323.				
	12 VAC 5-371-220. (12 VAC 5-371-220 (Quality of Care. (B) Cross reference to	to F-329.				
	Program	Dietary and Food Ser Cross Reference to F					
	12 VAC 5-371-240. F 12 VAC 5-371-240 (I	Physician Services. E) Cross reference to	to F-386.				
	12 VAC 5-371-300. F 12 VAC 5-371-300 (A	Pharmacy Services. A,C,G) Cross referer	nce to				

STATE FORM

F-425.

12 VAC 5-371-310. Administration.

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

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	12 VAC 5-371-310. 12 VAC 5-371-310 (Administration. (A) Cross reference	to F-508.					
	12 VAC 5-371-360. 12 VAC 5-371-360 (Clinical Records (E) Cross reference	to F513					
	12 VAC 5-371-360. 12 VAC 5-371-360 (F-514	Clinical Records (A,E,f,j) Cross Refere	ence to					

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MAY 23 2016