#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/20/2017 FORM APPROVED

CENT	ERS FUR MEDICARE &	WEDICAID SERVICES			OND 140. 0330-0391	
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	B. WING		C 12/08/2017	
NAME OF	F PROVIDER OR SUPPLIER	7002-70		STREET ADDRESS, CITY, STATE, ZIP CODE	12/00/2017	
NAME O	F PROVIDER OR SUFFLIER			1 DAIRY LANE		
WOOD	MONT CENTER		1	REDERICKSBURG, VA 22405		
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E 00	00 Initial Comments	·	E 000			
	survey was conducte 12/08/17. Correction compliance with 42 C Requirement for Long complaint was investi	s are required for FR Part 483.73, g-Term Care Facilities. One igated during the survey.	F 045			
E 01	· ·		E 015	1. No residents were affected.		
SS=	CFR(s): 483.73(b)(1)			2 All residents have the notant	ial ta ha	
	develop and impleme policies and procedur plan set forth in paragand the communication this section. The policies address the following  (1) The provision of sand patients whether place, include, but are (i) Food, water, medical supplies (ii) Alternate sources following:  (A) Temperatures is safety and for the safery place, light provisions.  (B) Emergency light	tubsistence needs for staff they evacuate or shelter in e not limited to the following: cal and pharmaceutical of energy to maintain the to protect patient health and fe and sanitary storage of nting. extinguishing, and alarm		<ol> <li>All residents have the potent affected.</li> <li>A provision of subsistence not for staff and residents will be incorporated into the facility Emergency Preparedness Plate (EPP) by the Center Executive Director/designee to include water, medical/pharmaceutic supplies, alternate sources of energy, fire detection, extinguishing, alarm systems sewage and waste disposal. Executive Director/designee then communicate this inform to all facility staff as part of the emergency-preparedness trait.</li> <li>Center Executive Director withis information from the EP monthly QAPI Committee me for education</li> </ol>	eeds c c c c s n ve food, al c center will nation the ning. ill share P at the	
		ce at §418.113(b)(6)(iii):]				
ABODATO	DV DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITLE	(X6) DATE	

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

program participation.

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DEPARTME	ENT OF HEALTH AND HU	JM ERVICES
CENTERS	FOR MEDICARE & MEDI	CAID SERVICES

PRINTED: 12/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495246		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING		С		
NAME OF PROVIDER OR SUPPLIER	700270	D. TIMO			/08/2017	
WOODMONT CENTER			STREET ADDRESS, CITY, STATE, 11 DAIRY LANE FREDERICKSBURG, VA 22			
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hospice-operated inport The policies and proof following:  (iii) The provision of some proper and provision of some provision of some provision of some provisions.  (B) Alternate source following:  (1) Temperatures and safety and for the of provisions.  (2) Emergency light (3) Fire detection systems.  (C) Sewage and was This REQUIREMENT by:  Based on staff intervier review it was determined failed to have a complet preparedness plan.  The facility staff failed to procedures for the provincluding but not limited pharmaceutical supplies to provide for sewage at The findings include:  On 12/01/17 at 10:00 a. of the facility's emergenconducted with OSM (of director of maintenance.	additional requirements for atient care facilities only. Redures must address the subsistence needs for and patients, whether they place, include, but are not greatical, and pharmaceutical as of energy to maintain the sto protect patient health safe and sanitary storage sphting.  In extinguishing, and alarm aste disposal.  It is not met as evidenced as and facility document and that the facility staff are emergency  of develop policies and rision of substance needs at to, food, water, and as for patients and staff and and waste disposal.  The energy of the protect patient health safe and staff and and waste disposal.  The energy of the protect patients and staff and and waste disposal.  The energy of the protect patients and staff and and waste disposal.	EC	and review pu review twice a determine con	tinued completeness sharing results with		

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HOMAN SERVICES			OMB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
IND PLAN OF CORRECTION	,	A. BUILDING		С
	495246	B. WING		12/08/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

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	PROVIDER OR SUPPLIER  ONT CENTER	700570		11 DAI	T ADDRESS, CITY, STATE, ZIP CODE RY LANE		
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E 018 SS=C	policies and proced substance needs in food, water, and phresidents and staff waste disposal. Os did not have it.  On 12/06/17 at app (administrative staff director and procedures and procedures and procedures and the communicative staff director (a) A system to tractor and sheltered patient and sheltere	ures for the provision of cluding but not limited to, armaceutical supplies for and to provide for sewage and M # 1 stated that the facility roximately 5:00 p.m. ASM member) # 1, the executive tor), ASM # 2, interim director # 3, clinical quality specialist, of the findings.  on was obtained prior to exit. Exing of Staff and Patients (2)  occdures. The [facilities] must ment emergency preparedness ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, vition plan at paragraph (c) of licies and procedures must be ed at least annually.] At a ees and procedures must		18 1. 2. 3.	No residents were affected.  All residents have the potential be affected.  A system to track the special location of on-duty staff and sheltered residents during a emergency situation will be incorporated into the facility Emergency Preparedness Place (EPP) by the Center Execution Director/designee. Center Executive Director/designee then communicate this infort to all facility staff as part of emergency-preparedness trace Center Executive Director visions information from EPP at the monthly QAPI Committee meeting for education.	ntial to fic d n y's lan ive e will rmation f the aining. will the	

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Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 3 of 348

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	RIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED C	
		495246	B. WING		12/08/2017
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	:
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
locati the [F and a shelfe emer must the re  *[For Polici (ii) Sa includ needs transp locati comm assist (v) A s emple hospi on-du reloca must the re  *[For proce which treatm respoi evacu means assist  *[For ( procee docum	PRTF's, LTC, Infer an emergered residents gency, the [PF document the eceiving facility Inpatient Hospes and proceduse consideration on the evacuation les consideration; idention(s) and priminunication with ance.  System to track eyees' on-duty ce's care during the document the ceiving facility CMHCs at §48 dures. (2) Safe includes consideration location(s) of communication (s) of communication that pentation that pentatio	staff and sheltered residents in CF/IID or PACE] care during ency. If on-duty staff and are relocated during the RTF's, LTC, ICF/IID or PACE] specific name and location of or other location.	EO	and review purposes, and review twice annually to determine continued com and accuracy, sharing rest the QAPI committee.	pleteness

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Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 4 of 348

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

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PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION NG	(X3) DA <sup>*</sup> COI	(X3) DATE SURVEY COMPLETED	
	495246		B. WING _		C <b>12/08/2017</b>		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405			
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	potential and actual secures and maintal secures and maintal *[For ESRD at § 49-procedures. (2) Saffacility, which including needs of the patient This REQUIREMEN by: Based on staff interreview it was determated to have a compreparedness plan.  The facility staff failed system to document staff.  The findings include On 12/01/17 at 10:00 of the facility's emery conducted with OSM director of maintenatemergency prepared a tracking system to patients and staff. On 12/06/17 at appreciation of the facility staff director (administrative staff director (administrative staff director (administrative of nursing and ASM) were made aware of	donor information, and ains the availability of records.  4.62(b):] Policies and e evacuation from the dialysis less staff responsibilities, and its.  IT is not met as evidenced review and facility document nined that the facility staff inplete emergency.  ed to develop a tracking thocations of patients and interview gency preparedness plan was a footner staff member) # 1, ince. Review of the facility's dness plan failed to evidence document locations of DSM # 1 stated that the facility oximately 5:00 p.m. ASM member) # 1, the executive for), ASM # 2, interim director # 3, clinical quality specialist, the findings.	EO	18			
E 022		n was obtained prior to exit. for Sheltering in Place	E 022	2			

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 5 of 348

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

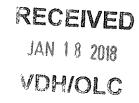
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
<b>495246</b> B. WING	C 12/08/2017
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER  STREET ADDRESS 11 DAIRY LANE FREDERICKSB	CITY, STATE, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C	DER'S PLAN OF CORRECTION (X5) PRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]  (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].  *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:  (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by:  Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan.	sidents were affected.  sidents have the potential to ected.  and procedure will be porated into the facility's gency Preparedness Plan by the Center Executive for/designee, specific to how cility will provide a means later in place for residents, and volunteers who remain facility during an ency. Center Executive for/designee will then unicate this information to fility staff as part of the ed emergency-preparedness fice/training.  Executive Director will his information from the enth monthly QAPI sittee meeting for education wiew purposes, and will twice annually to the continued exteness and accuracy, gresults with the QAPI

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 6 of 348



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

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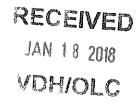
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	495246		B. WING	B. WING			C / <b>08/2017</b>
	PROVIDER OR SUPPLIER			11 DA	T ADDRESS, CITY, STATE, ZIP CODE IRY LANE PERICKSBURG, VA 22405	1	100/2017
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E 022	management.  The findings include On 12/01/17 at 10:0 of the facility's emer conducted with OSM director of maintena emergency prepare policies and procedup rovide a means to staff and volunteers how those policies a with the facility's emmanagement. OSM not have it.  On 12/06/17 at appr (administrative staff director (administrative)	gency preparedness plan was of (other staff member) # 1, ance. Review of the facility's dness plan failed to evidence ures for how the facility will shelter in place for patients, who remain in the facility and and procedures are aligned ergency plan and risk if # 1 stated that the facility did eximately 5:00 p.m. ASM member) # 1, the executive or), ASM # 2, interim director # 3, clinical quality specialist,	E 02	22			
	Policies/Procedures CFR(s): 483.73(b)(5 [(b) Policies and pro- develop and implem policies and procedu- plan set forth in para assessment at paragand the communicat this section. The poli- reviewed and update	cedures. The [facilities] must ent emergency preparedness ires, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of cies and procedures must be ed at least annually. At a s and procedures must	E 02	3 2.	No residents were affected.  All residents have the potent be affected.  A system of medical documentation will be incorporated into the facility Emergency Preparedness Pla (EPP) by the Center Executi Director/designee, a system preserves and protects confidentiality of resident information, and secures and	's an ve that	

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 7 of 348



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

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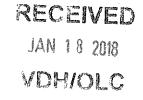
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		495246	B. WING _			08/2017
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405		T
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 023	(5) A system of med preserves patient in confidentiality of pa and maintains avail (3),(4),(6)] A system that preserves paties confidentiality of pa and maintains avail what's in SOM.  *[For RNHCIs at §4 procedures. (5) A system that does the follow (i) Preserves patient (ii) Protects confide (iii) Secures and marecords.  *[For OPOs at §486 procedures. (2) A system that donor information, potential and actual secures and maintath and actual secures and maintath are potential and actual secures and maintath are potential and actual secures and maintath are actual secures actua	dical documentation that information, protects tient information, and secures ability of records. [(5) or in of medical documentation ent information, protects tient information, and secures ability of records. This is  03.748(b):] Policies and ystem of care documentation ing: t information. intiality of patient information. aintains the availability of  6.360(b):] Policies and ystem of medical preserves potential and actual protects confidentiality of donor information, and ins the availability of records. IT is not met as evidenced  rview and facility document inned that the facility staff inplete emergency  ed to develop policies and the facility preserves patient is confidentiality of patient cures and maintains is.	E 02	maintains availability of The Center Executive Director/designee will information in the emer preparedness inservice/all facility staff.  4. Center Executive Direct share this information if EPP at the monthly QA Committee meeting for and review purposes, as review twice annually the determine continued contained accuracy, sharing retained the QAPI committee.	include this rgency- training for the tor will rom the PI education d will o mpleteness	

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Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 8 of 348



DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					RINTED: 12/18/2017 FORM APPROVED MB NO. 0938-0391
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	495246	B. WING	S		C 12/08/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ξ	

NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			
MOODE	ONT CENTER		11 DAIRY LANE			
##OODistore Officer			FREDERICKSBURG, VA 22405			
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E 024 SS=C	On 12/01/17 at 10:00 a.m. a review and interview of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to evidence policies and procedures for how the facility preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. OSM # 1 stated that the facility did not have it.  On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings.  No further information was obtained prior to exit. Policies/Procedures-Volunteers and Staffing	E 024				

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Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 9 of 348

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495246		B. WING		C 12/08/2017		
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(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	LD BE	(X5) COMPLETION DATE
E 024	procedures. (6) The emergency and othe strategies to address emergency. This REQUIREMENT by: Based on staff interreview it was determined to have a compreparedness plan. Facility staff failed to procedures for the ustaffing strategies at The findings include On 12/01/17 at 10:0 of the facility's emerconducted with OSM director of maintena emergency prepared policies and procedured other staffing strategies and staffing str	03.748(b):] Policies and a use of volunteers in an er emergency staffing as surge needs during an a rowiew and facility document a nined that the facility staff aplete emergency and other are in the emergency plan.  1. 0 a.m. a review and interview gency preparedness plan was a full (other staff member) # 1, nce. Review of the facility's dness plan failed to evidence are for the use of volunteers arategies are in the emergency and that the facility did not have commately 5:00 p.m. ASM member) # 1, the executive or), ASM # 2, interim director # 3, clinical quality specialist,	E 03	information in the emerg preparedness training for facility staff.  4. Center Executive Director share this information from EPP at the monthly QAP Committee meeting for eand review purposes, and review twice annually to determine continued command accuracy, sharing rest the QAPI committee.	all or will om the I ducation will pleteness	1/17/18
	Arrangement with O CFR(s): 483.73(b)(7	ther Facilities	E 02	25	meliyay Went yank ki ki asasa dobahaman	

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Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 10 of 348

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L	NAME OF	PROVIDER OR SUPPLIER	100210	13		REET ADDRESS, CITY, STATE, ZIP CODE	12/	08/2017
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		[(b) Policies and prodevelop and implementations are forth in parasessment at policies and updates following address the following address the following address the following address the following facilities at §483.73 (7) [or (5)] The development in the event operations to maintate to facility patients.  *[For PACE at §460.4 §483.475(b), CAHs at §483.475(b), CAHs at §485.920(b) and ESI Policies and procedude development of arrarefacilities] [or] other parasessments to maintait to facility patients.  *[For RNHCIs at §40.5 parasessments with other parasessments with other parasessments with other parasessments at parasessments with other parasessments with other parasessments with other parasessments and procedures to receive parasessments and procedures are parasessments are parasessments and procedures are parasessments are parasessments and procedures are parasessment	cedures. The [facilities] must hent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must be end at least annually. At a less and procedures must gr.]  18.113(b), PRFTs at last at §482.15(b), and LTC (b):] Policies and procedures. In a long procedures with lother providers to receive of limitations or cessation of in the continuity of services  84(b), ICF/IIDs at last §486.625(b), CMHCs at RD Facilities at §494.62(b):] lares. (7) [or (6), (8)] The langements with other roviders to receive patients ions or cessation of in the continuity of services	E	025	<ol> <li>No residents were affected.</li> <li>All residents have the pote be affected.</li> <li>Documentation will be incorporated into the facility Emergency Preparedness F (EPP) by the Center Execut Director/designee, specific arrangements and/or agreed with other facilities to rece residents during an emerge the event the facility is unat care for them. The Center Executive Director/designed include this information in emergency-preparedness the for all facility staff.</li> <li>Center Executive Director with share this information from EPP at the monthly QAPI Committee meeting for educand review purposes, and we review twice annually to determine continued compliand accuracy, sharing result the QAPI committee.</li> </ol>	ential to  ty's  Plan  tive  to  ments  ive  ency if  ble to  the  aining  will  the  ication  vill  eteness	

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 11 of 348

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495246			1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING		12	C <b>12/08/2017</b>		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 11 DAIRY LANE FREDERICKSBURG, VA 22	ZIP CODE		
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E 025	This REQUIREMENT by: Based on staff intereview it was determined to have a compreparedness plan. The facility staff failed of the arrangements facility has with other in the event the facility has many an emergency. The findings included On 12/01/17 at 10:0 of the facility's emergency prepared documentation of the agreements the facility receive patients in the care for them during that the facility on 12/06/17 at apprepared doministrative staff	rview and facility document mined that the facility staff applete emergency  ed to provide documentation and/or any agreements the er facilities to receive patients lity is not able to care for them by.  10 a.m. a review and interview gency preparedness plan was for (other staff member) # 1, nce. Review of the facility's dness plan failed to evidence e arrangements and/or any lity has with other facilities to be event the facility is not able ing an emergency. OSM # 1 by did not have it.  11 oximately 5:00 p.m. ASM member) # 1, the executive	EO				
	of nursing and ASM were made aware of No further information	n was obtained prior to exit.					
SS=C	CFR(s): 483.73(b)(8) [(b) Policies and prod	cedures. The [facilities] must	E 02	26			
THE PERSON NAMED IN PARTY OF THE PERSON NAMED	develop and impleme	ent emergency preparedness				Wilderstein of managery of	

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 12 of 348

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

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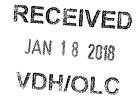
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405		
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	policies and proced plan set forth in para assessment at para and the communicat this section. The poreviewed and updat minimum, the policie address the following (8) [(6), (6)(C)(iv), (7) [facility] under a wait in accordance with secondance with section of care and care site identified be officials.  *[For RNHCIs at §40 procedures. (8) The waiver declared by the with section 1135 of at an alternative care management official This REQUIREMEN by:  Based on staff interreview it was determined to have a compreparedness plan.  The facility staff faile procedures in the enthe facility's role in plat altered care sites of the facility's emergence of the facility	ures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of licies and procedures must be ed at least annually. At a es and procedures must age;  If (a) (b) The role of the ver declared by the Secretary, section 1135 of the Act, in the different at an alternate by emergency management  O3.748(b): Policies and role of the RNHCI under a the Secretary, in accordance Act, in the provision of care as site identified by emergency s.  This not met as evidenced wiew and facility document and that the facility staff plete emergency plan that describe roviding care and treatment under an 1135 waiver.	E 02	<ol> <li>No residents were affected.</li> <li>All residents have the pote be affected.</li> <li>Policy and procedures will incorporated into the facil Emergency Preparedness (EPP) by the Center Exect Director/designee, specific facility's role in providing and treatment at altered caunder an 1135 waiver. The Executive Director/design include this information in emergency-preparedness that for all facility staff.</li> <li>Center Executive Director share this information from EPP at the monthly QAPI Committee meeting for ed and review purposes, and review twice annually to determine continued compand accuracy, sharing resurthe QAPI committee.</li> </ol>	l be ity's Plan utive to the care re sites e Center ee will a the raining will n the ucation will leteness	1/17/18

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 13 of 348



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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE
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	director of maintena emergency prepare policies and proced that describe the fact and treatment at altwaiver. OSM # 1 st have it.  On 12/06/17 at appr (administrative staff director (administrative staff (amergency prepared that complies with Franch must be reviewed annually.] The commall of the following:  (3) Primary and alter communicating with (i) [Facility] staff.  (ii) Federal, State, tri emergency manager  *[For ICF/IIDs at §48 alternate means for of ICF/IID's staff, Feder local emergency manager This REQUIREMENT by:	ance. Review of the facility's dness plan failed to evidence ures in the emergency plan cility's role in providing care ered care sites under an 1135 ated that the facility did not example or an example of the facility did not example or an	E 032		e potential to  pe facility's ness Plan Executive ecific to means for facility staff, and local ent agencies situation.  I include this ergency-

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 14 of 348



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

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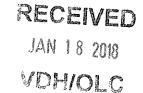
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
495246		B. WING		1	C 12/08/2017	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
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E 033 SS=C	failed to have a compreparedness plan.  The facility staff failed documentation that includes primary an communicating with tribal, and local emagencies by reviewing The findings included On 12/01/17 at 10:00 of the facility's emer conducted with OSM director of maintena emergency prepare of documentation the includes primary and communicating with tribal, and local emeagencies by reviewing OSM # 1 stated that On 12/06/17 at appreciation (administrative staff director (administrative staff director (administrative staff director (administrative staff director (staff d	ed to provide evidence of the communication plan d alternate means for a facility staff, Federal, State, ergency management ing the communication plan.  100 a.m. a review and interview regency preparedness plan was of (other staff member) # 1, ance. Review of the facility's dness plan failed to evidence the communication plan d alternate means for a facility staff, Federal, State, ergency management ing the communication plan. It the facility did not have it.  11 coximately 5:00 p.m. ASM member) # 1, the executive for), ASM # 2, interim director # 3, clinical quality specialist, for the findings.	E 03	share this information from EPP at the monthly QAPI Committee meeting for ed and review purposes, and review twice annually to determine continued comp and accuracy, sharing resurthe QAPI committee.	n the ucation will leteness	1/17/18

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 15 of 348



#### DEPARTMENT OF HEALTH AND JAN SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	TIPLE CONSTRUCTION NG	(>	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZO 11 DAIRY LANE FREDERICKSBURG, VA 224				
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E 033	and must be review annually.] The con all of the following:  (4) A method for sh documentation for care, as necessary maintain the contin  (5) A means, in the release patient info CFR 164.510(b)(1) required for HHAs runder §485.68(c), a §491.12(c).]  (6) [(4) or (5)]A meanumentary about the general condition and representative.  *[For RNHCIs at §4 sharing information patients under the flunder 45 CFR 164.  *[For RNHCIs at §4 sharing information patients under the flunder with care providers care, based on the made by the patient representative.  *[For RHCs/FQHCs of providing information and location and locat	ved and updated at least inmunication plan must include described an aring information and medical patients under the [facility's], with other health providers to uity of care.  event of an evacuation, to rmation as permitted under 45 (ii). [This provision is not under §484.22(c), CORFs and RHCs/FQHCs under  ans of providing information ondition and location of facility's] care as permitted 510(b)(4).  03.748(c):] (4) A method for and care documentation for RNHCl's care, as necessary, to maintain the continuity of written election statement to his or her legal  at §491.12(c):] (4) A means ation about the general on of patients under the mitted under 45 CFR  IT is not met as evidenced review and facility document ained that the facility staff	E 03	33				

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
495246		B. WING	B. WING		C 12/08/2017	
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405		100/2011
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	The facility staff failed documentation that includes a method for medical documentation and facility's care, as new providers to maintain reviewing the commodocumentation that policies and procedute facility will use to to include the general patients by reviewing. The findings include On 12/01/17 at 10:00 of the facility's emergency prepared evidence of documentation plansharing information after patients under the necessary, with othe the continuity of care communication plansfacility has developed that address the mean release patient information communication plansfacility did not have it facility did not have it	ed to provide evidence of the communication plan or sharing information and tion for patients under the cessary, with other health in the continuity of care by unication plan and the facility has developed ures that address the means or release patient information all condition and location of general the the the test of the communication plan.  Communication plan and interview gency preparedness plan was a force. Review of the facility's liness plan failed to provide intation that the includes a method for and medical documentation that the dipolicies and procedures are the facility will use to mation to include the general in of patients by reviewing the OSM # 1 stated that the	EO	33		
(	administrative staff n	eximately 5:00 p.m. ASM nember) # 1, the executive or), ASM # 2, interim director				·

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 17 of 348

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

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405	
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	of nursing and ASA were made aware of the made a	I # 3, clinical quality specialist, of the findings.  ion was obtained prior to exit. upancy/Needs  7)  ust develop and maintain an edness communication plan Federal, State and local laws and updated at least munication plan must include  ans of providing information occupancy, needs, and its sistance, to the authority the Incident Command  64(c)]: (7) A means of an about the ASC's needs, and assistance, to the authority the Incident Command	E 03	1. No residents were affected.	cy's lan tive to a ation to ction,  ancy cutive ide this cy-
	jurisdiction, the Incidesignee. This REQUIREMEN by: Based on staff intel	to the authority having dent Command Center, or IT is not met as evidenced view and facility document nined that the facility staff uplete emergency		EPP at the monthly QAPI Committee meeting for educe and review purposes, and wireview twice annually to determine continued comple and accuracy, sharing results the QAPI committee.	cation ill eteness

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 18 of 348

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495246	B. WING	<b>}</b>		12	C 2/08/2017	
	PROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE REDERICKSBURG, VA 22405	<u> </u>	/00/2011	
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	The facility staff faild documentation that includes a a means about the facility's nassistance, to the aincident Command reviewing the commodocumentation that includes a means of their occupancy.  The findings include On 12/01/17 at 10:0 of the facility's emer conducted with OSM director of maintena emergency prepared evidence of docume communication plan providing information and its ability to provauthority having juris Command Center, occumunication plan communication plan providing information OSM # 1 stated that On 12/06/17 at appreciation of nursing and ASM is a means of the providing information of the providi	led to provide evidence of the communication plan is of providing information needs, and its ability to provide authority having jurisdiction, the Center, or designee by nunication plan and the communication plan if providing information about it.  2:  00 a.m. a review and interview regency preparedness plan was M (other staff member) # 1, ance. Review of the facility's idness plan failed to provide entation that the includes a a means of in about the facility's needs, vide assistance, to the sediction, the incident or designee by reviewing the includes a means of in about their occupancy. It the facility did not have it.  Exercise to the executive or), ASM # 2, interim director # 3, clinical quality specialist,	EO	034				
		on was obtained prior to exit. aring Plan with Patients	E 03	35		NACOLITICA PARTICIPATORI DE PARTICIPATO DE PARTICIP		

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 19 of 348



#### DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING		E SURVEY
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11111		493240	D. WING			08/2017
*	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 2240		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	CFR(s): 483.73(c)(c)  [(c) The [LTC facility and maintain an emcommunication plans State and local laws updated at least an plan must include at (8) A method for she emergency plan, the is appropriate, with families or represent This REQUIREMENT by:  Based on staff interview it was determined to have a compreparedness plan.  The facility staff failed documentation that includes a method for the emergency plandetermined it is appropriate and their families and their families and their families and their families on 12/01/17 at 10:00 of the facility's emergency onducted with OSM director of maintenant.	y and ICF/IID] must develop all and regency preparedness in that complies with Federal, and must be reviewed and mually.] The communication ill of the following:  aring information from the at the facility has determined residents [or clients] and their tatives.  IT is not met as evidenced eview and facility document nined that the facility staff plete emergency  and to provide evidence of the communication plan for sharing information from and that the facility has repriate with residents or illies or representatives by  D. a.m. a review and interview gency preparedness plan was in (other staff member) # 1, noce. Review of the facility's	ΕO		affected.  The potential to the potential to the facility's dness Plan Executive specific to a information residents and resentatives.  The potential to the	
WINTERPOOR TO THE PROPERTY OF	evidence of docume communication plan	includes a method for rom the emergency plan,		determine continued and accuracy, sharing the QAPI committee.	completeness gresults with	1/17/18

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Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 20 of 348

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PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495246 **B. WING** 12/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION iD (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** TAG DEFICIENCY) E 035 | Continued From page 20 E 035 appropriate with residents or clients and their families or representatives by reviewing the plan. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) #1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings.

E 036

(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

No further information was obtained prior to exit.

**EP Training and Testing** 

CFR(s): 483.73(d)

E 036

SS=C

\*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).

1. No residents were affected.

- 2. All residents have the potential to be affected.
- 3. Documentation will be incorporated into the facility's Emergency Preparedness Plan (EPP) by the Center Executive Director/designee, specific to a written training and testing program that meets the requirements of the regulation
- 4. Center Executive Director will ensure that the emergency-preparedness training and testing program has been documented, reviewed, completed for all facility staff, and updated at least annually per regulation, and will share these findings at the monthly QAPI Committee meeting for its review to determine continued compliance.

1/17/18

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED	
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	PROVIDER OR SUPPLIEF	DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE		ZIP CODE	20012011		
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	*[For ESRD Facilit testing, and orientation, and orientation prograr emergency plan se section, risk assess this section, policie (b) of this section, paragraph (c) of the and orientation proupdated at least ar This REQUIREME by:  Based on staff intereview it was deterfailed to have a corpreparedness plan.  The facility staff fair documentation that training and testing requirements of the documentation that program has been least an annual based documentation of the any updates made.  The findings include On 12/01/17 at 10:00 of the facility's emeconducted with OSI director of maintenate emergency prepared evidence of that the	ies at §494.62(d):] Training, ation. The dialysis facility must tain an emergency ning, testing and patient in that is based on the ext forth in paragraph (a) of this isment at paragraph (a)(1) of es and procedures at paragraph and the communication plan at its section. The training, testing ogram must be reviewed and inually.  No is not met as evidenced erview and facility document mined that the facility staff implete emergency  led to provide evidence of the facility has a written it program that meets the eregulation and the training and testing reviewed and updated on, at its by asking for the annual review as well as	E 03	36			

PRINTED: 12/18/2017 **FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING\_ AND PLAN OF CORRECTION C 12/08/2017 **B. WING** 495246 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE FREDERICKSBURG, VA 22405 WOODMONT CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG DEFICIENCY) TAG E 036 Continued From page 22 E 036 of the regulation and documentation that the training and testing program has been reviewed and updated on, at least an annual basis by asking for documentation of the annual review as well as any updates made. OSM # 1 stated that the facility did not have it. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director 1. No residents were affected. of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. 2. All residents have the potential to be affected. No further information was obtained prior to exit. E 037 E 037 | EP Training Program 3. Documentation will be CFR(s): 483.73(d)(1) SS=C incorporated into the facility's (1) Training program. The [facility, except CAHs, Emergency Preparedness Plan AŚCs, PAČE organizations, PRTFs, Hospices, (EPP) by the Center Executive and dialysis facilities] must do all of the following: Director specific to facility staff receiving initial and annual (i) Initial training in emergency preparedness emergency-preparedness training. policies and procedures to all new and existing staff, individuals providing services under Center Executive Director will arrangement, and volunteers, consistent with their oversee all aspects of this training. expected role. (ii) Provide emergency preparedness training at 4. Center Executive Director will ensure that the initial and annual least annually. (iii) Maintain documentation of the training. emergency-preparedness training (iv) Demonstrate staff knowledge of emergency has been implemented and procedures. completed for all facility staff \*[For Hospitals at §482.15(d) and RHCs/FQHCs

at §491.12:] (1) Training program. The [Hospital

or RHC/FQHC] must do all of the following:

(i) Initial training in emergency preparedness

policies and procedures to all new and existing

staff, individuals providing on-site services under

arrangement, and volunteers, consistent with their

compliance.

1/17/18

consistent with regulation, and will

share these findings at the monthly

OAPI Committee meeting for its

review to determine continued

DEPART	MENT OF HEALTH	AND HON SERVICES					APPROVED . 0938-0391
CENTER	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE		
WOODM	ONT CENTER			FF	REDERICKSBURG, VA 22405		~
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E 037	least annually. (iii) Maintain docum (iv) Demonstrate st procedures. This is what's in SC  *[For Hospices at § hospice must do al (i) Initial training in policies and proced hospice employees services under arra expected roles. (ii) Demonstrate sta procedures. (iii) Provide emerge least annually. (iv) Periodically rev emergency prepare employees (includi special emphasis procedures necess others.  *[For PRTFs at §4 program. The PRT (i) Initial training in policies and proces staff, individuals pr arrangement, and expected roles. (ii) After initial train preparedness trair (iii) Demonstrate s procedures.	ncy preparedness training at nentation of the training. taff knowledge of emergency DM but is missing here.		037			

PRINTED: 12/18/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u> </u>	<u>. 0938-0391</u>
STATEMENT AND PLAN (	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	CON	TE SURVEY MPLETED
		495246	B. WING	<u>;                                    </u>		ı	/08/2017
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			1	11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
E 037	organization must of (i) Initial training in a policies and proced staff, individuals programment, contravolunteers, consisted (ii) Provide emerger least annually. (iii) Demonstrate staprocedures, includir what to do, where to case of an emerger (iv) Maintain docum *[For CORFs at §48 CORF must do all of (i) Provide initial traipreparedness polici and existing staff, in under arrangement, with their expected (ii) Provide emerger least annually. (iii) Maintain docum (iv) Demonstrate staprocedures. All new and assigned specifithe CORF's emerge their first workday. Tinclude instruction in alarm systems and a equipment.	ng.  2.84(d):] (1) The PACE lo all of the following: emergency preparedness ures to all new and existing oviding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in ncy. entation of all training.  25.68(d):](1) Training. The aff the following: Ining in emergency es and procedures to all new adividuals providing services and volunteers, consistent roles. Incy preparedness training at entation of the training. aff knowledge of emergency aff personnel must be oriented fic responsibilities regarding ancy plan within 2 weeks of the training program must at the location and use of signals and firefighting  625(d):] (1) Training program.	E	037			

DEPARTMENT OF HEALTH AND HOMAN SERVICES

PRINTED: 12/18/2017

FORM APPROVED

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 11 DAIRY LANE FREDERICKSBURG, VA 224	ZIP CODE	/08/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	(i) Initial training in policies and proced reporting and exting and where necessal personnel, and gue cooperation with fir authorities, to all neindividuals providing and volunteers, convoles.  (ii) Provide emerged least annually.  (iii) Maintain docum (iv) Demonstrate staprocedures.  *[For CMHCs at §44 CMHC must provide preparedness policing and existing staff, in under arrangement, with their expected and existing staff, in under arrangement, with their expected and existing staff, in under arrangement, with their expected and existing staff in the procedures. There are mergency prepared annually. This REQUIREMENT by:  Based on staff interreview it was determined to have a compreparedness plan.  The facility staff failed documentation of the preparedness training or paredness tr	emergency preparedness dures, including prompt guishing of fires, protection, ary, evacuation of patients, ests, fire prevention, and efighting and disaster ew and existing staff, g services under arrangement, esistent with their expected ency preparedness training at entation of the training.  aff knowledge of emergency  85.920(d):] (1) Training. The elinitial training in emergency es and procedures to all new endividuals providing services and volunteers, consistent roles, and maintain ele training. The CMHC must provide dness training at least eleast existenced wiew and facility document alined that the facility staff plete emergency end to provide evidence of eleacility's initial emergency end to provide evidence of eleacility's initial emergency end annual emergency	EC	037		

		AND HUMAN SERVICES				FORM A	12/18/2017 APPROVED 0938-0391
STATEMENT	OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		INSTRUCTION	(X3) DATE COMP	SURVEY
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	PROVIDER OR SUPPLIER  ONT CENTER				ET ADDRESS, CITY, STATE, ZIP CODE IRY LANE		
WOODIWI	ONI CENIER			FRED	DERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
E 037	•	ge 26 rgency preparedness training.	E O	37		не обудентву в фейбру — тогот постивалент постива	
	of the facility's emer conducted with OSN director of maintena emergency prepare evidence of docume emergency prepare emergency prepare documentation that initial & annual eme OSM # 1 stated that not all staff had On 12/06/17 at appr (administrative staff director (administratiof nursing and ASM were made aware of	gency preparedness plan was M (other staff member) # 1, ance. Review of the facility's dness plan failed to provide entation of the facility's initial dness training and annual dness training offerings and facility staff have received regency preparedness training. It the facility did not have it and been trained.  Toximately 5:00 p.m. ASM member) # 1, the executive or), ASM # 2, interim director # 3, clinical quality specialist, f the findings.					
SS=C	EP Testing Requirer CFR(s): 483.73(d)(2) (2) Testing. The [fact RNHCIs and OPOs] test the emergency [facility, except for R all of the following:  *[For LTC Facilities of The LTC facility must the emergency plan unannounced staff of the CFR testing the testing the staff of the LTC facility must be emergency plan unannounced staff of the CFR testing the testing the testing the testing the testing the testing the testing testing the tes		EO	2.	No residents were affected.  All residents have the potential be affected.  Documentation will be incorporated into the facility Emergency Preparedness P (EPP) by the Center Execut Director/designee, specific facility's related exercises, exercise analyses and responsand how the facility update	y's lan tive to the onses,	

and how the facility updated it

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	CON	FE SURVEY MPLETED  C
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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION OULD BE	(X5) COMPLETION DATE
E 039	community-based of exercise is not access facility-based. If the actual natural or marequires activation of [facility] is exempt from community-based of full-scale exercise for the actual event.  (ii) Conduct an additinctude, but is not limically based of (B) A tabletop exercise for the actual event.  (iii) Conduct an additinctude, but is not limically-relevant endiscussion led by a folinically-relevant endiscussion led by a facility facility emergency plan.  (iii) Analyze the [facility emergency plan.  (iiii) Analyze the [facility emergency plan.  *[For RNHCls at §40 §486.360] (d)(2) Tesmust conduct exerciplan. The [RNHCl at following:  (i) Conduct a paper-least annually. A table discussion led by a folinically relevant emore problem statements.	all-scale exercise that is a when a community-based essible, an individual, a [facility] experiences an an-made emergency that of the emergency plan, the rom engaging in a raindividual, facility-based or 1 year following the onset of a tional exercise that may mited to the following: scale exercise that is raindividual, facility-based. A croise that includes a group facilitator, using a narrated, an ergency scenario, and a set of the scenario of the scale exercise that includes a group facilitator, using a narrated, and a set of the scenario of the sce	EO	EPP based on the exercionallyses and responses. Executive Director will aspects of this training timely completion and oper regulation.  4. Center Executive Director ensure that the EPP exercise analyses and reand related plan updates conducted, completed a documented consistent regulations, and will shafindings at the monthly Committee meeting for to determine continued compliance.	Center oversee all oward compliance tor will reises, sponses are and with are these QAPI	AT A VAL AND A MARIA

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HOMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 495246 B. WING 12/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE **TAG** TAG DEFICIENCY) E 039 Continued From page 28 E 039 emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. The findings include: On 12/01/17 at 10:00 a.m. a review and interview

facility did not have it.

of the facility's emergency preparedness plan was conducted with OSM (other staff member) # 1, director of maintenance. Review of the facility's emergency preparedness plan failed to provide evidence of documentation of the facility's exercise analysis and response and how the facility updated its emergency program based on the exercise analysis. OSM # 1 stated that the

On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, the executive director (administrator), ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist,

No further information was obtained prior to exit.

were made aware of the findings.

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		E SURVEY MPLETED
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	PROVIDER OR SUPPLIER			11 DA	ET ADDRESS, CITY, STATE, ZIP CODE JRY LANE DERICKSBURG, VA 22405	, ( <i>L</i> )	100/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	The state of the s	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	An unannounced M survey was conduct 12/8/17. One compl the survey. Signification compliance with the Federal Long Tellmmediate Jeopardy the area of Quality of Severity Level 4, iso constituted the substancepting the plan for Jeopardy from the A the Immediate Jeop deficiency was assigned Level 2, isolated. The expanded because, other residents with	ledicare/Medicaid standard ed from 12/4/17 through aint was investigated during ant corrections are required for following 42 CFR Part 483 of the Care requirements. An exituation was identified in of Care at a Scope and plated, (F689) which standard quality of care. After or removal of Immediate administrator, and determining ardy was removed, the gned a scope and severity of the survey sample was not during a tour of the facility, all oxygen were identified and that their oxygen tanks were the Life Safety Code	F 00	10			
F 550 SS=D	94 at the time of the consisted of 26 curre 70, 52, 39, 184, 40, 47, 63, 12, 56, 23, 66 and three closed and 86. Resident Rights/Exe CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a ri self-determination, a access to persons and the consistency of t	)(2)(b)(1)(2)	F 55		Residents # 47 and # 284 had privacy bags put on their Fol Catheter drainage bags upon discovery and continue to ha privacy bags in place.	ley	

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

PRINTED:	12/18/2017
FORM	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495246	B. WING			C	
		493240			12/	08/2017	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			11 0	EET ADDRESS, CITY, STATE, ZIP CODE  DAIRY LANE  EDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The fapromote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding provision of service residents regardless. \$483.10(b) Exercise The resident has the rights as a resident or resident of the Unity \$483.10(b)(1) The fresident can exercise interference, coerciferom the facility. \$483.10(b)(2) The refree of interference, reprisal from the facility. \$483.10(b)(2) The resident can exercise of his or he subpart. This REQUIREMEN by:  Based on observatidocument review and services and to be suppart.	ility must treat each resident gnity and care for each er and in an environment that nce or enhancement of his or ecognizing each resident's cility must protect and of the resident.  Facility must provide equal are regardless of diagnosis, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source.  For Rights.  Fight to exercise his or her of the facility and as a citizen	F 5	охиноского года — «Дерейдай», писатом пометом поставления пометом пометом пометом пометом пометом пометом поме	<ol> <li>All residents with Indwelling Catheters have the potential affected. 100% audit was completed by the Unit Man for all current residents with indwelling catheters to ensithey all have privacy bags any deviations were correct immediately.</li> <li>Education was provided to staff by the Nurse Practice Educator or the Nursing Supervisor related to providignity for residents with indwelling catheters.</li> <li>Unit Managers will audit all residents with indwelling catheters.</li> <li>Unit Managers will audit all residents with indwelling catheters.</li> <li>Education was provided for these than randomly thereafter to privacy is provided for these residents. Results of audits brought to the Quality Assults and Performance Improvem Committee for follow up medicated.</li> </ol>	al to be nagers th ure that in place ted nursing ling ling ensure e will be rance ient	

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495246  NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
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F 550	dignity for two of 2 sample, Residents  1. The facility staff Resident #47's uring  2. The facility staff Resident # 284's or The findings included in the finding included in the finding in the fi	29 residents in the survey at #47 and #284.  If failed to provide privacy for inary catheter collection bag.  If failed to provide privacy for catheter collection bag.  If failed to provide privacy for catheter collection bag.  Ide:  If failed to provide privacy for mary catheter collection bag.  Ide:  If failed to provide privacy for mary catheter collection bag.  In admitted to the facility on mitted on 11/22/17. Resident included but were not limited to: kidney disease and adult failure to #47's most recent MDS  It), a five day Medicare and ARD (assessment reference coded the resident's cognition waired. Section G coded eing totally dependent of two or insfers, and as requiring ice of two or more staff with sing and personal hygiene.  Resident #27 as having an	F 5	-50			
	on 10/30/17 failed t	mprehensive care plan initiated to document information of the catheter collection bag.					

		AND HUMAN SERVICES				FORM	): 12/18/2017 APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		PLE CONSTRUCTION  G	(X3) DA	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
495246			B. WING	ì		12	C /08/2017	
NAME OF	PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODM	ONT CENTER			1	11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
And of the control of	On 12/4/17 at 12:12 #47 was observed in catheter collection in frame and was unco observed in the collection ext to the collection of the cover was observed next to the collection of 12/6/17 at 12:05 conducted with CNA #6. CNA #6 was as dignity for a resident stated, "We have a the privacy bag shoulding when the recommodulating when the recommoducted with RN (was asked how staff resident with a cathet cover is placed over asked if the privacy room, RN #1 stated, privacy bag can be at the bed.  On 12/6/17 at 5:45 pmember) #1 (the excinterim director of nuclinical quality special above concerns.  The facility policy title Federal Law" docume each patient with reseach patient in a ma	2 p.m. and 1:09 p.m. Resident ying in bed. The resident's pag was attached to the bed overed. Yellow urine was ection bag. A blue privacy diattached to the bed frame in bag.  5 p.m. an interview was a (certified nursing assistant) ked how staff maintains the with a catheter. CNA #6 privacy bag." CNA #6 stated and be used at all times resident is in and out of the p.m. an interview was (registered nurse) #1. RN #1 from maintains dignity for a peter. RN #1 stated a privacy the drainage bag. When bag should be used in the present and the wheelchair or a peter. RN #1 stated the attached to the wheelchair or a peter. RN #1 stated the attached to the wheelchair or a peter. RN #3 (the peter of the peter o	F	550				

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495246		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED				
		B. WING			C 12/08/2017			
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE  FREDERICKSBURG, VA 22405					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPE	BE	(X5) COMPLETION DATE	
F 550		ge 33 on was presented prior to exit. er is a tube placed in the body	F 55	iO				
	to drain and collect information was obt	urine from the bladder." This ained from the website: gov/ency/article/003981.htm						
		ailed to provide privacy for theter collection bag.						
	11/30/17 with diagnorus not limited to: atrial t	admitted to the facility on oses that included but were fibrillation (1), dysphagia, (2), ention of ileostomy (4) and omy.			,			
TO THE PROPERTY OF THE PROPERT		ost recent MDS (minimum ion assessment was not due						
	Resident # 284 date "Orientation to perso Judgement/Insight-ir Further review of the	g Assessment-Initial" for d 11/30/17 documented, on, place and time; ntact and clear speech." b "Nursing Assessment-Initial" ocumented, "Indwelling						
- The state of the	observed hanging or	neter collection bag was not the side of the bed and not be catheter collection bag				REPORTED AS A PARTY OF THE PROPERTY OF THE PARTY OF THE P		
		oximately 11:25 a.m. bserved dressed, in her shed down the hall by her				Oderania (Allender de Caración)		

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HOMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 495246 B. WING 12/08/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 550 F 550 Continued From page 34 husband. Observation of the wheelchair revealed the catheter collection bag, uncovered and hanging on the side of the wheelchair. When Resident # 284 was asked how she felt about the catheter bag being exposed, she stated, "I would like it covered." On 12/05/17 at approximately 11:30 a.m. a facility staff member took Resident # 284 from the hallway, back to her room and placed the catheter collection bag into a privacy cover. Review of Resident # 284's care plan dated 11/04/17 failed to evidence a care plan for an indwelling catheter. On 12/06/17 at approximately 2:10 p.m. an interview was conducted with LPN (licensed practical nurse) # 4 regarding the privacy of Resident # 284's catheter collection bag. LPN # 4 stated, "The collection bag should be place in a privacy bag at all times." On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) #1, executive director, ASM # 2, the interim director of nursing and ASM # 3, clinical quality specialist, were made aware of the findings. No further information was obtained prior to exit. 1. Resident # 12 had call bell placed F 558 | Reasonable Accommodations Needs/Preferences F 558 within reach and continues to have

other residents.

SS=D | CFR(s): 483.10(e)(3)

§483.10(e)(3) The right to reside and receive

endanger the health or safety of the resident or

This REQUIREMENT is not met as evidenced

services in the facility with reasonable

accommodation of resident needs and preferences except when to do so would it in place when in her room.

2. All residents have potential to be

audit of current residents

in the center.

Resident # 184 no longer resides

affected, as it relates to Call Bells

being within reach. House wide

DEPART	MENT OF HEALTH	AND HON SERVICES  & MEDICAID SERVICES			OME	ORM A B NO. (	12/18/2017 APPROVED 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X		SURVEY LETED
ND PLAN O	FCORRECTION		B. WING			C 12/08/2017	
		495246	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	12.10	0/2011
NAME OF F	ROVIDER OR SUPPLIER	···			DAIRY LANE		
WOODM	ONT CENTER				REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 558	interview, facility do record review, it was failed to provide ac residents' physical in the survey samp  1. The facility staff #12's call bell was 2. The facility staff accommodations to Resident #184.  The findings includ  1. Resident #12 with 1/15/10 with a readiagnoses that includementia, osteopobones), anemia (lo disease, depression cognitive deficit.  Resident #12's mo	tion, resident interview, staff ocument review and clinical as determined, the facility staff commodation to meet the needs for two of 29 residents le, Resident #12 and #184.  failed to ensure that Resident positioned within her reach.  failed to provide a meet the physical needs of e:  as admitted to the facility on admission on 5/5/16 with aded, but were not limited to: rosis (weakening of the wind red blood cells), acid refluxing difficulty swallowing, and	F	558	completed by Unit Managers ensure that room is set up to accommodate individual residneeds.  3. Education provided to facility related to ensuring residents heall bells within reach when in their rooms, provided by Nurse Practice Educator or supervise Education provided to nursing staff by the Nurse Practice Educator or Supervisor on ensuring residents room is set to best meet their needs.  4. Department Heads will audit to Bell Placement on daily round and Manager on Duty will audit and Managers on Duty will audit call bell placement on the weekends. Unit Managers and Supervisors will audit Call Be Placement randomly 3 times a	dent  staff nave n se or. g Call ds, dit d	
	set), a quarterly as (assessment refere revealed, in part, the answer the question of mental status) a assessment as being decisions regarding	sessment with an ARD ence date) of 11/17/17, nat Resident #12 was unable to ons on the BIMS (brief interview nd was coded on the staffing severely impaired to make g tasks of daily life. Resident ded as being dependent on	And the second s		week for 6 weeks and random thereafter. Social Services we audit resident rooms set up to accommodate needs weekly till 6 weeks and then randomly thereafter and with new admissions. Results of audits be brought to the Quality	ly ill mes	
	dates and times: 1	observed on the following 2/04/17 12:51 p.m Resident ead up against the bed rail.	William William Construction of the Constructi		Assurance and Performance Improvement Committee for follow up monthly.		1/17/18

follow up monthly.

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HOMAN 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 **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING C 495246 B. WING 12/08/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 558 Continued From page 36 F 558 from the bed frame. Debris observed on call bell. 12/04/17 01:10 p.m. Call bell hanging off of bed frame, out of Resident # 12's reach. 12/4/17 2:05 p.m. Call bell hanging off of bed frame, out of Resident # 12's reach. On 12/07/17 11:51 a.m. an interview was conducted with CNA (certified nursing assistant) #14, an aide working on the floor with Resident #12. CNA #14 was asked where a call bell should be placed. CNA #14 stated, "In the area of the resident, in case they have to push for help or need assistance, me personally I place it in their lap." CNA #14 was asked where Resident #12's call bell was placed. CNA #14 stated "She has a "pushy" one, I make her aware, most of the time I put it under her arm so she can push." At this time Resident #12's call bell was observed hanging off the bed. CNA #14 stated "Most of the time she throws it off of the bed when she gets mad." CNA #14 was asked how Resident #12 lets staff know she needs assistance or help when she throws the call bell on the floor. CNA #14 stated "She will scream." A review of Resident #12's comprehensive care plan dated 5/6/2016 did not reveal any documentation related to Resident #12 throwing her call bell on the floor or screaming for assistance.

screaming for assistance.

An interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON) on 12/7/17 at 12:30

Further review of Resident #12's clinical record did not reveal any documentation related to Resident #12 throwing her call bell on the floor or

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP COD DAIRY LANE EDERICKSBURG, VA 22405		/V0/2011
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	p.m. ASM #2 was a Resident #12 threw ASM #2 stated she further stated the chand whenever she what her expectation of call bells, the DC be placing the call hat least within reach An end of day meet 4:45 p.m. with ASM ASM #2, the interim #3, the clinical quali #2 and ASM #3 wer concerns. A facility time.  A review of the facil revealed, in part, the "POLICY: All (name patients will have a communication dev times when unattenlights and communic PURPOSE: To ensibetween staff and pince of the survey proceed the survey proceed accommodations to Resident #184.  Resident #184 was a 11/30/17 with diagnor not limited to: fracture obstructive pulmonal	asked if she was aware wher call bell on the floor. e was unaware. ASM #2 call bell should be placed in her e was in the bed. When asked on was in regards to placement DN stated that the staff should bell in the resident's hands or ch.  eting occurred on 12/7/17 at M #1, the executive director, and director of nursing, and ASM lity specialist. ASM #1, ASM ere made aware of the above policy was requested at this lity policy titled "Call Lights" are following documentation: the of facility company name) a call light or alternative vice within their reach at all inded. Staff will respond to call light or asfety and communication patients."		558			

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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		495246	B. WING			12/	08/2017
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			11	REET ADDRESS, CITY, STATE, ZIP CODE  DAIRY LANE REDERICKSBURG, VA 22405			
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F 558	a combination of enbronchitis (1)), atria characterized by rapthe atria of the hear the ventricles and reoutput and frequent (2)), pulmonary fibrocondition in which the becomes scarred or and stiff. That make breath, and your blooxygen (3)), diabeted. There was no compact) assessment as The Initial Nursing Adocumented Reside oriented to person, a documented the resin range of motion in "device/cast/splint" in Resident #184 was p.m. in bed, his left arm was able to move his arm.  A resident interview at 2:25 p.m. Resident the bedside tabed. Both his bedsid observed located on stated he had the states.	Inphysema and chronic I fibrillation (a condition oid and random contraction of the causing irregular beats of esulting in decreased heart ly clot formation in the atria posis (pulmonary fibrosis is a mentissue deep in your lungs over time. This tissue gets thick is it hard for you to catch your load may not get enough it is and high blood pressure.  Ideted MDS (minimum data of the dates of the survey.  Ideted MDS (minimum data of the dates of the survey.  Inssessment, dated 11/30/17, and #184 was alert and place and time. The form ident had functional limitation in his left arm and had a in place.  In the place of the survey of the secured across his chest. He is fingers but not the rest of the eside (right side) and to ble to the other side of the let table and night stand were his left side. Resident #184 aff put his "goodie bag" of the side of the bed, on the	F 5	558			

## DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495246	B. WING		12	C <b>12/08/2017</b>	
	WOODMONT CENTER		STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 22405		PCODE		
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	Observation was mon 12/5/17, the night were observed on the control of the contro	ade of Resident #184's room at stand and the bedside table he resident's left side.  5 a.m. Resident #184's room a room had been rearranged observed against the wall, to the right of the head of the onducted with other staff the occupational therapist on an OSM #9 was asked when placed on case load since 9 stated the resident was ay (11/30/17) and y worked with him on Friday, Tuesday and this morning. The room was changed today, social worker had left a coss that the resident would nged. He doesn't like the mais arranged (the new way) difying it until we reach a farrangement." When asked the eeds, since Resident #184 on his left side and has no M #9 stated, "Yes, it should the upon his initial assessment."	F 5	58			

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

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William.	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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		495246	B. WING			2/08/2017
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER		_	STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
F 558 F 580 SS=E	individual needs and Center's efforts to in physical environme environment of the bathroom, as well a feasible the Center's Center's physical er should be directed to in maintaining and/of functioning, dignity a possible in accordanceds and preferent provide a safe, cleat environment, allowing personal belongings includes ensuring the care and services sallayout of the Center independence and of Administrative staff executive director, Anursing, and ASM # above concern on 1.  No further information (1) Barron's Dictional Non-Medical Reader Chapman; page 124 (2) Barron's Dictional Non-Medical Reader Chapman; page 55.  (3) This information following website: https://medlineplus.cg	d preferences" means the individualize the patient's int. This includes the physical resident's bedroom and is individualized as much as scommon living areas. The invironment and staff behaviors toward assisting the resident or achieving independent and well-being to the extent ince with the resident's own ces1. The center must incomfortable and homelike ing the resident to use/his/her is to the extent possible. This last the resident can receive afely and that the physical maximizes resident does not pose a safety risk."  Immember (ASM) #1, the interim director of 3, were made aware of the 2/7/17 at 4:45 p.m.  In was obtained prior to exit.  In any of Medical Terms for the interior, 5th edition, Rothenberg and interior was obtained from the gov/pulmonaryfibrosis.html injury/Decline/Room, etc.)	F 5			

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

PRINTED: 12/20/2017 FORM APPROVED OMB NO. 0938-0391

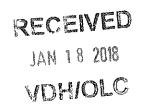
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING			C 12/08/2017	
WOODMONT CENTER		ν.	STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE  FREDERICKSBURG, VA 22405			<b></b>	
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F 580	§483.10(g)(14) Notifice (i) A facility must immodule consult with the residence consistent with his or representative(s) when (A) An accident involves results in injury and his physician intervention (B) A significant changemental, or psychosocideterioration in health status in either life-throlical complications) (C) A need to alter treament due to advect commence a new form (D) A decision to transpect from the facil §483.15(c)(1)(ii). (ii) When making notife (14)(i) of this section, all pertinent informations available and provide physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483.1 (B) A change in resident resi	reation of Changes. rediately inform the resident; rent's physician; and notify, her authority, the resident on there is- ring the resident which has the potential for requiring ; ge in the resident's physical, hal status (that is, a , mental, or psychosocial reatening conditions or ; hatment significantly (that is, han existing form of harse consequences, or to har of treatment); or have a specified in hication under paragraph (g) hithe facility must ensure that har specified in §483.15(c)(2) hed upon request to the his promptly notify the hent representative, if any, hor roommate assignment ho(e)(6); or har rights under Federal or has as specified in paragraph hecord and periodically hailing and email) and	F	2 3 3	resident # 83 medication was regiven. Physician was notified resident # 234 missing 4 doses antibiotic. Responsible Party notified of old bruise noted on resident #12's chin. Resident has been discharged from facil Resident # 286 is currently in hospital. These corrections we made by the Unit Managers.  All residents with changes of condition have potential to be affected. Audit was completed Unit Managers, by reviewing 2 hour report and eInteract Chan condition for the past 30 days ensure that appropriate notificate physician's and Responsible Parties has been completed and documented.  Education provided to licensed nursing staff by the Nurse Prace Educator regarding notifying Physician's and Responsible Pof changes in resident condition documentation of this notificated.	of of of was  # 56 ity. he re  I by 24 ges of to ation of the re  arties arties n and ion. cluding Joit port	

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

Event ID; DGWI11

Facility ID: VA0279

If continuation sheet Page 42 of 348



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

PRINTED:	12/20/2017
FORM A	APPROVED
OMB NO	0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495246	B. WING			12/08/2017		
	ROVIDER OR SUPPLIER			11 !	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405	<u> </u>		
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F 580	that is a composite §483.5) must disclo its physical configur locations that comp part, and must spectroom changes between the second changes between the se	posite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various rise the composite distinct iffy the policies that apply to een its different locations.  IT is not met as evidenced interview, staff interview, wiew and clinical record mined the facility staff failed to of a change in condition or ent for five of 29 residents in Residents #83, #234, #12,  ailed to notify Resident #83's 0 p.m. medications were not resident on 11/3/17.  failed to notify the physician not receive four doses of an ssion to the facility on	F	580	per week, to ensure that appr notifications have been comp and documented. Results of a will be brought to the QAPI Committee for follow up mo	oleted audits	e 1/17/18	
	on Resident #12's of 4. The facility staff responsible party (F discovered on her le physician interventi	failed to notify Resident #56's RP) when a wound was eft lower extremity requiring						

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		<b>495246</b> B. WING		C 12/08/2017			
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE  1 DAIRY LANE REDERICKSBURG, VA 22405		
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F 580	Resident 286's block the physician.  The findings included 1. The facility staff physician when 9:0 administered to the Resident #83 was a 9/24/17 and readme #83's diagnoses in pain in the right knew blood pressure. Resident with an adate) of 11/28/17, cognitively intact.  Review of Resident the following readment the following readment acrisoprodol (1) 3 and Advair diskus (2) a micrograms—one provided the above medication administresident was not adoft the above medication administresident was not addication adminis	e:  failed to notify Resident #83's 0 p.m. medications were not e resident on 11/3/17.  admitted to the facility on itted on 11/2/17. Resident cluded but were not limited to: ee, muscle weakness and high esident #83's most recent MDS 0, a 30 day Medicare of ARD (assessment reference coded the resident as as as a sission orders dated 11/2/17: 50 mg (milligrams) every night estation record) revealed the liministered the 9:00 p.m. dose ations as evidenced by the liministered the MAR. There was on the back of the MAR or in the treatment of the MAR or in th	F	580			
	on 11/6/17 documer exhibits or is at risk	nted, "Focus: Resident for alterations in					

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING \_ C B. WING 495246 12/08/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 580 Continued From page 44 F 580 comfort...Interventions: Medicate resident as ordered for pain...Focus: Resident exhibits or is at risk for respiratory complications related to Asthma...Interventions: Administer aerosol as ordered/indicated..." On 12/4/17 at approximately 2:14 p.m. an interview was conducted with Resident #83. The resident stated she did not get her medications for 24 hours after coming back from hospital. On 12/7/17 at 10:23 a.m. a telephone interview was conducted with LPN (licensed practical nurse) #6 (the nurse responsible for administering the 9:00 p.m. medications to Resident #83 on 11/3/17). LPN #6 was asked who should be notified if medications are not administered to a resident. LPN #6 stated she notifies the supervisor. When asked if she contacts the physician, LPN #6 stated, "I get him involved if need be. If I need another prescription or if I can't find the original one. I don't always notify the physician. It's not always needed and I have got a lot of other things to call him on." On 12/7/17 at 11:24 a.m. an interview was conducted with LPN #4. LPN #4 stated once a resident is readmitted to the facility, she writes out the medication orders and faxes the orders to the pharmacy. LPN #4 stated the pharmacy usually delivers the medications by the night of admission but this depends on what time the

medication list is faxed to the pharmacy. LPN #4 stated she also uses the Omni cell (a machine in the facility that contains various medications) but the Omni cell does not contain all medications. LPN #4 stated if scheduled medications aren't in the Omni cell and haven't been delivered by the

pharmacy then she calls the physician.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED			
2		495246	B. WING_		1:	12/08/2017		
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZII 11 DAIRY LANE FREDERICKSBURG, VA 2240	PCODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 580	Continued From particles of the continued From particles of the continued From particles of the continued quality special above concern.  The facility policy the shortages/Drugs Now "When medication unavailable, the lice initiate action in coordinate action in coordinate action orders to be managed with unavailable of the production orders to be managed with unavailable. This in the website:  https://medlineplus.tml  (2) Advair diskus is information was obto https://dailymed.nlmm?setid=4eeb5f6a-	p.m. ASM (administrative staff xecutive director), ASM #2 (the nursing) and ASM #3 (the stalist) were made aware of the tied, "Medication lot Available" documented, orders are not received or ensed nurse will immediately operation with the attending sharmacy provider. All unavailable to the patient will	F 58	DEFICIENCY				
	antibiotic after admi 12/4/17. Resident #234 was 12/4/17 with the dia MRSA (methicillin-re aureus) [1] in a wou	admitted to the facility on gnoses of but not limited to: esistant Staphylococcus nd, Chronic Obstructive, chronic back pain, scoliosis,	,					

		AND HUMAN SERVICES				FORM	): 12/18/2017 1APPROVED ): 0938-039
STATEMENT	RS FOR MEDICARE TOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED		
		495246	B. WING			12/08/2017	
	PROVIDER OR SUPPLIER  ONT CENTER			11 0	EET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
** PROCESSORS AVE	opiate addiction, chaortic valve endocadata set) assessme completed. A review assessment dated resident as being convast documented as activities of daily lividocumented as havinserted central cathoxygen therapy.  A review of the clinic "Discharge Medication and twice daily by mouth orders revealed this the facility admission."  A review of Residen MAR (Medication Activity admission. A review of Residen MAR (Medication Activity admission. A review of the pharmal revealed the Minocywas not delivered to 5:48 p.m. (See F 75:24 hours without the delivered and 2 of the sassessment dated.)	ronic pain syndrome, and rditis. An MDS (minimum and had not yet been and for the admission nursing 12/4/17 documented the agnitively intact. The resident is being able to participate in ang. The resident was also and a PICC (peripherally neter) [2] line and requiring a PICC (peripherally neter) [3] 100 mg (milligrams) in A review of the admission medication was written on an orders as well.  It #234's December 2017 diministration Record) on an administered until 9:00 p.m. sident had missed 4 doses of a admission.  Imacy delivery manifest and a missed 4 doses of a admission.  Imacy delivery manifest and a missed 4 doses of a macy delivery manifest and a missed 4 doses of a macy delivery manifest and a missed 4 doses of a macy delivery manifest and a missed 4 doses of a medication after it was a medication after it was a medication after it was a medication was and a medication was and a missed doses should ared as the medication was	F	580			

Further review of the clinical record failed to reveal evidence the physician was notified of Resident #234 not receiving this medication for

## DEPARTMENT OF HEALTH AND H N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(2	X3) DATE SURVEY COMPLETED
	•	495246	B. WING			C <b>12/08/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 11 DAIRY LANE FREDERICKSBURG, VA 2240		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BI HE APPROPRIA	
F 580	several doses as of On 12/08/17 at 10:3 Nurse) #2 stated sh (LPN #7 - Licensed (who had realized the administered and she doctor was notif Minocycline.  On 12/08/17 at 11:0 and LPN #9 (anothe Resident #234) both doctor of Resident Minocycline.  A review of the facil Condition: Notificatin notifying the physicin medication.  On 12/8/17 at 10:14 Staff Member - the and ASM #3 (the complete Specialist) were made on 12/8/17 at 10:50 Director, Administrating findings.  No further information the survey.  [1] MRSA stands for Staphylococcus aurinfection that is resist antibiotics. There ar Hospital-associated health care settings.	rdered.  32 a.m., RN (Registered ne was contacting the nurse Practical Nurse) from 12/7/17 ne medication had not been tarted the medication) about if fied of missed doses of 00 a.m. RN #2 stated LPN #7 er nurse that had worked with a stated they did not notify the	F 5	80		

		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	1 APPROVED 1. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495246	B. WING			1	C <b>/08/2017</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
	involved in football a Infection control is Infection and scrabandage until heale *Avoid contact with bandages *Avoid sharing perswashcloths, razors, *Wash soiled sheetswater with bleach are Infection and an Information obtained https://medlineplus.governation.com/several weeks. Unlificatheter (IV) which is more durable and blocked or infected. several months so the drawn or medication routinely injected intended int	with others, such as athletes and wrestling. Rey to stopping MRSA in a community-associated appes clean and covered with a dother people's wounds or conal items, such as towels, or clothes s, towels, and clothes in hot and dry in a hot dryer to be infected, see a health ments may include draining tibiotics. If from gov/mrsa.html  peripherally inserted central heter that extends from an the largest vein (superior r vena cava) near the heart as central IV access for see a standard intravenous is for short term use, a PICC does not easily become It may remain in place for that blood can be repeatedly and nutrients can be to the patient's bloodstream. It from the typinfo.org/en/info.cfm?pg=vas	F 5	80			
	by bacteria including	pneumonia and other ctions; certain infections of					

PRINTED: 12/18/2017

## DEPARTMENT OF HEALTH AND H N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

			TE SURVEY MPLETED				
		495246	B. WING			1	C (09/2047
	PROVIDER OR SUPPLIER			STR 11 D	DAIRY LANE EDERICKSBURG, VA 22405	<u>                                     </u>	/08/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	the skin, eye, lymph urinary systems; an are spread by ticks, animals. Information https://medlineplus.tml  3. The facility staff (responsible party) to on Resident #12's con Resident #12 was an 11/15/10 with a read diagnoses that includementia, osteoporobones), anemia (low	natic, intestinal, genital, and id certain other infections that lice, mites, and infected n obtained from gov/druginfo/meds/a682101.h failed to notify the RP when a bruise was discovered	F	580			
	set), a quarterly asset (assessment reference revealed, in part, that answer the questions of mental status) and assessment as being decisions regarding #12 was further code staff for activities of continuous and the "Effective Date: 11/8 Change in Condition has been not include: Skin wound reported to Primary Colinician notified) 11/8	t recent MDS (minimum data essment with an ARD nce date) of 11/17/17, at Resident #12 was unable to as on the BIMS (brief interview d was coded on the staff g severely impaired to make tasks of daily life. Resident ed as being dependent on daily living.  If #12's clinical record of following progress note; If 12's clinical record of following progress note; If 13's clinical record of following progress note; If 14's clinical record of following progress note; If 15's clinical record of following progress note; If 14's clinical record of following progress note; If 15's clinical recor					

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	1APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		495246	B. WING				C <b>/08/2017</b>
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	revealed, in part, a condated 11/8/17 that do following; "Old bruis right chin."  On 12/7/17 at 3:10 proconducted with LPN a floor nurse. LPN: notify the RP. LPN: notify the RP. LPN: RP with any change asked who he would unknown origin. LP notify the director of the MD (medical document of the MD (medical document) that the modern of the MD (registered Coordinator. RN #7 appropriate to notify change assessment change in condition asked to review Residated 11/8/17 regard RN #7 was asked winjury. RN #7 stated practitioner was notify was "Self" that was a should have been R looks like they just to (the nursing staff) sh RN #7 further stated RP) should have been RP should have should should have shoul	esident #12's clinical record change in condition document locumented, in part, the e, fadded (sic) bluish color to p.m. an interview was I (licensed practical nurse) #3, #3 was asked when he would #3 stated, "I would notify the in condition." LPN #3 was I notify regarding an injury of N #3 stated that he would nursing, the administrator, ctor) and the RP.	FS	580			

An end of day meeting occurred on 12/7/17 at

PRINTED: 12/18/2017

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION		ATE SURVEY OMPLETED
		495246	B. WING	- MANAGE - NO. 11	1:	C 2/08/2017
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE, ZI 11 DAIRY LANE FREDERICKSBURG, VA 2240	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	ASM #2, the interim #3, the clinical quali #2 and ASM #3 wer concerns. A facility time.  A review of the facilic Condition: Notification: Notification the following docum must immediately in the patient's physicion his/her authority, the Decision Maker, whinvolving the patient has the potential for intervention."  No further information and of the survey property of the survey property (R discovered on her lephysician intervention. Resident #56 was as with diagnoses that it to: dementia, a gastroperipheral vascular of the legs), high blood difficulty swallowing, count), an irregular his peaking.	#1, the executive director, director of nursing, and ASM ty specialist. ASM #1, ASM e made aware of the above policy was requested at this lity policy titled "Change in on of (sic)" revealed, in part, entation: "POLICY: A center form the patient, consult with an, and notify, consistent with an and notify, consistent with a patient's Health Care ere there is: An accident which results in injury and requiring physician  on was provided prior to the ocess.  ailed to notify Resident #56's P) when a wound was ft lower extremity requiring n.  dmitted to the facility 12/21/12 included, but were not limited to stomy tube (a tube to the total ty into the stomach), lisease (poor circulation to pressure, depression, anemia (low red blood cell teartbeat, and difficulty	F 580			
		recent MDS (minimum data essment with an ARD				

		AND HOWAN SERVICES & MEDICAID SERVICES			O	FORM	D: 12/18/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` ′		E CONSTRUCTION ,	(X3) DA	TE SURVEY MPLETED
		495246	B. WING			12	C 2/08/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
WOODM	ONT CENTER				DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
and the second s	(assessment refere coded Resident #56 the questions on the mental status) and the Resident #56 as be decisions regarding #56 was coded as the of daily living.  A review of Resident revealed, in part, the note dated 12/1/2011 12/1/2017. Visit Typ Illness: The patient (nursing facility) visit (atrial fibrillation, and (cerebral vascular as SEEN FOR: Wound (sic) stage 2 (two) usaline) wound flush, medically certified high and cally certified high and cour evidencing the RP with the review of Redid not reveal any denotified of the wound. The nurse who docuce condition in regards	nce date) of 10/13/2017 as being unable to answer BIMS (brief interview for the staff assessment coded ing severely impaired to make task of daily life. Resident being dependent with activities t #56's progress notes e following nurse practitioner	F 5	80			

On 12/7/17 at 3:10 p.m. an interview was conducted with LPN #3, a floor nurse. LPN #3

was asked when an RP should be contacted.
LPN #3 stated, "With any change in condition or change in treatments the RP should be notified."

#### DEPARTMENT OF HEALTH AND H N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495246	B. WING		-	C <b>2/08/2017</b>
NAME OF PROVIDER				STREET ADDRESS, CITY, STATE, Z 11 DAIRY LANE FREDERICKSBURG, VA 224	IP CODE	2/00/2017
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
On 12/7 conduct member #2 was ASM #2 condition An end 4:45 p.m ASM #2 #3, the of #2 and // concern time.  A review Condition following immediat patient's // her aut Maker, we patient's // her aut Maker, we patient's formula for the physical Resident the physical Resident for th	ted with AS r) #2, the in asked whe stated any n or change of day mee n. with ASN , the interin clinical qual ASM #3 wei s. A facility of the facil n. Notifical n. Hority inform physician, hority, the physicial clity staff facility staff facility staff facility stoke, hig prostate ca #286 was and readmit st that inclu stroke, hig prostate ca #286's mo an admiss	p.m. an interview was M (administrative staff sterim director of nursing. ASM in an RP should be notified, time there was a change of e of therapy.  Iting occurred on 12/7/17 at I #1, the executive director, a director of nursing, and ASM ity specialist. ASM #1, ASM re made aware of the above policy was requested at this ity policy titled "Change in the ation; "A Center must the patient, consult with the and notify, consistent with his patient's Health Care Decision is; A significant change in the ental, or psychosocial status."  ailed to notify the physician of d sugar of 454 as ordered by admitted to the facility on ted on 11/18/17 with ded but were not limited to the blood pressure, heart incer and arthritis.  Destrecent MDS (minimum ion assessment with an ARD ince date) of 11/25/17, coded	F 5	80		

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

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PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONST ING		CO	TE SURVEY MPLETED
		495246	B. WING			1	C / <b>08/2017</b>
	PROVIDER OR SUPPLIER			11 DAIRY	DDRESS, CITY, STATE, ZIP CODE LANE ICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	interview for menta score of 0 - 15, 15 daily decisions. Re requiring extensive dependent of one s daily living and support of eating.  Review of the physical documented, "Fingameals) & HS (hour doctor) (if blood sug (greater than) 400.  Review of the Dece administration recondingerstick blood sug (greater than) 400.  Review of LPN (lice 12/4/17 worksheet of Resident #286) BS  Review of the nurse documentation the president #286's ele 12/07/17 11:18 a.m. on 12/7/17 with ASM member) #2, the into When asked when a #2 stated, "Any charasked about Reside "There was an order doctor)."	I status (BIMS) exam, of a being cognitively for making sident # 286 was coded as assistance to being totally taff member for activities of ervision of one staff member cian's orders dated 11/18/17 erstick blood sugar AC (before of sleep). Call MD (medical gar is) < (less than) 70 or > mber 2017 MAR (medication rd) documented, "Accuchecks igar) AC + HS. Call MD/NP if BS (blood sugar) <70 >400. msed practical nurse) #2's documented, "(Name of 454."	F 5	80			

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 55 of 348



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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495246	B. WING		C <b>12/08/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	12/00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 583 SS=D	asked when she wo #2 stated, "If I find a burnt themselves ar to be notified." Whe was not notified as o blood sugar was 45 know there was an experience of the facility of the facility "Physician/Advance Notification" docume identification of a pacondition or abnorm licensed nurse will pobservations and daphysician/advanced No further information of the facility of facility (Personal Privacy/Cocce) (Personal Privacy/C	puld notify the physician, LPN a new wound. If the patient and because he wrote an order in asked why the physician ordered when Resident #286's 4, LPN #2 stated, "I didn't order for that."  p.m. ASM (administrative ne executive director and ASM for of nursing were made in all about the control of the con	F 580		acy, ial to th acility

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

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No.	

 OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	COM	E SURVEY APLETED
	495246	B. WING			1	C <b>'08/2017</b>
 (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	11 DAI FRED	T ADDRESS, CITY, STATE, ZIP CODE RY LANE ERICKSBURG, VA 22405  PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N O BE	(X5) COMPLETION DATE
§483.10(h)(2) The residents right to pright to privacy in h written, and electro the right to send an mail and other letter materials delivered including those delithan a postal service §483.10(h)(3) The rand confidential per (i) The resident has of personal and me provided at §483.70 federal or state laws (ii) The facility must Office of the State L to examine a reside administrative recordaw.  This REQUIREMENT by:  Based on observation document review are was determined the personal privacy for survey sample, Resultant privacy for survey sample, Resultant privacy for survey curtain between the personal privacy for survey curtain between the personal privacy for survey sample, Resultant privacy during woun privacy curtain between the personal privacy in the personal priva	facility must respect the ersonal privacy, including the is or her oral (that is, spoken), nic communications, including and promptly receive unopened ers, packages and other to the facility for the resident, wered through a means other ersonal and medical records. In the right to refuse the release dical records except as D(i)(2) or other applicable is. In allow representatives of the Long-Term Care Ombudsman ent's medical, social, and erds in accordance with State of the line and the staff interview, facility and clinical record review, it facility staff failed to provide two of 29 residents in the ident #12 and #9.  Failed to close the window Resident #12, providing an out the outside into Resident #9 dicare, by failing to pull the een Resident #9 and her in present in the room during	F		pulling the privacy curtains the blinds to the outside. Regional Nurse provided education to the Nurse Pract on providing privacy during wound care.  Unit Managers to observe procare of 5 residents per week ensure that privacy is provideduring care. Director of Nurvill observe Wound Care proby the Nurse Practitioner or week for 6 weeks and then randomly thereafter to ensure privacy is provided. Results these audits will be brought the Quality Assurance and Performance Improvement Committee monthly for revisional provided.	ersonal to ded arsing rovided ace per re that of before	

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

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495246	B. WING	j			12	C / <b>08/2017</b>
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP C 1 DAIRY LANE FREDERICKSBURG, VA 22405	:ODE		, OO/120 11
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
	The findings included 1. Resident #12 was 11/15/10 with a read diagnoses that includementia, osteopor bones), anemia (low disease, depression cognitive deficit.  Resident #12's mosset), a quarterly ass (assessment reference revealed, in part, the answer the question of mental status) an assessment as beind decisions regarding #12 was further cod staff for activities of On 12/07/17 at 09:4 made of OSM (other student nurse, provie #12. The curtain was shielding Resident #the room, but the winding testing to the student nurse in the winding resident #10.	as admitted to the facility on dmission on 5/5/16 with uded, but were not limited to; osis (weakening of the vired blood cells), acid reflux n, difficulty swallowing, and at recent MDS (minimum data essment with an ARD note date) of 11/17/17, at Resident #12 was unable to as on the BIMS (brief interview d was coded on the staffing severely impaired to make tasks of daily life. Resident ed as being dependent on daily living.  4 a.m. an observation was r staff member) #11, a ding a bed bath to Resident as pulled around the resident, 56 from people entering into andow blind was left open	F 5	583				
	allowing people on the outside of the building to observe Resident #12 while being bathed. At the time of the observation Resident #12 was naked with only a towel across her breasts and across the lower part of her body. When turned to her side, Resident #12's buttocks were exposed to the window.  On 12/07/17 at 09:48 a.m. an interview was conducted with LPN (licensed practical nurse) #2, at floor nurse. LPN #2 was asked what she did			AAAA AMBIYA AAAA WAXAAAAAAAAAAAAAAAAAAAAAAAAAAAAA				

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED			
		495246	B. WING		1	C <b>12/08/2017</b>		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE	2/00/2017		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	when providing a reprivacy. LPN #2 stated all times. If they are door and keep them roommate, I close of them covered. I cover am not bathing." We the windows, LPN # the "B" bed which is pull the blinds and of was asked why she stated, "Because if syou would be expossiseeing them. When dementia. LPN #2 spromote/maintain dispare."  On 12/07/17 at 11:25 conducted with LPN was asked to describe the privacy of a resident asked, "I close the make sure the blinds people to leave the resident. OSM #12 the RN (re OSM #11 was asked dignity and privacy we the resident. OSM # and the door. When a resident room, OSI referring to the blinds informed of the above being open during Referring to the blinds #11 stated, "I guess"	sident bed bath to promote ated, "I keep them covered at alone in the room I close the a covered If they have a surtain around them and keep wer the parts (of the body) I hen LPN #2 was asked about 2 stated, "If the resident is in close to the windows I will lose the curtain." LPN #2 would do this. LPN #2 someone walks by outside ing the resident to someone asked about a resident with stated, "You still gnity and treat all patients the #3, a floor nurse. LPN #3 be his process for protecting the treceiving bed bath. LPN eir door, pull the curtain and are closed, I may ask	F 5	33				

		HAND HEAN SERVICES			FORM	0: 12/18/201 MAPPROVE
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING	(X3) DAT	). 0938-039 TE SURVEY MPLETED
		495246	B. WING		i	C /08/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		JLD BE	(X5) COMPLETION DATE
	asked to if she should blinds beside Reside When starting Reside OSM #11 stated, "Ye On 12/07/17 at 11:4 conducted with CNA #14. CNA #14 was a resident's privacy dustated, "I protect the make sure they are out and any visitors, feel comfortable." Owindow blinds. CNA down, any old peeping On 12/7/17 at approximate (administrative staff quality specialist, was policy on privacy.  A review of the facilit Rights Under Federa following documentate each patient with reseach patient in a main that promotes maintend his/her quality of life. An end of day meeting 4:45 p.m. with ASM #2, the interim of #3, the clinical quality with research patient in a main that promotes maintend patient in a maintend pat	dent #12's bed were closed dent #12's bed were closed dent #12's bed bath should, res."  49 a.m. an interview was A (certified nursing assistant) asked how she preserved a uring a bed bath. CNA #14 eir privacy. I pull the curtain, covered, escort roommate, so they (the resident) can CNA #14 was asked about the A #14 stated, "I pull the blinds ing Tom can see."  eximately 1:00 p.m. ASM member) #3, the clinical as asked to supply a facility as asked to supply a facility revealed, in part, the ation; "PURPOSE: To treat spect and dignity and care for anner and in an environment tenance or enhancement of	F 58	583		

No further information provided prior to the end of the survey process. 2. The facility staff failed to provide Resident #9

concerns.

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

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	NG	COMPLETED		
		495246	B. WING		į	C / <b>08/2017</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	EMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 583	privacy curtain between roommate, who was Resident #9's wound right said and readmit that included but we cancer, muscle west the right buttock, typhypothyroidism. Resident with an assessment with an assessment with an assessment with an assessment with a scoring 09 out of 15 for mental status) eas requiring extensimore staff with transtoileting, and extensimember with dressimember with dressimember with dressimember with dressimember and extension for the resident orders revealed the 11/29/17, "Change for the resident orders revealed the 11/29/17, "Change for the resident orders revealed the 11/29/17 at 08:50 observation was considered to the resident orders and the resident orders and placed the properties and placed the supplies and placed the supplies and placed the supplies and placed the supplies and placed the resident placed t	and care, by failing to pull the veen Resident #9 and her is in present in the room during id care treatment.  Imitted to the facility on itted on 8/11/17 with diagnoses are not limited to pancreatic akness, pressure ulcer [1] to be two diabetes, and assident #9's most recent MDS assessment was a quarterly in ARD (assessment reference Resident #9 was coded as appaired in cognitive function on the BIMS (brief interview xam. Resident #9 was coded we assistance from two or affers, bed mobility, and sive assistance from one staffing and personal hygiene.  #9's telephone physician following order dated Medihoney [2] to Santyl [3] cral ulcer, cleanse with normal ryday)."	F 5	83		
		are observation, both ASM #4				

#### PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HU N SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 495246 R WING 12/08/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 'ID (X4) ID EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 583 Continued From page 61 F 583 and LPN #9 forgot to pull the privacy curtain between Resident #9 and her roommate. Resident #9's roommate was lying in the bed next to Resident #9. On 12/06/17 at 9:01 a.m., this writer stood on the side of the room next to Resident #9's roommate. Resident #9 was visible from that side of the room. On 12/07/17 at approximately 8:00 AM, an interview was conducted with LPN #9. When asked how to maintain privacy during wound care, LPN #9 stated she would close the door. pull the curtain, and try to cover up the resident whenever she can. When asked what she would have done differently when providing wound care to Resident #9, LPN #9 stated, "I don't recall pulling the curtain." When asked why it is important to pull the curtain during wound care, LPN #9 stated the curtain should be pulled to maintain privacy. On 12/07/17 at 4:45 p.m., ASM #1, the executive director, ASM #2, the interim DON (Director of Nursing) and ASM #3, the clinical quality specialist were made aware of the above

concerns.

The facility policy titled, "Wound Dressings" document in part, the following: "...7. Explain the

[1] A pressure ulcer is an inflammation or sore on the skin over a bony prominence (e.g., shoulder blade, elbow, hip, buttocks, or heel), resulting from prolonged pressure on the area, usually from being confined to bed. Most frequently seen in elderly and immobilized persons, decubitus ulcers may be prevented by frequently change of position, early ambulation, cleanliness, and use of

procedure and provide privacy."

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(1) 1 (0 1 1 2 2 2 2 2 1 1 2 2 2 2 2 2 2 2 2 2		ONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED C	
		495246	B. WING	B. WING			8/2017	
	ROVIDER OR SUPPLIER		÷	11 0	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405			
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F 583	called bedsores. Pre Dictionary of Medica Reader 2006; Mikel Charles F. Chapmar  [2] Medihoney- "Hon used for the treatme information was obta Institutes of Health. https://www.ncbi.nlm  [3] Santyl- enzymati collagen and necroti was obtained from the Health. https://dailymed.nlm	water or air mattress. Also essure sores. Barron's I Terms for the Non- Medical A. Rothenberg, M.D. and	F	583			,	
F 584 SS=D	S483.10(i) Safe Env The resident has a comfortable and hob but not limited to resupports for daily liv The facility must pro §483.10(i)(1) A safe homelike environment use his or her persopossible.  (i) This includes environment in the person of the perso	rironment. right to a safe, clean, melike environment, including ceiving treatment and ring safely.	F	23	<ol> <li>The gouges in the wall next occupied by resident #9 were by the maintenance supervision the survey.</li> <li>All residents have the potent affected. An inspection of a rooms and common areas we completed, and any needed recompleted.</li> <li>Education was provided to fastaff by the Maintenance Super or Nurse Practice Educator reconsuring a safe, comfortable homelike environment for the</li> </ol>	e repaired for during tial to be ill resident as repairs acility pervisor elated to and		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		495246	B. WING			C 12/08/2017	
		495240		CTD	EET ADDRESS, CITY, STATE, ZIP CODE	1210	18/2017
	ROVIDER OR SUPPLIER  ONT CENTER			11 D	AIRY LANE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	альна по спостенения по постенения по постенения посте	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 584	or theft.  §483.10(i)(2) House services necessary to and comfortable interested in good condition;  §483.10(i)(3) Clean in good condition;  §483.10(i)(4) Private resident room, as sponsor in good condition;  §483.10(i)(5) Adequal levels in all areas;  §483.10(i)(6) Comfolevels. Facilities initially 1990 must maintain 81°F; and  §483.10(i)(7) For the sound levels.  This REQUIREMENT by:  Based on observation document review, it staff failed to maintain homelike environment the survey sample,  The facility staff failed room was free from bed.  The findings included Resident #9 was additional and complete the survey sample.	keeping and maintenance to maintain a sanitary, orderly, erior; bed and bath linens that are ecloset space in each pecified in §483.90 (e)(2)(iv); attemption and safe temperature ally certified after October 1, a temperature range of 71 to emaintenance of comfortable emaintenance of comfortable its not met as evidenced iton, staff interview, and facility was determined, the facility was determined, the facility in a clean, comfortable, and ent for one of 29 residents in Resident #9.	F	4	residents, to include making Maintenance aware in a timely manner of any repair needs.  Management personnel will co assigned, regular rounds/inspect of all resident rooms and commareas, to identify and documen among other items, any issues detract from a safe, comfortable homelike environment for the residents. Results of these inspection will be discussed at the monthle QAPI Committee meetings.	onduct ctions non it, that le and	1/17/18

		AND HUMAN SERVICES		O		FORM	12/18/2017 APPROVED 0938-0391
STATEMEN	RS FOR MEDICARE FOR DEFICIENCIES DEFICIENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405	5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE ACTIO	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
F 584	that included but we cancer, muscle wearight buttock, type the hypothyroidism. Refuninimum data set) assessment with an date) of 11/09/17. It being moderately in scoring 09 out of 15 for mental status) eas requiring extensimore staff with transtoileting, and extensimore staff with transtoileting, and extensimember with dressimember with dressimember with dressimember described appeared the gouges were right side of her bed appeared the gouges ide rail.  On 12/06/17 at 07:5 in bed. The gouges the right side of her On 12/07/17 at 03:2 conducted with OSM maintenance director made aware that a rosm with the nurses' station, a rehab (rehabilitation orders help him kee fixed because it leavistated he is also alwars.	ere not limited to pancreatic akness, pressure ulcer to the	F	584			

needs to be fixed. OSM #1 stated that for the

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING			12/08/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE  FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 584	maintenance. OSM a lot of his time doi When asked if he wasked if he wasked and to Resident #9's room aware of any issue: #1 to Resident #9's had noticed on Resident #9's had noticed on Resident #9's had noticed to be pathomelike for her wasked, "Oh, no. #1 stated, "Oh, no. #1 stated, "Oh, no. #1 stated no one had gouges in the wall.  On 12/07/17 at 3:30 conducted with CN. #9. A CNA who wasked CNA #9 stated he for Resident #9. When noticed the wall with of Resident #9's be been like that for a had reported this to CNA #9 could not ewall to maintenance On 12/07/17 at 4:45 staff member) #1, the interim DON (D #3, the clinical qual of the above conce The facility policy til Needs" documents resident has the rig comfortable, and he but not limited to, resident to the state of th	as been by himself in #1 stated he has also spent ng emergency preparedness. was aware of any issues in 1, OSM #1 stated he was not is. This writer followed OSM room. When asked what he sident #9's wall, OSM #1 gouges in the wall on the right bed). That's a two-minute OSM #1 stated the wall may ched. When asked if it was all to have gouges in it, OSM Shouldn't be like that." OSM and made him aware of the open of the executive worked with a saked how long he had an the gouges on the right side of, CNA #9 stated the wall had few weeks. When asked if he anyone, CNA #9 stated, "No." explain why he didn't report the executive director, ASM #2, irrector of Nursing) and ASM ity specialist was made aware rns.	F 5	84			

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

PRINTED: 12/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING				
		495246	B. WING			12/0	) 08/2017	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	E		
				11	DAIRY LANE			
WOODMO	NT CENTER			FF	REDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 584	Continued From pag	a 66	F	584				
F 304	1		•	307				
	services necessary t	eeping and maintenance o maintain a sanitary orderly, rior." n was presented prior to exit.	Average physical and a second a					
F 607	The second secon		F	607	1. Investigations were	not completed of	n	
SS=D			ASSAULT ASSAUL	Landerson	these past events for			
			Anodistance	WATER PROPERTY AND ADDRESS OF THE PERTY	and # 12. Resident		<b>\$</b>	
		ty must develop and	VIII.		the facility without	· · · · · · · · · · · · · · · · · · ·	1	
and a terminal state of the sta	implement written po	olicies and procedures that:	****		Accused CNA recei		ł.	
	8493 12/h)/1) Drahib	oit and prevent abuse,	į	***************************************	as part of this Plan of		6.0	
		ition of residents and	Name of the last o		Resident # 12 was s		•	
	misappropriation of				Practitioner to exam	•	٠	
	Andreade les elles connects de l'	,, ,			identified areas and		***************************************	
5	§483.12(b)(2) Estab	lish policies and procedures			accordingly (forehea			
	to investigate any su	ich allegations, and	***************************************		further injuries note	,	1	
	8483 12(h)(3) Includ	le training as required at			All future investigat			
	paragraph §483.95,	<b></b>			completed thorough		er	
		T is not met as evidenced			policy and regulation	• •	ŧ .	
	by:		-		and Director of Nur			
	Based on observati	on, resident interview, staff	Water		responsible for inve	•		
		I record review, it was	and a second		reporting.	onemine and		
	determined that the				roporting.		-	
		and procedures for the			2. All residents have p	otential to be	THE PARTY OF THE P	
		and neglect for two of 29			affected. An audit v		V	
	1	vey sample, Residents # 66			the Nursing Leaders		4	
	and # 12.				review of the 24 hou		TANGETON AN EAST	
	1 The facility staff fa	ailed to implement their abuse			eInteract Change of		man and a state of the state of	
		ures for an allegation of abuse			·		S. C.	
		ne facility did not follow their			Incident Reporting f	-	Name of the last o	
		abuse policy in regards to the following:			days to ensure all ev			
	"Identification of pos	ssible incidents or allegations			investigated appropri	•	w	
		which need investigation; Investigation of			up, conclusion and r	eported		
		itions; Protection of patients			accordingly.			
		s; and Reporting of incidents,			- Comment			
i	investigations, and					***		

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

Event ID: DGW11

Facility ID: VA0279

If continuation sheet Page 67 of 348



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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495246	B. WING		C 12/08/2017
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP COD 1 DAIRY LANE REDERICKSBURG, VA 22405	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 607	of their investigation  2. The facility staff abuse policies and p #12 had two separa unknown origin.  The findings include  1. The facility staff fipolicies and procedifor Resident # 66; the abuse policy in regalidentification of possible which need investigations investigations and allegations of their investigations investigations of their investigations of abuse were requested from approximately 12:40 provided and one review, Resident # 66 was a 1/16/17 with diagnol limited to: hypertens gout, and anxiety.  Resident # 66's mosset) assessment, a an ARD (assessment and an ARD (assessment and an ARD (assessment an ARD (assessment and an A	failed to implement their procedures when Resident te incidents of injuries of a least the incidents of injuries of a least to implement their abuse are facility did not follow their ards to the following: a sible incidents or allegations ation; Investigation of ations; Protection of patients are; and Reporting of incidents, Center response to the results as:  Desimately 12:30 p.m., all a since the previous survey in the administrator. At D p.m. the allegations were asident was selected for a least to the facility on the sest that included but were not sion, rheumatoid arthritis, at recent MDS (minimum data Quarterly Assessment, with the reference date) of 11/3/17 as usually understood by	F 607	<ol> <li>Education was provinursing staff by the Educator related to ridentified injury, bru Policy and Procedur with facility staff.</li> <li>Nurse Management hour reports, eIntera Conditions, and Inci Clinical Morning Mall events have approinvestigations compaccording to policy a Results of these audibefore the Quality A Performance Improving Committee monthly</li> </ol>	Nurse Practice reporting any using ect. Abuse re also reviewed  team to audit 24 act Change of ident Reports in eeting to ensure opriate follow up leted and reported and regulation. its will be brought assurance and vement
	others and as able t Resident # 66 was	to usually understand others.  coded as being moderately daily decisions, scoring 10			

		AND HOMAN SERVICES & MEDICAID SERVICES			FORM	1 APPROVED 1 APPROVED 1 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		495246	B. WING_		i	/08/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	A Review of the FRI Incident for Resider revealed the followin FRI form: "Incident abuse/mistreat. De location, and action of Resident # 66) al CNA (certified nurse ago. She also state back. The resident injuries and no injur Resident told her daby CNA and receive fingernails while she investigation: The reand was transferred mechanical lift by two sustained during track (right) Forearm of She is on anticoaguskin. Name of employositions: CNA # 12 LPN (licensed praction investigator), LPN # Final Report on (Nation 4/2/2017 Notation must be wheelchair using a members. The injur was a skin tear to the	I (facility reported incident) at #66 dated: 3/27/2017, and was documented on the type: Allegation of scribe incident, including taken: On 3/27/2017: (name leged that she was slapped by its assistant) about a month at that she slapped the CNA is face was assessed for ites were noted. On 3/27/2017: aughter that she was slapped it a skin tear on her arm, from a was being restrained. Initial esident was combative in bed it to a wheelchair using a ro CNAs. The injury ansfer was a skin tear to the measuring 6 cm (centimeter). Itation therapy and has fragile byee(s) involved and their ical nurse) # 14 (initial 5).  The of Resident # 66) dated and that the Office of fication received a copy. below: "On 3/27/2017: The resident and was transferred to a mechanical lift by two staff y sustained during transfer e right forearm measuring 6.	F 60				
		pagulation therapy, Lovenox s.c. (sic) [subcutaneous] daily					

PRINTED: 12/18/2017

## DEPARTMENT OF HEALTH AND HU N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRIN	TED:	12/18/2017
F(	DRM.	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	
		495246	B. WING				C <b>08/2017</b>
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, Z 11 DAIRY LANE FREDERICKSBURG, VA 224				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	F	ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 607	and has fragile skir bruising. Investigat 3/27/2017: Resider she had sustained and there was purp the area. On 3/27/2 obtained from all in An interview of resicompetent was cor Worker. All resider care on the evening instances of neglec "Conclusion: Allega unsubstantiated. To by the resident were evidentiary data cobeing slapped was incident revealed the skin tear during transpecause of her level.	n. She is also susceptible to ion and Actions Taken: nt's skin was assessed and a skin tear on the right forearmole and yellow bruising around 2017: Statements were dividuals involved. 3/28/2017: dents who were deemed nducted by the Unit Social nts interviewed reported proper g shift; no reports of any ct or mishandling by staff." ations of abuse were the dates and times reported e not consistent. No lected from the allegation of identified. Investigation of the nat the resident sustained a nesfer; no injury to resident's eferred from bed to chair el of agitation. The transfer two individuals per facility	F6	607			
*	assistant) #12's em from ASM (Adminis	O CNA (certified nursing aployee record was requested strative Staff Member) #1, the The file was reviewed and did terns.					
	with ASM #1, regan Resident #66. ASM supporting docume give you a confirma allegation had beer agency)." When as statements, ASM #	i., an interview was conducted ding the allegation of abuse for M #1 stated, "Have no ints, I can find nothing. I can't ation of the fax (indicating this is reported to the state sked about the witness 1 stated, "I can find nothing. I it was thoroughly investigated					

		AND HOMAN SERVICES			FORM	: 12/18/2017 APPROVED
		& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION  G	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495246	B. WING _		i	C 08/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODN	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(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)	JLD BE	(X5) COMPLETION DATE
F 607	card for 3/27/17 for On 12/8/17 at 1:20 time card for CNA #better, she was wor A review of CNA #1; part the following: "Time period 3/27/2 Sun (Sunday) 3/26+Care/Dove/ Out 7:40 Mon (Monday)3/27-Care/Dove/ Out 7:40 Tue (Tuesday) 3/28 Care/Dove/ Out 8:16 Wed (Wednesday) 5509/Direct Care/Dove/ Out 7:20 Thur (Thursday) 3/3 Care/Dove/ Out 7:20 Fri (Friday) 3/31+ In Sat (Saturday) 4/01-Care/Dove/ Out: 7:20 Sun (Sunday) 4/02 (documented)."  On 12/8/17 at approximate the allegation was ASM #1 reviewed the see a time." When a continued working a	ation of abuse) was At this time CNA #12's time ward was requested.  p.m., ASM #1 provided the #12 and stated, "It gets even king."  2's time card documented in  017 -4/2/2017: - in: 11:01 PM 5509/Direct 6 AM - In: 11:02 PM 5509/Direct 5 AM + In: 11:06 PM 5509/Direct 8 AM 3/29+ In: 10:55 PM bye/ Out 7:01 AM 00+ In: 11:06 PM 5509/Direct 0 AM 11:05 PM Out: 7:39 AM + In: 11:12 PM 5509/Direct 4 AM	F 60	7		

stated, "Absolutely should have been put on admin (administrative) leave pending investigation. Should have completed our

investigation and if substantiated would have terminated the employee and reported her to the

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

PRIN	TED:	12/18/	2017
F	ORM A	<b>APPRO</b>	VEC
OMB	NO.	0938-0	<u>)391</u>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	TIPLE CONSTRUCTION  NG		COMPLETED			
		495246	B. WING		12	/08/2017		
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	ULD BE COMPLETION		
F 607	licensing board. If would have abuse RP (responsible pa ombudsman, Licen Licensure and Cert and a fax sent. I haw as completed." Vand procedures for followed, ASM #1 sevidence, no. There investigation, such documents showing The FRI documents done, but I am una On 12//8/17 at approcedures were of of the concern and forward."  Review of the facilit documented the fol Genesis HealthCar mistreatment, negle resident property, a residents. This incomplete facility and any not required to trea symptoms. The Ceprohibition program Screening of potent Training of employe ongoing training for Prevention of occur Identification of pos	it was unsubstantiated, then identification education. The rty), MD (medical doctor), sing office (OLC [Office of ification]) would be notified ave no evidence to support this when asked if the facility policy abuse prevention had been stated, "Based on this is no evidence of as interviews, no supporting the investigation was done, individual interviews were ble to produce them."  Toximately 1:45 p.m., a copy of revention policy and betained. ASM #1 was informed stated, "It is pretty straight  Typolicy "Abuse Prohibition" lowing: Under "POLICY:"  The Centers will prohibit abuse, eact, misappropriation of and exploitation for all lude, but is not limited to, oral punishment, involuntary physical or chemical restraint the patient's medical enter will implement an abuse at through the following: tial hires; sees (both new employees and all employees); rences; issible incidents or allegations pation; Investigation of	F 6	07				

DEPART	MENT OF HEALTH	AND HOAN SERVICES & MEDICAID SERVICES				FORM	: 12/18/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		495246	B. WING			l .	08/2017
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				11	DAIRY LANE		
WOODM	ONT CENTER			FF	REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE
F 607	Reporting of incider response to the result response to the result response to the result doing all that is with occurrences of abuexploitation, involur unknown source, aproperty for all patie. The Center Execution responsible for ope procedures that provinvoluntary seclusion exploitation, and mid. Actions to prever or mistreatment, incompared that may condetermine the direct and the direct and report the direct and report the incide immediately. 5.1.1 report the suspected center Executive Dother officials in acc 5.1.2 The employed the act of abuse will from duty, pending of suspected abuse patient's family and Injuries of unknown	ge 72  Its during investigations; and onts, investigations, and Center ults of their investigations.  The following was "To ensure Center staff are in their control to prevent se, mistreatment, neglect, intary seclusion, injuries of and misappropriation of ents." Under "PROCESS: 1. Inve Director, or designee is rationalizing policies and whibit abuse, neglect, in Injuries of unknown source, isappropriation of property into abuse, neglect, exploitation, cluding injuries of unknown repriation of resident property fy events - such as suspicious, occurrences, patterns, and institute abuse and tion of the investigation 5.1 ses an incident of suspected cluntary seclusion, injuries of misappropriation of patient e abuser to stop immediately ent to his/her supervisor. The notified supervisor will d abuse immediately to the irector (CED) or designee and cordance with state law e alleged to have committed I be immediately removed investigation. 5.1.3 All reports a must also be reported to the attending physician 5.3 origin will be investigated to or neglect is suspected. 6.	F6	:07			

PRINTED: 12/18/2017

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION ING	(X:	(X3) DATE SURVEY COMPLETED	
						С	
		495246	B. WING			12/08/2017	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP ( 11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIAT		
F 607	suspected or allege neglect, the CED or following. 6.1 Enter Management Syste allegations involving sexual, mental) not allegation is made. involving neglect, expected including injuries or misappropriation of than two hours after event results in seri allegations involving mistreatment (includes ource) and misappropriation of the serious bodily injury enforcement, Licentary and other agencies investigation within abuse that focuses neglect occurred an examination for sign 6.7.3 causative factor prevent further injurthoroughly document documentation of wincluded. 7. The Cefurther harm during the patient with a sapersons with whom conditions that would designee will: 8.1 Taraction depending or investigation; 8.2 Reinvestigations within Department of Health	rmation concerning a report of ad abuse, mistreatment, or r designee will perform the allegation into the Risk m (RMS). 6.2 Report gabuse (physical, verbal, later than two hours after the 6.3 Report allegations exploitation or mistreatment funknown source) and resident property not later the allegation is made if the ous bodily injury6.4 Report g neglect, exploitation or ding injuries of unknown propriation of resident property e event does not result in c.6.5 Notify local law sing Boards and Registries, as required 6.7 Initiate an 24 hours of an allegation of on: 6.7.1 whether abuse or and to what extent; 6.7.2 clinical has of injuries, if indicated; ors; and 6.7.4 interventions to y. 6.8 The investigation will be need Ensure that itnessed interviews is not review is not review in the review is an investigation. 7.1 Provide fe environment by identifying he/she feels safe and differ environment by identifying he/she feels safe and differ environment or the contact in the	F6	07			

DEPART	TMENT OF HEALTH	AND AN SERVICES			0		FORM	12/18/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED C		
		495246	B. WING	·			F	08/2017	
NAME OF	PROVIDER OR SUPPLIER			ł	STREET ADDRESS, CITY, STAT	E, ZIP CODE			
WOODM	ONT CENTER			1	11 DAIRY LANE FREDERICKSBURG, VA	22405	٠	:	
(X4) ID ' PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD TO THE APPROPI	BE	(X5) COMPLETION DATE	
F 607	will be maintained athree (3) years."  No further informatic completion of the sure 2. The facility staff abuse policies and #12 had two separa unknown origin.  Resident #12 was a 11/15/10 with a read diagnoses that includementia, osteoporobones), anemia (low disease, depression cognitive deficit.  Resident #12's most set), a quarterly ass (assessment reference revealed, in part, the answer the question of mental status) an assessment as beind decisions regarding #12 was further code staff for activities of was further coded the admission/entry or process to have an above her right eye, documentation in Resident #12 was open as the set of th	elated to allegations of abuse at the Center for not less than on was provided by urvey process failed to implement their procedures when Resident ate incidents of injuries with admitted to the facility on admission on 5/5/16 with added, but were not limited to; osis (weakening of the vered blood cells), acid reflux and difficulty swallowing, and at recent MDS (minimum data essment with an ARD note date) of 11/17/17, at Resident #12 was unable to as on the BIMS (brief interview and was coded on the staffing severely impaired to make tasks of daily life. Resident as being dependent on daily living. Resident #12 not there were no falls since prior assessment.  bserved during the survey abrasion on her forehead. There was no esident #12's clinical record.	F	607	7				
	above her right eye. documentation in Re concerning the abra	There was no esident #12's clinical record							

DEPARTMENT OF HEALTH AND HU N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	COMPLETED		
		495246	B. WING	ì		1	08/2017
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	1 47	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	revealed, in part, athe following; ""Effe (11:20 p.m.) Type: change in condition symptoms include: 11/8/2017. Change Clinician: (name of 4:00 p.m. Name of notified: SELF 11/4 Further review of Frevealed, in part, adated 11/8/17 that following; "Old bruing the chin."  Further review of the any documentation initiated.  A review of Reside plan did not reveal injuries in Novembound on 12/7/17 at 12:3 conducted with AS member) #2, the in (DON). ASM #2 we process followed if any injury. ASM #3 and investigated. As able to provide an in regards to bruise and the abrasion of forehead. ASM #2 it but that she was seen the abrasion had been there a western the service of the second the sec	progress note documenting ective Date: 11/8/17 23:20 Change in Condition. Note: A n has been noted. The : Skin wound or ulcer e reported to Primary Care f clinician notified) 11/8/2017 of Family / Healthcare agent		607			

CENTER STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER	AND HOAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495246	1 ' '	ST 11	E CONSTRUCTION  TREET ADDRESS, CITY, STATE, ZIP COL	Ol	FORM / MB NO. (X3) DATE COMP	12/18/2017 APPROVED 0938-0391 SURVEY PLETED 208/2017
WOODM( (X4) ID	ONT CENTER SUMMARY STA	TEMENT OF DEFICIENCIES	ID PREF		REDERICKSBURG, VA 22405  PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI	ECTION HOULD	N BE	(X5) COMPLETION
PRÉFIX TAG	(EACH DEFICIENC) REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPE	RIATE	DATE
F 607	Continued From pa	ge 76	E d	607			and the second s	
	writer and stated the where investigation Resident #12 in regard the abrasion or stated that the nurshallway so there was had happened.  On 12/7/17 at 3:10 conducted with LPN a floor nurse. LPN process if a resider of unknown origin. DON and Administranyone had reported I would document a interview the resides on investigation.  On 12/7/17 at 3:42 writer and stated the Resident #12's the was brought to the there was a concert the unit manager to did get back to methad followed up. A ASM #2 was asked bruise, ASM #2 state was asked whether unknown origin and	p.m. ASM #2 approached this at she was unable to find as had been conducted for gards to the bruise on her chin her forehead. ASM #2 further ses have all changed on that as no one who could say what p.m. an interview was N (licensed practical nurse) #3, #3 was asked to describe his at was seen to have an injury LPN #3 stated, "I notify the rator. I would look to see if sed it on the last 24-hour report. A description and try to ent. We need to rule out abuse would be initiated."  p.m. ASM #2 approached this last she remembered that issue of the bruise on her chin daily clinical meeting and an ASM #2 stated, "I asked investigate this but he never." ASM #2 was asked if she SM #2 stated that she did not. If she knew what had caused the total this was an injury of I should have been reported to SM #2 stated that it should.						
	abrasion to Reside to state how long it	2 was unable to explain the nt #12's head and was unable had been there. A FRI (facility had not been submitted for						

PRINTED: 12/18/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	B. WING			(	
NAME OF P	ROVIDER OR SUPPLIER	430240	10. 14.10	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	12/0	08/2017
WOODMO	NT CENTER				AIRY LANE DERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 607	Continued From page	77	F	607		or book and a second se	
	4:45 p.m. with ASM # ASM #2, the interim E clinical quality special ASM #3 were made a concerns.	g occurred on 12/7/17 at 1, the executive director, ON, and ASM #3, the ist. ASM #1, ASM #2 and ware of the above					
F 609 SS=D	CFR(s): 483.12(c)(1)( §483.12(c) In responsion neglect, exploitation, must:  §483.12(c)(1) Ensure involving abuse, neglemistreatment, includir source and misappropare reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not resist he administrator of the officials (including to the administrator of the administrat	se to allegations of abuse, or mistreatment, the facility that all alleged violations ect, exploitation or ag injuries of unknown oriation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and the sex where state law provides the state that the state survey agency and the state survey agency	F		1. Investigations were not com these past events for residen and # 12. Resident #66 still the facility without further in Accused CNA received abus as part of this Plan of Correce Resident # 12 was seen by the Practitioner to examine both identified areas and addresse accordingly (forehead and of further injuries noted for this All future investigations will completed thoroughly, timel policy and regulation. Admir and Director of Nursing are responsible for investigating reporting.  2. All residents have potential traffected. An audit was computed the Nursing Leadership team review of the 24 hour reports eInteract Change of Conditional contract contract the contract con	ts # 66 resides recident. se traini etion. ne Nurse hin). No s resider l be y and po nistrator and o be bleted by with a	in ng at.

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

PRINTED:	12/20/2017
FORM A	APPROVED
OMB NO.	0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULIDENTIFICATION NUMBER: A. BUILDI			(X3) DATE SURVEY COMPLETED		
		495246	B. WING			12/0	) 08/2017
WOODMO	ROVIDER OR SUPPLIER  NT CENTER	ATEMENT OF DEFICIENCIES	ID.	11 DAIR	ADDRESS, CITY, STATE, ZIP CODE Y LANE RICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	A THE STATE OF THE	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 609	Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on observation interview and clinical determined that the fallegations of abuse origin for two of 29 resample, Residents #  1. The facility staff far abuse for Resident # other officials in account through established with the state agency and with State law through the state agency and with State law through established with The findings included the form officials in account to the state agency and with State law through established on 12/8/17 at approximately 12:40	in 5 working days of the leged violation is verified e action must be taken.  T is not met as evidenced on, resident interview, staff record review, it was facility staff failed to report and injuries of unknown esidents in the survey 66 and # 12.  illed to report an allegation of 66 to the state agency and ordance with State law procedures.  alled to report injuries of a Resident #12 was observed er chin on 11/8/17 and an lead (date undetermined) to dother officials in accordance gh established procedures.  illed to report an allegation of 66 to the state agency and ordance with State law procedures.  illed to report an allegation of 66 to the state agency and ordance with State law procedures.  in the state agency and ordance with State law procedures.  in the allegations were sident was selected for	F 60	3.	Incident Reporting for the padays to ensure all events wer investigated appropriately wup, conclusion and reported accordingly.  Education was provided to the nursing staff by the Nurse Preducator related to reporting identified injury, bruising expedicy and Procedure also rewith facility staff.  Nurse Management team to a hour reports, eInteract Change Conditions, and Incident Repedinical Morning Meeting to all events have appropriate for investigations completed and according to policy and regulated regulated in the process of these audits will be before the Quality Assurance Performance Improvement Committee monthly for review.	ne ne ne ne nactice any t. Abus viewed nudit 24 ge of ports in ensure ollow up reported ation. e brough	e <del>za</del>

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

JACLUALITY OF DELIVERY		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495246	B. WING_			12/08/2017	
	PROVIDER OR SUPPLIER			-			
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	E (X5) COMPLETION ATE DATE	
F 609	Resident # 66 was 1/16/17 with diagnor limited to: hyperten gout, and anxiety.  Resident # 66's moset) assessment, an ARD (assessment, an ARD (assessment) and as able Resident # 66 was impaired for makin out of 15 on the Blistatus).  A Review of the FF Incident for Resident for Resident abuse/mistreat. Do location, and action of Resident # 66) at CNA (certified nursiago. She also statiback. The resident injuries and no injuries and no injuries and receive fingernails while shinvestigation: The rand was transferred mechanical lift by the sustained during transferred to the resident signal for the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred mechanical lift by the sustained during transferred to the resident signal was transferred to the resident sign	admitted to the facility on oses that included but were not oses, rheumatoid arthritis, and recent MDS (minimum data a Quarterly Assessment, with ent reference date) of 11/3/17 of as usually understood by to usually understand others, coded as being moderately g daily decisions, scoring 10 MS (brief interview for mental of the facility reported incident) and #66 dated: 3/27/2017, ing was documented on the excribe incident, including a taken: On 3/27/2017: (name alleged that she was slapped by the sassistant) about a month ed that she slapped the CNA at face was assessed for ries were noted. On 3/27/2017: laughter that she was slapped as kin tear on her arm, from the was being restrained. Initial resident was combative in bed do to a wheelchair using a wo CNAs. The injury ansfer was a skin tear to the measuring 6 cm (centimeter). ulation therapy and has fragile loyee(s) involved and their	F 60	09			
	investigator), LPN						

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>או מועוט</u>	<del>). 0936-0391</del>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED	
		495246	B. WING	·		12	C 2 <b>/08/2017</b>
NAME OF	PROVIDER OR SUPPLIER		J	٤	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ONT CENTER		ļ	ı	11 DAIRY LANE		
			-		FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 609	Continued From pa	ge 80	F(	609			On the control of the
	4/2/2017 Notation relicensure and Cert Documented in par Initial investigation: was combative in being a members. The injury was a skin tear to the composition of th	"On 3/27/2017: The resident ed and was transferred to a mechanical lift by two staff try sustained during transfer he right forearm measuring 6 coagulation therapy, Lovenox 9 s.c. (sic) [subcutaneous] daily 1. She is also susceptible to on and Actions Taken: 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	· · · · · · · · · · · · · · · · · · ·				
A CAN	assistant) #12's em	OCNA (certified nursing ployee record was requested trative Staff Member) #1, the	<ul> <li>Адабиторововання коротнолика</li> </ul>				The second of th

DEPARTMENT OF HEALTH AND HOAN SERVICES

PRINTED: 12/18/2017

FORM APPROVED

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495246	B. WING			1	C <b>/08/2017</b>	
•	PROVIDER OR SUPPLIER  ONT CENTER		STREET ADDRESS, CITY, STATE, ZIP O 11 DAIRY LANE FREDERICKSBURG, VA 22405					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	Executive Director. not reveal any condition 12/8/17 at 1:00 p.m with ASM #1, regar Resident #66. ASM supporting docume give you a confirmal allegation had beer and other officials). witness statements nothing. I can't find investigated to show was unsubstantiate time card for 3/27/1 On 12/8/17 at 1:20 time card for CNA #1 better, she was word A review of CNA #1 part the following: "Time period 3/27/2 Sun (Sunday) 3/26-Care/Dove/ Out 7:1 Mon (Monday)3/27-Care/Dove/ Out 7:4 Tue (Tuesday) 3/28 Care/Dove/ Out 8:1 Wed (Wednesday) 5509/Direct Care/D Thur (Thursday) 3/3 Care/Dove/ Out 7:2 Fri (Friday) 3/31+ In	The file was reviewed and did cerns.  I., an interview was conducted ding the allegation of abuse for M #1 stated, "Have no ents, I can find nothing. I can't ation of the fax (indicating this in reported to the state agency "When asked about the state agency "When asked about the state agency with the allegation of abuse) at the allegation of abuse at the condition of abuse at th	F	609				

DEPART	MENT OF HEALTH	AND MAN SERVICES			0	FOR	D: 12/18/2017 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495246	B. WING				2/08/2017
NAME OF I	PROVIDER OR SUPPLIER			l	REET ADDRESS, CITY, STATE, ZIP COD	E	•
WOODM	ONT CENTER				DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	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 AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	On 12/8/17 at appropriate the allegation of ASM #1 reviewed the see a time." When continued working a the allegation of abstated, "Absolutely admin (administrati investigation. Should investigation and if terminated the emplicensing board. If would have abuse in RP (responsible parambudsman, Licent Licensure and Cert and a fax sent. I had (notification) was confacility policy and proprevention had been "Based on this evide evidence of investig supporting docume was done. The FR interviews were don't the facility abuse procedures were of the concern and forward."  Review of the facility documented the fol Genesis HealthCarmistreatment, negletic services at the side of the concern and forward."	oximately 1:35 p.m. the FRI for reviewed with ASM #1 for the was reported on 3/27/17. he FRI and stated, "I do not asked if CNA #12 should have and caring for residents after use was reported, ASM #1 should have been put on	F	609	,		

PRINTED: 12/18/2017

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED			
		495246	B. WING		12	/08/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	residents. This included freedom from corporate seclusion, and any not required to treat symptoms. The Coprohibition program Screening of potent Training of employed ongoing training for Prevention of occur Identification of possibility of possibility incidents and allegate Protection of patient Reporting of incident response to the rest and allegate Protection of patient Reporting of incident response to the rest and allegate Protection of patient Reporting of incident response to the rest and in part doing all that is with occurrences of abute exploitation, involution unknown source, and property for all patient The Center Execution responsible for operior procedures that profin involuntary seclusion exploitation, and mid. Actions to prever or mistreatment, incomplete and misapping suspected abuse in Executive Director (officials in accordant employee alleged to abuse will be immediately and	oral punishment, involuntary physical or chemical restraint the patient's medical enter will implement an abuse through the following: tial hires; sees (both new employees and all employees); rences; sible incidents or allegations pation; Investigation of ations; ts during investigations, and Center ults of their investigations."	F 6	0.9		

STATEMENT OF DEPICIENCES MAD PLAN OF CORRECTION (XX) PREVIOUS PROVIDERS UNITY OF DEPICIENCES AND PLAN OF CORRECTION (XX) DESCRIPTION A BUILDING COMPLETE CYC.  NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER  SUMMANY STATEMENT OF DEPICIENCES PREPRIED SUBJECT OF DEPICIENCES PREPRIED COMPLETE PROPRIED COMPLETE PROPRIED CYC.  (X4) DEPARTMENT OF DEPICIENCES PROPRIED BY YOU. REGULATORY OR LSC IDENTIFYING INFORMATION)  F 609  Continued From page 84 suspected abuse must also be reported to the patient's family and attending physician 5.3 injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. 6. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment (following. 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbar, sexual, mental) not later than two hours after the allegation is made. 6.3 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury. 6.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required. 8.2 Report findings of all completed investigations within fire (5) working days to the Department of Health using the state on-line reporting system or state-approved forms 10. All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years."		TMENT OF HEALTH	AND ()IAN SERVICES & MEDICAID SERVICES		0	FORM	D: 12/18/2017 MAPPROVED D: 0938-0391
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER  SIMMARY STATEMENT OF DEFICIENCIES (PACH) DEFICIENCY MUST are PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  F 609  Continued From page 84 suspected abuse must also be reported to the patient's family and attending physician 5.3 injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. 6. Upon receiving information concerning a report of suspected or alleged abuse, mistratement, or neglect, the CED or designee will perform the following. 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident properly not later than two hours after the allegation is made 6.3 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident properly within 24 hours if the event does not result in serious bodily injury. 6.4 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident properly within 24 hours if the event does not result in serious bodily injury. 6.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required 8.2 Report findings of all completed investigations within fire (5) working days to the Department of Health using the state on-line reporting system or state-approved forms 10. All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years.*  2. The facility staff failed to report injuries of unknown origin when Resident #12 was observed to have a bruise to her chin on 11/8/17 and an abrasion to her forehead (date undetermined).	STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '			MPLETED
WOODMONT CENTER    TOTAL CONTROL   SUMMARY STATEMENT OF DEFICIENCIES   CEACH DEFICIENCY MUST BE PRECEDED BY FULL   FREETIX   REGULATORY OR LISC IDENTIFYING INFORMATION    FREETIX   TAG   TAG			495246	B. WING		12	
TROUDMONT CENTER   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   REGULATORY ORLSC IDENTIFYING INFORMATION)   PREFIX   PROVIDER'S PLAN OF CORRECTION SHOULD BE CAGOS -REFERENCY MAY PROPRIATE   CAMERINA STAGE   PROVIDER'S PLAN OF CORRECTION SHOULD BE CAGOS -REFERENCY MAY PROPRIATE   CAMERINA STAGE   PROVIDER'S PLAN OF CORRECTION SHOULD BE CAGOS -REFERENCY MAY PROPRIATE   CAMERINA STAGE   PROVIDER'S PLAN OF CORRECTION SHOULD BE CAGOS -REFERENCY MAY PROPRIATE   CAMERINA STAGE   PROVIDER'S PLAN OF CORRECTION SHOULD BE CAGOS -REFERENCY MAY PROPRIATE   CAMERINA STAGE   CAGOS -REFERENCY MAY PROPRIATE   CAMERINA STAGE   CAGOS -REFERENCY MAY PROPRIATE   CAGOS	NAME OF	PROVIDER OR SUPPLIER		i		CODE	
F 609  Continued From page 84 suspected abuse must also be reported to the patient's family and attending physician 5.3 injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. 6.  Upon receiving information concerning a report of suspected or allegad buse, mistreatment, or neglect, the CED or designee will perform the following. 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. 6.3 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property not later than two hours after the allegation is made if the event results in serious bodily injury 6.4 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury 6.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required 8.2 Report findings of all completed investigations within fire (5) working days to the Department of Health using the state on-line reporting system or state-approved forms 10. All documentation related to allegations contained at the Center for not less than three (3) years."	WOODM	ONT CENTER		1		5	
suspected abuse must also be reported to the patient's family and attending physician 5.3 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. 6.  Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the CED or designee will perform the following. 6.1 Enter allegation into the Risk Management System (RMS). 6.2 Report allegations involving abuse (physical, verbal, sexual, mental) not later than two hours after the allegation is made. 6.3 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property not later than two hours after the allegation is made if the event results in serious bodily injury 6.4 Report allegations involving neglect, exploitation or mistreatment (including injuries of unknown source) and misappropriation of resident property within 24 hours if the event does not result in serious bodily injury. 6.5 Notify local law enforcement, Licensing Boards and Registries, and other agencies as required 8.2 Report findings of all completed investigations within fire (5) working days to the Department of Health using the state on-line reporting system or state-approved forms 10. All documentation related to allegations of abuse will be maintained at the Center for not less than three (3) years."	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	COMPLETION
to have a bruise to her chin on 11/8/17 and an abrasion to her forehead (date undetermined).	F 609	suspected abuse mpatient's family and Injuries of unknown determine if abuse Upon receiving info suspected or allegeneglect, the CED or following. 6.1 Enter Management Syste allegations involving sexual, mental) not allegation is made. involving neglect, expected including injuries or misappropriation of than two hours after event results in seriallegations involving mistreatment (inclusionary and other agencies findings of all compicts) working days to using the state on-listate-approved form related to allegation at the Center for notice.	attending physician 5.3 a origin will be investigated to or neglect is suspected. 6. rmation concerning a report of ad abuse, mistreatment, or designee will perform the allegation into the Risk m (RMS). 6.2 Report g abuse (physical, verbal, later than two hours after the 6.3 Report allegations exploitation or mistreatment f unknown source) and resident property not later r the allegation is made if the ous bodily injury 6.4 Report g neglect, exploitation or ding injuries of unknown propriation of resident property e event does not result in c. 6.5 Notify local law sing Boards and Registries, as required 8.2 Report leted investigations within fire the Department of Health ne reporting system or ns 10. All documentation s of abuse will be maintained t less than three (3) years."	F 609			
	A THE STATE OF THE	to have a bruise to habrasion to her fore	ner chin on 11/8/17 and an head (date undetermined).				APP. THE PROPERTY OF THE PROPE

## DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED					
		495246	B. WING	_			C	
			B. WIIIO		REET ADDRESS, CITY, STATE, ZIP CODE		2/08/2017	
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIER  ONT CENTER			11	DAIRY LANE REDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 609	11/15/10 with a readiagnoses that incl dementia, osteoporbones), anemia (lor disease, depression cognitive deficit.  Resident #12's moset), a quarterly assessment refere revealed, in part, the answer the question of mental status) are assessment as beindecisions regarding #12 was further coded to admission/entry or Resident #12 was further coded to	idmission on 5/5/16 with uded, but were not limited to; rosis (weakening of the wored blood cells), acid reflux in, difficulty swallowing, and set recent MDS (minimum data sessment with an ARD ence date) of 11/17/17, nat Resident #12 was unable to ins on the BIMS (brief interview and was coded on the staffing severely impaired to make in tasks of daily life. Resident ded as being dependent on a fally living. Resident #12 that there were no falls since prior assessment.  Observed during the survey abrasion on her forehead in the There was no desident #12's clinical record asion.  Int #12's clinical record, progress note documenting cive Date: 11/8/17 23:20 Change in Condition. Note: A has been noted. The Skin wound or ulcer a reported to Primary Care clinician notified) 11/8/2017 Family / Healthcare agent	F6	609				
		change in condition document		***************************************				

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				OMR M	<u>U. 0938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		PLE CONSTRUCTION		ATE SURVEY OMPLETED
		495246	B. WING	·		1	C <b>2/08/2017</b>
•	PROVIDER OR SUPPLIER  ONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE		
VVOODINI				İ	FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 609	dated 11/8/17 that of following; "Old bruis right chin."  Further review of the any documentation initiated.  A review of Resider plan did not reveal injuries in November on 12/7/17 at 12:30 conducted with ASI member) #2, interir ASM #2 was asked investigation for Resident was seen stated that it should ASM #2 was asked investigation for Resident was not aware abrasion currently of ASM #2 stated that she was not aware abrasion on the forthere a while. ASM an investigation into On 12/7/17 at 3:00 writer and stated the where investigation of stated that the nurshallway so there was had happened.  On 12/7/17 at 3:10	documented, in part, the se, fadded (sic) bluish color to the clinical record did not reveal that an investigation had been in #12's comprehensive care any documentation regarding er 2017 and December 2017.  Op.m. an interview was M (administrative staff m director of nursing (DON). It to describe the process if a to have any injury. ASM #2 if she was able to provide an esident #12 in regards to a poccurring 11/8/17 and the pon Resident #12's forehead. If she would look into it but that of a bruise she had seen the ehead but thought it had been to the abrasion.  p.m. ASM #2 approached this at she was unable to find is had been conducted for pards to the bruise on her ching her forehead. ASM #2 further the shave all changed on that as no one who could say what					
	conducted with LPN	N (licensed practical nurse) #3,	İ				

DEPARTMENT OF HEALTH AND HOAN SERVICES

PRINTED: 12/18/2017 FORM APPROVED

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CO	COMPLETED	
		495246	B. WING		12	/08/2017	
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 609	a floor nurse. LPN process if a resider of unknown origin. DON and Administranyone had reported I would document a interview the resides so an investigation. On 12/7/17 at 3:42 writer and stated the Resident #12's the was brought to the there was a concert the unit manager to did get back to me. had followed up. A ASM #2 was asked whet unknown origin and the state agency, A have been. ASM #2 was asked whet unknown origin and the state agency, A have been. ASM # abrasion to Resider to state how long it reported incident) heither injury.  An end of day meet 4:45 p.m. with ASM ASM #2, the interim clinical quality spect ASM #3 were made concerns. A copy of requested at this times.	#3 was asked to describe his not was seen to have an injury LPN #3 stated, "I notify the rator. I would look to see if ad it on the last 24-hour report. I description and try to ent. We need to rule out abuse would be initiated."  p.m. ASM #2 approached this at she remembered that issue of the bruise on her chin daily clinical meeting and n. ASM #2 stated, "I asked investigate this but he never "ASM #2 was asked if she SM #2 stated that she did not. If she knew what had caused stated that she did not. ASM her or not this was an injury of I should have been reported to SM #2 stated that it should 2 was unable to explain the not #12's head and was unable had been there. A FRI (facility lad not been submitted for ting occurred on 12/7/17 at 1#1, the executive director, n DON, and ASM #3, the ialist. ASM #1, ASM #2 and a ware of the above of the facility abuse policy was ne.		09			
	No further informati the survey process.	on provided prior to the end of	• Abrevior i vession socconsion			III. Jamona Heonatawa V Jama	

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

PRINTED: 12/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495246	B. WING		С	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/08/2017	
WOODMO	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	BE COMPLETION	
	S483.12(c) In responsing lect, exploitation, or must:  \$483.12(c)(2) Have eviolations are thorough s483.12(c)(3) Preventing lect, exploitation, or investigation is in programmed investigation is in programmed segmental accordance with State Survey Agency, within incident, and if the aller appropriate corrective This REQUIREMENT by:  Based on observation interview and clinical redetermined that the fact thoroughly investigate injuries of unknown ori in the survey sample, If the facility staff failed documentation that an Resident # 66 was thored.	the to allegations of abuse, or mistreatment, the facility vidence that all alleged the investigated.  If further potential abuse, or mistreatment while the press.  Ithe results of all deministrator or his or her ative and to other officials in a law, including to the State 5 working days of the ged violation is verified action must be taken. It is not met as evidenced action met as evidenced action and the interview, it was cility staff failed to an allegation of abuse and gin for two of 29 residents Residents # 66 and # 12.	F 6	1. Investigations were not co these past events for reside #12. Resident #66 still res facility without further inc Accused CNA received ab as part of this Plan of Corr Resident # 12 was seen by Practitioner to examine bo areas and addressed accord (forehead and chin). No fu noted for this resident. All investigations will be compare thoroughly, timely and per regulation. Administrator a of Nursing are responsible investigating and reporting  2. All residents have potential affected. An audit was conthe Nursing Leadership tear review of the 24 hour report Change of Condition and In Reporting for the past 30 darall events were investigated appropriately with follow unconclusion and reported according and reported according to the Nurse Practice related to reporting any idea injury, bruising ect. Abuse Procedure also reviewed wistaff.	ents #66 and ides in the ident. use training ection. the Nurse th identified lingly rther injuries future pleted policy and nd Director for .  to be impleted by its, eInteract incident ays to ensure its, eordingly. the nursing Educator intified Policy and	

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

PRINTED: 12/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495246	B. WING			C (08/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		08/2017
****	··· AFLITEN			11 DAIRY LANE		
WOODING	ONT CENTER		1	FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 610	Continued From pag	ge 89	F6	10		
on the same of the	1. The facility staff fa	=		4. Nurse Management team	e to sudit 24	
		an allegation of abuse for		hour reports, eInteract C	;	200
		thoroughly investigated.		Conditions, and Incident	•	
	On 12/8/17 at approximately 12:30 p.m., all			Clinical Morning Meetin		
	allegations of abuse since the previous survey			events have appropriate	<b>2</b> }	
	were requested from the administrator. At approximately 12:40 p.m. the allegations were			investigations completed	<b>-</b> 3	
		o p.m. the allegations were esident was selected for		according to policy and a		
	review, Resident #66		and the same of th	Results of these audits w		
-		<b>3</b> .		before the Quality Assur		The street
	Resident # 66 was a	admitted to the facility on		Performance Improveme	ent Committee	
***************************************	1/16/17 with diagnos	ses that included but were not		monthly for review.		1/17/18
		sion, rheumatoid arthritis,				
	gout, and anxiety.			CC-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-	Books	
	Resident # 66's mos	st recent MDS (minimum data			guest-	
1		Quarterly Assessment, with	-		,	
		nt reference date) of 11/3/17			#	
VANORATION		6 as usually understood by		TORROGEN	Morann.	
TANK I SAN AND AND AND AND AND AND AND AND AND A		o usually understand others.		Taxanian Anna Anna Anna Anna Anna Anna Anna	TO THE PARTY.	
		coded as being moderately			TO THE PARTY OF TH	
		daily decisions, scoring 10		NO CARACTER .	second.	
		S (brief interview for mental			Acceptance.	
	status).				- Control	
-	A Review of the FRI	(facility reported incident)	werkensam consider			
		t #66 dated: 3/27/2017,	appropriate to the state of the		diane.	
,	revealed the followin	ng was documented on the		operation of the control of the cont	VOVERNA	
	FRI form: "Incident ty				America	
		scribe incident, including			1	
		taken: On 3/27/2017: (name				
		eged that she was slapped by		ov constant		
		's assistant) about a month			Control of the Contro	
		d that she slapped the CNA state state was assessed for		Constant		
				Address of the second of the s		
}	injuries and no injuries were noted. On 3/27/2017: Resident told her daughter that she was slapped					

by CNA and received a skin tear on her arm, from

DEPAR1	MENT OF HEALTH	AND HON SERVICES					FORM.	APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					·	0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION  3	-		SURVEY PLETED
		495246	B. WING					)8/2017
NAME OF E	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
IAMINE OI I	TOTIBET OF OUT THE		:		11 DAIRY LANE			
WOODM	ONT CENTER				FREDERICKSBURG, VA 22405			
(X4) ID PREFIX	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULDI	BE	(X5) COMPLETION DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	j	DEFICIENCY)	(OI I)		
F 610		ige 90 e was being restrained. Initial	F	610	0			
	investigation: The r	esident was combative in bed d to a wheelchair using a	Louis de la constante de la co					
	mechanical lift by ty	vo CNAs. The injury						
	RT (right) Forearm	ansfer was a skin tear to the measuring 6 cm (centimeter).	Acceptable and a value of the					
	She is on anticoagu	ulation therapy and has fragile loyee(s) involved and their	Approximate Assessments (Approximate Assessments Approximate Assessments Asses					
	positions: CNA # 12	2	de maria de maria de maria de maria de maria de maria de maria de maria de maria de maria de maria de maria de					
	investigator), LPN #	tical nurse) # 14 (initial # 5	Action of Action and Action of Actio		,			,
	Final Report on (Na	ame of Resident # 66) dated made that the Office of	www.distantive.com					
	Licensure and Cert	ification received a copy.						
	Documented in par Initial investigation:	"On 3/27/2017: The resident						
	was combative in b	ed and was transferred to a mechanical lift by two staff	***************************************					
	members. The inju	ry sustained during transfer						
	cm. She is on antic	he right forearm measuring 6 coagulation therapy, Lovenox						
	(a blood thinner) 30	) s.c. (sic) [subcutaneous] daily n. She is also susceptible to						
	bruising. Investigat	ion and Actions Taken: nt's skin was assessed and	-					
	she had sustained	a skin tear on the right forearm						
	the area. On 3/27/2	ole and yellow bruising around 2017: Statements were	***					A CANADA A SA CANADA CA
	obtained from all in	dividuals involved. 3/28/2017: dents who were deemed	ALL COMPANY AND ADDRESS OF THE ADDRE					
	competent was cor	nducted by the Unit Social	reason been visual in Mer					**************************************
	care on the evening	nts interviewed reported proper g shift; no reports of any	department voca					September 1971 and the
	instances of neglect	ct or mishandling by staff." ations of abuse were	A PONTENDEN OF THE PROPERTY OF					
	unsubstantiated. T	he dates and times reported	**************************************					ACCUSA STREETMENT PROVIDE
	by the resident wer	e not consistent. No	MINISTER SANCES					THE PROPERTY OF THE PROPERTY O

PRINTED: 12/18/2017 FORM APPROVED

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495246	B. WING_		12	2/08/2017	
	PROVIDER OR SUPPLIER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	OTION OULD BE ROPRIATE	(X5) COMPLETION DATE		
F 610	being slapped was incident revealed the skin tear during transface. She was transposed because of her level was conducted by a policy & procedure.  On 12/8/17 at 12:50 assistant) #12's emfrom ASM (Administ Executive Director. Not reveal any conducted any conducted by the secutive Director. Not reveal any conducted by the secutive Director. Not reveal any conducted and the secutive Director. Not reveal any conducted and other decimal docume give you a confirmal allegation had been and other officials). Witness statements nothing. I can't find investigated to show was unsubstantiate time card for 3/27/1 On 12/8/17 at 1:20 time card for CNA #1 part the following:  "Time period 3/27/2 Sun (Sunday) 3/26-Care/Dove/ Out 7:1 Mon (Monday)3/27-Care/Dove/ Out 7:4	identified. Investigation of the nat the resident sustained a insfer; no injury to resident's sferred from bed to chair all of agitation. The transfer two individuals per facility.  O CNA (certified nursing apployee record was requested strative Staff Member) #1, the The file was reviewed and didectriate.  In, an interview was conducted ding the allegation of abuse for M #1 stated, "Have no ents, I can find nothing. I can't ation of the fax (indicating this in reported to the state agency." When asked about the endence it was thoroughly with the allegation of abuse) and." At this time CNA #12's 7 forward was requested.  p.m., ASM #1 provided the #12 and stated, "It gets even thing."  2's time card documented in 2017 -4/2/2017: Fin: 11:01 PM 5509/Direct 6 AM Fin: 11:02 PM 5509/Direct	F 6				

		AND I AN SERVICES				FORM	: 12/18/2017 APPROVED
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NOMBER.	a. Build	ING			C
		495246	B. WING			12/	08/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				11 DAIRY LANE FREDERICKSBURG, VA 22405		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	Care/Dove/ Out 7:2 Fri (Friday) 3/31+ In Sat (Saturday) 4/01 Care/Dove/ Out: 7:2 Sun (Sunday) 4/02 documented)."  On 12/8/17 at approximate the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation of about the allegation and if sterminated the emplicensing board. If it would have abuse it RP (responsible parombudsman, Licensure and Certificant and a fax sent. I had (notification) was confacility policy and proprevention had been "Based on this evidence of investigations and the FRI supporting documer was done. The FRI	8 AM 3/29+ In: 10:55 PM ove/ Out 7:01 AM 0+ In: 11:06 PM 5509/Direct 0 AM 1: 11:05 PM Out: 7:39 AM 1: 11:12 PM 5509/Direct 14 AM (no time in or out  eximately 1:35 p.m. the FRI for eviewed with ASM #1 for the was reported on 3/27/17. The FRI and stated, "I do not asked if CNA #12 should have and caring for residents after use was reported, ASM #1 should have been put on re) leave pending di have completed our substantiated would have oyee and reported her to the was unsubstantiated, then dentification education. The ty), MD (medical doctor), sing office (OLC [Office of fication]) would be notified we no evidence to support this mpleted." When asked if the	F	310			

Event ID: DGWI11

PRINTED: 12/18/2017

DEPARTMENT OF HEALTH AND HU I SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		E SURVEY IPLETED			
		495246	B. WING				1	08/2017
	PROVIDER OR SUPPLIER  ONT CENTER			11 DAIRY I	ICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 610	the facility abuse procedures were of of the concern and forward."  Review of the facility documented the form of the concern and forward."  Review of the facility documented the form of the facility documented the form of the section of the section of the section of the section of the section of the prohibition program of the section of the properties of the section of the protection of the protection of the protection of the protection of the section	roximately 1:45 p.m., a copy of revention policy and brained. ASM #1 was informed stated, "It is pretty straight by policy "Abuse Prohibition" llowing: Under "POLICY:" e Centers will prohibit abuse, ect, misappropriation of and exploitation for all lude, but is not limited to, oral punishment, involuntary physical or chemical restraint to the patient's medical enter will implement an abuse a through the following: tial hires; ees (both new employees and erall employees); rences; esible incidents or allegations pation; Investigation of ations; to during investigations, and Center cults of their investigations."  The following was the following was the results of their investigations of their investigations of their control to prevent se, mistreatment, neglect, intary seclusion, injuries of and misappropriation of	F6	10	DEFICIENCY			
	The Center Execution responsible for oper procedures that procedures that procedures that procedures that procedures that procedures that procedures that procedures that procedures that procedures that procedures that procedures the procedures that procedures the procedures that procedures the procedures that procedures the procedures that procedures the procedures that procedures the procedures that procedures the procedures that procedures the procedures that procedures the proce	ents." Under "PROCESS: 1. ve Director, or designee is rationalizing policies and shibit abuse, neglect, n. Injuries of unknown source,						

DEPART	MENT OF HEALTH	AND ()AN SERVICES					FORM.	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		PLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		495246	B. WING					C <b>08/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE			
WOODM	ONT CENTER				FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD	BE	(X5) COMPLETION DATE
F 610	exploitation, and mi5.1.1 The notified suspected abuse in Executive Director (officials in accordar reports of suspecte to the patient's fami 5.3 Injuries of unknown to determine if abus 6.7 Initiate an inves allegation of abuse abuse or neglect of 6.7.2 clinical examinindicated; 6.7.3 cau interventions to previous tigation will be Ensure that docume interviews is include patients from further investigation. 7.1 Prenvironment by identify the feels safe and safe8. The CED increasary correctives all completed investigation on-line reporting sysum 10. All documental abuse will be maintaless than three (3) yillow the facility staff two injuries of unknown resident #12.	sappropriation of property. supervisor will report the mediately to the Center (CED) or designee and other nce with state law 5.1.3 All d abuse must also be reported ily and attending physician own origin will be investigated se or neglect is suspected tigation within 24 hours of an that focuses on: 6.7.1 whether curred and to what extent; nation for signs of injuries, if sative factors; and 6.7.4 vent further injury. 6.8 The thoroughly documented entation of witnessed ed. 7. The Center will protect or harm during an rovide the patient with a safe entifying persons with whom and conditions that would feel or designee will: 8.1 Take all e action depending on the igation; 8.2 Report findings of tigations within fire (5) working ment of Health using the state stem or state-approved forms ation related to allegations of ained at the Center for not vears."	F	610				·

PRINTED: 12/18/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495246		1	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495246	B. WING		1:	C 12/08/2017	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE 11 DAIRY LANE FREDERICKSBURG, VA 2	E, ZIP CODE	100/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
	11/15/10 with a read diagnoses that includementia, osteoportones), anemia (low disease, depression cognitive deficit.  Resident #12's mos set), a quarterly ass (assessment reference revealed, in part, that answer the question of mental status) an assessment as bein decisions regarding #12 was further code staff for activities of was further coded that admission/entry or process to have an above her right eye. documentation in Reconcerning the abrase A review of Resident #2 was of process to have an above her right eye. documentation in Reconcerning the abrase A review of Resident revealed, in part, a pthe following; "Effect (11:20 p.m.) Type: Change in condition in symptoms include: Staff 2017. Change in Clinician: (name of change in SELF 11/8/2017. Change in Clinician: (name of change) in condition in Section 11/8/2017. Change in Clinician: (name of change) in condition in SELF 11/8/2017. Change in Clinician: (name of change) in condition in SELF 11/8/2017. Change in Clinician: (name of change) in condition in SELF 11/8/2017. Change in Clinician: (name of change) in condition in symptoms include: SELF 11/8/2017. Change in condition in symptoms include: SELF 11/8/2017. Change in condition in symptoms include: SELF 11/8/2017. Change in condition in symptoms include: SELF 11/8/2017. Change in condition in symptoms include: SELF 11/8/2017. Change in condition in symptoms include: SELF 11/8/2017. Change in condition in symptoms include: SELF 11/8/2017.	dmission on 5/5/16 with ided, but were not limited to; osis (weakening of the vired blood cells), acid reflux in, difficulty swallowing, and it recent MDS (minimum data essment with an ARD ince date) of 11/17/17, at Resident #12 was unable to its on the BIMS (brief interview if was coded on the staff if its geverely impaired to make tasks of daily life. Resident ed as being dependent on daily living. Resident #12 hat there were no falls since rior assessment.  Deserved during the survey abrasion on her forehead. There was no esident #12's clinical record its ince its clinical record. The was noted that it is clinical record. The condition. Note: A has been noted. The skin wound or ulcer reported to Primary Care linician notified) 11/8/2017 family / Healthcare agent.	F 6	310			

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		_,		<u>)MR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495246	B. WING	<b>-</b>		1	/08/2017
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			1	11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 610	dated 11/8/17 that of following; "Old bruis right chin."  Further review of the any documentation initiated.  A review of Resider plan did not reveal a injuries in November On 12/7/17 at 12:30 conducted with ASM member) #2, directed was asked to describe was seen to have a it should be reported was asked if she was investigation for Resident was not aware abrasion currently of ASM #2 stated that she was not aware abrasion on the forest there a while. ASM an investigation into On 12/7/17 at 3:00 writer and stated that where investigations Resident #12 in regand the abrasion on stated that the nurse hallway so there was had happened.	documented, in part, the se, fadded (sic) bluish color to se, fadded (sic) bluish color to e clinical record did not reveal that an investigation had been at #12's comprehensive care any documentation regarding er 2017 and December 2017.  In p.m. an interview was a language (and interview was a language) of nursing (DON). ASM #2 is the process if a resident my injury. ASM #2 stated that and investigated. ASM #2 as able to provide an esident #12 in regards to a language and the en Resident #12's forehead. She would look into it but that of a bruise she had seen the ehead but thought it had been #2 stated that she would start	F	610			
		(licensed practical nurse) #3,					- Company and Address of the Company and Address

DEPARTMENT OF HEALTH AND MAN SERVICES

PRINTED: 12/18/2017

FORM APPROVED

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

DENTIFICATION NUMBER		1''	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		495246	B. WING			12/08/2017	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, 11 DAIRY LANE FREDERICKSBURG, VA 22				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 610	a floor nurse. LPN process if a resident of unknown origin. DON and Administration anyone had reported I would document a interview the resides so an investigation. On 12/7/17 at 3:42 director of nursing (and stated that she #12's the issue of the brought to the daily was a concern. AS manager to investig back to me." ASM #6 followed up. ASM #2 state was asked bruise, ASM #2 state was asked whether unknown origin and the state agency, Ashave been. ASM #3 abrasion to Resider to state how long it reported incident) he either injury.  An end of day meet 4:45 p.m. with ASM ASM #2, the interim clinical quality speci ASM #3 were made concerns. A copy of requested at this time.	#3 was asked to describe his not was seen to have an injury LPN #3 stated, "I notify the rator. I would look to see if ed it on the last 24-hour report. It description and try to ent. We need to rule out abuse would be initiated."  p.m. ASM #2 the interim (DON)approached this writer remembered that Resident the bruise on her chin was clinical meeting and there is M #2 stated, "I asked the unit gate this but he never did get #2 was asked if she had #2 stated that she did not. If if she knew what had caused ted that she did not. ASM #2 for not this was an injury of I should have been reported to SM #2 stated that it should 2 was unable to explain the not #12's head and was unable had been there. A FRI (facility and not been submitted for thing occurred on 12/7/17 at #1, the executive director, in DON, and ASM #3, the ialist. ASM #1, ASM #2 and a aware of the above if the facility abuse policy was ne.	F 6	110			
	No further information	on provided prior to the end of	(				

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DEPARTMENT OF HEALTH AND HOAN	SERVICES
CENTERS FOR MEDICARE & MEDICAID S	SERVICES

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

F 610 Continued From page 98 the survey process.  F 623 SS=D CFR(s): 483.15(c)(3)-(6)(8)  F 626 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 627 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 628 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 620 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 620 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 621 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 622 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 623 SS=D CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 624 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 625 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 626 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 627 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 628 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 620 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 620 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 621 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 622 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 623 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 624 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 625 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 626 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 627 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 628 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F 629 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  F	VEY
A95246  B. WING	:D
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405    CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   CEACH CORRECTION SHOULD BE C	
WOODMONT CENTER    11 DAIRY LANE   FREDERICKSBURG, VA 22405	)17
Continued From page 98   February process.   February process.   February process.   Separation page 98   February process.	
(X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 610   Continued From page 98 the survey process.	1
F 610 Continued From page 98 F 623 SS=D CFR(s): 483.15(c)(3)-(6)(8)  FREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 610 Continued From page 98 The survey process of the survey proces	
the survey process.  Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)  facility.  Any residents with a transfer within or out of the facility has	(X5) PLETION PATE
S483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.  (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and  (iii) Include in the notice the items described in paragraph (c)(5) of this section.  S483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.  (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	17/18

Event ID: DGWI11

		AND HU SERVICES					FORM	: 12/18/2017   APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	O.	(X3) DAT	E SURVEY MPLETED
		495246	B. WING					C /08/2017
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP	CODE		
WOODM	ONT CENTER				DAIRY LANE EDERICKSBURG, VA 22405	;		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	× .	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 623	required by the resi- under paragraph (c (E) A resident has r days.  §483.15(c)(5) Contenotice specified in p must include the fol (i) The reason for te (ii) The effective dat (iii) The location to a transferred or disch (iv) A statement of te including the name, and telephone numereceives such reque to obtain an appeal completing the form hearing request; (v) The name, addretelephone number of Long-Term Care Or (vi) For nursing facil and developmental disabilities, the mail telephone number of the protection and a developmental disabilities, the mail telephone number of the protection and a developmental disabilities, the mail telephone number of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities, the mail telephone rumber of the protection and a developmental disabilities and the protection and the protection and the protection and the protection and the protection	ransfer or discharge is dent's urgent medical needs, $0(1)(i)(A)$ of this section; or not resided in the facility for 30 ents of the notice. The written paragraph (c)(3) of this section lowing: ransfer or discharge; the of transfer or discharge; which the resident is arged; he resident's appeal rights, address (mailing and email), ber of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State	F6	23				
		a Drotantian and Advacacy		1				

Facility ID: VA0279

PRINTED: 12/18/2017 FORM APPROVED

	MENT OF HEALTH	AND HOAN SERVICES		0	FORM	: 12/18/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '	TIPLE CONSTRUCTION ING	` СОМ	E SURVEY IPLETED
		495246	B. WING			C 08/2017
	PROVIDER OR SUPPLIER ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE	(X5) COMPLETION DATE
F 623	for Mentally III Indiv §483.15(c)(6) Chan If the information in effecting the transfer must update the red as practicable once becomes available. §483.15(c)(8) Notice In the case of facility the administrator of written notification put to the State Survey State Long-Term Cathe facility, and the well as the plan for relocation of the res 483.70(l). This REQUIREMEN by: Based on staff inte	iduals Act.  Iges to the notice.  Ithe notice changes prior to ear or discharge, the facility cipients of the notice as soon the updated information	F 6	23		

Resident #83 was admitted to the facility on 9/24/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle

the facility staff failed to provide written

Resident #83 transferred to the hospital on 10/28/17. The facility staff failed to provide written notification of the transfer to Resident #83,

the survey sample, Resident #83.

the resident's representative and the

notification of transfer to a resident/representative and the ombudsman for one of 29 residents in

ombudsman.

	TMENT OF HEALTH	I AND HUN SERVICES		( )	FORM	): 12/18/2017 MAPPROVED ): 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DAT COM	TE SURVEY MPLETED
		495246	B. WING			C / <b>08/2017</b>
NAME OF I	PROVIDER OR SUPPLIER	<del></del>	i	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER		1	11 DAIRY LANE FREDERICKSBURG, VA 22405		-
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	weakness and high #83's most recent in day Medicare assess (assessment refere the resident as cognist Review of Resident the resident was tra 10/28/17. Further refailed to reveal Resi representative, or thany written notificati Resident #83 was re 11/2/17.  On 12/7/17 at 10:53 conducted with OSM social worker). OSM services departmen notification of transferesidents' families of the hospital. OSM #5 any information in with the hospital. OSM #6 a follow up phone cat ransferred and admidoes not issue writter residents, families of stated the nurses do	a blood pressure. Resident MDS (minimum data set), a 30 ssment with an ARD ence date) of 11/28/17, coded nitively intact.  It #83's clinical record revealed ensferred to the hospital on review of the clinical record ident #83, the resident's he ombudsman was provided ion regarding the transfer. The eadmitted to the facility on the seadmitted to the facility on the seadmitted to the social and does not issue written for or discharge to residents, for the ombudsman.  In an interview was the social and the seadmitted to the social and the seadmitted to residents, for the ombudsman.  In an interview was the seadmissions stated she does not provide writing when residents go to the stated she does complete all after residents are nitted to the hospital but she	F 623			

she didn't know what information the

On 12/7/17 at 10:59 a.m. an interview was conducted with RN (registered nurse) #2. RN #2 was asked if nurses provide written notification to

documentation contained.

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND ( **1AN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING C B. WING 495246 12/08/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) F 623 Continued From page 102 F 623 residents' families after residents transfer to the hospital. RN #2 stated, "No." RN #2 stated documents such as an E-Interact form (a form that documents the resident's medical information and synopsis of why the resident is sent to the hospital), history/physical, lab tests, medication list and face sheet are sent with the residents and are to be provided to the staff at the hospital. RN #2 stated the only notification provided to families is over the phone. When asked if the

On 12/7/17 at 2:23 p.m. ASM (administrative staff member) #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were made aware of the above concern.

ombudsman is provided notification, RN #2

The facility policy titled, "Discharge and Transfer" documented, "A Center must immediately inform the resident/resident representative, consult with the resident's physician, and notify consistent with below, when there is a decision to transfer or discharge the resident from the Center. The resident and resident representative must be notified in writing and in a language and manner they understand...For residents transferred to a hospital: 5.1 For unplanned, acute transfers, resident, family, and legal representative will be notified verbally. 5.1.1 Written notice must be provided if the Center will not take the resident back from the hospital..."

No further information was presented prior to exit.
F 625
SS=D CFR(s): 483.15(d)(1)(2)

F 625

Facility ID: VA0279

stated, "No."

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

PRINTED:	12/20/2017
FORM A	APPROVED
OMB NO.	0938-0391

CENTER	S FOR MEDICARE OF	MEDICAID SERVICES					C.V.D 110	. 0000-0031
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST A. BUILDING		*	(X3) DATE S COMPL					
		405246	B. WING				0	
		495246	D. YVEVO		TOTE	TARRETO OTTA STATE TIP CORE	12/(	)8/2017
NAME OF PE	ROVIDER OR SUPPLIER			1		T ADDRESS, CITY, STATE, ZIP CODE		
WOODMO	NT CENTER			1		ERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		And distribution of the state o	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	1	(X5) COMPLETION DATE
F 625	§483.15(d) Notice of §483.15(d)(1) Notice nursing facility transfethe resident goes on nursing facility must puthe resident or reside specifies- (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed pplan, under § 447.40 (iii) The nursing facility bed-hold periods, which paragraph (e)(1) of the resident to return; and (iv) The information sof this section.  §483.15(d)(2) Bed-hold the time of transfer of hospitalization or their facility must provide the resident representative specifies the duration described in paragraph This REQUIREMENT by:  Based on staff intervand clinical record rethe facility staff failed notification at the time hours of being transfer	bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to ent representative that  e state bed-hold policy, if e resident is permitted to sidence in the nursing  enyment policy in the state of this chapter, if any; by's policies regarding ich must be consistent with his section, permitting a d pecified in paragraph (e)(1)	F	625	3.	Resident #84 has discharged fracility. Resident #83 remains facility; any future transfers waritten bed-hold notification paintin 24 hours of transfer.  All residents transferring to the hospital have potential to be at Prior to the survey, no written notification was provided for a resident transfer out of the fact the hospital.  Education was provided by the Administrator to the Admission regarding this regulation. Administrator to the Admission regarding this regulation. Administrator of bed-hold to reand/or their representative, what transfer to the hospital.  Administrator/designee will at hospital transfers for the next of and randomly thereafter, to enswritten notification is provided audit will be conducted by place phone call to the resident or representative to ensure they have received. Results of these audit be brought before the QAPI Comonthly for review.	s in the vill have vill have or ovided effected. any ility to ens Team nissions ovide esidents to any sure d. This cing a ave dits will	1
	1 The facility staff fa	uled to provide Resident #84						

	The same of the sa	
DEPARTMENT OF HEALTH AND	<b>K</b> AN	<b>SERVICES</b>
CENTERS FOR MEDICARE & ME	EDICAID	<b>SERVICES</b>

PRINTED: 12/18/2017 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER:	1''	NG		COMPLETED	
		495246	B. WING		1:	2/08/2017	
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405	DDE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 625	or the representative upon or within 24 he transfer to the hosp.  2. The facility staff for the resident's reprofered to the hosp.  The findings included transferred to the hosp.  The findings included transferred to the hosp.  The facility staff for the representative upon or within 24 hosp.  Resident # 84 was a 7/6/17 and discharge with the diagnoses of ulcers, stroke, demonstrative ulcers, ulcers, stroke, demonstrative ulcers, ulcers, stroke, demons	e a copy of the bed hold policy burs of a family-initiated ital.  ailed to provide Resident #83 presentative written notification by when the resident was pospital on 10/28/17.  failed to provide Resident #84 e a copy of the bed hold policy purs of a family-initiated ital.  admitted to the facility on ed on 9/11/17 to the hospital, of but not limited to pressure entia, dysphagia, high blood and chronic kidney disease. DS (Minimum Data Set) prior ded as seeing severely in ability to make daily life 5 out of a possible 15 on the wfor Mental Status) exam. Indeed as requiring extensive to des of activities of daily living.  The second failed to reveal any and and/or responsible party copy of the Bed Hold policy in 24 hours of transfer to the possible party.	F 6:	25			
		Member, the Admissions		-			

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 105 of 348



#### PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HU N SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 495246 12/08/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 625 Continued From page 105 F 625 Director) she stated the resident or family is followed up with at the hospital 1 to 2 days after transfer to the hospital, and notified of the bed hold policy via phone. OSM #5 stated no one goes to the hospital to provide a written copy. She stated she would check with the company's in-hospital liaison about whether or not that individual had been providing the written bed hold notification after the resident arrived to the hospital. On 12/07/17 at 02:04 PM, OSM #5 stated the hospital liaison for the company had not been providing the written bed hold policy on site at the hospital, so no one was providing the resident or responsible party with a written bed hold notice at the time of or within 24 hours of transfer to the hospital. On 12/07/17 at 02:01 PM, ASM #3 (Administrative Staff Member - the corporate

Clinical Quality Specialist) provided the facility's policy for "Discharge and Transfer" which documented, "5. For residents transferred to a hospital: 5.1 For unplanned, acute transfers, resident, family, and legal representative will be notified verbally .....5.4 The Bed Hold Notice of Policy & Authorization form will be provided per

The facility policy titled, "Bed Holds" documented, "When a resident/patient ('resident') is transferred out of the service location to a hospital or on therapeutic leave, the designee will provide the resident/resident representative with the written Bed Hold Policy Notice & Authorization form (name of form)- regardless of payer. If the resident representative is not present to receive

the Accounts Receivable Policies and Procedures, Bed Holds policy."

	MENT OF HEALTH				FORM	// APPROVED ), 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	TE SURVEY MPLETED C
		495246	B. WING			/08/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE	
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG,	VA 22405	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 625	REGULATORY OR LSC IDENTIFYING INFORMATION)		F	025		

the survey.

No further information was provided by the end of

2. The facility staff failed to provide Resident #83 or the resident's representative written notification

of the bed hold policy when the resident was transferred to the hospital on 10/28/17.

Resident #83 was admitted to the facility on

DEPART	MENT OF HEALTH	AND HUI SERVICES				FORM	APPROVED . 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		495246	B. WING	_		12	/08/2017
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
11000					PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	COMPLETION DATE
F 625	were not limited to: weakness and high #83's most recent of day Medicare asset (assessment refere the resident as cog Review of Resident the resident was tra 10/28/17. Further of failed to reveal Resident to reveal Resident to reveal Resident to reveal Resident to reveal Resident to reveal Resident to reveal Resident to the facility on 11/2/17.  On 12/7/17 at 10:53 conducted with OS social worker). OS services department regarding the bed of the admission pack admitted to the facinot provide any information to the hospital. OS documentation with to the hospital but sedocumentation con On 12/7/17 at 10:53	#83's diagnoses included but pain in the right knee, muscle blood pressure. Resident MDS (minimum data set), a 30 ssment with an ARD ence date) of 11/28/17, coded nitively intact.  #83's clinical record revealed ansferred to the hospital on eview of the clinical record ident #83 or the resident's provided notification of the icy when the resident was ent #83 was readmitted to the 3 a.m. an interview was M (other staff member) #21 (a M #21 stated the social at does not issue information	F	625			

Event ID: DGWI11

PRINTED: 12/18/2017

DEPART	MENT OF HEALTH	AND LAN SERVICES & MEDICAID SERVICES				FORM	12/18/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	NSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED	
		495246	B. WING			12/	08/2017	
NAME OF F	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COI <b>RY LANE</b>	DE		
WOODM	ONT CENTER				ERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 625	form that document information and syr sent to the hospital (laboratory) tests, in are sent with the rethe hospital. When policy is issued to residents are transfistated, "No."  On 12/7/17 at 11:55 makes a follow up a family when a residently when a residently strength of the does not provide the resident/representation on 12/7/17 at 2:23 member) #1 (the exinterim director of new sent to the document of the doc	such as an E-Interact form (a tis the resident's medical hopsis of why the resident is an interact physical, lab hedication list and face sheet sidents who are transferred to a asked if the facility bed hold esidents/representatives when ferred to the hospital, RN #2 is a.m. OSM #5 stated she ohone call with the resident or ent is transferred to the stated she documents the tative's wish to hold a bed or e facility computer system but		625			ę.	
F 641 SS=D	Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment m resident's status. This REQUIREMEN by: Based on staff inte		F. Commence of the commence of	641 1.	Resident #40 MDS was by the MDS Coordinate accurate coding.  The Director of Nursing designee shall audit M progress to ensure Oxy N0100C is accurately to ARD.	tor to reflecting or DS's in		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C		
		495246	B. WING		12/08/2	017
	(EACH DEFICIENC	R TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	RRECTION CON	(X5) IPLETION DATE
F 641	accurate clinical rethe survey sampled. The facility staff fat MDS (minimum dassessment, with date) of 11/3/17, for Resident #40.  The findings included Resident #40 was 8/8/17 with diagnor limited to: stroke, swallowing (1)), dispressure.  The most recent for assessment, a quassessment reference in a sessment refere	iled to maintain a complete and ecord for one of 29 residents in e. Resident #40.  alled to accurately code the ata set) assessment, a quarterly an ARD (assessment reference or the use of oxygen for	F	3. Clinical Reimburse (Regional MDS No educate Clinical Recoordinator (Facilia on the Resident As Instrument (RAI) Section N 0100C to Director of Nursing of weekly MDS for N0100C for accurate transmission x2 merandomly thereafted compliance. Director will submit results monthly QAPI me	eimbursement (ity MDS Nurse) sessment (for MDS for by 12/31/17.  If will audit 10% or Section (for section for section for to boths and then for to determine for of Nursing of audits to the	1/17/18

DEPAR1	MENT OF HEALTH	AND AN SERVICES				FOF	ED: 12/18/2017 RM APPROVED IO: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) [	OATE SURVEY OMPLETED
		495246	B. WING				C 1 <b>2/08/2017</b>
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CO <b>DAIRY LANE</b>	DE	
WOODM	ONT CENTER				EDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 641	Resident #40's Octa administration reco 2L/min (minute) via with two prongs that nostrils)." The Octo Resident #40 received 14-day look back pure MDS assessment.  Resident #40's Now documented, "O2 2 documentation of the through 11/3/17, duthe 11/3/17 quarter spaces on the MAF.  The nurse's note didocumented in part nurse's notes dated documented in part labored (sic) on 2L/On 12/07/17 8:48 a conducted with RN MDS nurse. Resident #40's MAR 2017 were reviewed confirmed the oxyg Section O. RN #7 completed by her becorporate travel MDS was requemented (ASM) #3, stated the facility did	ober 2017 MAR (medication rd) documented O2 (oxygen) NC (nasal cannula) (a tube at insert into the resident's ober MAR documented that wed oxygen on 11 days of the eriod for the 11/3/17 quarterly rember 2017 MAR PL/min via NC." The was no he use of oxygen from 11/1/17 uring the look-back period, for ly MDS assessment, the R were blank.  Atted 11/1/17 at 2:10 a.m. t, "On O2 therapy." The d, 11/2/17 at 9:21 p.m. t, "Respiration even and non rmin via NC continuously."  A.m. an interview was (registered nurse) #7, the ent #40's quarterly MDS with was reviewed with RN #7. Rs for October and November d with RN #7. RN #7 en should have been coded in stated this MDS was not out was completed by the		641			

assessment instrument) manual for completing

PRINTED: 12/18/2017

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

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTIONS		(X3) DATE SURVEY COMPLETED		
		495246	B. WING_			12/0	: 8/2017
	PROVIDER OR SUPPLIER			11 DAIRY LANE	S, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD EFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 641	the MDS. A copy of provided for completed for continuous of administered via material aresident to relive the ASM (administered via material for continuous of administered via for continuous of administered via for continuous of administered via for continuous of contin	of the RAI manual was eting Section O that ing Instructions for Column 2: its, procedures and programs ned by the resident after reentry to the facility and within back period. Oxygen therapy: ir intermittent oxygen lask, cannula, etc. delivered to hypoxia in this item."  trative staff member) #1, ASM #2, interim director of f3, were made aware of the 12/7/17 at 4:45 p.m.  tion was provided prior to exit. hary of Medical Terms for the er, 5th edition, Rothenberg and f8.  1)-(3) ensive Person-Centered Care e Care Plans facility must develop and ne care plan for each resident structions needed to provide n-centered care of the resident and standards of quality care. blan must- thin 48 hours of a resident's mum healthcare information riy care for a resident	F 65	1. Resider dischar Resider have hat comple needs, 2. All new survey plans ir regulatievidence Unit M 3. Educati	ent # 184 has been rged from the facility ents # 234, # 284 and ad baseline care planeted to meet their curby the Unit Manager wly admitted resident exit have baseline can place according to the to meet their need by audit completed anager.	# 39 as rrent r. ts since are ads, as ted by	

DEPAR	MENT OF HEALTH	AND HAN SERVICES		0		APPROVED
TATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ABD SERVICES  (X2) MULTIPLE CONSTRUCTION A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405  EFICIENCIES ECCEDED BY FULL 495246  B. WING  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 655  Regional Nurse related to this regulation and ensuring that new residents have a baseline care plan developed within 48 hours to properly provide care for the resident.  4. Clinical Management Team will review all new admissions during the Clinical Morning Meeting to ensure that the Baseline Care Plan is completed and meets the resident's needs. The results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly for review.	SURVEY PLETED		
		495246	B. WING	· · · · · · · · · · · · · · · · · · ·	1	) 8/2017
	PROVIDER OR SUPPLIER			11 DAIRY LANE		
WOODM	ONT CENTER			FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 655	(B) Physician orders (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recom §483.21(a)(2) The fromprehensive care plan if the companies (i) Is developed with admission. (ii) Meets the require (b) of this section (ethics section).  §483.21(a)(3) The resident and their resident and the fact (iv) Any updated information of the comprehension the comprehension of	ed on admission orders.  s.  mendation, if applicable.  acility may develop a e plan in place of the baseline prehensive care plan- hin 48 hours of the resident's  ements set forth in paragraph excepting paragraph (b)(2)(i) of  facility must provide the expresentative with a summary plan that includes but is not  of the resident. The resident medications and  and treatments to be a facility and personnel acting fility.  Formation based on the details  we care plan, as necessary.  IT is not met as evidenced  rview, facility document frecord review it was fility staff failed to develop a formet the resident's needs formet in the survey sample;		Regional Nurse related to the regulation and ensuring that residents have a baseline can developed within 48 hours properly provide care for the resident.  4. Clinical Management Team review all new admissions the Clinical Morning Meetitensure that the Baseline Can is completed and meets the resident's needs. The result these audits will be brought the Quality Assurance and Performance Improvement	t new tre plant to the will during ng to the Plant ts of the before	1/17/18

The facility staff failed to develop a baseline care plan for Resident #234 to address

	TMENT OF HEALTH	AND HUN SERVICES			FORM	: 12/18/201 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	COM	E SURVEY IPLETED
		495246	B. WING		1	C <b>08/2017</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE API  DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	resident-specific ne  2. The facility staff care plan for Resident colostomy and indw  3. The facility staff ficare plan to address receiving dialysis.  4. The facility staff ficare plan to address oxygen.  The findings include  1. The facility staff ficare plan for Resident staff ficare plan for Resideresident-specific need to the plan for Resideresident #234 was 12/4/17 with the diagonal method in the diagonal field in a would pulmonary Disease, opiate addiction, chraortic valve endocardata set) assessment	eds present on admission.  failed to develop a baseline ent # 284 to address the care # 284's feeding tube, relling catheter.  ailed to develop a baseline is the needs of Resident #39  ailed to develop a baseline is Resident #184's use of seeds present on admission.  admitted to the facility on gnoses of but not limited to: esistant Staphylococcus and, Chronic Obstructive chronic back pain, scoliosis, onic pain syndrome, and ditis. An MDS (minimum	F 6	55		

oxygen therapy.

assessment dated 12/4/17 documented the resident as being cognitively intact. The resident was documented as being able to participate in activities of daily living. The resident was also documented as having a PICC (peripherally inserted central catheter) [2] line and requiring

A review of Resident #234's baseline (interim)

	MENT OF HEALTH					FORM	): 12/18/2017 1 APPROVED ): 0938-0391
STATEMENT	RS FOR MEDICARE  OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DA1	TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	3	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 655	care plan on 12/8/1 revealed Resident included interventio (ADL) and discharg resident was care pcare needs of oxyginfection, and havin therapy.  On 12/08/17 at 09:4 RN #2 (Registered baseline care plans ADL, and patient-spthe oxygen, wound and use of the PICO planned. She state should be fully deveadmission, and each been on the resider evening of 12/6/17, were not care plans. A review of the facil Care Plans documed 1.1 Must be develoged include the minimum necessary to prope but not limited to: 1 admission orders; 1 dietary orders; 1.1.4 On 12/8/17 at 10:14 Staff Member - the and ASM #3 (the composition of the property of the facil Care Plans orders; 1.1.4 On 12/8/17 at 10:14 Staff Member - the and ASM #3 (the composition of the property	ge 114 7 at approximately 9:30 a.m., #234's baseline care plan ns for activities of daily living le. There was no evidence the planned for resident-centered en therapy, having a MRSA g a PICC line for antibiotic  40 a.m., in an interview with Nurse), she stated the should include pain, falls, skin, pecific needs. RN #2 stated with MRSA and the presence of line should have been care and that the baseline care plan beloped within 48 hours of the should have not's baseline care plan by the RN #2 verified these areas and as of 12/08/17 at 9:40 a.m. ity policy, "Person-Centered anted, "1. Baseline care plan: ped within 48 hours and m healthcare information rly care for a patient including 1.1 Initial goals based on 1.1.2 physician orders; 1.1.3 therapy services"  4 a.m., ASM #2 (Administrative interim director of nursing) prorate Clinical Quality and AM, ASM #1 (the executive enware of the findings.	F6	655			

DEPARTMENT OF HEALTH AND HU SERVICES	
DEPARTMENT OF TIEACHTAND TO: A CERTIFICATION	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495246	B. WING		12/	08/2017	
	PROVIDER OR SUPPLIE	R	1	TREET ADDRESS, CITY, STATE, ZIP CODE  1 DAIRY LANE  REDERICKSBURG, VA 22405			
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F 655	[1] MRSA stands Staphylococcus a infection that is reantibiotics. There Hospital-associate health care setting MRSA happens to skin-to-skin containvolved in footbal infection control is hospitals. To prev MRSA *Practice good hy *Keep cuts and so bandage until health and set and so bandage until health and set and so bandages *Avoid sharing pewashcloths, razor *Wash soiled she water with bleach If a wound appear care provider. Treathe infection and aliformation obtain https://medlineplutes.	for methicillin-resistant fureus. It causes a staph resistant to several common are two types of infection. The MRSA happens to people in the gs. Community-associated to people who have close and wrestling. The skey to stopping MRSA in the rent community-associated regions clean and covered with a sted the other people's wounds or the other people's wounds or the state of the sta	F 655				

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

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION		E SURVEY PLETED
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		495246	B. WING			12/	08/2017
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(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	routinely injected in Information obtaine https://www.radiologc_access  2. The facility staff care plan for Resident end indwelling cath Resident # 284 was 11/30/17 with diagn not limited to: atrial osteoporosis (3), at attention to gastros  Resident # 284's m data set), an admis at the time of surve  The facility's "Nursi Resident # 284 date "Orientation to pers Judgement/Insight-Further review of the for Resident # 284 Colostomy and Induced Review of Resident # 284 Colostomy and Induced Review of Resident to evidence a basel care needs for Resident was colostomy and induced to evidence and induced resident was colostomy and induced resident was colostomy and induced residence and induced resident was colostomy and induced residence and	n and nutrients can be to the patient's bloodstream. In the patient's bloodstream. In the patient's bloodstream. In the patient's bloodstream. In the patient's bloodstream. In the patient's bloodstream. In the patient's bloodstream and the patien	F	355			
	comprehensive car	e plan failed to evidence a s Resident # 284's feeding	A something A contract of the				

DEPART	MENT OF HEALTH	AND HUM SERVICES  & MEDICAID SERVICES					FORM	APPROVED 0938-0391
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WOODM	ONT CENTER		· .	Ī	11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 655	On 12/07/17 at 2:40 conducted with RN regarding the basel Resident # 284. W timeframe for the deplan of care RN # 9 of admission." Who for the development RN # 9 stated, "The coordinator."  12/07/17 at 2:50 p.r conducted with ASM member) # 2, interiment # 3 clinical quality sersponsible for the care plan for Reside "Everyone, the IDT.  The facility's policy documented, "The implement a baseling within 48 hours for instructions needed person-centered castandards of quality.  On 12/06/17 at approximation (administrative staff director, ASM # 2, in ASM # 3, clinical quaware of the finding.)  No further information (administrative staff director).	d indwelling catheter.  D. p.m. an interview was (registered nurse) # 9 line plan of care (IPOC) for hen asked about the evelopment of the baseline stated, "It's done in 48 hours en asked who is responsible to of the baseline plan of care MDS (Minimum Data Set)  m. and interview was (administrative staff m director of nursing and ASM pecialist. When asked who is development of the baseline ents # 284, ASM # 2 stated, (interdisciplinary team)."  "Person-Centered Care Plan" Center must develop and he person-centered care plan each patient that includes the to provide effective and are that meet professional or care."  roximately 5:00 p.m. ASM f member) # 1, executive enterim director of nursing and liality specialist, were made is.	F	655	5			
	(1) A swallowing dis	order. This information was						

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND MAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ C B. WING 12/08/2017 495246 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 655 Continued From page 118 F 655 obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdi sorders.html. (2) Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosi s.html. (3) An ileostomy is used to move waste out of the body. This surgery is done when the colon or rectum is not working properly. This information was obtained from the website:

(4) A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm.

https://medlineplus.gov/ency/article/007378.htm.

3. The facility staff failed to develop a baseline care plan to address the needs of Resident #39

receiving dialysis.

Resident #39 was admitted to the facility on 10/3/17 with diagnosis that included but were not limited to: high blood pressure, diabetes, seizure disorder, below the knee amputation, infection of the right lower leg and end stage renal failure requiring hemodialysis.

Hemodialysis is a procedure used in toxic conditions and renal failure in which wastes and impurities are removed from the blood by a special machine. The blood is shunted to and from a dialyzer where, through diffusion and

CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				MR MO.	0930-0391
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F 655	ultrafiltration, wasted. The most recent Mi assessment), a Me with an assessment coded the resident make daily decision. Treatments, Procederesident was coded resident was coded resident at the facility and the comprehensive care plant on dialysis. Further comprehensive care Review of the compevidence any docur resident being on his most acare plan that adoptovided for a dialyst that it should be additionable and when asked if a resimmediate need for upon admission, LF any medical conditions would be addressed only initiate the five skin, constipation, at The MDS nurse should be addressed only initiate was constipation, at a care and the most acare should be addressed only initiate the five skin, constipation, at a care as."	DS (minimum data dicare 60-day assessment, treference date of 11/28/17, as being cognitively intact to as. In Section O - Special dures and Programs, the as receiving dialysis while a sity.  al record failed to reveal a related to the resident being review revealed a e plan dated, 10/13/17. Orehensive care plan failed to mentation related to the emodialysis.  Inducted with LPN (licensed on 12/7/17 at 11:44 a.m. sident on dialysis should have dresses the care to be as resident, LPN #3 stated dressed on the care plan. I sident on dialysis has an his care plan to be initiated by #3 stated, "I would think on that requires treatment d on the care plan. I usually basics upon admission; pain, advanced directive and falls. Sould address all of the other and to the other and the care with LPN #4 on the care with LPN #4	F	355			
	Resident #39's dialy	sis care needs; the catheter clamp at the bedside, things				And and a second	

DEPARTMENT OF HEALTH AND HUN

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		& MEDICAID SERVICES			<u>OMB</u>	NO. 0938-0391
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*		.00210	<u> </u>	STREET ADDRESS, CITY, STATE, ZIF	CODE	
NAME OF F	PROVIDER OR SUPPLIER			11 DAIRY LANE		
WOODM	ONT CENTER			FREDERICKSBURG, VA 2240	15	
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F 655			F 65	25		99
	to watch for a resid	ent receiving dialysis should				
	be on the care plan	, LPN # 4 stated, "Yes, I would				
	think so." When asl	ked if she initiated care plans				
	and updated care p	lan, LPN #4 stated she only				
	initiates a care plan	if they come in with a wound,	a controller and a cont			
	that's the only one I	have ever done." When	Company of the Compan			
	asked who updates	or develops the baseline care				A model is A steel
	plan, LPN #4 stated	MDS nurse does that."	-			
	•			AND THE PROPERTY OF THE PROPER		AAAAA
	An interview was co	onducted with administrative		van		A CONTRACTOR OF THE CONTRACTOR
	staff member (ASM	<ol> <li>#3, clinical quality specialist,</li> </ol>				
	on 12/7/17 at 3:00 t	o.m. When asked if the facility				100000
	utilizes a baseline d	are plan, ASM #3 stated, "We	A remainder			**************************************
	do not utilize a pape	er baseline care plan, it is the	***			
	expectation of the a	admitting nurse to initiate the				
	care plan for the re-	șident's needs upon				
	admission."	•				i
	<del>-</del>		ANNEROMAN			
	The facility policy. "	Person - Centered Care Plan"	and the state of t			A 400000000
	documented in part	, "The Center must develop	a de la company de			Table 1 to Control of
	and implement a ba	aseline person-centered care	Lyamayaaa			Antoniosis
	nlan within 48 hours	s for each patient that includes				444
	the instructions nee	eded to provide effective and				
	person-centered ca	re that meet professional				
	standards of quality	care."				4
			****	<b>*</b>		
	Administrative staff	member (ASM) #1, the	-			
	executive director.	ASM #2, the interim director of				
	nursing, and ASM #	t3, were made aware of the	***			
	above concern on 1	12/7/17 at 4:45 p.m.				Andrews I. com
	No further informati	ion was obtained prior to exit.	***************************************			TELL ACTIONS On MANY
		·				***************************************
	(1) Barron's Diction	ary of Medical Terms for the				TO THE PARTY OF TH
	Non-Medical Reade	er, 5th edition, Rothenberg and	***************************************			AMP II BILLAND T

Chapman; page 266.

4. The facility staff failed to develop a baseline care plan to address the needs of Resident #184

DEPART	MENT OF HEALTH	AND HUM SERVICES & MEDICAID SERVICES			4000	FORM.	APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	СОМ	E SURVEY PLETED		
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F 655	Continued From pa	en.	F6	655	·				
	11/30/17 with diagnot limited to: fractive pulmonic chronic nonreversity a combination of erbronchitis (1)), atria characterized by rathe atria of the heat the ventricles and routput and frequent (2)), pulmonary fibric condition in which the becomes scarred of and stiff. That make breath, and your blooxygen (3)), diabeted. There was no compactly assessment as The Initial Nursing of documented Residual oriented to person, documented under oxygen via nasal."  The review of the brack to the use of the person of the brack to the use of the person	admitted to the facility on loses that included, but were ure of the left humerus, chronic ary disease (general term for ole lung disease that is usually imphysema and chronic all fibrillation (a condition pid and random contraction of it causing irregular beats of esulting in decreased heart thy clot formation in the atria osis (pulmonary fibrosis is a he tissue deep in your lungs over time. This tissue gets thick is it hard for you to catch your old may not get enough es and high blood pressure.  Deleted MDS (minimum data is of the dates of the survey.  Assessment, dated 11/30/17, ent #184 was alert and place and time. The form "Respiration - regular Method:  aseline care plan dated idence any documentation of oxygen for Resident #184.  Conducted with RN (registered 17 at 2:22 p.m. When asked baseline care plan, RN #7 a IPOC (baseline plan of care) orgam." When asked who							

		AND MAN SERVICES				FORM	): 12/18/2017 MAPPROVED
		& MEDICAID SERVICES	T		- CONSTRUCTION		). 0938-0391
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MOODIN	UNI CENIER			FI	REDERICKSBURG, VA 22405		
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F 655			F (	355			na mikawa masa ya masa
	When asked if the	the nurses upon admission." use of oxygen should be on lan, RN #7 stated, "Yes, it "	том на применя применя применя применя применя применя применя применя применя применя применя применя применя				
	practical nurse) #3	onducted with LPN (licensed on 12/6/17 at 2.34 p.m. sident on oxygen should have	AN REPORTANT DE L'ANGEL PROPRETATION DE L'ANGEL L'ANGE				THE RESIDENCE AND ADDRESS OF A SCIENCE AND ADD
	a care plan that add LPN #3 stated that	dresses the use of the oxygen, it should be addressed on the sked if a resident on oxygen	A AND THE PROPERTY OF THE AND				CONTRACTOR OF THE PROPERTY OF
	has an immediate r initiated upon admis	need for his care plan to be ssion, LPN #3 stated, "I lly only initiate the five basics	Processor Proces				Action of the state of the stat
	upon admission; pa advanced directive should address all o	in, skin, constipation, and falls. The MDS nurse of the other areas."	обельного подвижения в подвижения				or management was a vicinity of the contract o
	staff member (ASM	onducted with administrative l) #3, clinical quality specialist, o.m. When asked if the facility	o de la composição de l				of the control of the
	utilizes a baseline c do not utilize a pape	eare plan, ASM #3 stated, "We be baseline care plan, it is the admitting nurse to initiate the	Military visions at 1.311mmper/aparages				
7000000	care plan for the resadmission."	sident's needs upon	MARKON INCOMPOSATION OF THE PROPERTY OF THE PR	ob obstantian			NATIONAL PROPERTY OF THE PROPE
	executive director, // nursing, and ASM #	member (ASM) #1, the ASM #2, the interim director of 3, were made aware of the	мин постоя назавина «Мойророфіц» «Айгіфо				
reconnect remainment		2/7/17 at 4:45 p.m. on was obtained prior to exit.	Vermonia a presidente del constante de la cons	OFFICE AND A STATE OF THE STATE			9 80 4 4 4 4 4 4
THE ACTUAL PROPERTY OF THE PRO	Non-Medical Reade Chapman; page 124	ary of Medical Terms for the er, 5th edition, Rothenberg and 4.	ANALYSIS CONTRACTOR CO				
	(2) Barron's Dictional Non-Medical Reade	ary of Medical Terms for the er, 5th edition, Rothenberg and					V II V

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

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C
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	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		
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F 655	following website: https://medlineplu	5. In was obtained from the	F 65	6	1 4 42
	S483.21(b) Compi §483.21(b) Compi §483.21(b)(1) The implement a compounce of plan for each resident rights set §483.10(c)(3), that objectives and time medical, nursing, needs that are ideassessment. The describe the follow (i) The services the or maintain the rephysical, mental, are required under §4 (ii) Any services the under §483.24, §4 provided due to the under §483.10, increatment under §4 (iii) Any specializer rehabilitative service of the PA rationale in the resident's represervable of the resident's represervable of the resident's represervable of the resident's represervable of the resident's represervable of the resident's represervable of the resident's desired outcomes	rehensive Care Plans a facility must develop and brehensive person-centered resident, consistent with the forth at §483.10(c)(2) and t includes measurable eframes to meet a resident's and mental and psychosocial ntified in the comprehensive comprehensive care plan must ving - at are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and at would otherwise be required 83.25 or §483.40 but are not e resident's exercise of rights cluding the right to refuse 483.10(c)(6). d services or specialized ces the nursing facility will t of PASARR . If a facility disagrees with the SARR, it must indicate its sident's medical record. with the resident and the ntative(s)- goals for admission and		1. Residents # 40, # 286 an have all had care plans reinclude use of Oxygen. I 39 Care Plan was updated include Dialysis. Reside Care Plan updated to include offered to include Dialysis. Resident # 28 longer has an Indwelling or a Tube Feeding. Resident is being offered showers per care plan. Resident is heel boots in place and is offered showers 2 X weed plan. These corrections we completed by the Unit M 2. All residents have the posterior be affected. Audits com Unit Managers for residents Audits Catheters to ensure that the an appropriate care plant residents are being offered showers 2 X week. Audits completed of care plantage interventions for heel boensure that they are in plantage in the posterior of the plantage interventions for heel boensure that they are in plantage in the plantage in the plantage in the plantage in the plantage in the plantage in the plantage in the plantage in the plantage in the plantage in the plantage in the plantage in the plantage in plantage in the plantage in the plantage in plantage in the plantage in plantag	evised to Resident # d to nt # 284 lude 4 no Catheter ident # 64 2 X week # 19 has s being ek per care vere lanager. tential to pleted by ents with alysis, velling hey have All ed lit ed ots to

	MENT OF HEALTH	AND MAN SERVICES	•			FORM.	12/18/2017 APPROVED 0938-0391
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F 656	future discharge. Fawhether the resider community was assolical contact agency entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMEI by:  Based on observation document review a was determined the and implement a conserve of 29 resider Resident's #40, #39 #43.  1. The facility staff of comprehensive car #40's use of oxygen.  2. The facility staff of comprehensive car #39's care and served.  3. The facility staff of comprehensive car #39's care and served.  4. The facility staff comprehensive car 286's oxygen.  4. The facility staff comprehensive car 284's indwelling cat (colostomy) (3) and colostomy) (4) and colostomy) (5) and colostomy) (6) and colostomy) (7) and colostomy) (8) and colostomy) (8) and colostomy) (9) and colost	acilities must document ont's desire to return to the sessed and any referrals to sies and/or other appropriate pose.  Is in the comprehensive care as in accordance with the orth in paragraph (c) of this of the in paragraph (c) of this of the interview, facility and clinical record review, it as facility staff failed to develop omprehensive care plan for onts in the survey sample, and a failed to develop a graph to address Resident onto a failed to develop a graph to address Resident of the plan to addres		656	<ol> <li>Education provided to the I Leadership Team and MDS Regional Nurse on the prace regulation for developing a revising Care Plans. This education included updatin C.N.A's Kardex with intervon the care plan to ensure the are followed accordingly.</li> <li>Care Plans will be reviewed Clinical Management Team the Clinical Morning Meeting days per week to ensure the new orders and changes are addressed accordingly on the Plan and that the Kardex goundated. Results of these will be taken to the Quality Assurance and Performance Improvement Committee in for review.</li> </ol>	S by the stice and g the ventions hat they ing 5 at all exts audits	

DEPARTMENT OF HEALTH AND HU SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	12/18/201 APPROVEI 0938-039
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F 656	Continued From pa	ge 125	F 656			

The findings include:

administration.

1. Resident #40 was admitted to the facility on 8/8/17 with diagnoses that included, but were not limited to: stroke, dementia, dysphagia (difficulty in swallowing), diabetes, and high blood pressure.

6a. The facility staff failed to apply Resident #19

6b. The facility staff failed to provide Resident #19 showers two times a week per the

7. The facility staff failed to follow Resident # 43's comprehensive care plan in regards to oxygen

soft heel boots to her right foot per the

comprehensive care plan.

comprehensive care plan.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/3/17, coded the resident as being severely cognitively impaired to make daily decisions. Resident #40 was coded as requiring extensive assistance to being totally dependent of one or more staff members for all of her activities of daily living. In Section O - Special treatments, Procedures and Programs, the resident was not coded as having received oxygen during the assessments 14-day look back period.

A physician order dated, 8/9/17 and signed by the physician on 10/12/17, documented, "Oxygen via nasal cannula @ (at) 2 L (liters) for shortness of breath."

DEPART	MENT OF HEALTH	AND HOWAN SERVICES			0		0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		LETED	
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F 656	The review of the control of the con	comprehensive care plan dated ridence the use of oxygen by tober 2017 MAR (medication and) documented O2 (oxygen) a NC (nasal cannula) (a tube at insert into the resident's ober MAR documented that ived oxygen on 11 days of the period for the 11/3/17 quarterly onducted with LPN (licensed on 12/7/17 at 2:06 p.m. When	F	656				
	asked who does the LPN # 4 stated, "It I travel nurse) helps nurses on the floor stated, "Not routine."  An interview was on nurse) #7, the MDS When asked who stated that per factorare plan for the trassessment. She the nursing depart When asked if oxy RN #7 stated, "Yes Basic Nursing, Ess (Potter and Perry, reference for care a written guideline promoting continuing cont	ne care plans in this facility, believe (name of corporate with that." When asked if the update the care plans, LPN #4						

care. The written care plan communicates nursing care priorities to other health care

PRINTED: 12/18/2017

	TMENT OF HEALTH	AND HU SERVICES				FORM	: 12/18/201 APPROVE : 0938-039
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	coordinates resource care. A correctly for easy to continue car If the patient's status nursing diagnosis an no longer appropriate plan. An out of date compromises the quarter of the facility policy, "For documented in part, individualized care plays after completion assessment for each measurable objective patient's medical, nursing and revised as needed to reflect changing needs and The ASM (administrate executive director, Anursing and ASM #3, were made aware of 12/7/17 at 4:45 p.m.	care plan also identifies and ses used to deliver nursing mulated care plan makes it re from one nurse to another. It is has changed and the not related interventions are to related interventions are to or incorrect care planuality of nursing care."  Person-Centered Care Plan" "A comprehensive, plan will be developed within 7 on of the comprehensive in patient that includes es and timetables to meet a parsing, nutrition, and mental peds that are identified in the essmentsCare plans will be did a minimum of quarterly and the response to care and	F 6	56			

Chapman; page 178.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

2. The facility staff failed to develop a care plan to address Resident #39's care and services for

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

	CO CONTRACTOR AND		/VO) 1411	7101	E CONSTRUCTION	(Y3) DAT	E SURVEY
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F 656	10/3/17 with diagnoral limited to: high blood disorder, below the the right lower leg as requiring hemodially. Hemodiallysis is a productions and renaimpurities are remospecial machine. The most recent MI assessment, a Mewith an assessment make daily decision Treatments, Proceded the resident make daily decision Treatments, Proceded the resident was coded resident at the facilial Review of the companion of the	admitted to the facility on osis that included but were not old pressure, diabetes, seizure knee amputation, infection of and end stage renal failure visis.  Incocedure used in toxic all failure in which wastes and oved from the blood by a line blood is shunted to and are, through diffusion and is are removed." (1)  DS (minimum data dicare 60-day assessment, at reference date of 11/28/17, as being cognitively intact to its. In Section O - Special dures and Programs, the las receiving dialysis while a sty.  Incomplete the service of the serv	F	856			
A COMPANY OF THE COMP		. When asked if all of	VOID 1				

	MENT OF HEALTH	AND HUN SERVICES				FORM	): 12/18/2017 // APPROVED ): 0938-0391
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F 656	site observation, the to watch for a reside to watch for a reside be on the care plan think so." When asl and updated care pinitiates a care plan that's the only one I asked who updates plan, LPN #4 stated. Administrative staff executive director, nursing, and ASM # above concern on 1 No further information. Non-Medical Reade Chapman; page 26: 3. The facility staff from prehensive care 286's oxygen.  Resident # 286 was 02/15/17 with a read Diagnosis include by weakness, prostate	e clamp at the bedside, things ent receiving dialysis should , LPN # 4 stated, "Yes, I would ked if she initiated care plans lans, LPN #4 stated she only if they come in with a wound, have ever done." When or develops the baseline care if MDS nurse does that."  member (ASM) #1, the ASM #2, the interim director of 13, were made aware of the 12/7/17 at 4:45 p.m.  on was obtained prior to exit. eary of Medical Terms for the ear, 5th edition, Rothenberg and 6.	F6	56			

Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/25/17, coded Resident # 286 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0

- 15, 15 being cognitively for making daily decisions. Resident # 286 was coded as

DEPART	MENT OF HEALTH	AND MAN SERVICES & MEDICAID SERVICES					FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		COV	E SURVEY MPLETED
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F 656	dependent of one sidaily living and supplor eating.  On 12/04/17 at application Resident # 286 was oxygen by nasal carconcentrator.  On 12/05/17 at application # 286 was observed receiving oxygen by concentrator.  On 12/05/17 at application # 286 was receiving oxygen by concentrator.  On 12/05/17 at application # 286 was receiving oxygen by concentrator.  On 12/06/17 at 9:05 observed in bed was receiving oxygen by concentrator.  The physician's Teledocumented, "Oxygen cannula) at 2 (two) 3.5 (three and a hall Review of Resident plan dated 11/29/17 comprehensive can The MAR (medication Resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented, "Oxygen to 3.5L (three and a hall resident # 286 datedocumented).	assistance to being totally taff member for activities of ervision of one staff member roximately 11:55 a.m. sobserved in bed receiving nnula (2) from oxygen a roximately 8:53 a.m. Resident d in bed eating breakfast and y nasal cannula from oxygen a roximately 4:00 p.m. Resident d in bed, awake. Resident # oxygen by nasal cannula from trator.  5 a.m. Resident # 286 was atching television, and was y nasal cannula from oxygen a roximately 4:00 p.m. Resident # 286 was atching television, and was y nasal cannula from oxygen a roximately 4:00 p.m. Resident # 286 was atching television, and was y nasal cannula from oxygen a roximately 10:00 p.m. Resident # 286 was atching television, and was y nasal cannula from oxygen a roximately NC (nasal Li (liters). Oxygen titrate up to		356				

	MENT OF HEALTH	AND HULES SERVICES				FORM	APPROVED 0938-0391
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F 656	On 12/06/17 at 2:45 conducted with RN coordinator regarding plan for Resident # review the compreh # 286 dated 11/29/1 care plan to address RN # 7 stated, "The who was responsible care plan, RN # 7 streceived the order scare plan."  On 12/07/17 at 10:0 this surveyor with a address Resident # documented, "Focur risk for cardiovascui complications related (coronary artery discention (hypertension) hype 12/06/2017. Created "Interventions" it docordered via (by) NC per orders. Date Infon: 12/06/2017."  On 12/07/17 at 2:40	om 12/01/17 through 12/07/17.  ip.m. an interview was (registered nurse) # 7, MDS ing the comprehensive care 286. RN # 7 was asked to ensive care plan for Resident 7. When asked if there was a Resident # 286's oxygen, in the facility provided in the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan is Resident exhibits or is at the facility provided copy of a care plan to 286's oxygen. The care plan to 286's oxygen. The care plan is the facility provided copy of a care plan to 286's oxygen.	F 6	}	NCY)		
	conducted with RN (regarding the compr Resident # 286. Whatimeframe and the redevelopment of the # 9 stated, "It's done by the MDS coordinatesponsible for updates."	registered nurse) # 9 rehensive care plan for en asked about the					

DEPART	MENT OF HEALTH	AND MAN SERVICES					APPROVED 0938-0391	
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F 656	stated, "Nursing sho	ould do it." roximately 2:50 p.m. and	F6	56				
	interview was cond staff member) # 2, ASM # 3, clinical qu who is responsible	ucted with ASM (administrative interim director of nursing and lality specialist. When asked for the development of care ASM # 2 stated, "Everyone,						
	documented, "2. A person-centered ca	re plan must be developed for ust describe the following: 2.1	venance and a major control of the c					
	(administrative staft director, ASM # 2, i	roximately 5:00 p.m. ASM f member) # 1, executive nterim director of nursingand iality specialist, were made is.	The state of the s					
	No further informati	on was obtained prior to exit.					N della ///www.nora	
`	regulate the amount information was obtained.	se in which the body cannot t of sugar in the blood. This tained from the website: .gov/medlineplus/ency/article/						
	to 6 L/min. The nas extend approx. 1 cr connected to a com connected to the ox treat conditions in v oxygen content is n	deliver oxygen at levels from 1 al prongs of the cannula in into éach naris and are amon tube, which is then aygen source. It is used to which a slightly enriched eeded, such as emphysema.						

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HUN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING \_ B. WING 495246 12/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG **DEFICIENCY**) F 656 F 656 Continued From page 133 patient varies with respiratory rate and other factors. This information was obtained from the

(3) An oxygen concentrator works much like a window air conditioning unit: it takes in air, modifies it and delivers it in a new form. An oxygen concentrator takes in air and purifies it for use by people requiring medical oxygen due to low oxygen levels in their blood. It works by: taking in air from its surroundings, compressing air, while the cooling mechanism keeps the concentrator from overheating, removing nitrogen from the air via filter and sieve beds, adjusting delivery settings with an electronic interface and delivering the purified oxygen via a nasal cannula or mask. This information was obtained from: https://www.inogen.com/resources/oxygen-concentrators/how-does-an-oxygen-concentrator-work/.

http://medical-dictionary.thefreedictionary.com/na

4. The facility staff failed to develop a comprehensive care plan to address Resident # 284's indwelling catheter (1), ileostomy (colostomy) (3) and feeding tube (4).

Resident # 284 was admitted to the facility on 11/30/17 with diagnoses that included but were not limited to: atrial fibrillation (2), dysphagia, (5), osteoporosis, attention of ileostomy and attention to gastrostomy (feeding tube).

Resident # 284's most recent MDS (minimum data set), an admission assessment was not due at the time of survey.

The facility's "Nursing Assessment-Initial" for Resident # 284 dated 11/30/17 documented.

website:

sal+cannula.

	MENT OF HEALTH	AND MAN SERVICES				FORM	: 12/18/2017 I APPROVED : 0938-0391	
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F 656	Judgement/Insight-Further review of the for Resident # 284 Colostomy and Indo-Review of the resided ated 12/04/17 failed address Resident # colostomy and indo-Conducted with RN coordinator regarding plan for Resident # review the compreh # 284 dated 12/04/10 care plan to address tube, colostomy and stated. "There isn't	on, place and time; intact and clear speech."  le "Nursing Assessment-Initial" documented, "Feeding tube, welling catheter."  ent's comprehensive care planted to evidence a care plan to 284's feeding tube, welling catheter.  p.m. an interview was (registered nurse) # 7, MDS in the comprehensive care 284. RN # 7 was asked to be sive care plan for Resident 17. When asked if there was a Resident # 284's feeding d indwelling catheter RN # 7 one." When asked who was eloping the oxygen care plan	E	656				
	12/07/17 at 2:50 p.r conducted with ASM member) # 2, interii # 3 clinical quality s responsible for the care plan for Reside "Everyone, the IDT On 12/06/17 at appropriate (administrative staff director, ASM # 2, in ASM # 3, clinical quaware of the finding	m. and interview was  M (administrative staff m director of nursing and ASM pecialist. When asked who is development of the interim ents # 284 ASM # 2 stated, (interdisciplinary team)."  roximately 5:00 p.m. ASM f member) # 1, executive interim director of nursingand isality specialist, were made						
	no turtner informati	on was obtained prior to exit.					N T P C C C C C C C C C C C C C C C C C C	

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

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F 656	References:  (1) You have an ind bladder. "Indwelling This catheter drains a bag outside your have an indwelling incontinence (leaka being able to urinate catheter necessary, This information wa https://medlineplus.00140.htm.  (2) A swallowing disobtained from the whitps://www.nlm.nih sorders.html.  (3) An ileostomy (cowaste out of the boothe colon or rectum information was obthe tolon or rectum information was obthe stomach wall. It stomach. This inforwebsite: https://medlineplus.com/sites//medlineplus.com/sites//medlineplus.com/sites//medlineplus.com/sites//www.nlm.nih.sites.html.	welling catheter (tube) in your "means inside your body. It means inside your bladder into body. Common reasons to catheter are urinary ige), urinary retention (not ie), surgery that made this is obtained from the website: gov/ency/patientinstructions/0 corder. This information was	F	656				

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	<u>. 0938-0391</u>	
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WOODM	ONT CENTER			ļ	11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	Resident #64 was a 10/05/17 with diagnost limited to atrial f blood pressure, rencholesterol, thyroid Resident #64's mos set) assessment wawith an ARD (asses 10/12/17. Resident	a week per the re plan.  admitted to the facility on closes that included but were fibrillation, heart failure, high closed insufficiency, high disorder, and post stroke. St recent MDS (minimum data as an admission assessment essment reference date) of t #64 was coded as being	F6	356	3			
	decisions scoring 18 interview for mental was coded as require from two or more statements and transfers, toileting, a "8/8" was coded und	the ability to make daily 5 out of 15 on the BIMS (brief I status) exam. Resident #64 iring extensive assistance taff with bed mobility, and personal hygiene. An der the area of "Bathing" ng had not occurred over the ek period.						
	conducted with Resi stated he does not r Resident #64 stated that he had a showe	31 p.m., an interview was ident #64. Resident #64 had receive showers at the facility. If he could only recall one time er. Resident #64 stated wash him with a wash cloth im every morning.						
- VALVE TO ANGELON AND ANGELON ANGELON AND ANGELON ANGELON AND ANGELON ANG	living) records dated failed to evidence Re	#64's ADL (activity of daily daily 10/2017 through 12/2017 esident #64 had received a ed bath documented was on						
***************************************	through December 2	er sheets dated October 2017 2017 revealed Resident #64's in Thursdays and Mondays.				TO WE THE PROPERTY OF THE PROP		

DEPARTMENT OF HEALTH AND MAN SERVICES

PRINTED: 12/18/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION  NG	COMPLETED			
		495246	B. WING		12/08/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(FACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BY FULL AGE OF CORRECTION SHOULD BY FULL AGE OF CORRECTION SHOULD BY FULL AGE OF CORRECTION ACTION A					
F 656	Further review of the evidence Resident since his admission.  Review of Resident plan for ADL (activity documented the form decreased ability to grooming, personal bed mobility, transformationinterves shower 2x a week, adls (sic)."  On 12/06/17 at 1:4 conducted with CN 8, Resident #64's CCNAs were respond documenting any nCNA #8 also stated documented on this cleaned with showed determine when RecCNA #8 stated that and that his CNA less on 12/06/17 at 11:3 conducted with LPI When asked how of #8 stated, "Shower schedules depend documented in the sign off if baths and baths should be given their tablet for AE was not done."	the shower sheets failed to #64 had received showers in to the facility.  It #64's comprehensive care ty daily living) dated 10/9/17, Illowing: "Resident is at risk for to perform ADLS in bathing, I hygiene, dressing, eating, ier, entionsResident get a Resident needs assist with  It purposes to perform an interview was A (certified nursing assistant) # CNA. CNA #8 stated that sible for doing showers and ew areas on a skin sheet. I that nail care would be as sheet because nails were ers. CNA #8 could not esident # 64 had a shower last, she rarely worked with him	F 6				

DEPART	MENT OF HEALTH	AND MAN SERVICES					FORM.	APPROVED	
CENTER	S FOR MEDICARE	& MEDICAID SERVICES			****	U	OMB NO. 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C			
		495246	B. WING				l	08/2017	
NAME OF F	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE				
MANUE OF 1				1	11 DAIRY LANE				
WOODM	ONT CENTER			F	FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD	BE	(X5) COMPLETION DATE	
	Continued From part 15. When asked documented, CNA shower book. CNA sheets have a date sheet and all room who receive shower #15 stated that one CNAs should be signumber of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the residence of the shower of the shower the shower the shower the residence of the res	where resident showers are #15 stated that each unit has a #15 stated that the shower documented on the top of the numbers listed for residents is on that assigned day. CNA is a shower is completed, the gring off next to the room dents who received a shower, here is no signature next to the esn't necessarily mean the mpleted. CNA #15 stated the have forgot to document. CNA dent refuses a shower, she will en asked if she has ever shower, CNA #15 stated, "Yes, get to people." When asked if ave to miss their shower, CNA will are to miss their shower, CNA will are with Resident #64.  38 a.m., an interview was N (licensed practical nurse) #2. nurses ensure residents are LPN #2 stated that she would book. LPN #2 stated if a sir shower on a shift, the assed on to the next shift. Sident may not get a shower shower day. LPN #2 stated finally receives a shower, it will the shower book. When asked on the shower logs in the #2 stated that if the shower ed then it wasn't done.  2 a.m., an interview was	F	656					
	conducted with RN	(registered nurse) #7. When of the care plan, RN #7 stated							

DEPART	MENT OF HEALTH	AND HUT SERVICES				FORM	APPROVED . 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C				
		495246	B. WING				08/2017			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
WOODM	ONT CENTER		11 DAIRY LANE FREDERICKSBURG, VA 22405							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE			
F 656	the care plan serve resident's needs. Free meant if a resident care plan to showed documented evider #7 stated the care pataff are not providicare.  On 12/07/17 at 4:45 staff member) #1, the interim DON (D #3, the clinical qual of the above concernostericable physical well-being. To promote the patient team to obtain the prepresentative inpureffective communication."  No further informations.	d as a guide to determine RN #7 was asked what it who has interventions on the r 2 x a week, but there is no note this was being done. RN plan was not being followed if ng showers per the plan of p.m., ASM (administrative the executive director, ASM #2, irector of Nursing) and ASM ity specialist were made aware rns.  Ited, "Person Centered Care in part, the following: "Purpose: in the patient's highest I, mental and psychosocial note positive communication it, resident representative, and patient's and resident into the plan of care, ensure that it is a possible to apply soft heel boots.	. F 6	856						

comprehensive plan of care.

Resident #19 was admitted to the facility on

8/25/16 with diagnoses that included but were not limited to: anemia, high blood pressure, diabetes mellitus, post stroke with aphasia (difficulty

speaking), hemiplegia (paralysis on one side of the body), and Parkinson's Disease. Resident

DEPARTI	MENT OF HEALTH	AND AND SERVICES  & MEDICAID SERVICES					<b>FORM</b>	12/18/2017 APPROVED 0938-0391
STATEMENT (	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495246	B. WING					08/2017
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODMO	NT CENTER			1	11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		i	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE ATE	(X5) COMPLETION DATE
	assessment was a ARD (assessment in Resident #19 was of intact in the ability to scoring 12 out of 15 for mental status) ecoded as requiring staff member with opersonal hygiene; eor more staff with bassistance with batton 12/04/17 at 11:4 made of Resident # sleeping in bed. A sher chair.  On 12/04/17 at 12:2 made of Resident # bed. A CNA (certification was observed on 12/06/17 at 09:0 made of Resident # asleep. One soft he chair next to her be on 12/06/17 10:37 made of Resident # foot. Resident #19 been on her right footserved in the chair sheet) dated 12/4/1	MDS (minimum data set) quarterly assessment with an reference date) of 9/20/17. coded as being cognitively o make daily life decisions on the BIMS (brief interview xam. Resident #12 was extensive assistance from one dressing, toileting, and extensive assistance from two ed mobility and limited hing.  16 a.m. an observation was 19. Resident #19 was soft heel boot was observed in 23 p.m. an observation was 19. Resident #19 was lying in ed nursing assistant) entered her lunch tray. A soft heel on the chair beside her bed.  10 a.m., an observation was 19. She was lying in bed heel boot was observed on the d.  24 a.m., an observation was 25 a.m., an observation was 26 a.m., an observation was 27 b. She was lying in bed heel boot in place to her right stated her heel boot had not hot. The heel boot was	F	656				

	MENT OF HEALTH				FORM	): 12/18/2017 1 APPROVED ): 0938-0391
STATEMENT	S FOR MEDICARE  OF DEFICIENCIES  F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495246	B. WING			C /08/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
WOODMO	ONT CENTER		1	I1 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Review of Resident care plan dated 9/2 following: "Resident as evidenced by ind moisture/excessive Soft heel boots as of Review of the Dece administration reconot documenting th #19's feet were in pon the TAR as an FReview of the ADLs tracker revealed an Resident #19's hee On 12/06/17 at 11:3 conducted with LPN When asked how Opreventive measure resident, LPN #8 st skin intervention on into the computer, the able to see/view this section of the computer on 12/06/17 at 1:40 conducted with CN/2 conducte	er was initiated on 8/25/16.  #19's comprehensive skin 2/16 documented the t is at risk for skin breakdown continence, limited mobility, perspirationInterventions: ordered."  ember 2017 TAR (Treatment rd) revealed that nursing was at the heel boots to Resident place. The order was written ryl (For Your Information).  (activities of daily living) instruction for soft heels to ls.  30 a.m. an interview was at (licensed practical nurse) #8.  CNAs would know what skin es to put into place for each atted when the nurse puts the the care plan and places it the nursing aides should be sintervention under the ADLs	F 656			

preventive measures.

stated that CNAs can look on the ADL tracker on their tablet. CNA #8 stated that she was not familiar with Resident # 19 and could not determine what she needed in place for skin

On 12/06/17 at 2:10 p.m., an interview with CNA

	MENT OF HEALTH	AND MAN SERVICES			0		FORM A	12/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495246	B. WING				· ·	8/2017
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE	, ZIP CODE		
WOODM	ONT CENTER				DAIRY LANE		*	
AACCDIAI	ONI OLIVILIA			FRI	EDERICKSBURG, VA 2	2405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
	#10, Resident #19's CNAs would know measures to put int CNA #10 stated that residents' closet and be put into place should be closet. When asked Resident #19's roo heel boots could be closet. When asked Resident #19's chairs saw a heel boot. Con and it fell off, so CNA #10 then removed should have them of asked where else should have them of asked where else should go to the nurse on 12/06/17 at 2:10 Resident #19's right skin was intact and 12/07/17 at approximation was conducted with nurse. When asked boots, LPN #9 state boots was to protect getting DTIS (Deep when it would be rewear soft heel boots.)	s CNA. When asked how what skin preventive o place for each resident, at she would look in the d instructions for anything to would be listed in the closet. Skin preventive measures place for Resident # 19, CNA does not normally work with the normally works on the 200 m. No instructions for the found in Resident #19's d what the CNA observed in the found in Resident #19's d what the CNA observed in the found in Stated, "Maybe it was someone put in in the chair." Eved the blankets covering ther soft heel boot was not when asked if her soft heel blace, CNA #10 stated, "She in, I would think." When the can look to see what place, CNA #10 stated, "I see and ask."	F	556				
ORM CMS-256	37(02-99) Previous Versions	Obsolete Event ID: DGWI11	I	Facility	y ID: VA0279	If continuation	sheet Page	e 143 of 348

	TMENT OF HEALTH	AND HUI SERVICES					FORM	): 12/18/2017 /I APPROVED ): 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		(X3) DAT	TE SURVEY MPLETED
	,	495246	B. WING				t	/08/2017
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
WOODM	IONT CENTER		PERMANAMENTAL		11 DAIRY LANE FREDERICKSBURG, VA 22	405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 656	1	age 143 e wearing them in bed.	F6	56				
	interview was condunurse) #4, Resident the purpose of soft the point of soft hee free floating, to previously on the bed. to relieve pressure. aids usually put soft should ensure that the conductor of 12/06/17 at 5:30 staff member) #1, the conductor of the cond	D p.m. ASM (administrative he executive director, ASM #2,						
A short and model Advance.	#3, the clinical quali of the above concer	To the state of th	The state of the s					
**************************************	No further information	ion was presented prior to exit.	·····appin melanisas					
AND AND DESCRIPTION OF THE PROPERTY OF THE PRO	6b. The facility staff #19 showers two tin comprehensive care		TOTAL CONTRACTOR CONTR	AND AN A WATER OF THE PARTY PARTY AND AND AN ADDRESS OF THE PARTY AND A				
	bed. Resident #19 bed on the following 11:46 a.m., 12:23 p. 12/5/17 08:56 a.m., p.m., 12/6/17 07:49 3:04 p.m. and 12/7/	made of Resident #19 lying in was observed to be lying in g dates and times: 12/4/17 at .m., 1:52 p.m., 3:00 p.m., 09:36 a.m., 12:00 p.m., 2:47 a.m., 9:03 a.m., 11:35 a.m., 17 at 9:46 a.m		COLUMN ASSESSATION AND A COLUMN ASSESSATION AND A COLUMN ASSESSATION ASSESSATI				
	conducted with Resistated she had not be	3 a.m. an interview was ident #19. Resident #19 been out of bed in two weeks. I that no one has ever asked		THE THE TOTAL COMMENT OF THE PARTY OF THE PA				

DEPART	MENT OF HEALTH	AND MAN SERVICES & MEDICAID SERVICES				FORM	12/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY IPLETED C
		495246	B. WING			1	08/2017
NAME OF F	PROVIDER OR SUPPLIER		1,	1	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE		
WOODM	ONT CENTER	·		1 1	REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 656	her if she would like #19 stated she wou asks to get out the	e to get out of bed. Resident ald like to get of bed but never bed.	F	656			
	conducted with Res Resident #19 recei- out of the bed, Res receive showers at could not remembe	35 a.m. further interview was sident #19. When asked how wes showers if she never gets ident #19 stated she does not the facility. Resident #19 or the last time she had a by. Resident #19 stated she in bed.	ANN THE STATE OF T				
	(activities of daily livand revised 7/6/17 "Resident/Patient related to: chronic ifunctional ability. Gare needs will be apply the review period	t #19's comprehensive ADL ving) care plan dated 9/2/16 documented the following: equires assistance in ADL care liness, compromising soal: Residents/Patients ADL anticipated and met through x 90 daysInterventions: ower 2 x (two times) a week."					
	Resident #19 was a on Wednesdays ar shift. Further revie August 2017 until [	ver log sheets revealed supposed to receive a shower and Saturdays during the day w of the shower logs from December 2017 revealed not received any showers.					
	December 2017 All report revealed that	t #19's October 2017 through DL (activities of daily living) t Resident #19 was ving a shower on 10/28/17.	Y			,	
	conducted with LPI When asked how o	33 a.m., an interview was N (licensed practical nurse) #8. often showers are given, LPN					endance with the control of the cont

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DEPARTMENT OF HEALTH	AND HUI( ) SERVICES
CENTERS FOR MEDICARE	
	(VA) ADOMEDICUBBLIEDIĆLIA

<u> </u>	TO TOTAL MEDICAL TOTAL					(XO) DAT	ב מיוטינביי
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 12/08/2017	
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		495246	B. WING				
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	*	
woonM	OUT CENTED				AIRY LANE		
WOODIN	ONT CENTER			FRE	DERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	3	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	schedules depend documented in the sign off if baths and baths should be given their tablet for AE was not done."  On 12/07/17 at 09:3 conducted with CNA shower book. CNA shower book. CNA sheets have a date sheet and all room who receive shower #15 stated once a sc CNAs should be signumber of the reside CNA #15 stated if the room number, it does shower was not cornursing aide could I #15 stated that if a she will tell the nurse ever missed a resident shower, CNA #15 stated that she #19.  On 12/07/17 at 09:3 conducted with LPN When asked how mare receiving shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be shower would be signed.	on the room. Showers are shower book. Nursing aides is showers are given. Bed wen every day. They document DLS. If it is not documented, it as a.m., an interview was a (certified nursing assistant) where resident showers are #15 stated that each unit has a #15 stated that the shower documented on the top of the numbers listed for residents rs on that assigned day. CNA shower is completed, the gning off next to the room lents who received a shower here is no signature next to the esn't necessarily mean the mpleted. CNA #15 stated the have forgot to document. CNA resident refuses a shower, se. When asked if she has lent shower, CNA #15 stated, can't get to people." When should have to miss their tated that they shouldn't. CNA was not familiar with Resident B8 a.m., an interview was I (licensed practical nurse) #2. urses ensure that residents ers, LPN #2 stated that she ower book. LPN #2 stated that their shower on a shift due, e passed on to the next shift.	F	356			

	MENT OF HEALTH						FORM	12/18/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING					(X3) DATE SURVEY COMPLETED	
		495246	B. WING	ì	)			08/2017	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE	CODE			
WOODM	ONT CENTER				FREDERICKSBURG, VA 2240	5			
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD SE APPROPF	BE	(X5) COMPLETION DATE	
F 656	stated when the resishower, it will be do When asked what is logs in the shower is shower was not doo. On 12/08/17 at 8:22 conducted with RN asked the purpose the care plan serveresident's needs. If meant if a resident care plan to shower documented eviden #7 stated the care pstaff are not providicare.  On 12/07/17 at 4:45 staff member) #1, the interim DON (Di #3, the clinical quality of the above concerns. No further information.  Resident # 43 was a 7/8/17 and readmitted that included but we congestive heart fail	deduled shower day. LPN #2 sident finally receives a cumented in the shower book. Dlanks meant on the shower book, LPN #2 stated that if the cumented then it wasn't done.  2 a.m., an interview was (registered nurse) #7. When of the care plan, RN #7 stated d as a guide to determine RN #7 was asked what it who has interventions on the 2 x a week, but there is no lice this was being done. RN plan was not being followed if any showers per the plan of the executive director, ASM #2, irector of Nursing) and ASM ity specialist were made aware	F	656					
	••	st recent MDS (minimum data						AAAAAAAA	

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

PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	TIPLE CONSTRUCTION ING		COMPLETED		
		495246	B. WING		12	2/08/2017	
	PROVIDER OR SUPPLIER  ONT CENTER			STREET ADDRESS, CITY, STATE 11 DAIRY LANE FREDERICKSBURG, VA 2:	•		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	set) assessment, a an ARD (assessment an ARD (assessment) and ARD (assessment) and ARD (assessment) as able to under was coded as being daily decisions, socious of the complex of the com	a Quarterly Assessment, with ent reference date) of 10/15/17 43 as understood by others erstand others. Resident # 43 g cognitively intact for making bring 15 out of 15 on the BIMS mental status).  Prehensive care plan revealed the following: Under "Focus: or is at risk for respiratory ed to history of CHF ailure), PNA (pneumonia) and Date Initiated 09/28/17" Under as ordered via nasal cannula. 8/2017"  Jan order dated 9/20/17 and ed by the physician on 12/4/17 (GEN 2L/MIN VIA NASAL NUOUS." Review of the AR is as follows: "O2 @ annula Continuous" dated  Tryations were made of ygen:  A. Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen set at the Resident # 43 oxygen noted	F6	556			

Facility ID: VA0279

DEPART	MENT OF HEALTH	AND MAN SERVICES			( )	FORM	APPROVED 0938-0391
STATEMENT	RS FOR MEDICARE  OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		495246	B. WING	i			08/2017
NAME OF I	PROVIDER OR SUPPLIER			i i	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			1	1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.DBE	(X5) COMPLETION DATE	
F 656	During an interview LPN (licensed pracasked the purpose stated the purpose direction on how to During an interview LPN # 10, LPN # 10, LPN # 10, LPN # 10 the care plan. LPN guide to get the patto try to keep them the care plan to fine patient. The care plan to fine patient. The care plan to fine patient. The care plan to fine patient in the patient's toiletin would even give infective they were diabetic aperhaps their respirately with the patient prector Clinical Quality Specific C	on 12/6/17 at 3:02 p.m. with tical nurse) # 3, LPN # 3 was of the care plan. LPN # 3 of the care plan was to give care for the resident.  on 12/7/17 at 12:06 p.m. with 0 was asked the purpose of # 10 said the care plan was a tient to their best potential and at that level. Staff would use dout how to care for the olan would give information on g, eating, transfer status and ormation on whether or not each how to care for them and ratory status too.  on 12/7/17 at approximately M (Administrative Staff executive Director, ASM # 2, of Nurses, and ASM # 3, the ecialist, this observation was the policy: RED CARE PLAN"	F	656			

#### DEPARTMENT OF HEALTH AND HUNN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495246	B. WING_			C 12/08/2017	
	PROVIDER OR SUPPLIER			11 DA	ET ADDRESS, CITY, STATE, ZIP CODE NRY LANE DERICKSBURG, VA 22405	ţ Tânf	00/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION S		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Basic Nursing, Esse (Potter and Perry, 2 reference for care pa written guideline fipromoting continuity criteria to be used in care. The written canursing care prioritic professionals. The coordinates resource care. A correctly for easy to continue carl f the patient's status nursing diagnosis ar no longer appropriate plan. An out of date compromises the questional care Plan Timing ar CFR(s): 483.21(b)(2) §483.21(b)(2) A combediagnosis ar compromises the questional care plan to the comprehensive as (ii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctudes but is not liming the comprehensive as (iii) Prepared by an infinctude as (iii) Prepared	entials for Practice, 6th edition, 007, pages 119-127), was a lans. "A nursing care plan is or coordinating nursing care, of care and listing outcome in the evaluation of nursing are plan communicates as to other health care care plan also identifies and les used to deliver nursing imulated care plan makes it in the from one nurse to another. It is has changed and the indirect care plan indirect care plan indirect care plan indirect care plan indirect care plan indirect care plan indirect care plan indirect care plan indirect care plan indirect care plan must indirect care plan must interdisciplinary team, that interd	F 65	7 1.	Resident #12 has had care plupdated to reflect bruise on and area on forehead. Reside 56 has been discharged from facility. Residents # 72 and have had care plans updated reflect recent falls and new interventions. Resident # 19 care plan was updated to reflect recent chair. Resident # 74 Plan was updated to reflect FR Restrictions. Resident # 47 Plan was updated to reflect FR wound. These corrections we made by the Unit Managers.  All residents have the potentibe affected. Audit was comply the Unit Managers of all	chin ent # the # 62 to 's lect Care Fluid Care current ere	

DEPART	MENT OF HEALTH	AND MAN SERVICES  & MEDICAID SERVICES				FORM	12/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, .		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	B. WING			1	08/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	WOODMONT CENTER				DAIRY LANE EDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 657	resident's care plan (F) Other appropria disciplines as deter or as requested by (iii)Reviewed and re team after each ass comprehensive and assessments. This REQUIREMEN by: Based on observat document review and was determined the and revise the care in the survey sampl #62, #19, #74 and #  1. The facility staff Resident #12's com following injuries of her chin and an abr  2. The facility staff comprehensive care code status change resuscitate.  3. The facility staff f Resident #72's com following the 9/27/1  4. The facility staff f Resident #62's com	the development of the ite staff or professionals in mined by the resident's needs the resident. Evised by the interdisciplinary sessment, including both the ite quarterly review.  It is not met as evidenced ion, staff interview, facility and clinical record review, it a facility staff failed to review plan for seven of 29 residents e, Resident #12, #56, #72, #47.  If alled to review and revise aprehensive care plan unknown origin, a bruise to asion to her forehead.  If alled to review and revise the e plan when Resident #56's d from a full code to a do not alled to review and revise aprehensive care plan 7, 10/2/17 and 10/11/17 falls.  It is alled to review and revise aprehensive care plan 7, 10/2/17 and 10/11/17 falls.  It is not met as evidenced in the eview and revise aprehensive care plan 7, 10/2/17 and 10/11/17 falls.	F	657	residents with Fluid Restrict were reviewed to ensure car in place. Audit was completed all residents with pressure residents with injuries and the last month were review ensure that care plan was unaccordingly.  3. Education was provided to Clinical Management Team Regional Nurse related to the regulation to ensure that Car Plans are revised with channels are review Care Plans during the Clinical Morning Meeting and changes are addressed accordingly on the Care Platthat the Kardex gets update Results of these audits will taken to the Quality Assurate Performance Improvement Committee monthly for review Care Platthat for review Care Improvement Committee monthly for review Cample and the	are plans eted of ulcers to uce. I falls in red to pdated  the n by the he are ages. n will he 5 days I falls an and ed. be unce and	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING				C 08/2017
	PROVIDER OR SUPPLIER  ONT CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 657	comprehensive car discharged from or recommendations of the facility staff of the comprehensive car physician-ordered of 12/1/17.  7. The facility staff of Resident #47's comprehensive car physician-ordered of 12/1/17.  7. The facility staff of Resident #47's compresident acquired of November 2017.  The findings included of the facility staff of Resident #12's compositive of the chin and an about the facility staff of the chin and an about the facility staff of the facility staff	re plan after Resident #19 was recupational therapy with for a BRODA chair.  Failed to revise Resident #74's e plan to include the fluid restriction ordered on failed to review and revise apprehensive care plan after the ew pressure injuries in e:  failed to review and revise apprehensive care plan unknown origin, a bruise to rasion to her forehead.  admitted to the facility on admission on 5/5/16 with uded, but were not limited to; rosis (weakening of the world blood cells), acid reflux and, difficulty swallowing, and sessment with an ARD and the recent MDS (minimum data sessment with an ARD and the recent #12 was unable to the son the BIMS (brief interview and was coded on the staffing severely impaired to make tasks of daily life. Resident ded as being dependent on	F	357			

	TMENT OF HEALTH	AND CIAN SERVICES  & MEDICAID SERVICES			0	FOR	D: 12/18/2017 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	i` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	B. WING				C 2/08/2017
NAME OF	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIF	CODE	
WOODM	ONT CENTER				I DAIRY LANE REDERICKSBURG, VA 2240	15	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 657	Continued From pa	ge 152	F (	357			
	process to have an above her right eye documentation in R concerning the abra A review of Resider revealed, in part, a the following; ""Effe (11:20 p.m.) Type: change in condition symptoms include: 11/8/2017. Change Clinician: (name of 4:00 p.m. Name of notified: SELF 11/8 Further review of Rerevealed, in part, a dated 11/8/17 that do	esident #12's clinical record asion.  It #12's clinical record, progress note documenting ctive Date: 11/8/17 23:20 Change in Condition. Note: A has been noted. The Skin wound or ulcer reported to Primary Care clinician notified) 11/8/2017 Family / Healthcare agent					
	Further review of Redid not reveal any dinvestigation had be	esident #12's clinical record ocumentation that an en initiated to determine how stained the injuries to her chin					
Тата менен жазан жаз	plan did not reveal a	t #12's comprehensive care any documentation regarding r 2017 and December 2017.		weekillisanamanaman vararay — dibibi			
Act 1 this manuscript	conducted with LPN a floor nurse. LPN # purpose of a compre	4 a.m., an interview was (licensed practical nurse) #3, 43 was asked to describe the ehensive care plan. LPN #3 by to take care of a patient; if		МОООРОСКООТ МИККИ АНТИКА КИБАККИМАКА КАКШИМИКИ МОКИСКОСКО			

DEPARTMENT OF HEALTH AND HU( ) SERVICES	
CENTERS FOR MEDICARE & MEDICARD SERVICES	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		495246	B. WING		1	08/2017
NAME OF PROVIDER OR SUPPLIER  WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE CO		(X5) COMPLETION DATE
F 657	on oxygen the care administer O2 whet #3 was asked who care plans and whether LPN #3 stated, "Event updating care plans example, if I got a real I would update the chow a care plan is the is done on the compound on 12/7/17 at 12:30 conducted with ASM member) #2, the interpretation of the care plan when a care p	plan tells us how to ther continuous or PRN." LPN is responsible for updating the en would they be updated. erybody is responsible for s. The nurses and MDS. For new order for an antibiotic then care plan." LPN #3 was asked updated. LPN #3 stated that It puter.  In p.m. an interview was a ferrim director of nursing as asked who was responsible enprehensive care plans. ASM plans were updated by the entreself. ASM #2 was asked ould be updated, ASM #2 re is a change in condition, a ferrim or a change in preferences." who was responsible for lan when there was an injury. In the was an injury and the entreself. ASM #2 was asked unknown origin, the bruise on identified on 11/8/17 and the entrese was undetermined). ASM plan was not updated as she those incidents. At this time a olicy regarding e plans was requested.	F 6	57		