CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			·	OMR NO	<u>). 0938-0391</u>	
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495246	B. WING	·		12	/08/2017	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
WOODM	ONT CENTER			!	11 DAIRY LANE			
AACCODIA	ONI CENIER				FREDERICKSBURG, VA 22405			
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F 657	be: 5.2 Reviewed a quarterly and as ne care and changing. An end of day meet 4:45 p.m. with ASM ASM #2, interim din the clinical quality s and ASM #3 were n concerns. No further informati end of the survey proceed of the survey proceed status change resuscitate. Resident #56 was a with diagnoses that to; dementia, a gast feeding directly into vascular disease (phigh blood pressure swallowing, anemia irregular heartbeat, Resident #56's mos set), a quarterly ass (assessment referenceded Resident #56 the questions on the mental status) and the Resident #56 as beidecisions regarding	and revised a minimum of eded to reflect the response to needs and goals." ing occurred on 12/7/17 at #1, the executive director, ector of nursing, and ASM #3, pecialist. ASM #1, ASM #2 nade aware of the above on was provided prior to the	F	357				

DEPARTMENT OF HEALTH AND MAN SERVICES

PRINTED: 12/18/2017

FORM APPROVED

	TMENT OF HEALTH	The state of the s			FOR	D: 12/18/2017 M APPROVED	
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DA	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
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F 657	Continued From pa	ge 155	F 657				
	revealed, in part, a December 2017 with documentation, "1/3 (cardiopulmonary re NOT ATTEMPT CP) A review of Resider plan dated 1/3/17 redocumentation; "Fo Date Initiated: 11/14 Further review of Rerevealed, in part, a Care Instructions" for documenting; "Part attempt CPR; allow [do not resuscitate])	2/17 YES - ATTEMPT CPR esuscitation). 1/3/17 NO - DO R." at #56's comprehensive care evealed, in part, the following cus: Resident is Full Code. 1/17. Created on 9/29/2017." esident #56's clinical record 'Resident / Patient Health form dated 10/30/17 C. Code Status. No, do not death to occur naturally (DNR III." Signed and dated on the #56's RP (responsible).					
THE TRANSMITTER PROPERTY OF THE PROPERTY OF TH	revealed, in part, a l	esident #56's clinical record Durable Do No Resuscitate ated by Resident #56's n 10/30/17.				ore control population. A Children on my man of annual con-	
	conducted with ASM member) #2, the into (DON). ASM #2 was for updating the com #2 stated the care p MDS coordinator or when a care plan wo stated "Anytime ther change in therapies	p.m. an interview was I (administrative staff erim director of nursing s asked who was responsible aprehensive care plans. ASM lans were updated by the herself. ASM #2 was asked build be updated, ASM #2 te is a change in condition, a or a change in preferences."					

care plan should have been reviewed and revised

PRINTED: 12/18/2017

	TMENT OF HEALTH	AND MAN SERVICES & MEDICAID SERVICES				FORM	D: 12/18/2017 MAPPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				11 DAIRY LANE FREDERICKSBURG, VA 22405		
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F 657	not resuscitate and status from a full co it should have been code status. ASM a responsible at that it and revising the carnurse who took the nurse that signed the was not available for An end of day meet 4:45 p.m. with ASM ASM #2, the interim clinical quality speci ASM #3 were made concerns. No further information of the survey proceed of the survey proceed as a significant #72's care 10/2/17 and 10/11/1 Resident #72's care 10/2/17 and 10/11/1 Resident #72 was a 8/9/16 with diagnose limited to: depression heartbeat. Review of the most set) a significant character as a significa	hysician signed a durable do changed Resident #56's de to a DNR. ASM #2 stated updated to reflect the correct #2 was asked who was time, 10/30/17, for reviewing re plan. ASM #2 stated the order was responsible. The de documentation on 10/30/17 or interview. ing occurred on 12/7/17 at #1, the executive director, DON, and ASM #3, the falist. ASM #1, ASM #2 and a ware of the above	F	357			

	TMENT OF HEALTH	· · · · · · · · · · · · · · · · · · ·			FORM): 12/18/2017 MAPPROVED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 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 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 657	Continued From page	ge 157	F 65	57		The common wave many and commo
	investigation forms on 922/17, 10/2/17 a prevent future falls v investigation forms.	#72's clinical record and fall documented the resident fell and 10/11/17. Interventions to were documented on the fall				
	on 8/9/16 and updat evidence document	ent's falls care plan initiated ted on 11/22/17 did not ation regarding the falls or the ventions documented on the ms.				
	a.m. with RN (register educator. When ask RN #2 stated, "Nurs on the tablets the Cl assistants) have the residents had a care can have plans specified guidelines for their care plan would be restated, "New orders, illness, ADLs (activities, ADLs (activities, ADLs (activities, ADLs) (activities, AD	ted who uses the care plan, es and nurse managers and NAs (certified nursing plan." When asked why plan, RN #2 stated, "So we cific to each patient and have are." When asked when a eviewed and revised, RN #2 changes in condition, acute ies of daily living), falls, they rewound issues as well." It care plans were updated, at we know what proper not just the nurses but the 2 was asked to review plan. When asked if there resident's falls on 922/17,				
	•	nducted on 12/17/17 at 2:30				William Walker

p.m. with ASM (administrative staff member) #2, the interim director of nursing. When asked why

		AND MAN SERVICES & MEDICAID SERVICES				FORM	: 12/18/201 APPROVE : 0938-039	
STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODM	ONT CENTER				I DAIRY LANE REDERICKSBURG, VA 22405			
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	residents had care provide care for the when care plans wo ASM #2 stated, "An asked if care plans resident fall, ASM # On 12/7/17 at 4:45 pmember) #1, the exthe interim director of the findings. No further information 4. The facility staff faresident #62's care 4/16/17, 9/9/17 and Resident #62 was an 1/24/17 with diagnoslimited to: seizures, pressure, falls and device work the most assessment, with an Resident #62 as rare or to understand and term memory proble	plans, ASM #2 stated, "To residents." When asked ould be reviewed and revised, y change in condition." When would be updated after a 2 stated yes. p.m. ASM (administrative staff ecutive director and ASM #2, of nursing were made aware on was provided prior to exit. ailed to review and revise plan following the 4/4/17, 10/2/17 falls. dmitted to the facility on ses that included but were not schizophrenia, high blood	F 6	57				

each fall.

Review of Resident #62's clinical record and fall investigation forms documented that the resident had fallen on 4/4/17, 4/16/17, 9/9/17 and 10/2/17.

Interventions to prevent future falls were documented on the fall investigation forms for

DEPARTMENT OF HEALTH AND HULL SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MIDENTIFICATION NUMBER: MODDMONT CENTER PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION A. BUILDING C B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
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	1/30/17 and revised documentation of the recommended on the An interview was coal. When as RN #2 stated, "Nurson the tablets the Coassistants) have the residents had a carroan have plans speguidelines for their coare plan would be stated, "New orders illness, ADLs (activities, ADLs (activities, ADLs (activities, ADLs (activities) and the interventions to use nurse's aides." RN #2 stated, "So the interventions to use nurse's aides." RN #2 Resident #72's care was any documentate Resident #62's falls and 10/2/17, RN #2 When asked if falls and if there should be "With each fall yeah." An interview was coplimated in the residents had care provide care for the when care plans wo ASM #2 stated, "Any Man and Table 19 stated,	ent's fall care plan initiated on d on 5/3/17 did not evidence he falls or the interventions he fall investigation forms. Inducted on 12/07/17 at 10:00 tered nurse) #2, staff ked who uses the care plan, ses and nurse managers and the care plan, ses and nurse managers and the plan." When asked why e plan, RN #2 stated, "So we defic to each patient and have care." When asked when a reviewed and revised, RN #2 stated, and the plans were updated, that we know what proper the care plans were updated, that we know what proper that we have a sked to review the plan. When asked if there are plans that we have an updates for the plans that we have a plans that we h	F 6	57	

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE		0	PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED C
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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 **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 657 Continued From page 160 On 12/7/17 at 4:45 p.m. ASM (administrative staff member) #1, the executive director and ASM #2, the interim director of nursing were made aware of the findings. No further information was provided prior to exit. 5. The facility staff failed to revise the care plan after Resident #19 was discharged from occupational therapy with recommendations for a BRODA chair. 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 #19's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/20/17. Resident #19 was coded as being cognitively intact in the ability to make daily life decisions scoring 12 out of 15 on the BIMS (brief interview for mental status) exam. Resident #12 was coded as requiring extensive assistance from one staff member with dressing, toileting, and personal hygiene; extensive assistance from two or more staff with bed mobility and limited assistance with bathing. A "7" was coded for "Transfers: How the resident moves between surfaces including to or from bed, chair, wheelchair, standing positon, (excludes to and from bath/toilet)," indicating that the activity only occurred once or twice during the seven day look back period. Review of Resident #19's clinical record revealed

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

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PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HUK 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 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)ID. (X4) ID COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 657 F 657 Continued From page 161 that Resident #19 was discharged from occupational therapy on 10/13/17. The following was documented: "Baseline: 9/14/17: Bedbound. Poor positioning with Geri chair for feeding. Impulsive with self-feeding. 10/11/2017: Borrowed tilt in space [1] in repair status. Initiated letter of medical necessity for pt. (patient) to obtain personalized tilt in space. Currently training broda chair with good success...Caregivers inconsistent with seating and positioning schedule ensuring patient is up in broad (sic) chair for lunch...Discharge (10/13/17) Goal met with highest level available with BRODA [2] chair. 20" Tilt to space order submitted. Discharge recommendations: Caregiver support, Equipment recommended upon discharge: All equipment provided by facility as patient is a LTC (long term care) resident." Review of Resident #19's comprehensive care plan dated 9/2/2016 failed to reveal an intervention for the BRODA chair. Review of Resident #19's ADL (activities of daily living) task list failed to reveal an intervention or special instructions for the use of a BRODA chair. On 12/06/17 at 1:40 p.m., an interview was

familiar with Resident # 19.

conducted with CNA #8. When asked how CNAs would know the needs of each resident, CNA #8 stated that CNAs can look on the ADL tracker on their tablet. CNA #8 stated that she was not

On 12/07/17 at 09:12 a.m., an interview was conducted with OSM (other staff member) #7, the

Resident #19 was awaiting a specialized chair but the therapy department had issued her a BRODA

Director of Therapy. OSM #7 stated that

	MENT OF HEALTH	AND MAN SERVICES		*	0		FORM A	12/18/2017 PPROVED 938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 657	Continued From pa	=	F	357	•			
	On 12/07/17 at 09:2 conducted with LPN Resident #19's nurs of the care plan, LP of the care plan is the each resident. Where required a specialize not aware of that. If her care plan. Is it she needs a special was responsible for #2 stated that the N for updating the care that she could not fit BRODA chair. On 12/07/17 at 09:5 working with Reside if Resident #19 requires that she with the N on 12/07/17 at 09:5 conducted with RN asked how nurses we resident, RN #4 state care plan. When as	20 AM, an interview was N (licensed practical nurse) #2, se. When asked the purpose PN #2 stated that the purpose to tell nursing the needs of en asked if Resident #19 red chair, LPN #2 stated, "I'm would expect to see that on a Geri chair? I don't know if elized chair." When asked who updating the care plan, LPN MDS nurses were responsible re plan. LPN #2 confirmed ind an intervention for the						
	used a BRODA chain her for a new chair. would know that Re BRODA chair rather RN #4 stated that Relabeled on the chair would receive this in or they would find a asked who was resi	when asked how CNAs esident #19 needed to use a rethan a regular wheelchair, Resident #19 had her name r. RN #4 also stated CNAs information in a verbal report resource to ask. When ponsible for updating the care that the nurses on the floor or						
OPM CMS-25	67/02-99) Previous Versions	Obsolete Event ID: DGWI1	1	Facility ID: VA02	27 9	If continuation	sheet Page	e 163 of 348

	TMENT OF HEALTH	I AND HU SERVICES	•			FORM	12/18/2017 APPROVED 0938-0391
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	changes. When as had a unit manager asked if Resident # on her care plan, RI think so. When ask care plan, RN #4 stabout therapy. On 12/07/17 at 8:22 conducted with RN MDS nurse. RN #7 plan quarterly, annu change. RN #7 state responsible for update episodic issue such specialty chair should once recommended it is an intervention f When asked the purstated the care plan determine the reside was important to ensaccurate, RN #7 stated the therap update the care plan. On 12/07/17 at 4:45	update the care plan for any ked if her unit (cardinal) elements (card	F 6	57			
		e interim DON (Director of				manon.versea — Bridinass	

concerns.

specialist were made aware of the above

No further information was presented prior to exit.

[1] Tilt to Space wheelchair "helps to facilitate feeding and respiratory function, reduce pressure beneath the pelvis, and improve visual alignment

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	MENT OF HEALTH	- W. C.				APPROVE	
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			The				
F 686	Continued From pa	ae 233	F 68	36			
		rd) revealed that nursing was					
		at the heel boots to Resident		777			
		lace. The order was written					
		YI (For Your Information).		E constant of the constant of			
		•					
		(activities of daily living)		- Managara			
		instruction for soft heels to		-th-			
	Resident #19's heel	s.					
	On 40/06/47 at 44:0	0 a.m. an interview was					
	—	I (licensed practical nurse) #8.					
		NAs (certified nursing					
		w what skin preventive		oo aa a		* The second sec	
		o place for each resident, LPN				VAT TILLOW AND THE STATE OF THE	
	#8 stated when the						
		care plan and places it into the					
1	HILL TOTAL OF THE P			1		3	

preventive measures.

computer, the nursing aides should be able to see/view this intervention under the ADLs (activities of daily living) section of the computer.

On 12/06/17 at 1:40 p.m., an interview was conducted with CNA#8. When asked how CNAs would know the needs of each resident, CNA#8 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 #10, Resident #19's CNA. When asked how CNAs would know what skin preventive measures to put into place for each resident, CNA #10 stated that she would look in the residents' closet and instructions for anything to be put into place should be listed in the closet. When asked what skin preventive measures should be put into place for Resident # 19, CNA #10 stated that she does not normally work with

DEPARTMENT OF HEALTH A	ND H AN SERVICES
CENTERS FOR MEDICARE &	MEDICAID SERVICES

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

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405					
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F 686	or more staff with bassistance of Resident as sleeping in bed. A control of Resident as bed. A control certification of Resident as sleep. One soft here of Resident as sleep. One soft here of Resident add not have a soft foot. Resident #19 been on her right foots resident as control certification. Resident and the characteristic of Resident and the c	ded mobility and limited thing. 46 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 ied nursing assistant) entered ther lunch tray. A soft heel on the chair beside her bed. 03 a.m., an observation was #19. She was lying in bed ieel boot was observed on the ed. a.m., an observation was #19. She was lying in bed ieel boot in place to her right is stated her heel boot had not boot. The heel boot was air next to her bed. 1 #19's POS (physician order 17 documented the following bots when in bed for skin in er was initiated on 8/25/16. 1 #19's comprehensive skin 2/16 documented the tis at risk for skin breakdown continence, limited mobility, a perspirationInterventions:	F6	86					

	MENT OF HEALTH	AND HUN SERVICES & MEDICAID SERVICES			O	FOR): 12/18/2017 MAPPROVED): 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CO	ODE	
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F 686	information was obtained from the was obtain	tained from the website: com/ g is a specialized type of silicone. This information the website: m.nih.gov/pubmed/27802960 specialized medical honey ds. This information was	F	586			
	she was in bed. Resident #19 was a 8/25/16 with diagnoral limited to: anemia, I mellitus, post stroke speaking), hemiplet the body), and Park #19's most recent Massessment was a ARD (assessment in Resident #19 was a intact in the ability to scoring 12 out of 15 for mental status) e coded as requiring a staff member with a status in the staff member with a staff m	admitted to the facility on uses that included but were not high blood pressure, diabetes with aphasia (difficulty gia (paralysis on one side of cinson's Disease. Resident MDS (minimum data set) quarterly assessment with an reference date) of 9/20/17. Coded as being cognitively of make daily life decisions on the BIMS (brief interview xam. Resident #12 was extensive assistance from one distance from two extensive assistance from two		марада до 1900 г. поделения управления положения в поделения положения положения положения положения положения			

DEPARTM	ENT OF HEALTH	AND HEAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
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		495246	B. WING			1	08/2017
NAME OF PRO	OVIDER OR SUPPLIER			ľ	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODMO	NT CENTER			ı	11 DAIRY LANE FREDERICKSBURG, VA 22405		
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e33 e ii E nd ii ppre cdra Taws nti () E n ii h sou () A ti c n	or Stage 4 pressurable eschar (i.e. or rythema or fluctual mb should not be staged on-blanchable deciscoloration nact or non-intact ersistent non-blanchable discoloration of the would exper forces at the would may ever could extent of tissurable or other understand shear forces at the would may ever could extent of tissurable or other understand the would may ever could extent of tissurable or other understand the would may ever could extent of tissurable or other understand the would may ever the would may ever could extent of tissurable or other understand the would may ever could extent of tissurable or other understand was obtained to describe value or or the would make the stages of the stages of the would make the would ma	r eschar is removed, a Stage are injury will be revealed. dry, adherent, intact without ance) on the heel or ischemic softened or removed. The Injury: Persistent are red, maroon or purple skin with localized area of chable deep red, maroon, are pidermal separation and bed or blood filled blister. The change often precede skin coloration may appear pigmented skin. This injury and/or prolonged pressure the bone-muscle interface. The bone-muscle interface and injury, or may resolve and finecrotic tissue, are, granulation tissue, fascia, derlying structures are visible, thickness pressure injury as 3 or Stage 4). Do not use ascular, traumatic, matologic conditions." This tained from the website: rg/national-pressure-ulcer-advingual-of-pressure-injury/ The san FDA (Federal Drug proved prescription medicine tissue from wounds so they		686			

	MENT OF HEALTH	AND HUCH SERVICES			O	FOR	D: 12/18/2017 M APPROVED O. 0938-0391
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F 686	adverse microclima the pelvis and shear should not be used associated skin dar incontinence associated skin injury (I (skin tears, burns, a Stage 3 Pressure Ir Full-thickness loss is visible in the ulce epibole (rolled wour Slough and/or esch of tissue damage vareas of significant wounds. Undermin Fascia, muscle, ten and/or bone are not	ries commonly result from the and shear in the skin over in the heel. This stage to describe moisture mage (MASD) including liated dermatitis (IAD), atitis (ITD), medical adhesive MARSI), or traumatic wounds abrasions). Injury: Full-thickness skin loss of skin, in which adipose (fat) in and granulation tissue and and edges) are often present, ar may be visible. The depthories by anatomical location; adiposity can develop deep ing and tunneling may occur, don, ligament, cartilage at exposed. If slough or eschart of tissue loss this is an	F	686			
197.000	tissue loss Full-thickness skin a or directly palpable ligament, cartilage of and/or eschar may ledges), undermining Depth varies by ana eschar obscures the an Unstageable Pressu full-thickness skin a Full-thickness skin a extent of tissue dam	ure Injury: Obscured					

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F 686	(http://www.npuap.o-clinical-resources/jions/). The updated stagin following definitions Pressure Injury: A pressure injury is and/or underlying s prominence or relaidevice. The injury open ulcer and may as a result of intensor pressure in combination of soft tis may also be affected.	org/resources/educational-and pressure-injury-staging-illustrat og system includes the		686			
	erythema of intact s Intact skin with a lo erythema, which m pigmented skin. Pre erythema or change or firmness may pre changes do not inc discoloration; these pressure injury. Stage 2 Pressure la loss with exposed of Partial-thickness lo dermis. The wound moist, and may als	calized area of non-blanchable ay appear differently in darkly esence of blanchable es in sensation, temperature, ecede visual changes. Color lude purple or maroon e may indicate deep tissue					

Granulation tissue, slough and eschar are not

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	pre-admission inforneeds prior to admi comprehensive eva admission/re-admis patient's skin integrip prevention intervent through review of al information. 3.1 Inc newly identified skin 24-Hour Summary I inspection on admis weekly. Document Record (TAR) or in 3.3 Perform wound measurements and Report upon initial ic integrity, weekly, an wound. 3.4 Perform or dressings for predeclines and docum comprehensive, interincluding prevention indicated4.7 Implet treatments/techniquity orderedReview caindicated"	mation to plan for patient's ssion. 2. Complete sluation of the patient upon is in to the Center. 3. Identify ity status and need for it it it is appropriate assessment slude all patients who have impairments on the Center's Report. 3.2 Perform skin is in/re-admission and on Treatment Administration (name of computer program). Observations and complete Skin Integrity dentification of altered skin d with anticipated decline of a daily monitoring of wounds sence of complications or	F 68	86		

12-24 hours

extent of tissue damage. The stages were revised based on questions received by NPUAP (National Pressure Ulcer Advisory Panel) from clinicians attempting to diagnose and identify the stage of pressure injuries. Schematic artwork for each of the stages of pressure injury was also revised and will be available for use at no cost through the NPUAP website in approximately

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND K AN 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 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 PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 686 Continued From page 226 F 686 various days. RN #1 stated, "I would assume it was not done. There is always calling the nurses to verify but typically if you don't see it, it's not done." Review of nurses' notes for the above dates that treatment was not documented on the TARs (and not completed by PT) failed to reveal documentation that treatment was implemented except on the following dates: -10/30/17- "Medications and treatments administered as ordered..." -11/6/17- "Treatment to Left buttock and Right inner calf redness continued as ordered..." -11/7/17- "Treatment to Left buttock and Right inner calf redness continued as ordered...' Also note- Resident #47 was sent to the hospital on 11/11/17 but returned the same day. On 12/6/17 at 2:18 p.m. a telephone interview was conducted with ASM (administrative staff member) #4 (the nurse practitioner who gave the verbal dressing order on 10/28/17). ASM #4 was read the verbal order and asked to clarify the type of dressing she wanted ordered. ASM #4 confirmed she wanted a silicone dressing. On 12/6/17 at 5:45 p.m. ASM #1 (the executive

director), ASM #2 (the interim director of nursing) and ASM #3 (the clinical quality specialist) were

made aware of the above concerns.

The facility policy titled, "Skin Integrity Management" documented, "PURPOSE: To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and promote healing of all wounds.

PRACTICE STANDARDS: 1. Review

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F 686	Continued From pa	ge 225	F 68	36		· ·
	cleft with NS wound	flush, apply santyl to wound	-	*		-
:		a) dressing Q (every) Day &				
		RN #1 was asked what				
		wound dressing order contain.				naare woods
		der should specify the type of				***
		nat to apply if any medication				A VA WATER
		used, the dressing and the				awater (Asia

frequency of the dressing change. RN #1 was asked if the order should specify the type of dressing. RN #1 stated she was not sure if the policy specifies the exact type of dressing to be used but she has seen orders for specific dressings and orders for generalized dressings. RN #1 was asked how staff would know what type of dressing to apply if the order only documented "dressing" and did not specify the type. RN #1 stated the facility has multiple types of dry dressings and unless the physician

specifies the type of dressing, the nurses use the dressing that looks applicable for the wound. RN #1 stated she would assume another nurse would use her discretion and "see what's in the cart or supply room." RN #1 was asked if the physician's order should specify the type of dressing to be used. RN #1 stated, "No. They usually say dry dressing. If they want something specific like allevyn they will say." RN #1 was asked what was to stop an unfamiliar nurse from using any type of dressing. RN #1 stated, "Nothing. There is no way to specify if they write dry dressing." RN #1 was asked how nurses evidence treatments are completed and stated the treatments are documented on the treatment record. When asked if the nurses' initials indicate the treatment was completed, RN #1 stated, "Yes. If it's not on the TAR, then sometimes it may be documented in the nurses' notes." RN #1 was asked what it meant if this surveyor could not find documentation of treatments being done on

DEPART	MENT OF HEALTH	AND HON SERVICES					FORM A	12/18/2017 APPROVED 0938-0391
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F 686	stage 3 ulcer- Orde ointment & silicone	red NS wound flush; Santyl	F	386			enteri serim de de la companya de la manda de la companya de la companya de la companya de la companya de la c	
	Resident #43's com on 10/27/17 docum risk for skin breakd mobility, incontinenresident in reposition skin for signs/symp Pressure redistribute protocol, Pressure as per protocolFor breakdown natal cledimited mobilityInterestment as ordered the care plan failed regarding the acquired model.	nprehensive care plan initiated ented, "Focus: Resident is at own as evidenced by limited ceInterventions: Assist oning q 2 hrs (hours). Monitor toms of skin breakdown. tion surfaces to bed as per redistribution surfaces to Chair ocus: Resident has actual skin eft related to incontinence, erventions: Provide wound ed. Skin check per policy" It to document information red pressure injuries.						
	conducted with RN was asked what the treatment is initiated admitted with press "The admitted with press and with any impair the provider to receprovider is in house treatment. The nur the pressure injury the care plan reflect asked how long shot treatment order for pressure injury. RN assessment is done	g. p.m. an interview was (registered nurse) #1. RN #1 er facility process is to ensure d for residents who are sure injuries. RN #1 stated, see does the skin assessment ment found the nurse contacts sive a treatment order or if the er they assess and order the rese documents the wound on tracking form and makes sure to the wound." RN #1 was build it take to obtain a a new admission with a N #1 stated, "As soon as the er and no later than the end of as shown the treatment order						

dated 10/28/17 that documented, "Cleanse natal

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			<u> </u>	FREDERICKSBURG, VA 224		}
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THE PROPERTY OF THE PROPERTY O	buttock and right incremained documen and an allevyn dres and 11/12/17 (Sund treatment to the right the nurse signed off an allevyn dressing inner calf. On 11/12 treatment to the left A nurse practitioner documented, "Skin: ulcer- 4.5x3.5 cm, 1 w/ increased slough pushed against has red/brown/green dra amount. R. inner castage 3 ulcer- 9.5x5 inner calfe (sic.) stars slough. L. sacral 2 sone: 9x6 cm, 100% DTI- 2x4 cm, closed 1. Wounds: Natal clc Continue NS wound silicone dressg (dresto) the amount of fluobtained wound cult hospital for r/o (rule I&D (incision and dra Report called to the charge nurse. R. inrinto stage 3 ulcers comb NS wound flush, Sar	ge 223 ner calf dated 11/5/17 ted as requiring medi honey sing. On 11/11/17 (Saturday) ay) the nurse failed to sign off nt lower buttock. On 11/11/17 freatment of medi honey and to the left buttock and right 2/17 the nurse failed to sign off buttock and right inner calf. note signed on 11/15/17 Natal cleft IAD turned stage 3 00% slough, no odor, larger & from 6-12 o'clock when a very foul smelling dark sinage of a moderate to large alfe (sic.) stage 2 turning into x0 cm w/ 90% slough, flat. L. ge 3 ulcer- 3x5.5 cm, 90% stage 3 ulcers combined into slough. L. heel suspected light red/purple bruisePlan: eft IAD turned stage 3 ulcer- flush, Santyl ointment & ssing) qd, however d/t (due id obtained upon palpation ure and am sending to the out) sepsis w/ evaluation for ainage) of sacral wound. ER (emergency room) her calfe (sic) stage 2 turning ontinue NS wound flush, icone dressg qd. L. sacral 2 ined into one ulcer: Continue ntyl ointment & silicone uspected DTI (deep tissue	F 68	86		

injury) (1)- PT to perform CPI (a treatment modality) M-F (Monday through Friday) & sure prep (protectant wipes) q shift. L. inner thigh

		AND HOAN SERVICES & MEDICAID SERVICES			FORM): 12/18/2017 MAPPROVED): 0938-0391
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F 686	w/ 100% slough. L. tissue injury)- 3.5x8 bruisePlan: 1. Wo stage 3 ulcer- DC'd treatment orders & Santyl ointment & s R. lower buttock statreatment orders & Santyl ointment & s calfe (sic.) stage 2 to DC'd previous treat wound flush, Santyl qd. L. sacral 2 stag treatment orders & Santyl ointment & s further documented Monday through Frid A physician's order "(Change) tx's (trea post. (posterior) this wound flush, santyl (dressing) qd." And 11/9/17 documented clarification and for ultrasound mist, sand treatment with santy Review of PT notes completed as presonable to the November 2017 for the natal cleft dadocumented as required to the properties of the specified as a sequence of the properties of the specified as a sequence of the properties of the specified as a sequence of the properties of the specified as a sequence of the properties of the specified as a sequence of the properties of the specified as a sequence of the properties of the specified as a sequence of the properties o	ugh (sic), #2- 1cm in diameter heel suspected DTI (deep cm, closed light red/purple cunds: Natal cleft IAD turned (Discontinued) previous changed to NS wound flush, illicone dressg (dressing) qd. age 2 ulcer- DC'd previous changed to NS wound flush, illicone dressg qd. R. inner turning into stage 3 ulcerment orders & changed to NS ointment & silicone dressg e 3 ulcers: DC'd previous changed to NS wound flush, illicone dressg qd" The note of PT to treat the wounds	F 686	6		

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	check was performed injury/wound(s) wer Location(s): rt (right left buttock. The followere previously identification of the follows: Other Wound santyl and dressing: A physician's order of "Cleanse new wound buttock & rt inner can apply medi honey (adaily." Resident #47 to reveal evidence of buttock was comples section for 11/6/17 at the next assessment injury was a progress practitioner on 11/6/ "Natal cleft IAD- 2.7." R. (Right) lower butting granulation. R. inner cm. R. hip 3 new uld 2. 4.5 cm in diameter granulatedPlan Monursing Sunday pm. Medi honey gel & sil day). Wound rounds A nurse practitioner	ed. The following New skin e identified: Other Wound(s): i) inner calf, rt lower buttock, llowing skin injury/wound(s) ntified and were evaluated as nd(s): Location(s): Rt buttock, daily. dated 11/5/17 documented, dated 11/5/17 documented, dated to left buttock, rt lower alf (with) wound cleanser-4) & Allevyn (5) dressing 7's November 2017 TAR failed of treatment to the right lower and 11/7/17 was blank. Int of Resident #47's pressure as note signed by the nurse 17. The note documented, x0.5cm, 50% slough, no odor. sock stage 2 ulcer- 2x1 cm, or calfe (sic) stage 2 ulcer- 5x3 cers of stage 2: 1.1.5x0.5 cm, ar, & 3. 2.5x1 cm, all ultiple new ulcers noted by Ordered NS wound flush, icone dressings qd (every	F 64	86			

ulcer- 4.5x2.5cm, 75% slough, no odor, larger w/ (with) increased slough. R. lower buttock stage 2 ulcer- 1x0.5 cm, granulation. R. inner calfe (sic) stage 2 turning into stage 3 ulcer- 8.5x4 cm w/ 40% slough, flat. R hip 3 new ulcers of stage 2 previously reported per nursing, none noted upon assessment. L (left). sacral 2 stage 3 ulcers: #1-

DEPAR	TMENT OF HEALTH	AND HAN SERVICES			Account to		APPROVED . 0938-0391
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F 686	documented as 10/ was drawn to indica on 10/28/17 and the the clinical record of Also, further review evidence this treatm prescribed. All sec 10/26/17 through 10 contain signed initia was done except for documented betwe 10/29/17. The next assessme injury was a progre- practitioner on 11/1. "Natal cleft IAD (inci- dermatitis)- 2.7x0.5 slough, no odorPl pressure ulcer- Cor ointment & silicone Resident #47's Nov the same above ph TAR failed to revea completed as preso was blank; the sect 11/3/17 was blank (between the section 11/6/17 and 11/7/17 [physical therapy] to care per physician's concerns were iden A Braden scale for dated 11/2/17 document	augh the date on the TAR was 126/17, a line with an arrow ate the beginning of treatment are was no physician order in locumented until 10/28/17. To of the TAR failed to reveal ment was completed as tions for the dates from 10/31/17 were blank and did not als to indicate the treatment or what appeared to be a "z" en the dates of 10/28/17 and ent of Resident #47's pressure as note signed by the nurse 1/17. The note documented, continence associated from (centimeters), 50% and Natal cleft stage 3 antinue NS wound flush, Santyl dressing qd." Tember 2017 TAR documented ysician's order. Review of this I evidence this treatment was cribed. The section for 11/1/17 of there was an initial signed in the sections for 1/2/17 or there was an initial signed in the sections for 1/2/17 and no official). Predicting pressure injury risk predicting pressure injury risk	F6	886			

DEPARTMENT OF HEALTH AND HAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING C 495246 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 (X3) DATE SURVEY COMPLETED C 11 DAIRY LANE FREDERICKSBURG, VA 22405		MENT OF HEALTH	AND HON SERVICES		•		FOR	D: 12/18/2017 M APPROVED D. 0938-0391
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CALL DEPARTMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIE	NAME OF I	PROVIDER OR SUPPLIER						
FRETEX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 686 Continued From page 219 as moderately impaired. Section G coded Resident #47 as being totally dependent of two or more staff with transfers, and as requiring extensive assistance of two or more staff with bed mobility, dressing and personal hygiene. Section M documented Resident #47 presented with one stage three pressure injury (1), one unstageable pressure injury with slough and/or eschar (1) and two unstageable deep tissue pressure injuries (1). Review of Resident #47's clinical record revealed a nurse's note dated 10/26/17 that documented, "A skin check was performed. The following skin injury/wound(s) were previously identified and were evaluated as follows: Pressure Area(s): Location(s) coccy, (tail bone). "The note did not document any description of the pressure injury and the clinical record failed to reveal any physician's orders for the treatment of the wound. The next assessment of Resident #47's pressure injury was a progress note signed by the nurse practitioner on 10/28/17. The note documented, "Natal cleft (crease between the buttocks) stage 3 pressure ulcer (injury) (1) - Ordered NS (normal saline) wound flush, Santyl ointment (2) & silicone dressing (3) ad (every day)." A physician's verbal order dated 10/28/17 documented, "Cleanse natal cleft with NS wound flush, apply santyl to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." The order did not specify the type of dressing. Resident #47's October 2017 TAR (treatment	WOODM	ONT CENTER						:
as moderately impaired. Section G coded Resident #47 as being totally dependent of two or more staff with transfers, and as requiring extensive assistance of two or more staff with bed mobility, dressing and personal hygiene. Section M documented Resident #47 presented with one stage three pressure injury (1), one unstageable pressure injury with sough and/or eschar (1) and two unstageable deep tissue pressure injuries (1). Review of Resident #47's clinical record revealed a nurse's note dated 10/26/17 that documented, "A skin check was performed. The following skin injury/wound(s) were previously identified and were evaluated as follows: Pressure Area(s): Location(s) coccyx (tail bone)." The note did not document any description of the pressure injury and the clinical record failed to reveal any physician's orders for the treatment of the wound. The next assessment of Resident #47's pressure injury was a progress note signed by the nurse practitioner on 10/28/17. The note documented, "Natal cleft (crease between the buttocks) stage 3 pressure uicer (injury) (1)- Ordered NS (normal saline) wound flush, Santyl ointment (2) & silicone dressing (3) qd (every day)." A physician's verbal order dated 10/28/17 documented, "Cleanse natal cleft with NS wound flush, apply santyl to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." The order did not specify the type of dressing.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETION
Cleanse natal cleft (with) NS wound flush, apply	F 686	as moderately impa Resident #47 as be more staff with trans extensive assistance bed mobility, dressin Section M documer with one stage three unstageable pressur eschar (1) and two pressure injuries (1) Review of Resident a nurse's note date "A skin check was p injury/wound(s) were were evaluated as f Location(s) coccyx (document any desc and the clinical reco physician's orders for The next assessme injury was a progres practitioner on 10/26 "Natal cleft (crease pressure ulcer (injur saline) wound flush, dressing (3) qd (ever A physician's verbal documented, "Clear flush, apply santyl to dressing Q (every) I The order did not sp Resident #47's Octo administration record	sired. Section G coded ing totally dependent of two or sfers, and as requiring to of two or more staff with any and personal hygiene. Inted Resident #47 presented to pressure injury (1), one are injury with slough and/or unstageable deep tissue. #47's clinical record revealed to 10/26/17 that documented, performed. The following skin to previously identified and collows: Pressure Area(s): (tail bone)." The note did not ription of the pressure injury for failed to reveal any for the treatment of the wound. Int of Resident #47's pressure is note signed by the nurse is not in the nurse in the nurse is not in the nurse is not in the nurse in the n	F	686			

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HAN 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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 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 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Skin Management Program, to F 686 F 686 Continued From page 218 include process upon identification survey sample, Residents #47 and #19. of a new skin concern, obtaining 1. Resident #47 was admitted to the facility on treatment, carrying out the 10/26/17 with a pressure injury. The facility staff treatment order and documentation failed to implement treatment for the wound until and monitoring. Education was 10/28/17. On 10/28/17 when a treatment order provide to the Nursing Staff by the was obtained, the staff failed to clarify the type of dressing that was needed. Also, the facility staff Nurse Practice Educator regarding failed to implement treatment per physician's Skin Management System to orders for the pressure injury and other acquired include prevention measures as pressure injuries on multiple occasions until the appropriate. Skin Sweep of all resident was hospitalized on 11/15/17. current residents completed by 2. The facility staff failed to implement pressure Supervisors and Unit Managers to prevention measures and ensure Resident #19's identify any other skin concerns. right heel boot was in place to her right heel while 4. Treatment/Wound Nurse will audit she was in bed. 24 hour report, eInteract Change The findings include: of Conditions and Incident Reporting 3 X week to ensure that 1. Resident #47 was admitted to the facility on any new skin concerns get 10/26/17 with a pressure injury. The facility staff failed to implement treatment for the wound until addressed timely with appropriate 10/28/17. On 10/28/17 when a treatment order treatments. Treatment/Wound was obtained, the staff failed to clarify the type of Nurse will also audit the TARs 3 dressing that was needed. Also, the facility staff X week to ensure that ordered failed to implement treatment per physician's

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

orders for the pressure injury and other acquired pressure injuries on multiple occasions until the

10/26/17 and readmitted on 11/22/17. Resident #47's diagnoses included but were not limited to:

diabetes, chronic kidney disease and adult failure

assessment with an ARD (assessment reference date) of 11/29/17, coded the resident's cognition

resident was hospitalized on 11/15/17.

Resident #47 was admitted to the facility on

to thrive. Resident #47's most recent MDS

(minimum data set), a five day Medicare

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 219 of 348

1/17/18

treatments are being carried out

audit residents at risk for skin breakdown 3 X week for 6 weeks

accordingly. Unit Managers will

and randomly thereafter to ensure

appropriate. Results of these audits

that interventions are in place as

will be brought before the QAPI

Committee monthly for review.

DEPART	MENT OF HEALTH	AND HU SERVICES		0	FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
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WOODM	ONT CENTER		F	REDERICKSBURG, VA 22405	
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F 684	c_access [3] Minocycline is upy bacteria including respiratory tract information the skin, eye, lympl urinary systems; are spread by ticks animals. Information obtained https://medlineplustml Treatment/Svcs to CFR(s): 483.25(b) Skin Information obtained https://medlineplustml Treatment/Svcs to CFR(s): 483.25(b) (1) Pressured and the compressional standary pressure ulcers and ulcers unless their demonstrates that (ii) A resident with professional standary pressure ulcers and ulcers unless their demonstrates that (ii) A resident with professional standary pressure ulcers and ulcers unless their demonstrates that (ii) A resident with professional standary promote healing, promo	d from gyinfo.org/en/info.cfm?pg=vas sed to treat infections caused g pneumonia and other ections; certain infections of natic, intestinal, genital, and independent of certain other infections that lice, mites, and infected of from gov/druginfo/meds/a682101.h Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. Orehensive assessment of a rmust ensure thaterds of practice, to prevent does not develop pressure infection and prevent revent infection and prevent revent infection and prevent revent infection and prevent	F 684		ssure ure upleted urent ers to s are in audit ents at cording ensure ace as the

Nurse Practice Educator on the

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMR MO	<u>. 0938-0391</u>
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F 684	[1] MRSA stands for Staphylococcus au infection that is resignational infection that is resignational infection that is resignational infection. There are settings MRSA happens to skin-to-skin contact involved in football Infection control is hospitals. To prevent MRSA *Practice good hygitals. To prevent infection and scribandage until health and ages *Avoid sharing persignation washcloths, razors, *Wash soiled sheet water with bleach all fa wound appears care provider. Treat the infection and ar Information obtaine https://medlineplus. [2] PICC stands for catheter. A long catheter. A long catheter. A long catheter. A long catheter (IV) which is more durable and blocked or infected several months so drawn or medication infected several months so drawn or medication.	or methicillin-resistant reus. It causes a staph istant to several common re two types of infection. It MRSA happens to people in s. Community-associated people who have close twith others, such as athletes and wrestling. Key to stopping MRSA in not community-associated iene apes clean and covered with a ed other people's wounds or sonal items, such as towels, or clothes is, towels, and clothes in hot and dry in a hot dryer to be infected, see a health tments may include draining notibiotics.	F	684	4		

DEPARTMENT OF HEALTH AND

PRINTED: 12/18/2017 FORM APPROVED

	MENT OF HEALTH	AND HI N SERVICES				FORM	: 12/18/2017 APPROVED 0938-0391
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	"Discharge Medicat undated, which doc Minocycline [3] 100 mouth. A review of revealed this medic on the facility admiss." A review of Residen MAR (Medication Act 12/7/17 at 04:00 p.m. Minocycline was not on 12/6/17. The rest the medication since the medication since the medication since was delivered and the medication arrival administered since the medication arrival market was delivered. A review of the facility Shortages/Drugs Not ensuring administration has been delivered. On 12/8/17 at 10:14 Staff Member - the coff was a ware of the facility and was delivered.	cal record revealed the ion List" from the hospital, umented an order for mg (milligrams) twice daily by the admission orders ation was also documented is ion orders dated 12/4/17. It #234's December 2017 dministration Record) on metaled that the tradministered until 9:00 p.m. sident had missed 4 doses of eladmission. Imacy delivery manifest mocycline was filled on delivered to the facility until (See F755). The resident without the medication after it merefore missed 2 doses after elath that should have been the medication was available. Ity policy "Medication of the medication once it a.m., ASM #2 (Administrative director of nursing) and ASM inical Quality Specialist) were indings; and on 12/8/17 at (the Administrator), was	Fe	884			

the survey.

No further information was provided by the end of

	MENT OF HEALTH	AND AN SERVICES				FORM	: 12/18/2017 I APPROVED : 0938-0391
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	nerve pain. This infethe website: https://dailymed.nlmm?setid=b11dbff5-c (2) Advair diskus is information was obtainformation was obtainformation was obtainformation was obtainformation was estid=4eeb5f6a-4 4. The facility staff f physician-ordered mfor Resident #234. Resident #234 was a 12/4/17 with the diag MRSA (methicillin-reaureus) [1] in a would pulmonary Disease, opiate addiction, chraortic valve endocardata set) assessment dated 1 resident as being cowas documented as activities of daily living documented as having inserted central cathoxygen therapy. On 12/07/17 at 03:36 Practical Nurse) repersident # 234 was and that a physician-	ised to treat seizures and formation was obtained from a.nih.gov/dailymed/drugInfo.cf isee-4a63-a093-f6efebdc2f6f isee-4a63-a093-f6efebdc2f6f isee-4a63-a093-f6efebdc2f6f isee-4a63-a093-f6efebdc2f6f isee-4a63-a093-f6efebdc2f6f isee-4a63-a093-f6efebdc2f6f isee-4a63-a093-f6efebdc2f6f isee-4a63-a093-f6efebdc2f6f isee-4a9e-9692-adefa2caf8fc	F	584			

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F 684	she writes out the method the orders to the phermacy usually donight of admission to the medication list is #4 stated she also used to the committed of the com	ent is readmitted to the facility, nedication orders and faxes armacy. LPN #4 stated the elivers the medications by the but this depends on what time is faxed to the pharmacy. LPN uses the Omni cell but the contain all medications. LPN ed medications aren't in the n't been delivered by the calls the physician. p.m. ASM (administrative staff ecutive director), ASM #2 (the ursing) and ASM #3 (the alist) were made aware of the led, "Medication of Available" documented, orders are not received or insed nurse will immediately peration with the attending narmacy provider. All navailable to the patient will gencyIf a medication red during normal pharmacy difference calls the pharmacy difference to be sent with the very. 2.2. If the next available my or missed dose in the schedule, take the emergency stock supply to	F	684	4			

Event ID: DGWI11

DEPARTMENT OF HEALTH	AND HE AN SERVICES				O		APPROVED 0938-0391
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/EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CR	PROVIDER'S PLAN OF EACH CORRECTIVE AC COSS-REFERENCED TO DEFICIENCE	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 684 Continued From pareadmission. LPN review the MARs are admission medication. LPN #6 stated if the then nurses should call the pharmacy stated the pharmacy stated the pharmacy afternoon and late a medications can also to cell (STAT bowneant by circled in stated it usually me medication, the me or the resident was made aware she in that were supposed Resident #83 during addition to the day circling medications assumed the reside #6 was made aware to evidence Reside on 11/3/17. LPN #6 an order to hold me resident may have procedure. LPN #6 no order to hold me not sure. Those are on 12/7/17 at 11:24 conducted with LPN administering the 9			34	DET CILIN			

medications if the resident is sent to the hospital. LPN #4 stated she waits to see if the resident is admitted to the hospital and once admitted, she returns the medications to the pharmacy. LPN #4

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	facility until 11/3/17 review of the facility containing various raccessed if a reside been delivered) inveand Advair diskus wadministered per the Further review of Re (including nurses' ne form) failed to revea facility on 11/3/17. In nurse) #4 did docum under a medication a.m.; however, an ir 12/8/17 at 9:07 a.m. wrote "LOA." LPN # was in the facility on 11/6/17 document exhibits or is at risk comfortInterventio ordered for painFor risk for respiratory or AsthmaInterventio ordered/indicated" On 12/4/17 at approximately was condured the facility on the respiratory or asthmaInterventio ordered/indicated"	at 11:18 p.m.; however, STAT (immediate) box (a box nedications that can be ent's medications have not entory list revealed gabapentin ere available and could be exprescribed order. esident #83's clinical record otes and a leave of absence all Resident #83 was out of the Note- LPN (licensed practical nent "LOA" (leave of absence) that was scheduled at 9:00 eterview with that nurse on revealed she accidentally et confirmed Resident #83 11/3/17. prehensive care plan revised ted, "Focus: Resident	F 68	34		

On 12/7/17 at 10:23 a.m. a telephone interview

responsible for administering the 9:00 p.m. dose of Advair diskus to Resident #83 on 11/3/17). LPN #6 was asked what should be done to ensure residents receive their medications upon

was conducted with LPN #6 (the nurse

PRINTED: 12/18/2017 FORM APPROVED DEPARTMENT OF HEALTH AND MAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 12/08/2017 B. WING 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 SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 684 Continued From page 210 following website: https://medlineplus.gov/pulmonaryfibrosis.html. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; pages 281 and 285. 3. The facility staff failed to administer Resident #83's medications per physician's orders on 11/3/17. Resident #83 was admitted to the facility on 9/24/17 and readmitted on 11/2/17. Resident #83's diagnoses included but were not limited to: pain in the right knee, muscle weakness and high blood pressure. Resident #83's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/28/17, coded the resident as cognitively intact. Review of Resident #83's clinical record revealed the following readmission orders dated 11/2/17: -gabapentin (1) 600 mg (milligrams) three times a day -Advair diskus (2) 250 micrograms/50 micrograms- one puff twice daily Review of Resident #83's November 2017 MAR (medication administration record) revealed the resident was not administered the scheduled doses of gabapentin on 11/3/17 at 9:00 a.m. and 1:00 p.m. and was not administered the scheduled doses of Advair diskus on 11/3/17 at 9:00 a.m. and 9:00 p.m. as evidenced by the nurses circling their initials on the MAR. The

back of the MAR documented "11/3/17 9AM NO AM Meds given. NP (Nurse practitioner) aware."

A pharmacy manifest dated 11/3/17 revealed the above medications were not delivered to the

		AND HU I SERVICES				FORM	: 12/18/2017 APPROVED
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	. 0938-0391 E SURVEY IPLETED
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F 684	not documented it's An interview was considered it's An interview was considered it's An interview was considered it's 12/7/17 at 10:28 a.r. 2017 MAR was reviphysician order for the security of the sec	onducted with LPN #3 on m. Resident #184's December ewed with the 12/1/17 the Accuchecks. When asked the MAR for the scheduled eant, LPN #4 stated, "It's not umented, it's not done." member (ASM) #1, the ASM #2, the interim director of 3, clinical quality specialist, of the above concern on common and the concern on th	F 6	84			

Chapman; page 55.

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

Chapman; page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and

(3) This information was obtained from the

	MENT OF HEALTH	I AND MAN SERVICES & MEDICAID SERVICES				FORM APPROVED 1B NO. 0938-0391
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F 684	"device/cast/splint"	in place.	F 6	84		·
	"Accucheks (finger	r dated 12/1/17 documented, stick blood sugars) AC HS (bedtime) X (times) 1				
	(medication admini "Accuchek AC & Histo evidence docum readings on the foll 12/1/17 at 9:00 p.m 12/2/17 at 7:30 a.m 12/3/17 at 11:30 a.m 12/4/17 at 4:30 p.m	i., 11:30 a.m. and 4:30 p.m. m. and 4:30 p.m. i. and 9:00 p.m. i., 11:30 a.m. and 9:00 p.m.				
		e's notes failed to evidence ccucheks or blood sugar ove dates.				
	documented in part diagnosis of diabete hypoglycemia/hype high blood sugars) documented in part ordered and report	e care plan dated, 12/6/17, t, "The resident has a es. At risk for rglycemia (too low and too (4)." The "Interventions" t, "Labs (laboratory tests) as results to MD (medical d record blood glucose (sugar)				
	conducted with LPN The 12/1/17 physic December 2017 MA	5 a.m. an interview was N (licensed practical nurse) #4. Ian order and Resident #184's AR was reviewed with LPN #4. The blanks for the scheduled				

Accucheck times meant, LPN #4 stated, "If it's

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 .		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	B. WING			C 12/08/2017	
NAME OF	PROVIDER OR SUPPLIER		*	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			1	1 DAIRY LANE		
AACCOIN	ONICENTER			F	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	D BE	(X5) COMPLETION DATE
	m?setid=c8ecbd7a- (2) Glucagon Glu for treating severe information was obt (3) This information website: https://www.mayocl ypoglycemia/sympte 2. The facility staff forder for obtaining fresident #184. Resident #184 was 11/30/17 with diagnoral limited to: fractu obstructive pulmonal chronic nonreversible a combination of embronchitis (1)), atrial characterized by rapthe atria of the heart the ventricles and reoutput and frequents (2)), pulmonary fibrocondition in which the becomes scarred over and stiff. That make breath, and your blooxygen (3)), diabete There was no composet) assessment as The Initial Nursing A documented the resist operson, place and	n.nih.gov/dailymed/druglnfo.cf -0e22-4fc7-a503-faa58c1b6f3f cagon is an effective therapy hypoglycemia. This ained was obtained from the inic.org/diseases-conditions/h oms-causes/syc-20373685 ailed to follow the physician's inger stick blood sugars for admitted to the facility on oses that included, but were re of the left humerus, chronic ary disease (general term for le lung disease that is usually hyphysema and chronic fibrillation (a condition oid and random contraction of causing irregular beats of esulting in decreased heart y clot formation in the atria sis (pulmonary fibrosis is a ne tissue deep in your lungs wer time. This tissue gets thick is it hard for you to catch your od may not get enough is and high blood pressure. Neted MDS (minimum data of the dates of the survey. Sesessment, dated 11/30/17, dent was alert and oriented time. The form documented ctional limitation in range of	F	684			

DEPARTMENT OF HEALTH AND HU

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	TMENT OF HEALTH	AND WAN SERVICES & MEDICAID SERVICES				FORM): 12/18/2017 APPROVED): 0938-0391
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F 684	Continued From page	ge 206	F(684			
	AND ADMINISTRAT injection: Administer (units)- 100 or U - 2 within 15 minutes be after a meal. 2.3 Do Individualize and adbased on route of acmetabolic needs, ble results and glycemic for Hypoglycemia. Cincrease the risk of	tion documented, "DOSAGE FION. 2.2 Subcutaneous r HUMALOG (trademark) U 00 by subcutaneous injection efore a meal or immediately					
	content or timing of (kidney) or hepatic (higher risk of hypogl PRECAUTIONS. Hy life-threatening. Mor	meals)Patient with renal liver) impairment may be at ycemia. WARNINGS AND poglycemia: May be nitor blood glucose and frequency with changes to of glucose lowering					
1	director, ASM #2, the and ASM #3, the cor made aware of the co	o.m. ASM #1, the executive the interim director of nursing the porate quality specialist were concern for harm. ASM #3 to fight it. We deserve it".					
	No further information	on was provided prior to exit.		PROBEET POSSOBOLA IA ANNO			
and the second s	acting human insulinglycemic control in a	HUMALOG is a rapid analog indicated to improve dults and children with is information was obtained		THE COLUMN TWO IS NOT			

from:

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	not see the cart, "I vit and I would be chebecause I gave him An additional interviat 12:34 p.m. with L#2, the nurse who gon 12/4/17 at 4:30 p staff followed when receiving short actin "That particular day His partner was ther crackers and he had 5:00 o'clock and sind p.m. I gave him his imy other medication another nurse and the was told his blood su When asked who ga (2), LPN #2 stated, "I have learned this again." An interview was corrapproximately 2:20 pmember) #10, a phare #286's Humalog insute the pharmacist, OSM problem. You can't be what the blood sugar without eating they are blood sugar." An interview was conp.m. with LPN #4, the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the pharmacist of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a LPN #4 stated, "Subdivision of the glucagon injection asked how she had a left which in the glucagon injection asked how she had a left which in the glucagon injection asked how she had a left which in the glucagon injection and the glucagon injection and the glucagon injection and the glucagon inject	vould definitely be looking for ecking on the resident 24 units that acts so quickly." ew was conducted on 12/7/17 PN (licensed practical nurse) ave Resident #286 the insulin.m. When asked the process they had a diabetic resident g insulin, LPN #2 stated, I was giving him his insulin. e and was giving him I juice there. This was about ce dinner comes around 5:30 insulin and then I went to give s. Then I was called to help in around at 7:00 (p.m.) I larger had dropped to 42*." I we the resident the glucagon (Name of LPN #4). LPN #2 and from this. I would never do inducted on 12/7/17 at it.m. with OSM (other staff remacist. When Resident illin order was reviewed with 1 #10 stated, "Yeah, that is a giving insulin no matter is. If they go a long time re at risk for having a low ducted on 12/7/17 at 2:30 and in to Resident #286. When indinistered the medication, I (subcutaneously)." When I documented it LPN #4	. F	584				

DEPARTMENT OF HEALTH AND HU SERVICES

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DEPART	MENT OF HEALTH	AND MAN SERVICES & MEDICAID SERVICES				FC	DRM APPROVED NO. 0938-039)
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F 684	the physician and re (2) to be given to R intramuscularly or swritten the order on showed it to this wr Further review of R orders dated 11/18/"Hypoglecemic (sichypoglycemic (low line) Review of the hypodocumented, "TRE Unconscious. Performeasurement. If les ordered low parame Glucagon 1 mg (mi DOCUMENTATION MAR (if indicated)."	eceived an order for glucagon esident #286 either subcutaneously (RN #2 had the palm of her hand and iter)." esident #286's physician's '17 documented, '17 documented, '19 protocol standing orders for plood sugar) protocol." glycemic protocol ATMENT Symptomatic orm fingerstick blood glucose is than 70 or physician eter immediately administer ligram) IM (intramuscularly). I Glucagon administration on	F	684				
	the director of nursi process CNAs follo delivered and the restated, "I would exphere' and shake the asked what the CN could not be arouse tell the nurse. When follow when a medi with meals, ASM #2 give it as close to the within 15 minutes at the tray would be oblood sugar was 45 what would be the second sugar was 45 what would be second sugar was 45 what would be the second sugar was 45 what would be second sugar was 45 what would sugar was 45 what	ng. When asked what the w when dinner trays are esident was asleep, ASM #2 sect the CNA to say 'your tray's em to wake them up." When A should do if the resident ed, ASM #2 stated she should a asked the process staff cation is ordered to be given 2 stated, "First of all I would be meal time as possible, at the most if I was anticipating in time." When asked if the 44 and the insulin was given staff expectation, ASM #2 ep an eye out for the (food)						

cart." When asked what staff should do if they did

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**************************************	4:30 p.m. and she funits of Humalog in notified the physicia sugar reading, LPN doctor. Review of Rorders dated 11/18/11/18/17, document "Fingerstick blood s (bedtime) Call MD (70 - > (greater than orders further documents SQ w (with)/lun (diabetes mellitus)." physicians orders and MD of blood sugar gdocumented on the administration reconhave called the physicians enders with LPN # documented in part (incorrect date) Accumented in part (incorrect date) Accum	and given Resident #286 24 sulin. When asked if she had an of the resident's blood #2 stated, she did not call the resident #286's physician 17, signed by the physician on red in part the following: red in part: "Humalog 24 red and w/dinner- DM LPN #2 was shown the red stated that (order to notify greater than 400) was not MAR (medication d). When asked if she should sician, LPN #2 stated yes. The December 2017 MAR was red the following: "Start: 11/15/17 rechecks (sic.) AC (before red) call MD/NP (nurse lood sugar) < 70 > 400." LPN red stated she red Resident #286's blood red insulin administered on the recumented it on a slip of a copy of this paper was reded. Review of LPN #2's ret the following: Resident #286's (A later ber 2017 MAR revealed that	F 6					

	MENT OF HEALTH	AND IAN SERVICES & MEDICAID SERVICES			FORM): 12/18/2017 // APPROVED): 0938-0391
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F 684	42*. LPN #2 was a last had his blood s it was last checked 452, and at that tim was administered. time Resident #286 around 4:30 p.m. T same thing (a low b occurred on 12/1/17 *Hypoglycemia is a abnormally low lever your body's main er treatment of hypoglyget your blood sugarange - about 70 to mg/dL (3.9 to 6.1 m either with high-sug On 12/4/17 at 7:35 conducted with CN/#1. CNA #1 was as delivering the reside p.m. CNA #1 stated sleeping and his frie had been trying to whalf. I told him I wo said she would be of that by the time she resident's room the room. When asked someone who "didn she would tell the number of the practical nurse) #2, insulin to Resident #2.	sked when the resident had ugar checked. LPN #2 stated around 4:30 p.m. and was e 24 units of Humalog insulin LPN #2 was asked the last had eaten. LPN #2 stated, he visitor stated that the blood sugar episode) had 7. condition characterized by an el of blood sugar (glucose), hergy source. Immediate ycemia involves quick steps to ar level back into a normal 110 milligrams per deciliter, or illimoles per liter, or mmol/L) - ar foods or medications. (3) p.m. an interview was A (certified nursing assistant) eled if she remembered ent's meal tray around 7:05 d, "He (Resident #286) was end was in there with him and wake him up for an hour and a uld let the nurse know, she on the way." CNA #1 stated was coming out of the nurse was coming back to the what she did when she saw 't look right" the CNA stated	F 6			

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

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
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	PROVIDER OR SUPPLIER DINT CENTER			11 D	EET ADDRESS, CITY, STATE, ZIP CODE AIRY LANE DERICKSBURG, VA 22405		2/08/2017	
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F 684	1. Resident #286 was 2/15/17 and readmitted diagnoses that included diabetes, stroke, high disease, prostate candidates, prostate candidates, an admission (assessment reference Resident # 286 as socinterview for mental standard to 15, 15 being cognitive decisions. Resident # requiring extensive as dependent of one staff.	admitted to the facility on ed on 11/18/17 with ed but were not limited to blood pressure, heart cer and arthritis. It recent MDS (minimum on assessment with an ARD ed date) of 11/25/17, coded oring a 15 on the brief atus (BIMS) of a score of 0 ely for making daily	F	684				
	for eating. An observation was mapproximately 7:10 p.n. another surveyor. The CNA (certified nursing Resident #286's dinnersident #286's dinnersident wake the resident. On 12/4/17 at 7:15 p.m. observed lying in his bewith snoring respiration was set up on a bed side stop in the sident #286) upwrong with him. The viresident's (Resident #2 wet." At this time LPN #2 was alerted to the siglucometer check was enother the sident was set upon a set upon a bed sident #286) upwrong with him. The viresident's (Resident #2 wet." At this time LPN #2 was alerted to the siglucometer check was enother the sident was alerted to the sident was all the sident was alerted to the sident was alerted to the sident was all the sident was all the sident was alerted to the sident was all the sident was all the	ade on 12/4/17 at n. of Resident #286 by surveyor observed the assistant) #1 prepare r tray. The resident was d the CNA did not attempt a. Resident #286 was ed, eyes closed, somnolent is. The resident's food tray de table over the bed. A lated he could not wake o, he didn't know what was sitor further stated the 86's) gown was "soaking (licensed practical nurse)						

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

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PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
by: Based on facility doc review, it is failed to en with profeshighest let in the survand #234. 1. The fact from having requiring a administe facility state administe human insumonitor and resident a recommendation in the resident fact from the fact from	resident in remark revised to revise a profou an injection red to revise failed to red to red to red to red to red to research within the ded time of a diministration of the red to return the sadministration of the red to red to red to revise failed to revise failed to red t	is not met as evidenced aterview, staff interview, lew and clinical record ained that the facility staff ment and care in accordance indards to maintain the being for four of 29 residents it, Residents #286, #83, #184 illed to prevent Resident 286 and low blood sugar episode of glucagon (2) to be the the resident. On 12/4/17 follow the physician's order to insulin (a rapid acting ith meals and failed to s the resident to ensure the the manufacturer's frame of 15 minutes after the thered. The Humalog insulin 4:30 p.m. and 5:00 p.m. and tray was not delivered until illed to follow the physician's inger stick blood sugars for alled to administer Resident there physician's orders on alled to administer a the index available	F	684	residents with these orders to that the orders have been follocorrectly and to identify any hypoglycemic episodes durin 30 days. An audit was comp the MARs for current resident last 30 days to identify any or in administration. 3. Education was provided to the staff by the Nurse Practice Educator related to diabetic management ensuring that residents receive meal or a snack after administration. Education was also p to the Licensed Nursing Staff Nurse Practice Educator related medication administration and documentation, and also inclusing process for obtaining medicated the back up box as appropriated. Unit Managers will audit /mor Insulin Dependent Diabetic R. 5 times per week for six week then randomly thereafter, to expression the same post insuladministration and no adverse are noted. Unit Managers will audit MARs 3 Xweek for 6 we then randomly thereafter, for one in medication administration. Of these audits will be brought the QAPI Committee monthly review.	g the last leted of ts for the missions enursing ucator nt, and etheir tration of rovided by the ed to I ded the ions from e. effects and nsure that lin effects II also eeks, and omissions Results before	1

The findings include:

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

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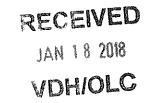
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F 684 SS=G	next shift. It is doc LPN #2 was asked book is blank. LPN documented then it On 12/7/17 at 12:3 with ASM (administ interim director of rasked how often re ASM #2 stated the weekly schedule. documented the bastated in the comprisheets. An end of day mee 4:45 p.m. with ASM ASM #2, the interir #3, the clinical qua #2 and ASM #3 we concerns. A facility time. No further informate end of the survey properties and applies to all treating facility residents. Bassessment of a resthat residents recearcordance with presidents with a state of the survey properties to all treating facility residents. Bassessment of a resthat residents recearcordance with presidents with a state of the survey properties to all treating facility residents. Bassessment of a resthat residents recearcordance with presidents with presidents as a state of the survey properties to all treating facility residents recearcordance with presidents as a state of the survey properties to all treating facility residents recearcordance with presidents as a state of the survey properties to all treating facility residents recearcordance with presidents as a state of the survey properties to all treating facility residents recearcordance with presidents as a state of the survey properties to all treating facility residents recearcordance with presidents as a state of the survey properties to a survey properties to a state of the survey properties to a survey properties t	and then it is passed on to the umented in the shower book." what it meant if the shower #2 stated, "If it wasn't towas not done." O an interview was conducted trative staff member) #2, the nursing (DON). ASM #2 was esidents were to be showered, residents were on a twice When asked where the staff aths/showers provided ASM #2 uter or on the shower/bath log occurred on 12/7/17 at #1, the executive director, in director of nursing, and ASM lity specialist. ASM #1, ASM are made aware of the above policy was requested at this sion was provided prior to the process. I care fundamental principle that ment and care provided to ased on the comprehensive esident, the facility must ensure live treatment and care in rofessional standards of rehensive person-centered	F 67		has been lity. are or order. for insulin foring have An audit was		

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

Event ID: DGWI11

Facility ID: VA0279

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DEPART	MENT OF HEALTH	AND H AN SERVICES			0		1938-0391
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WOODM	ONT CENTER			1	REDERICKSBURG, VA 22405		
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F 677	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:: conducted with CN #15. When asked documented, CNA shower book. CNA have a date documented all room number receive showers or stated once a show should be signing of the residents who restated if there is no number, it doesn't was not completed aide could have for stated if a resident the nurse. When a resident shower, C sometimes I can't ga resident should h#15 stated they show as not familiar with the nurse. Under the stated if a resident should h#15 stated they show as not familiar with the nurse. LPN ensured that reside #2 stated, "Through don't get their show should give the should give t	s are given twice a week. The 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 certified nursing assistant) where resident showers are the stated each unit has a sented on the top of the sheet ers listed for residents who in that assigned day. CNA #15 wer is completed, the CNAs off next to the room number of ecceived a shower. CNA #15 is signature next to the room necessarily mean the shower. CNA #15 refuses a shower, she will tell asked if she has ever missed a NA #15 stated, "Yes, get to people." When asked if ave to miss their shower, CNA #15 outlon't. CNA #15 stated she outlon't. CNA #15 stated she		677			no. 100 of 348

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	TMENT OF HEALTH			O	FORM	: 12/18/2017 I APPROVED
STATEMEN"	RS FOR MEDICARE TOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE CONSTRUCTION NG	(X3) DAT COM	. 0938-0391 TE SURVEY MPLETED
		495246	B. WING _			C /08/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOODE	ONT CENTER			11 DAIRY LANE		
WOODIN	ONICENIER			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)	LD BE	(X5) COMPLETION DATE
F 677	mental status) and Resident #56 as be decisions regarding #56 was coded as to of daily living. Under Status, Bathing, Rei "8 Activity itself did in A review of the unit part, that Resident #11/29/17. A review of Resident #11/29/17. A review of Resident documentation reve #56 had been bather between 11/1/17 and (6:48 p.m.), 11/23/11/129/17 at 14:59 (2) A review of Resident plan dated 1/3/17 redocumentation; "For assistance / is depedaily living) care in (leating, bed mobility, toileting) due to cogidisease compromisi Initiated: 11/15/17. Resident's ADL care met in order to main level of functioning adays. Interventions: was no documentation:	the staff assessment coded ing severely impaired to make task of daily life. Resident being dependent with activities in Section G, Functional sident #56 was coded as an not occur." bathing sheets revealed, in #56 had last been bathed on the following dates d 12/6/17; 11/18/17 at 18:48 7 at 14:56 (2:56 p.m.),	F 67	77		

On 12/06/17 at 11:33 a.m. an interview was conducted with LPN (licensed practical nurse) #8. When asked how often showers are given, LPN

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>ЭМВ ИО</u>	<u>. 0938-0391</u>
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14/00DB#	ONT CENTER		1	1	11 DAIRY LANE		
AACCOLL	UNI CENTER				FREDERICKSBURG, VA 22405		·
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direction of the second	down. CNA #8 also finger nails if she vis asked if Resident # she stated she was CNA #8 to observe Upon observation, cobserved. CNA #8 food was underneat CNA #8 stated she #64 and his regular When asked if his fi #8 stated they did n On 12/07/17 at 4:45 staff member) #1, the interim DON (Di #3, the clinical quality of the above concern No further information. 2. The facility staff if assistance to Resident #56 was a with diagnoses that to; dementia, a gast	o stated she will also clean isibly sees them dirty. When 64's fingernails were clean, 6 not sure. This writer asked Resident # 64's fingernails. CNA #8 was asked what she stated it appeared that old the the resident's fingernails. rarely works with Resident CNA left early that day. Fingernails appeared long, CNA not appear long to her. 5 p.m., ASM (administrative the executive director, ASM #2, irector of Nursing) and ASM ity specialist were made aware	F	377			
	vascular disease (po high blood pressure swallowing, anemia irregular heartbeat, a Resident #56's most set), a quarterly asso (assessment referer	oor circulation to the legs), b, depression, difficulty (low red blood cell count), an and difficulty speaking. It recent MDS (minimum data essment with an ARD nce date) of 10/13/2017 as being unable to answer					

the questions on the BIMS (brief interview for

DEPARTMENT OF HEALTH AND AN SERVICES

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	TMENT OF HEALTH	* / /					FORM	: 12/18/2017 APPROVED
STATEMEN	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ISTRUCTION	O	(X3) DAT	. 0938-0391 E SURVEY IPLETED
NAME OF	DOOMET OF SUPPLIED	495246	B. WING	STREET	ADDRESS, CITY, STATE, ZIP	CODE		C 08/2017
	PROVIDER OR SUPPLIER ONT CENTER			11 DAIR	RY LANE ERICKSBURG, 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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ORRECTION ON SHOULD IE APPROPE	BE	(X5) COMPLETION DATE
F 677	On 12/05/17 02:10 made of Resident # to have black and y underneath the nails be long. On 12/06/17 at 10:0 made of Resident # to have black and y underneath the nails be long. On 12/06/17 at 11:3 conducted with LPN When asked who w nail care, LPN #8 st department will have will send the resider stated, "Nurses sholong or dirty. Both the responsible for ensuring fingernails RN #1 stated the nuresident is diabetic. On 12/06/17 at 1:40 conducted with CNA 8, Resident #64's CI were responsible for documenting any ne CNA #8 also stated documented on this	p.m. an observation was 64. All fingernails appeared ellow debris that was thick s. His fingernails appeared to 9 a.m. an observation was 64. All fingernails appeared ellow debris that was thick s. His fingernails appeared ellow debris that was thick s. His fingernails appeared to 3 a.m., an interview was I (licensed practical nurse) #8. as responsible for providing ated sometimes the activity e a manicure day and nurses that to get manicures. LPN #8 uld be checking if nails are the CNAs and nurses are uring nails are clean." p.m., an interview was (registered nurse) #1. RN #1 urses are responsible for are cleaned and trimmed. rses will cut fingernails if the p.m., an interview was a (certified nursing assistant) # NA. CNA #8 stated CNAs and ow areas on a skin sheet.	F 6	77				

nails. If the nails are too long, she will file them

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	<u> 0938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
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NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1 DAIRY LANE		
WOODM	ONT CENTER		l	F	REDERICKSBURG, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRICENCY)	BE	(X5) COMPLETION DATE
F 677	#3, the clinical quali of the above concer	irector of Nursing) and ASM ty specialist were made aware	F 6) 77			
	documents in part, comprehensive ass consistent with the part the Center must proservices to ensure the activities of daily livicircumstances of the demonstrate that sun avoidable. Activities of daily livicircumstances of the demonstrate that sun avoidable. Activities activities activities activities of daily livicircumstances of the demonstrate that sun avoidable. Activities activi	the following: "Based on the essment of a patient and patient's needs and choices, wide necessary care and hat a patient's abilities in ng do not diminish unless e individual's clinical condition ach diminution was ties of daily living include: essing, grooming, and oral fer and ambulation, including to the total condition, including					
	1b. The facility staff fingernails were free On 12/04/17 at 05:0 made of Resident # appeared to be long appeared to be dirty underneath his nails	9 p.m. an observation was 64. All his fingernails . All fingernails to both hands with black and yellow debris		на дели перед на деле деле деле на деле на перед на пере			1
To the second se	conducted with Resistated staff have not he has been at the f	ident #64. Resident #64 t cleaned or cut his nails since acility. Resident #64 had longer than how he keeps		THE CONTRACT OF THE CONTRACT O			

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CENTERS FOR MEDICARE	& MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495246	B. WING		1:	C 2/08/2017
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER		The state of the s	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 ACTIVE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	#15. When asked of documented, CNA shower book. CNA sheets have a date sheet and all room who receive shower #15 stated that once CNAs should be signumber of the reside CNA #15 stated if the room number, it does shower was not cornursing aide could the #15 stated if a resident shower are sident should have that she was not far On 12/07/17 at 09:3 conducted with LPN When asked how not receiving showers, I check the shower bresident misses the shower would be patent what blanks meant of shower book, LPN #2 stated in the what blanks meant of shower book, LPN #2 was not documented in the was not documented.	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 are on that assigned day. CNA is a shower is completed, the gning 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 y shouldn't. CNA #15 stated miliar with Resident #64. 38 a.m., an interview was N (licensed practical nurse) #2. The properties of the extension of the next shift. Sident may not get a shower shower day. LPN #2 stated in ally receives a shower, it will he shower book. When asked on the shower logs in the #2 stated that if the shower of the it wasn't done.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				STREET ADDRESS, CITY, STATE, 11 DAIRY LANE FREDERICKSBURG, VA 22	ZIP CODE	
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F 677	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, transformationintervision of the form of t	the shower sheets failed to #64 had received showers in to the facility. It #64's comprehensive care ity daily living) dated 10/9/17, Illowing: "Resident is at risk for to perform ADLS in bathing, Il hygiene, dressing, eating, Fer, entionsResident get a Resident needs assist with It part of the perform and the performance in the performa	F 6	77		

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

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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) 144 E OF		493240	J D. W. 10			/08/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (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		N SHOULD BE	(X5) COMPLETION DATE
F 677	was coded as requifrom two or more standard from two or more standard following the stated he does not resident #64's mose to assessment was with an ARD (asses 10/12/17. Resident cognitively intact in decisions scoring 15 interview for mental was coded as requifrom two or more standard from two or more	ring extensive assistance raff with personal hygiene. Idmitted to the facility on oses that included but were ribrillation, heart failure, high all insufficiency, high disorder, and post stroke. It recent MDS (minimum data as an admission assessment sment reference date) of #64 was coded as being the ability to make daily 5 out of 15 on the BIMS (brief status) exam. Resident #64 ring extensive assistance aff with bed mobility, and personal hygiene. Ander the area of "Bathing" and had not occurred over the k period. 1 p.m., an interview was ident #64. Resident #64 had eceive showers at the facility. he could only recall one time or. Resident #64 stated wash him with a wash cloth	F	procedure for provious on shower days. 4. The Director of Nurwill audit shower seafingernails 2 times weeks and then range thereafter to ensure provided. Results of brought to the Qual and Performance In Committee monthly	rsing/designed chedule and a week for 6 domly ADL care is f audits will be ity Assurance approvement	e e

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

IDENTIFICATION AND TO		(X2) MULTIP A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED C	
		495246	B. WING		12/08/2017
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 658	information was obt	age 190 tained from the website: ephew.com/key-products/adva gement/allevyn/allevyn-adhesi	F 658	3	
F 677 SS=D	CFR(s): 483.24(a)(2) §483.24(a)(2) A res	sident who is unable to carry y living receives the necessary	F 677	showers 2x weekly. Reside has had nails trimmed and of by staff during survey. Reside	ent #64 clean sident #
	services to maintain personal and oral hy This REQUIREMEN by: Based on observat interview, clinical redocument review, it staff failed to provid (activities of daily liv were coded as being extensive assistance the survey sample of the survey sample of the survey staff	n good nutrition, grooming, and hygiene; NT is not met as evidenced tion, resident interview, staff ecord review and facility twas determined the facility le assistance with ADLS ving) for two residents who ag dependent or requiring the (Resident # 64 and 56), in of 29 residents.		56 has been discharged from facility. 2. All resident have the potent be affected. The Director of Nursing/designee will revise shower schedule, and a 100 audit of all residents nails we completed by the Unit Manawith trimming and cleaning provided as appropriate.	tial to of se the % vas agers,
	was coded as required from two or more standard from two or more stand	failed to provide bathing lent #56, who was coded as th activities of daily living.		3. Education was provided to a staff by the Nurse Practice Educator or the Nursing Supervisor related to import of showers, ADL and nail can Also included in this educat was the documentation of should be at th	tance are. tion howers l. nursing

		AND HUN SERVICES & MEDICAID SERVICES				F	NTED: 12/18/2017 FORM APPROVED 3 NO. 0938-0391
STATEMEN	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		CONSTRUCTION		3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP (CODE	12/00/2017
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	or pressure in comb tolerance of soft tiss may also be affected perfusion, co-morbio tissue Stage 3 Pressure Inj Full-thickness loss o is visible in the ulcer epibole (rolled wound Slough and/or escha of tissue damage valareas of significant a wounds. Undermining Fascia, muscle, tend and/or bone are not elobscures the extent of Unstageable Pressure. This information was http://www.npuap.orgsory-panel-npuap-aniology-from-pressure-updates-the-stages-of (2) "SANTYL Ointmend Administration)-approach that removes dead tistican start to heal. Programagement is impontant to heal. Programagement is important to heal.	e and/or prolonged pressure ination with shear. The ue for pressure and shear d by microclimate, nutrition, lities and condition of the soft ury: Full-thickness skin loss f skin, in which adipose (fat) and granulation tissue and d edges) are often present. It may be visible. The depth ries by anatomical location; diposity can develop deeping and tunneling may occur. In ligament, cartilage exposed. If slough or eschar of tissue loss this is an interpretational-pressure-ulcer-advingulcer-to-pressure-injury-and-inf-pressure-injury/ Int is an FDA (Federal Drug oved prescription medicine is ue from wounds so they be rewound care trant to help remove your wound properly" This ned from the website: In a specialized type of licone. This information	F	558			

DEPARTMENT OF HEALTH AND	MAN SERVICES
CENTERS FOR MEDICARE & MED	ICAID SERVICES

NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER SUMMARY STATEMENT OF DEFICIENCIES 11 DAIRY LANE FREDERICKSBURG, VA 22405 FREDERICKSBURG, VA 22405 PROVIDER CATION SHOULD BE PRECEDED BY SHULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 188 ordered. ASM #4 confirmed she wanted a silicone dressing. 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. When asked what standard of practice the facility safef uses. On 12/7/17 at 3:00 p.m. ASM #3 stated the facility did not have a policy regarding order clarification. No further information was provided prior to exit. (1) "Pressure injuries are staged to indicate the extent of tissue damage. The stages were revised based on questions received by NPUAP (National Pressure Ulcer Advisory Panel) from clinicians attempting to diagnose and identify the stage of pressure injurity was also revised and will be available for use at no cost through the NPUAP website in approximately 12-24 hours (http://www.npuap.org/resources/educational-and -clinical-resources/pressure-injury-staging-illustrat lons/). The updated staging system includes the following definitions: Pressure Injury: A pressure injury: A pressure injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intext skin or an		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION NG		MPLETED C
WOODMONT CENTER IDARY LANE FREDERICKSBURG, VA 22405			495246	B. WING		12	
F 658 Continued From page 188 ordered. ASM #4 confirmed she wanted a silicone dressing. 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. When asked what standard of practice the facility taffu uses, ASM #3 stated the facility company has a team that develops the policies and these policies are the standards of practice the facility staffu uses. On 12/7/17 at 3:00 p.m. ASM #3 stated the facility did not have a policy regarding order clarification. No further information was provided prior to exit. (1) "Pressure injuries are staged to indicate the extent of tissue damage. The stages were revised based on questions received by NPUAP (National Pressure Ulcer Advisory Panel) from clinicians attempting to diagnose and identify the stage of pressure injuries. Schematic artwork for each of the stages of pressure injuries are staged to cost through the NPUAP website in approximately 12-24 hours (http://www.npuap.org/resources/educational-and-clinical-resources/pressure-injury-staging-illustrat ions/). The updated staging system includes the following definitions: Pressure injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an					11 DAIRÝ LANE	E	
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open ulcer and may be painful. The injury occurs	F 658	ordered. ASM #4 or silicone dressing. On 12/7/17 at 2:23 member) #1 (the exinterim director of noclinical quality speciabove concern. Why practice the facility facility company has policies and these practice the facility: On 12/7/17 at 3:00 did not have a policies. No further information of the stage of the pressure of the stages of	p.m. ASM (administrative staff kecutive director), ASM #2 (the ursing) and ASM #3 (the ialist) were made aware of the hen asked what standard of staff uses, ASM #3 stated the solicies are the standards of staff uses. p.m. ASM #3 stated the facility y regarding order clarification. on was provided prior to exit. as are staged to indicate the nage. The stages were uestions received by NPUAP Ulcer Advisory Panel) from g to diagnose and identify the njuries. Schematic artwork for of pressure injury was also available for use at no cost of website in approximately org/resources/educational-and pressure-injury-staging-illustrating system includes the incominant of the skin off tissue usually over a bony ed to a medical or other an present as intact skin or an		58		

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION 495246 B. WING TREDET ADDRESS, CITY, STATE, ZIP CODE 12/08/2017 NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER WOODMONT CENTER WOODMONT CENTER WOODMONT CENTER TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FERENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 187 was shown the treatment order dated 10/28/17 that documented, "Cleanse natal cleft with NS wound flush, apply santly to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." RN #1 was asked what elements should a wound cressing order contain. RN #1 stated the order should specify the type of wound cleanser, what to apply if any medication or ointment is to be used, the dressing and the frequency of the dressing change. RN #1 was asked if the order should specify the type of dressing. RN #1 stated she would know what type of dressing to paphy if the order only documented "dressing has been dress for specific dressings and orders for generalized dressings. RN #1 stated she would know what type of dressing has multiple types of dry dressings and unless the physician specifies the type of dressing has multiple types of dry dressing and unless the physician's order should specify the type of dressing to be used. RN #1 stated she would assume another nurse would use her discretion and "see what's in the cart or supply room." RN #1 was asked if the physician's order should specify the type of dressing to be used. RN #1 stated, "No. They usually say dry dressing." Why was to specify the type of dressing any type of dressing. TN #1 was asked what was to sto pan unfamiliar nurse from using any type of dressing. The precedent of the provision of the provisi		RTMENT OF HEALTH					FC	TED: 12/18/201 ORM APPROVEI
ABUILDING 495246 B. WING TOMPLETED C TOMPLETED TAG (A) ID (A				T				
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER X-10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 187 was shown the treatment order dated 10/28/17 that documented, "Cleanse natal cleft with NS wound flush, apply santyl to wound bed and cover (with) dressing Q (every) Day & PRN (as needed)." RN #1 was asked what elements should a wound dressing order contain. RN #1 stated the order should specify the type of dressing. RN #1 stated she was not sure if the policy specifies the exact type of dressing to apply if the order only documented "dressing" and did not specify the type of vype. RN #1 tasted the facility has multiple types of dry dressing to apply if the order only documented "dressing" and did not specify the type of vype. RN #1 stated the facility has multiple types of dry dressing and unless the physician specifies the type of dressing, the nurses use the dressing that looks applicable for the wound. RN #1 stated she would assume another nurse would use her discretion and "see what's in the cart or supply room." RN #1 was asked if the physician's order should specify the type of dressing to be used. RN #1 stated. "No. They usually say dry dressing. If they want something specific like allevyn (4) they will say." RN #1 was asked what was to stop an unfamiliar nurse from using any type of dressing. RN #1 stated, "No. They usually say dry dressing. If they want something specific like allevyn (4) they will say." RN #1 was asked what was to stop an unfamiliar nurse from using any type of dressing. RN #1 stated, "No. They usually say dry dressing. If they want something specific like allevyn (4) they will say." RN #1 was asked what was to stop an unfamiliar nurse from using any type of dressing. RN #1 stated. "No. They usually say dry dressing. If they want something specific like allevyn (4) they will say." RN #1 was asked what was to stop an unfamiliar nurse from using any type of dressing to the stop and the				1			(X3)	COMPLETED
WOODMONT CENTER ### STREET ADDRESS, CITY, STATE, ZIP CODE 11 DARY LANE ### FREDERICKSBURG, VA 22405 CAU D (EACH DEFICIENCY MUST SE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN DE CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) #### F658 Continued From page 187				B. WING	<u>_</u>			
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On 12/6/17 at 2:18 p.m. a telephone interview was conducted with ASM (administrative staff member) #4 (the nurse practitioner who gave the		that documented, "O wound flush, apply so (with) dressing Q (erneeded)." RN #1 was should a wound drestated the order should a wound drestated the order should a wound to appoint to be used frequency of the dressing. RN #1 stated if the order should specifies the example of dressing and orders. RN #1 was asked he type of dressing to a documented "dressing to a documented "dressing that looks a #1 stated she would use her discretion and specifies the type of dressing that looks a #1 stated she would use her discretion and supply room." RN #1 order should specify used. RN #1 stated, dressing. If they war allevyn (4) they will sawas to stop an unfamily type of dressing. RN is no way to specify if On 12/6/17 at 2:18 p. was conducted with #1	Cleanse natal cleft with NS santyl to wound bed and cover every) Day & PRN (as was asked what elements essing order contain. RN #1 ould specify the type of wound pply if any medication or sed, the dressing and the essing change. RN #1 was hould specify the type of ated she was not sure if the exact type of dressing to be een orders for specific rs for generalized dressings. ow staff would know what apply if the order only ing" and did not specify the the facility has multiple types of unless the physician of dressing, the nurses use the applicable for the wound. RN It assume another nurse would not "see what's in the cart or each type of dressing to be the type of the type					

verbal dressing order on 10/28/17). ASM #4 was read her note and the verbal order and was asked to clarify the type of dressing she wanted

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

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

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG		TE SURVEY MPLETED C
		495246	B. WING_			/08/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	medication administration." 5. The facility staff order for Resident 10/28/17. Resident #47 was 10/26/17 and readir #47's diagnoses in diabetes, chronic k to thrive. Resident (minimum data set assessment with a date) of 11/29/17, as moderately import Review of Resident a progress note sig on 10/28/17. The corease between the ulcer (injury) (1)- Common the common of the common	failed to clarify a physician's #47's wound dressing on admitted to the facility on mitted on 11/22/17. Resident cluded but were not limited to: idney disease and adult failure #47's most recent MDS), a five day Medicare n ARD (assessment reference coded the resident's cognition aired. It #47's clinical record revealed gned by the nurse practitioner note documented, "Natal cleft ne buttocks) stage 3 pressure ordered NS (normal saline) of ointment (2) & silicone very day)." It order dated 10/28/17 anse natal cleft with NS wound to wound bed and cover (with) Day & PRN (as needed)." specify the type of dressing. It ober 2017 TAR (treatment ord) documented, "10/26/17-(with) NS wound flush, apply id & cover (with) dressing Q	F 65			
	conducted with RN	8 p.m. an interview was I (registered nurse) #1. RN #1				

	TMENT OF HEALTH	AND HUNN SERVICES			FORM): 12/18/2017 /I APPROVED): 0938-0391
STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495246	B. WING		12	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	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ULD BE	(X5) COMPLETION DATE
F 658	transcribed by a He with appropriate transcrify accuracy and by a HUC. PURPO practitioner orders to patient's care and transcribed of the facility Physician/Advanced "POLICY Physician (APP) orders will be on a monthly basis completeness, and federal requirement current and accurate orders. PRACTICE licensed nurse will reprinted orders and of time interval (telephonic" The oxygen concentration on the flow knob until the becenter the ball on the No further information.	alth Unit Coordinator (HUC) ining. A licensed nurse must sign off on orders transcribed SE To communicate all o caregivers regarding reatment." y policy: "Monthly d Practice Provider" Under in/Advanced practice provider reviewed by a licensed nurse to ensure accuracy, compliance with state and s. PURPOSE To provide a record of physician/APP STANDARDS2. The eview the previous month's orders that were written in this one, verbal, written orders) trator manufacturer's user d, under "NOTE: To properly locate the prescribed flow meter. Next, turn the all rises to the line. Now, e L/min. line prescribed" on was provided prior to exit.	F6	558		
Transfer to the state of the st	treated as a drug. It such as atelectasis of any drug, the dosage should be continuous	age 1122, "Oxygen should be has dangerous side effects, or oxygen toxicity. As with e or concentration of oxygen sly monitored. The nurse ck the physician's orders to				

verify that the client is receiving the prescribed oxygen concentration. The six rights of

DEPART	MENT OF HEALTH	AND IAN SERVICES & MEDICAID SERVICES			FORM	: 12/18/2017 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COM	E SURVEY IPLETED
		495246	B. WING _		1	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	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658	During an interview with LPN # 3 when transcription of physwhen a physician of the pharmacy, then checks about 10 to the pharmacy has rwould be hand writt (Medication Administration Recompany's policies.	on 12/06/17 at 03:02 p.m. asked the process for sician orders, LPN ##3 sated rder is received it is faxed to the staff receiving the order 15 minutes later to make sure eceived the order. The order en on the MAR/TAR stration Record/Treatment ord). Next month the printed om the pharmacy and the new here. If for some reason it is opy the nurse would hand order is not on the printed et it means the order was not acy and the nurse would have and fax it again. If the order ysicians' order sheet and not nen there is a pharmacy issue.	F 65	8		

Review of the facility policy: "Transcription of Orders" documented the following: under "POLICY Orders from an authorized licensed

independent practitioner are transcribed by a licensed nurse. Written orders may be

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

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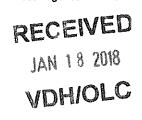
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CON	(X3) DATE SURVEY COMPLETED C	
		495246	B. WING	·	····		/08/2017
NAME OF	PROVIDER OR SUPPLIER			l	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER		,		DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
Vocame della community en encommunity en encommunit	observed to be set 12/05/17 08:31 a.m 1.5 liters/minute 12/06/17 07:10 a.m noted to be set at 1 12/06/17 09:12 a.m 1.5 liters/minute During an interview LPN (licensed pract asked to view the ox 43's concentrator for the flow meter was center of the ball in on the 1.5 L/min. Lirview the physician order orde liters/minute. LPN # and when the MAR documentation that to be set to 1 liter pet the December 2017 1L/min via nasal car 9/20/17. LPN # 2 had discrepancy betwee MAR. LPN # 2 was was and stated that During an interview ASM (Administrative Executive Director, 7 of Nurses, and ASM Specialist, this observed administration physician orders, and physician orders, and and stated that physician orders, and physician orders are stated that physician orders.	at 1.5 liters/minute . Resident # 43 oxygen set at . Resident # 43 oxygen	F	658			

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 184 of 348



CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	COM	TE SURVEY MPLETED
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14/00D84	ONT CENTER			11	DAIRY LANE		•
AACCDIA	ONI CENIER			FF	REDERICKSBURG, VA 22405		
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F 658	Continued From pa	ge 182	F	658			The state of the s
		adults and children with					WE STOCK I STO
		his information was obtained		West reasons and			
	from:			anna trippina			The state of the s
		n.nih.gov/dailymed/drugInfo.cf	T 0000000	***************************************			-
	m?setid=c8ecbd/a-	-0e22-4fc7-a503-faa58c1b6f3f		TANAMAN TANAMA			
	4. The facility staff f	ailed to accurately transcribe		NAMES OF TAXABLE			A Company of the Comp
	a physician order fo	r Resident # 43's oxygen to	and the second s	4 PAGE 111 P			
	the MAR (Medication	on Administration Record).		anner a conduct			
	Resident # 43 was :	admitted to the facility on	47 TO THE RESIDENCE OF	and the same of th			
		ed on 9/19/17 with diagnoses					
		ere not limited to: anemia,	TOTAL PARTIES				
		lure, hypertension, diabetes,					****
	nyperiipidemia, anx	iety, and depression.					
***************************************		st recent MDS (minimum data					
,		Quarterly Assessment, with		W 199			
		nt reference date) of 10/15/17 3 as understood by others		***			** T Y Y THE STATE OF THE STATE
1		rstand others. Resident # 43					married Avenue and Ave
		cognitively intact for making					The Asset Woodsenbord
	daily decisions, scor	ring 15 out of 15 on the BIMS					Andreas Communication of the C
	(brief interview for n	nental status).					
	Review of a physicia	an order dated 9/20/17 and		or management			A COUNTY VOICE OF THE COUNTY O
	most recently signed	d by the physician on 12/4/17					mooy was minor
	•	GEN 2L/MIN VIA NASAL					
		IUOUS." Review of the R is as follows: "O2 @					5 P 2 P 2 P 2 P 2 P 2 P 2 P 2 P 2 P 2 P
		nnula Continuous" dated		ALEMANA A VARIOUS NA			
	9/20/17.						· · · · · · · · · · · · · · · · · · ·
- The second second	The following chara	vations sere made of		***************************************			
The second secon	Resident # 43's oxyg						
7	·	The second secon					
	12/04/17 11:59 a.m. 1.5 liters/minute	Resident # 43 oxygen set at		ALTER (1994 - 1994)		A LANGUAGE	

12/04/17 05:48 p.m. Resident # 43 oxygen

DEPARTMENT OF HEALTH AND

PRINTED: 12/18/2017

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	TMENT OF HEALTH	AND HU SERVICES & MEDICAID SERVICES			la de la companya de	FOR	D: 12/18/2017 M APPROVED O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
		495246	B. WING	3		1	C 2/08/2017
NAME OF	PROVIDER OR SUPPLIER	3			STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
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	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	D BE	(X5) COMPLETION DATE
	to fill out the MAR a administration recor an order when need normally call the phy clarification." The Hu Resident #286 was a #5 stated, "Hmm. Hu insulin and that's a vam going to call the made aware that the the order, LPN #5 st remember taking off A request was made ASM (administrative director of nursing fo on clarifying physicial On 12/7/17 at 10:05 staff member) #3, the stated, "The facility's company's policies. That writes and create On 12/7/17 at 3:00 p. did not have a policy On 12/7/17 at 4:45 p. member) #1, the exemplement of nur clinical quality special findings. No further information 1) Humalog insulin	says and I follow the process nd TAR (treatment d)." When asked who clarified ed, LPN #5 stated, "I vsician who wrote it and I do a umalog insulin order for reviewed with LPN #5. LPN umalog, that's a short acting ery high dose. I personally MD (medical doctor)." When a staff stated he had taken off ated, "I don't actually that order." on 12/7/17 at 8:30 a.m. of staff member) #2. the interim r a copy of the facility's policy n orders. a.m. ASM (administrative as corporate clinical specialist standards of practice are the The company has a team	F	658	8		

	IMENT OF HEALTH	The second secon			_		APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II	TIPLE CONSTRUCTION	<u> </u>	(X3) DATE	0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	ING		COMP	LETED
		495246	B. WING			12/0	8/2017
NAME OF	PROVIDER OR SUPPLIER		<u>. </u>	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
MOODA	ONT CENTED			11 DAIRY LANE			
AAOODIAI	ONT CENTER		ŀ	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 (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
	documented, "Huma (subcutaneously) Q Humalog 24 units as w/dinner DM." Review of the Dece administration recording and the resident had received the insulin lunch. The resident's blood 238. It was document received the insulin lunch. The resident's 99 to 314. It was downed to 314.	cian's orders dated 11/18/17 alog 20 units sq (every) AM DM (diabetes). q w (with)/ Lunch and mber 2017 MAR (medication d) documented, "Humalog 20 as documented that the ed the insulin each morning. I sugars ranged from 121 to nted that the resident had on 12/3/17 and 12/4/17 at as blood sugars ranged from cumented that the resident ulin on 12/2/17, 12/3/17 and ne residents blood sugar 54. Inducted on 12/7/17 at o.m. with OSM (other staff rmacist. When asked who orders, OSM #10 stated, "If n, the pharmacist calls." B's Humalog insulin order ne pharmacist, OSM #10 problem. You can't be giving at the blood sugar is. If they	F 6		ENCY)		
	having a low blood s to state whether the clarify the order with A telephone intervieu at 4:16 p.m. with LPN #5, the nurse who too orders for Resident #	ut eating they are at risk for ugar." OSM #10 was not able pharmacist had attempted to the physician. v was conducted on 12/7/17 N (licensed practical nurse) ok off the Humalog insulin £286. When asked about the when taking off orders, LPN					

#5 stated, "I look at the time it was written and

DEPARTMENT OF HEALTH AND

PRINTED: 12/18/2017

CENTE	RS FOR MEDICARE	AND HUNN SERVICES & MEDIC. D SERVICES			FORM	D: 12/18/2017 MAPPROVED D: 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
		495246	B. WING		12	C /08/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 14	100/2017
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTINUENTIFYING INFORMATION)	ID PREFI TAG	, , , , , , , , , , , , , , , , , , , ,	OULD BE	(X5) COMPLETION DATE
F 658	Continued From pag	ge 179	F6	558		
	No further information end of the survey pro	on was provided prior to the ocess.				**************************************
	following website; http://www.npuap.org	was obtained from the g/resources/educational-and- uap-pressure-ulcer-stagesca				
	following website: https://www.ncbi.nlm 86636/ 3. The facility staff fa 11/18/17 order for Hu human insulin (1)) 20 breakfast and Humal administered with lun	vas obtained from the .nih.gov/pmc/articles/PMC26 iled to clarify the physician's imalog insulin (a rapid acting units to be administered at og 24 units to be ch and dinner for Resident e resident's blood sugar.		•		
	2/15/17 and readmitte diagnoses that includ	ed but were not limited to blood pressure, heart				
ii Find d	data set), an admissic assessment reference Resident # 286 as sconterview for mental st 15, 15 being cognitiv lecisions. Resident # equiring extensive as lependent of one staff	t recent MDS (minimum on assessment with an ARD e date) of 11/25/17, coded oring a 15 on the brief atus (BIMS) of a score of 0 ely for making daily 286 was coded as sistance to being totally f member for activities of ision of one staff member				

PRINTED: 12/18/2017 **DEPARTMENT OF HEALTH AND** VAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 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 (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 658 Continued From page 178 F 658 unable to determine. When asked who completed the treatments between 12/2 - 12/5/17, LPN #12 stated the treatments were signed off as being completed by an LPN who was no longer with the facility. LPN #12 was asked what had the staff been using to follow the prescribed order. LPN #12 stated, "The staff have been using another resident's Medihoney." On 12/7/17 at 12:30 p.m. an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked what process the nursing staff followed if they do not have a prescribed treatment/medication to administer as ordered. ASM #2 stated. "They should call the pharmacy and have them process the order." ASM #2 was asked if it was appropriate to use another resident's treatment/medication. ASM #2 stated "No." ASM #2 was asked if she was aware Resident # 56 did not have Medihoney available to administer to her wound between 11/29/17 and 12/6/17. ASM #2 stated that she had not been made aware of that. ASM #2 was asked to provide a policy regarding obtaining medications/treatments from the pharmacy. On 12/7/17 at 3:00 p.m. ASM #3 was asked what

concerns.

medications.

professional standard of practice the facility uses, ASM #3 stated they follow their policies. A policy was not provided for the use of another resident's

An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and

ASM #3 were made aware of the above

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HUM **N SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICARÓ SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 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 (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PRFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 658 Continued From page 177 F 658 On 12/6/17 at 12:30 p.m. LPN (licensed practical nurse) #12 approached this writer and stated she was ready to provide wound care for Resident # 56. As LPN #12 gathered her supplies she stated Resident #56's Medihoney had not arrived from the pharmacy. LPN #12 was asked when the Medihoney was ordered. LPN #12 stated, "It was ordered - I don't know - I want to say the 30th or the 1st." LPN #12 was asked what she normally did if she didn't have what she needed for a resident's treatment. LPN #12 stated, if another resident on the hall has the same prescription I will use another resident's supply until I get what I need from the pharmacy." LPN #12 was asked if anyone had contacted the pharmacy. LPN #12 stated, "Not that I know of. I don't know why the pharmacy hasn't been contacted. I didn't know anything about it yesterday because all the treatments were done when I came on shift. I assumed that her (Resident # 12's) supplies were here so I didn't question it." LPN #12 was asked

what was she going to do next. LPN #12 stated, "I am going to contact the pharmacy and see if they've sent it. I know they got the order because I received a fax confirmation." At this time LPN #12 went to verify the fax order went to the pharmacy. LPN #12 was unable to locate the fax confirmation that the order was sent to the pharmacy. LPN #12 reviewed the order and stated she was the one who had signed off on the order. LPN #12 further stated, "It looks like it was not "taken off" but I remember sending it to the pharmacy it must not have gone through." When

asked when the order for Medihoney was received by nursing LPN #12 stated, "On 11/29/17 the Medihoney was ordered and not received." LPN #12 was asked who did the treatment on 11/30/17. LPN #12 stated she was

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	prescribed medication ordered and used a for eight days.	failed to obtain Resident #56's on from the pharmacy as nother resident's medication		7 (c)				
	with diagnoses that to; dementia, a gast feeding directly into vascular disease (po high blood pressure, swallowing, anemia	dmitted to the facility 12/21/12 included, but were not limited rostomy (a tube to deliver the stomach), peripheral por circulation to the legs), depression, difficulty (low red blood cell count), an and difficulty speaking.		Radia konjingo y rimmoonin koo o da iyo waxaa aasa kaamaa oo ii iro rimmoonin oo kaama				
W/AMERICA TERROLOGIA VA	set), a quarterly asse (assessment referent coded Resident #56 the questions on the mental status) and the Resident #56 as beint decisions regarding to #56 was coded as be of daily living. Reside	recent MDS (minimum data essment with an ARD ace date) of 10/13/2017 as being unable to answer BIMS (brief interview for the staff assessment coded and severely impaired to make eask of daily life. Resident eing dependent with activities ent #56 was also coded as in 50% of her nutrition						
	2 pressure ulcer on F "11/28/17. Cleanse ((stage) 2 ulcer [1] (St Partial-thickness skin NS (normal saline) w Medihoney [2] (medic with wound healing) a	following orders for a stage Resident #56's lower left leg; L) outer calfe (sic) stg. age 2 Pressure Injury: loss with exposed dermis.) ound cleanser, dry, apply cally certified honey for use and then silicone dsg day)." Signed and dated by		ФМИНОМ — — « пооттярня постоя на селения селения постоя на селения постоя на селения селения постоя на селения пост				

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	facility be sure the o #2 didn't have any c was a standard of pr amount of intake wh physician-ordered flu "yes, it is." When as practice the facility fo would have to find or On 12/07/17 at 10:05 corporate Clinical Qu facilities standards or policies. The compa and creates its own s facility policy, "Fluid E "Intake and output wi documented as follow Monitor fluid intake; n She also provided the Restriction" which do Order must include vo permitted during 24-1 Pluid intake. Monitor of Cocument: 8.1 Intake Patient's compliance of esponse" A review of the care p estriction was not add 657). On 12/7/17 at approximated of the findings.	imented, how could the rder was being followed, ASM omment. When asked if it ractice to document the en a resident is on a uid restriction, ASM #2 stated, sked what standard of ollows, ASM #2 stated she ut. 5 a.m., ASM #3 (the ractice are the company's ny has a team that writes standards." She provided the Balance" which documented, Il be monitored and ws:Fluid Restriction: nonitor output if ordered." It facility policy, titled "Fluid cumented, "1. Verify order. olume or range of fluid hour period4. Monitor output as ordered8. e; 8.2 Output, if ordered; 8.3	F6	58				
I N	o runtrier intormation	was provided by the end of				Part of the Part o	[

DEPARTMENT OF HEALTH AND MAN SERVICES
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	restriction and asker resident had too more questioned CNA #1 for the shift. Review #14 by LPN #12 revinot been exceeded. On 12/7/17 at approphone interview with physician order for stated the fluid intaked documented. She is the order, she search monitoring form but stated she then calle who wrote the order restriction amounts LPN #13 stated she next shift that she wand what restriction. On 12/06/17 at 2:41 December 2017 fluid from the electronic hrequested. On 12/06 (Administrative Staff of Nursing (DON) prand stated this was that the fluid restriction was followed that the fluid restriction was followed. When info aware Resident #74 LPN #12 was not aw	od how she would know if the uch fluids, LPN #12 went and 4 about the resident's fluids w of resident's intake with CNA realed the fluid restriction had	F6	58			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUIL		TIPLE CONSTRUCTION	OMB No (X3) D	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
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O O Fit Oth Lit and aw	as requiring extensing toileting, dressing, mindependent for eating incontinent of bladded incontinent of bladded incontinent of bowel. In a review of the clinic physician's order data restriction per neprhorement of the content of the clinic physician's order data restriction per neprhorement of the content of the cont	n. Resident # 74 was coded by care for bathing, hygiene, hobility and transfers; as ing; and as frequently er and occasionally. The resident was coded as ces. al record revealed a ed 12/1/17 for "Fluid of (nephrologist) at Dialysis 24H (ounces per 24 hours) dent #74 on 12/04/17 at at 07:30 a.m., 12/06/17 at 6/17 at 12:33 p.m., revealed ave fluids at the bedside. p.m., in an interview with ursing Assistant), who at #74, she stated the fluid restriction and could defend the interview of the MAR ation Record) revealed the id restriction was R and the nurse was aware the nurse's initials next to a including the initials of actical Nurse) on 12/6/17. It was asked how the was documented as it was	F	65				

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	ordered and used a for eight days. 3. The facility staff 11/18/17 order for hadministered at breat to be administered Resident #286 regasugar. 4. The facility staff of a physician order for the MAR (Medication order for Resident #10/28/17. The findings included 1. The facility staff and track the fluid in was on physician-order for Resident # 74 was a 1/13/17 and readminication of the Mark (ESRD), resident # 74 was a 1/13/17 and readminication of the most of the most recent Mcquarterly assessment Reference Date) of coded as being modernake daily life decis	failed to clarify the physician's numalog insulin 20 units to be eakfast and humalog 24 units with lunch and dinner for ardless of the resident's blood failed to accurately transcribe or Resident # 43's oxygen to on Administration Record). failed to clarify a physician's #47's wound dressing on e: failed to monitor, document, nake of Resident #74 who dered fluid restriction. admitted to the facility on the don 10/11/17 with the to limited to End Stage Renal and dialysis, dementia with cerebrovascular disease, petes, metabolic	F 6	completed of all roxygen orders to transcribed correct completed of all corders to ensure a clear. 3. Education was problement of the clear orders of the claim orders, clarifying ordering of medical borrowing medical residents. 4. Unit Managers will documentation and orders in the Clinic Meeting. Unit Meeting. Unit Meeting. Unit Meeting will medications and the consure medication and not being born residents. Results will be brought to Assurance and Per Improvement Comfor review.	ensure ettly. Audit was current Treatment ccurate and ovided to the Staff by the lucator on anscribing of of orders, ations and not ations from other Ill audit nursing d Physician's ical Morning anagers and l audit reatments weekly domly thereafter ions are available rowed from other of these audits the Quality rformance	

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	can start to heal. Promanagement is imponoliving tissue from information was obtained from the work obtained from the http://outside-us.der. (4) Silicone dressing dressing containing was obtained from the https://www.ncbi.nlm Services Provided MCFR(s): 483.21(b)(3) §483.21(b)(3) Component Services provide as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on observation document review, and was determined the for professional standard residents in the survey #56, #286, #43, and #1. The facility staff facility	oper wound care ortant to help remove n your wound properly" This ained from the website: om/ specialized medical honey s. This information was ebsite: masciences.com/medihoney is a specialized type of silicone. This information ne website: .nih.gov/pubmed/27802960 eet Professional Standards of or arranged by the facility, mprehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. T is not met as evidenced on, staff interview, facility d clinical record review, it acility staff failed to follow les of practice for five of 29 by sample; Residents #74, ited to monitor, document, ake of Resident #74 who	F 65	1.	Resident # 74 currently h restriction documented. # 56 has been discharged facility. Resident # 286 is longer in the facility. Resident # 43 had order corrected for oxygen. These correction made by the Unit Manage Resident # 47 has expired Audit was completed by the Managers. For all resident Fluid Restrictions to ensure documentation was in place House audit completed to medications were available residents and that no borrownedications was occurring was completed of all residents.	Resident from the no sident # her s were rs. he Unit se with re that ce. ensure e for all wing of a Audit	

prescribed medication from the pharmacy as

with insulin orders to ensure they

are appropriate. Audit was

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	Full-thickness skin a extent of tissue dam be confirmed because schar. If slough or 3 or Stage 4 pressur Stable eschar (i.e. discription of the confirmed or fluctuant limb should not be sufficiently in the color changes. Discounting a dark wou pain and temperature color changes. Discounting a dark wou pain and temperature color changes. Discounting a dark wou pain and temperature color changes. Discounting a dark wou pain and temperature color changes. Discounting a dark wou pain and temperature color changes. Discounting a dark wou pain and temperature color changes. Discounting a dark wou pain and temperature color changes. Discounting a dark wou pain and temperature color changes. Discounting intense a dark would be colored to the colored the colored tissue, muscle or other under this indicates a full the (Unstageable, Stage DTPI to describe vasing information was obtain http://www.npuap.org.sory-panel-npuap-anri	and tissue loss in which the nage within the ulcer cannot use it is obscured by slough or reschar is removed, a Stage ure injury will be revealed. dry, adherent, intact without nce) on the heel or ischemic softened or removed. The Injury: Persistent up red, maroon or purple skin with localized area of chable deep red, maroon, or epidermal separation und bed or blood filled blister. The change often precede skin coloration may appear bigmented skin. This injury and/or prolonged pressure the bone-muscle interface. Silve rapidly to reveal the use injury, or may resolve for necrotic tissue, and pressure injury as 3 or Stage 4). Do not use secular, traumatic, natologic conditions." This injury atalogic conditions. This injury atalogic conditions. This injury and from the website: grantonal-pressure-ulcer-advingualcer-to-pressure-injury-and-	F 6	357	7		

(2) "SANTYL Ointment is an FDA (Federal Drug Administration)-approved prescription medicine that removes dead tissue from wounds so they

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	visible and deeper ti Granulation tissue, s present. These injur adverse microclimat the pelvis and shear should not be used to associated skin dam incontinence associat intertriginous dermat related skin injury (N (skin tears, burns, al Stage 3 Pressure Inj Full-thickness loss of is visible in the ulcer epibole (rolled wound Slough and/or escha of tissue damage var areas of significant a wounds. Underminin Fascia, muscle, tend and/or bone are not e obscures the extent of Unstageable Pressure Stage 4 Pressure Inju issue loss Full-thickness skin ar or directly palpable fa igament, cartilage or and/or eschar may be edges), undermining a opeth varies by anato eschar obscures the en unstageable Press or Unstageable Press	d blister. Adipose (fat) is not issues are not visible. slough and eschar are not ries commonly result from the and shear in the skin over in the heel. This stage to describe moisture rage (MASD) including ated dermatitis (IAD), titis (ITD), medical adhesive MARSI), or traumatic wounds brasions). The first of the skin in which adipose (fat) and granulation tissue and dedges) are often present. It may be visible. The depthories by anatomical location; diposity can develop deeping and tunneling may occur. In the loss this is an religious. If slough or eschar of tissue loss this is an religious. If slough or escharof tissue loss with exposed scia, muscle, tendon, bone in the ulcer. Slough or extent of tissue loss this is sure losation. If slough or extent of tissue loss this is sure ligion.	F	657			
l fi	Instageable Pressure ıll-thickness skin and	e Injury: Obscured I tissue loss		and Hannassanna		NA PERSONAL SE AND SECTION SE	

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	On 12/6/17 at 5:45 member) #1 (the exinterim director of nuclinical quality speciabove concerns. No further information "Pressure Injury: A pressure injury: A pressure injury is and/or underlying so prominence or related device. The injury capen ulcer and may as a result of intense or pressure in combitolerance of soft tiss may also be affected perfusion, co-morbiotissue. Stage 1 Pressure Injerythema of intact skilled.	plan should reflect that. p.m. ASM (administrative staff fecutive director), ASM #2 (the ursing) and ASM #3 (the ralist) were made aware of the on was presented prior to exit. Incomplete damage to the skin of tissue usually over a bony ed to a medical or other an present as intact skin or an be painful. The injury occurs and/or prolonged pressure ination with shear. The ue for pressure and shear d by microclimate, nutrition, dities and condition of the soft in the soft in the staff in the soft in the soft in the staff in the staff in the staff in the soft in the staff	F 6	57			
	pigmented skin. Pres	y appear differently in darkly sence of blanchable s in sensation, temperature,					

pressure injury.

loss with exposed dermis

or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue

Stage 2 Pressure Injury: Partial-thickness skin

Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or

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	injury/wound(s) were Location(s): rt (right) left buttock. The follows: Other Wound santyl (2) and dressing the next assessment injury was a progress practitioner on 11/6/1 "Natal cleft IAD (incodermatitis) - 2.7x0.5c slough, no odor. R. dulcer (injury) (1) - 2x1 calfe (sic) stage 2 ulculcers of stage 2: 1.1 diameter, & 3. 2.5x1 Multiple new ulcers in Ordered NS (normal Medihoney gel (3) & selectory day). Wound Review of Resident # plan failed to reveal a the new pressure injury lower buttock, right in buttock. On 12/6/17 at 12:08 producted with RN (regarding the process RN #1 stated any nurse put typically the unit mourse was employed a facility during the time in nurse is supposed to a suppose to the supposed to a suppose to the suppose of the	ed. The following New skin e identified: Other Wound(s): inner calf, rt lower buttock, lowing skin injury/wound(s) atified and were evaluated as id(s): Location(s): Rt buttock, ing daily. Int of Resident #47's pressure is note signed by the nurse if 7. The note documented, intinent associated im (centimeters), 50% (Right) lower buttock stage 2 cm, granulation. R. inner cer- 5x3 cm. R. hip 3 new if 1.5x0.5 cm, 2. 4.5 cm in cm, all granulatedPlan: oted by nursing Sunday pm. saline) wound flush, silicone dressings (4) qd rounds on Wednesdays." 47's comprehensive care in in in in in in in iterview was in iterial in ite	F 6	57					

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND JAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 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) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) Continued From page 166 F 657 stated a second check should be done during the clinical morning meetings with the nursing leadership who should review new orders and update the care plans if it had not already been done. On 12/7/17 at approximately 5:00 PM at the end-of-day meeting, ASM #1 (the executive director), ASM #2 (the interim director of nursing) and ASM #3 were made aware of the findings. No further information was provided by the end of 7. The facility staff failed to review and revise Resident #47's comprehensive care plan after the resident acquired new pressure injuries in November 2017. Resident #47 was admitted to the facility on 10/26/17 and readmitted on 11/22/17. Resident #47's diagnoses included but were not limited to: diabetes, chronic kidney disease and adult failure to thrive. Resident #47's most recent MDS (minimum data set), a five day Medicare assessment with an ARD (assessment reference

planned on 10/30/17.

date) of 11/29/17, coded the resident's cognition as moderately impaired. Section M documented Resident #47 presented with one stage three pressure injury (1), one unstageable pressure injury with slough and/or eschar (1) and two unstageable deep tissue pressure injuries (1).

Review of Resident #47's clinical record revealed Resident #47 was admitted with a stage 3 pressure injury (1) to the natal cleft (crease between the buttocks). This wound was care

A nurse's note dated 11/5/17 documented, "A skin

	TMENT OF HEALTH	I AND HU SERVICES				FORI	D: 12/18/201 M APPROVEI
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	D. 0938-039 ATE SURVEY DMPLETED
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F 657	Continued From pa	ge 165	F	357			
·	physician's order da restriction per neprh Center. 32 Fluid oz "	ated 12/1/17 for "Fluid no (nephrologist) at Dialysis /24H (ounces per 24 hours) sident # 74 on 12/04/17 at		The second secon			
	12:39 p.m., 12/05/1 08:00 a.m., and 12/0 the resident did not	7 at 07:30 a.m., 12/06/17 at 06/17 at 12:33 p.m., revealed have fluids at the bedside.	POCCHIENCE AND A PROPERTY OF THE PROPERTY OF T				
		prehensive care plan dated e fluid restriction was not an.		WATER AND THE PROPERTY OF THE PERSONNELS OF THE	*		
	interview was condu Practical Nurse) who for Resident #74's flut stated fluid restriction When asked who ad plans, LPN #13 state manager (for which to or the supervisor. Lift know anything about plans; that she did no to, she had never ad	ximately 10:45 a.m., an octed with LPN #13 (Licensed to took off the physician order uid restriction. LPN #13 in should be care planned. Ids changes to the care ed she thought it was the unit there wasn't one at the time) PN #13 stated she did not adding changes to care of know if she was supposed ded anything to a care plan.		Мобильности пада установа пода на пределения на пределения на пределения в пределен			
e de la companya del la companya de	RN #7 (Registered N stated that changes s plan right away by wt RN #7 stated it is pol	a.m., in an interview with lurse), the MDS nurse, she should be added to the care noever took off the order. icy for nurses to update the events, and that anybody plan.		л верхинация — ранаруального фейсоприявания шей правительного поставления правительного правительного правител			
	ASM #3 (Administrati	a.m., in an interview with ve Staff Member) (the ality Specialist) she stated		ON PA PRINCIPO A PARILIMANTA PARILIMANA PARI		Ordenin and Angeles and Angele	`

any nurse can update the care plan. ASM #3

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	by holding the head was obtained from http://www.sunrisemirs/quickie/tilt-in-spa [2] BRODA chair- "predistribution to help for residents who are themselves." This in https://www.brodase 6. The facility staff facomprehensive care physician-ordered flu 12/1/17. Resident # 74 was a 1/13/17 and readmitt diagnoses of but not Disease (ESRD), rer	upright." This information nedical.com/manual-wheelcha ce-wheelchairs. rovides comfort and pressure maintain long term comfort e unable to reposition nformation was obtained from eating.com/conditions/. ailed to revise Resident #74's plan to include the uid restriction ordered on dmitted to the facility on ted on 10/11/17 with the limited to End Stage Renal hal dialysis, dementia with cerebrovascular disease,	F 6	357			

having dialysis services.

encephalopathy, altered mental status, depression, dysphagia, bipolar disorder, glaucoma and hyperparathyroidism. The most recent MDS (Minimum Data Set) was a quarterly

assessment with an ARD (Assessment

Reference Date) of 11/6/17. Resident # 74 was coded as being moderately impaired in ability to make daily life decisions, scoring a 7 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident # 74 was coded as requiring extensive care for bathing, hygiene, toileting, dressing, mobility and transfers; as independent for eating; and as frequently incontinent of bladder and occasionally

incontinent of bowel. The resident was coded as

A review of the clinical record revealed a

DEPART	MENT OF HEALTH	AND HOAN SERVICES & MEDICAID SERVICES				FORM	: 12/18/2017 I APPROVED : 0938-0391
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F 686	hall. This writer the Resident # 19's roo heel boots could be closet. When aske Resident #19's cha saw a heel boot. Con and it fell off, so CNA #10 then removed the control of the contro	she normally works on the 200 en followed CNA #10 into m. No instructions for the found in Resident #19's d what the CNA observed in ir, CNA #10 stated that she NA #10 stated, "Maybe it was someone put in in the chair." oved the blankets covering. Her soft heel boot was not when asked if her soft heel place, CNA #10 stated, "She on, I would think." When the can look to see what in place, CNA #10 stated, "I see and ask."		686			

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '		NSTRUCTION	•		SURVEY PLETED
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F 686	to relieve pressure. aids usually put sof should ensure that On 12/06/17 at 5:30 staff member) #1, the interim DON (D #3, the clinical qual of the above conce No further information of aintegrity management of the plant period comprehencare including preveas indicated. 4.1 Imprevention for identifications and utilization of the plant period comprehencare including preveas indicated. 4.1 Imprevention for identifications and utilizations.	RN #4 stated the nursing theel boots on but the nurse they are in place. D.p.m. ASM (administrative he executive director, ASM #2, irector of Nursing) and ASM ity specialist were made aware rns. on was presented prior to exit. "Skin Integrity Management"	F 68	36				
F 687 SS=D	No further information Foot Care CFR(s): 483.25(b)(2	on was presented prior to exit.	F 68	7	Resident # 63 w podiatrist on 12/ toenails trimmed	/21/17 and h	ne ad	,
	and care to maintain health, the facility m (i) Provide foot care	ents receive proper treatment nobility and good foot		2.	All residents have be affected. How residents was co Managers to detended of having the	use audit of completed by I termine who	urrent Unit was in	

		Bert Harm	'A	
DEPARTMENT	OF HEALTH	I AND H	AN	SERVICES
CENTERS FOR	MEDICARE	& MEDIC	ΔID	SERVICES

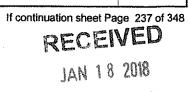
PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	ING	COM	IPLETED
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TRACE OF THE PARTY	to prevent complicate medical condition(s) (ii) If necessary, as appointments with arranging for transpappointments. This REQUIREMED by: Based on observatinterview, facility do record review, it was failed to provide for in the survey samp. The facility staff fail toenails in a timely. The findings included Resident #63 was a 4/2/05. Resident #6 were not limited to: major depressive direcent MDS (minimassessment with an date) of 10/24/17, cognitively intact. Sas requiring extensibed mobility, dressibed mobility mobility, dressibed mobility m	ations from the resident's and sist the resident in making a qualified person, and cortation to and from such or and portation to and from such or and review, staff ocument review and clinical as determined the facility staff of care for one of 29 residents are, Resident #63. Bed to trim Resident #63's manner. Be: Admitted to the facility on 33's diagnoses included but diabetes, low back pain and isorder. Resident #63's most um data set), a quarterly a ARD (assessment reference oded the resident as section G coded Resident #63 are assistance of one staff with and, eating and personal prehensive care plan revised anted, "Focus: The resident liabetes: Insulin nitions: Diabetic foot check toes/ankles/soles/heels skin integrity, color, eanliness. Toenails for	F6	trimmed either by nu podiatrist. A contract obtained for a new Powill start visiting the 1/11/2018. Podiatrist visiting center Month whose nails can be trinursing have had their trimmed. 3. Education was provide Nursing Staff by the Practice Educator, on and Procedure for Nathails are to be trimmer residents shower days appropriate, otherwise residents name will be the Podiatry List. 4. Unit Managers will as residents per week for ensure nails are being accordingly. Results caudits will be brought Quality Assurance and Performance Improve Committee monthly for	ct was odiatrist who center on will be ally. Residents immed by r nails led to the Nurse the Process il Care. ed on s if e the e added to udit 5 r 6 weeks to trimmed of these before the d ment	1/17/18

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

Event ID: DGWI11

Facility ID: VA0279



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



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F 687	Review of Resident the resident was la	age 237 It #63's clinical record revealed ist seen by the podiatrist on	F	687			
	conducted with Re stated she would li and she had told si weeks that her toe Resident #63 was told and reported sin her room. Wher by a podiatrist, Reshad been a long tin #63's feet were stic sheet while the res Resident #63's toe toenails on both feresident's toes. The	p.m. an interview was sident #63. Resident #63 ke to get her toenails trimmed taff for the past two or three nails needed to be trimmed. unable to state who she had he had told staff who had been a sked if she had been seen sident #63 stated she had but it ne. At this time, Resident king out of the bottom of the ident was lying in bed. nails were observed. All et were grown out past the ne toenails on the great toes and were approximately one great toes.					
	#63's toenails was remained the same	_		PRODUCE TRAINED AND AND AND AND AND AND AND AND AND AN			
	conducted with CN #6. CNA #6 was as residents' toenails a diabetic residents' podiatrist. CNA #6 alert then the resident the podiatrist and C they see the need of	5 p.m. an interview was A (certified nursing assistant) sked how staff ensures are cared for. CNA #6 stated toenails are cared for by the stated usually if the resident is ent will ask the nurse to see CNAs also let nurses know if during resident care.		оме в проделения мерене по поставления в поставления в поставления в поставления в поставления в поставления в			
миност гистандо	On 12/6/17 at 12:08	8 p.m. an interview was		A STATE OF THE STA			

DEPAR1	TMENT OF HEALTH	AND HE AN SERVICES			· j	FO	ED: 12/18/2017 RM APPROVED NO: 0938-0391
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F 687	was asked how star are cared for. RN # are monitored daily toenails get long, githe ordinary occurs nurse or unit manar name in the book to RN #1 stated the poto the facility once a Con 12/6/17 at 12:50 were observed with resident's toenails resident's toenails resident #60 be seen by the pod previous month but cancelled. When a made for the podial date, RN #1 stated responsible for han arrangements. RN sure Resident #63's be seen by the pod	ff ensures residents' toenails if 1 stated residents' toenails with patient care and if the row fungus or anything out of then staff notifies the charge ger who puts the resident's be seen by the podiatrist. Designation of the staff notifies the charge ger who puts the resident's be seen by the podiatrist. Designation of the supposed to come a month. By p.m. Resident #63's toenails RN #1. RN #1 confirmed the needed to be cut. RN #1. RN #1 confirmed the needed to be cut. RN #1. Si was assisted out of bed to intrist one day during the then the podiatrist called and sked if arrangements were trist to schedule a make-up the executive director was	F	687			
	conducted with ASI member) #1 (the extracted the podiatris August. ASM #1 st communication from office that the podialicensed and the issue podiatrist had to be re-credentialed. As communication with	n the facility's compliance atrist had an issue with his sue had cleared but the					

the facility in October but didn't show up. ASM #1

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DEPARTMENT OF HEALTH AND HULL A SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 687	to the facility during cancelled. ASM #1 of pursuing another communicates with he may see if the refacility to see a poor On 12/6/17 at 5:45 interim director of reclinical quality speciabove concern. The facility policy to Daily Living): Foot and observations for provided for reside	it was also supposed to come in the previous week but it stated he was in the process in podiatrist. ASM #1 stated he in Resident #63's daughter so resident could go out of the diatrist. p.m., ASM #1, ASM #2 (the nursing) and ASM #3 (the cialist) were made aware of the cialist) were made aware of the cialist in the cial state of the	F	687				
F 689 SS=J	*"NAIL GROWTH, toenails - especiall average, fingernail per month, while tomm per month." https://www.aad.or are/nail-care. (1.6 Free of Accident H CFR(s): 483.25(d) (§483.25(d) Accident The facility must es §483.25(d)(1) The as free of accident	nts.		689	1. The oxygen tank from Res 40's room was removed by Administrator and secured Resident # 40 has since be discharged from the facilit Resident # 12 has her fall a place while in bed according order and care plan.	y en y. matts in		

DEPARTMENT OF HEALTH AND IOAN	SERVICES
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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		STRUCTION		PLETED	
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F 689	supervision and as accidents. This REQUIREMEI by: Based on observated document review a was determined that maintain a safe environment in the surrand #10. This citatilevel four isolated a plan of correction, i isolated. 1. An oxygen tank with 40's room. The twas approximately square inch) reading was sitting, without night stand with no constituted the notiful the separate occar in place as ordered comprehensive car. The findings include 1. Resident #40 was 8/8/17 with diagnost limited to: stroke, description.	NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to vironment for two of 29 vey sample, Resident's #40 on was originally found at a and upon acceptance of the it was lowered to a level two was observed in Resident ank was unsecured. There 2000 PSI (pounds-force per ag on the gauge of the tank. It a stand or holder, next to the support. The observation fication of immediate jeopardy. failed to place the fall mat ent #12's bed when she was sident #12 was observed on asions in bed without a fall mat by the physician and per the e plan.	F 6		All residents have potential affected. House audit was completed by the Unit Miduring survey to ensure the were no other unsecured tanks. All residents with for Fall Matts were reviewensure that fall matts were per order. Education was provided for staff during survey related Oxygen Storage. Education provided again for facility post survey, by the Nurse Educator, related to Oxygen Storage. Education was performed to nursing staff by the Nurse Educator, related to Prevention and ensuring the interventions are in place order. The Interdisciplinary Team monitor for unsecured oxygen tanks on their daily round Managers will audit reside orders for Fall Matts 3 X of weeks and randomly the to ensure the fall matts are per order. Results of these will be brought before the Assurance and Performance Improvement Committee in the surface of the second	anagers nat there oxygen orders wed to e in place or all d to on was staff e Practice gen orovided arse d to Fall hat fall per m will ygen s. Unit ents with week for ereafter e in place audits Quality ce		

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '			COMPLETED				
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F 689	The most recent Massessment, a quality of care on 1 The most recent Massessment, a quality decision requiring extensive dependent of one her activities of datreatments, Proced #40 was not coded during the past 14- On 12/5/17 at 9:40 observed unsecure was approximately square inch) readility was observed sitting next to the night st. The 12/5/17 at 9:40 observed unsecure was approximately square inch) readility was conduct there were no other found in the building on 12/5/17 at approximately supervisors at the Office of Licensure contacted regarding Resident #40. Afte Supervisors agree assessment concern. The executive dire and the clinical quality of care on 1 Following the notifical possible process.	arterly assessment, with an ence date of 11/3/17, coded the severely cognitively impaired to ens. The resident was coded as a assistance to being totally or more staff members for all of elily living. In Section O - Special dures and Programs, Resident d as having received oxygenday look back period. I a.m. an oxygen tank was ed by three surveyors. There are 2000 PSI (pounds-force pering on the gauge of the tank. It eng, without a stand or holder, and with no support. 5 a.m. A sweep of the entire elted by the survey team and er unsecured oxygen tanks		389					

	TMENT OF HEALTH	AND HON SERVICES & MEDICAID SERVICES		0	FORM	: 12/18/2017 APPROVED : 0938-0391
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WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 224	105	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 689	Resident #40's roor tank. The executive tank out of the resident tank out of the resident." The physician or 10 via nasal cannula @ of breath." The review of the construction of the constru	lity specialist were shown in with the unsecured oxygen is director removed the oxygen lent's room. I dated, 8/9/17 and signed by /12/17, documented, "Oxygen is (at) 2 L (liters) for shortness comprehensive care plan dated dence the use of oxygen. Oxygen: High Pressure inted in part, "Cylinders must	F 68	9		

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

room is stored, LPN #3 stated, "It has to be in a holder or on the back of a wheelchair in a holder."

An interview was conducted with RN (registered nurse) #4 on 12/5/17 at 10:22 a.m. When asked how oxygen tanks are stored, RN #4 stated, "The

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 243 of 348

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JAN 18 2018

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILD	ING		c		
		495246	B. WING				08/2017	
• • • • • • • • • • • • • • • • • • • •	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405			
					PROVIDER'S PLAN OF CORRECTION	N.	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPORTION OF THE CONTROL OF T	BE	COMPLETION DATE	
F 689	are in the medication the Cardinal unitanks in a stand. We resident's room is a be in a rack or on the pouch." When a freely, without a state A Plan of Correction 12:42 p.m. The Platthe following: 1. "Oxygen cylinder #40's) room by Execon 12/05/17, and state 2. Education initiate all staff currently or policy for Oxygen Shall work until they education; this will Practice Educator in utilizing the facility staff are educated 3. 100% Room and completed by the Education of Nursing Oxygen Storage. In noted. 4. Routine room round administrative staff stored securely per Assessment and Promittee met on identified by the surplan. 5. Allegation of constitutions in the complete in th	on room." The mediation room to was observed with eight was observed with eight was observed, how a tank in a stored, RN #4 stated, "It has to he back of the wheelchair in asked if a tank can stand and, RN #4 stated, "No." In was presented on 12/5/17 at an of Correction documented removed from (Resident active Director at 10:00 a.m. tored according to policy. The duty were education on the storage, on 12/5/17. No staff whave completed this be completed by the Nurse in person or via telephone by staffing schedule to ensure all accordingly. It and common area audit executive Director and Interim to ensure no other improper to other improper storage was unds will be conducted daily by to ensure that all oxygen is policy. The Quality erformance Improvement 12/5/17 to discuss the findings revero and to review this action inpliance 12/5/17 at 12:30 p.m."		689			,	
	members from vary between 12:55 p.m	ring departments on 12/5/17 . and 1:02 p.m. All staff						

DEPART	MENT OF HEALTH	AND HON SERVICES				FORM	: 12/18/2017 I APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	X2) MULTIPLE CONSTRUCTION . BUILDING			E SURVEY MPLETED
		495246	B. WING			l l	/08/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	education received oxygen tanks. Interviews were cormembers from vary between 3:06 p.m. received the educat facility policy on the An interview was coa.m. with CNA #12, aide. When asked i regarding how to m#12 stated, "No. I gridin't answer becauknow how to take coxygen tank was to #12 stated, "It has to When asked why, Coank falls it's like a griding the staff education that education prior to when the coangent tank was coan, with LPN #11, how an oxygen tank #11 stated, "Put it in torpedo if it falls." Weducation that night #11 stated, "I did." An interview was coan, with CNA #13, asked how an oxyge #13 stated, "Make sasked if she received."	ed could verbalize their on the proper storage of aducted with five staff ring departments on 12/5/17 and 3:11 p.m. All staff had tion and could verbalize the storage of oxygen tanks. Inducted on 12/6/17 at 6:50 a 11:00 p.m. to 7:00 a.m. f she had received education anage an oxygen tank, CNA ot called (by the facility) but I are of it." When asked how an be managed and stored, CNA to be in a sack or a pouch." CNA #12 stated, "If the oxygen grenade going off." Review of log did not evidence CNA #12 had received	F	689			

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

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495246	B. WING	·		C 12/08/2017		
*	NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER			11	TREET ADDRESS, CITY, STATE, ZIP CODE I 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	varying department oxygen on 12/6/17 a.m. All staff membregarding the storal verbalize the facility oxygen tanks. On 12/6/17 at 8:45 ASM (administrative this surveyor they somewhers and had the facility. He staff them in one hour, to contacting the staff executive director so has to be 100% colleopardy could be as to be 100% colleopardy could be 100% colleopardy could be 100% colleopardy could be 100% colleopardy could be 100% coll	nducted with employees of its related to the storage of between 8:15 a.m. and 8:22 pers received the education ge of oxygen tanks and could y policy on the storage of a.m. the executive director, e staff member) #1, informed still had not reached eight staff left messages for them to call left that if he hadn't heard from then he, himself would be members. ASM #1, the stated he understood that it mpleted before the immediate	F	689				

	MENT OF HEALTH				Marine and the second s	FORM	: 12/18/2017 APPROVED . 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495246	B. WING			1	C <u>/08/2017</u>
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE		
WOODM	ONT CENTER				REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	conducted with two were not marked as education on oxyge members could ver regarding the storagthey had received that night. On 12/7/17 at 8:40 received that all sta one staff member whad been educated tanks. The Immedia 8:40 a.m. Guidance for safe hwas provided by the www.jointcommissis http://www.jointcomay be impractical have piped nonflammay provide these cylinders of various cylinders must be sanother enclosure to cylinders could fall, possibly resulting in propelling the cylindangerous projectile. The executive direct abatement of the Imat 8:57 a.m. No further observat stored improperly were reconsidered improperly were reconsidered as the stored improperly were resulted as the stored improperly were regarded.	a.m. interviews were of the staff members who is having received their in tank storage. Both staff balize the facility policy ge of oxygen tanks and that heir education prior to working a.m. final documentation was ff members, other than the who was out of the country, in the storage of oxygen ate Jeopardy was abated at anadling of oxygen cylinders a Joint Commission at on.org mmission.org> as follows: "It for some organizations to imable medical gases, so they gases in freestanding sizes. All freestanding tored in a rack, a cart, or o protect them. Unsecured breaking the valve and a rapid release of the gas, iter and turning it into a e." stor was made aware of the immediate Jeopardy on 12/7/17 ions of oxygen tanks being iver noted.	F	589			
	No further informati	on was provided prior to exit.					<u> </u>

PRINTED: 12/18/2017

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		E CONSTRUCTION	COMPLETED			
		495246	B. WING			1	C 08/2017	
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	(X5) COMPLETION DATE		
F 689	(1) Barron's Diction Non-Medical Read Chapman; page 1 2. The facility staff down beside Resident Besident Place as ordere comprehensive cathree separate occin place as ordere comprehensive cathres as 11/15/10 with a readiagnoses that incomprehensive cathres as 11/15/10 with a readiagnoses that incomprehensive cathres as 11/15/10 with a readiagnoses that incomprehensive deficit. Resident #12 was 11/15/10 with a readiagnoses that incomprehensive cathres as 11/15/10 with a readiagnoses that incomprehensive deficit. Resident #12 was 11/15/10 with a readiagnose that incomprehensive cathres was 11/15/10 with a readiagnose that incomprehensive cathres was 11/15/10 with a readiagnose that incomprehensive cathres was 11/15/10 with a readiagnose was 11/15/10 with	nary of Medical Terms for the der, 5th edition, Rothenberg and 78. If failed to place the fall mat dent #12's bed when she was esident #12 was observed on casions in bed without a fall mat d by the physician and per the are plan. admitted to the facility on admission on 5/5/16 with luded, but were not limited to; prosis (weakening of the low red blood cells), acid reflux on, difficulty swallowing, and lost recent MDS (minimum data assessment with an ARD	F 6	i89				
	(assessment refer revealed, in part, the answer the question of mental status) assessment as be decisions regardin #12 was further constaff for activities of the following dates 12/04/17 at 01:15 folded and proppe	ence date) of 11/17/17, hat Resident #12 was unable to ons on the BIMS (brief interview and was coded on the staffing severely impaired to make g tasks of daily life. Resident oded as being dependent on of daily living.						

DED45T	MENT OF LIENTLE	AND HUN SERVICES					12/18/2017 APPROVED
CENTER	IVIENT OF REALTH	& MEDICAID SERVICES					0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	СОМ	E SURVEY IPLETED
		495246	B. WING	***************************************		L	08/2017
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			Į.	DAIRY LANE 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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	folded and propped Resident # 12's bed eyes closed. 12/06/17 09:17 a.m lying in her bed with pads on either side mat is folded and a A review of Resider revealed, in part, the mat at all times whichair." A review of Resider plan dated 5/5/16 redocumentation; "Fofalls: Impaired mol requires assistance 9/13/17. Intervention Date Initiated 8/24/ On 12/07/17 at 11:4 conducted with CN #14. CNA #14 was when a resident ne "It should be in the asked if she looked stated that she did she didn't refer to the what to do when ta CNA #14 stated, "T #14 was asked was know what to do wistated, "I would say find their chart." Cithat Resident #12 r CNA #14 stated that stated that she did their chart." Cithat Resident #12 r CNA #14 stated that stated that stated that Resident #12 r CNA #14 stated that stated that stated that stated that Resident #12 r CNA #14 stated that stated that stated that stated that stated that Resident #12 r CNA #14 stated that stat	m., Fall mat observed to be against the wall at the end of d. Resident lying in bed with a., Resident # 12 observed to her eyes closed. Bumper and upper side rails up. Fall the end of the bed. Int # 12's clinical record the following order; "1/31/11 Fall the in bed. 3/9/12 Pull alarm in the theory of falls and the with transfers. Date Initiated: ons: fall mat when in bed.		689			

PRINTED: 12/18/2017 FORM APPROVED

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HU **N 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 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 689 Continued From page 249 F 689 on several occasions. CNA #14 stated, "From me being around her most of the time I know that it is in place. Most times it stays on her floor." On 12/7/17 at 12:30 an interview was conducted with ASM (administrative staff member) #2, the interim director of nursing (DON). ASM #2 was asked what the CNAs and nursing staff should do if there was an order for fall mats to be down when the resident was in bed. ASM #2 stated the floor mat should be down. ASM #2 was asked specifically about Resident #12's order for a fall mat. ASM #2 stated she had seen the floor mat down when she did rounds that morning. ASM #2 was made aware of the three observations (2 observations on 12/4/17 and one on 12/6/17) where Resident #12 was lying in bed, and the

floor mat was folded and placed against the wall at the end of the bed. ASM #2 was asked to provide a policy for use of safety devices.

A review of the facility document titled "Falls Management" did not reveal any documentation regarding the use of fall mats / safety devices for

An end of day meeting occurred on 12/7/17 at 4:45 p.m. with ASM #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above

No further information was provided prior to the

F 690

SS=D | CFR(s): 483.25(e)(1)-(3)

end of the survey process.

F 690 Bowel/Bladder Incontinence, Catheter, UTI

fall prevention.

concerns.

DEPARTMENT OF HEALTH AND HU CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DARY LANE FREDERICKSBURG, VA 22405			& WEDICAID SERVICES	(V2) 8#H	TID! E	CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DARY LANE FREDERICKSBURG, VA 22405 124	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	l'''			, COM	PLETED
MODDMONT CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DARY LANE FREDERICKSBURG, VA 22405 TO ANY LANE FREDERICKSBURG, VA 22405	AND PLAN OF	IF CORRECTION		A. BUILD				
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			405246	B. WING			12/	08/2017
WOODMONT CENTER (X4)ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 690 Continued From page 250 §483.25(e) (Incontinence. §483.25(e) (Incontinence and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that (I) A resident who enters the facility without an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary, and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore 11 DARY LANE FREDERICKSBURG, VA 22405 PREFIX REPOXIDERS PLAN OF CORRECTION (COMPOSITE STAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION			493240			REET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY	NAME OF PR	PROVIDER OR SUPPLIER						
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG	WOODMO	ONT CENTER						
SUMMARY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 690 Continued From page 250 §483.25(e) (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility without an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore F 690 1. Residents #284 and #286 indwelling-catheter tubing found on the floor was immediately removed and secured. Resident #286 is no longer in the facility. Resident #284 has tubing maintained in a sanitary manner. 2. All residents with indwelling catheters to ensure the tubing was secured off the floor, with any identified deviations corrected immediately. 3. Education was provided to the nursing staff by the Nurse practice Educator or the	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						ΩN	(X5)
Systas.25(e) (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. Systas.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that— (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore indwelling-catheter tubing found on the floor was immediately removed and secured. Resident #286 is no longer in the facility. Resident #284 has tubing maintained in a sanitary manner. 2. All residents with indwelling catheters have the potential to be affected. A 100% audit was completed, by the Unit Managers, for all current residents with indwelling catheters to ensure the tubing was secured off the floor, with any identified deviations corrected immediately. 3. Education was provided to the nursing staff by the Nurse Practice Educator or the	PRÉFIX	(EACH DEFICIENC)	Y MIJST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION DATE
§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility staff failed to ensure appropriate care services of a Foley Catheter to Nutrsing Supervisor Telated to providing foley-catheter care, including ensuring that tubing is not touching the floor. 4. The Unit Managers will audit residents with indwelling catheters 3x/week for six weeks, then randomly thereafter, to ensure tubing is secured in place and not Facility ID: VA0279 If continuation sheet Page 25		§483.25(e) (1) The resident who is cor admission receives maintain continent condition is or becond possible to mai §483.25(e)(2) For a incontinence, base comprehensive as ensure that- (i) A resident who indwelling catheter resident's clinical catheterization was (ii) A resident who indwelling catheter is assessed for renas possible unless demonstrates that and (iii) A resident who receives appropria prevent urinary tracontinence to the estate of	nence. Ifacility must ensure that Intinent of bladder and bowel on It services and assistance to It e unless his or her clinical It personant in the resident with urinary It don'the resident's It is not catheterized unless the It is not catheter as soon It is resident's clinical condition It is incontinent of bladder It is treatment and services to It infections and to restore It			indwelling-catheter to found on the floor was immediately removed secured. Resident #25 longer in the facility. #284 has tubing main a sanitary manner. 2. All residents with independent of the polyber affected. A 100% completed, by the Union Managers, for all curresidents with indwer catheters to ensure the was secured off the fany identified deviate corrected immediated. 3. Education was proving staff by the Practice Educator or Nursing staff by the Practice Educator or Nursing Supervisor of providing foley-cather including ensuring the is not touching the flow to weeks, then randomly thereafter, to ensure secured in place and	abing as as and and as is no Residen atained in addit was at audit was audit a	

DEPARTMENT OF HEALTH AND H AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		495246	B. WING			1	C 08/2017
	PROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE REDERICKSBURG, VA 22405	1 1 1 L I	00/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	prevent infections for survey sample; Res 1. The facility staff frindwelling urinary car Resident # 284. 2. The facility staff frindwelling urinary car Resident # 286. The findings include 1. The facility staff frindwelling urinary car Resident # 284. Resident # 284 was 11/30/17 with diagnon to limited to: atrial frosteoporosis (2), attraction to gastroste Resident # 284's modata set), an admiss at the time of survey On 12/05/17 at approximate the time of survey on 12/05/17 at approximate the sident # 284 was wheelchair being pus	or two of 29 residents in the sident # 284 and # 286. ailed to maintain the atheter tubing off the floor for failed to maintain the atheter tubing off the floor for sident to maintain the atheter tubing off the floor for admitted to the facility on each that included but were fibrillation, dysphagia (1), ention of ileostomy (3) and omy (feeding tube) (4). Dest recent MDS (minimum ion assessment was not due of the wheelchair revealed in the side of th	F6	90	touching the floor. Resaudits will be brought to QAPI Committee for formonthly.	o the	
	interview was conductorical nurse) # 4 rocatheter tubing. Who	elchair. eximately 2:10 p.m. an cited with LPN (licensed egarding the placement of en told of the observation of heter tubing being dragged		STANKA A MANAGEMINING SOMEONIA A STANKA PARA PARA PARA PARA PARA PARA PARA PA			

		AND HOWAN SERVICES					APPROVED . 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
-		495246	B. WING	·			C / 08/2017
NAME OF I	PROVIDER OR SUPPLIER			1 -	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER		11 DAIRY LANE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 690	on the floor under harmonic transfloor." On 12/06/17 at app (administrative staff director, ASM # 2, i ASM # 3, clinical quaware of the finding. No further information of the finding obtained from the white harmonic ha	rer wheelchair LPN # 4 stated, g should always be off the roximately 5:00 p.m. ASM f member) # 1, executive nterim director of nursing and uality specialist, were made js. ion was obtained prior to exit.	F	690			

PRINTED: 12/18/2017

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

FORM APPROVED OMB NO. 0938-0391		PRINTE):	12/18/2017
OMB NO. 0938-0391		FORM	vI.	APPROVED
	(OMB NO	<u>).</u>	0938-0391

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	COMPLETED C 12/08/2017	
		495246	B. WING			12/0	8/2017
	PROVIDER OR SUPPLIER ONT CENTER		:	,	STREET ADDRESS, CITY, STATE, ZIP CODE I1 DAIRY LANE FREDERICKSBURG, VA 22405		
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F 690	indwelling urinary Resident # 286. Resident # 286 wa 02/15/17 with a re Diagnosis include weakness, prostarbone, type 1(one) kidney disease. Resident # 286's idata set), an adm (assessment referencesident # 286 as interview for mention - 15, 15 being cogdecisions. Resider equiring extensive dependent of one daily living and surfor eating. On 12/05/17 at approximately resident # 286 we Foley catheter tube floor below the best on 12/06/17 at approximately resident was compractical nurse) # placement of a restated, "The tubin When informed on 286's catheter tube his bed, LPN #4 selipped to the best of the series of the serie	as admitted to the facility on admission date of 11/18/17. but were not limited to muscle te cancer, secondary cancer to diabetes mellitus (1) and most recent MDS (minimum ission assessment with an ARD rence date) of 11/25/17, coded a scoring a 15 on the brief al status (BIMS) of a score of 0 initively intact for making daily ent # 286 was coded as e assistance to being totally staff member for activities of pervision of one staff member opposition of one staff member december of the status of the sident's catheter tubing LPN # 4 g should be kept off the floor." If the observation of Resident # bing resting on the stated it should have been it.		690			
	On 12/06/17 at ap	oproximately 5:00 p.m. ASM aff member) # 1, executive					The state of the s

DEPARTMENT OF HEALTH AND HUMAN 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 _ С 12/08/2017 B. WING 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 DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 690 Continued From page 254 F 690 director, 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. References: (1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm. 1. Resident #56 no longer resides in F 693 Tube Feeding Mgmt/Restore Eating Skills F 693 the center. CFR(s): 483.25(g)(4)(5) SS=D 2. All residents who receive tube §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, feedings have potential to be both percutaneous endoscopic gastrostomy and affected. An audit was completed percutaneous endoscopic jejunostomy, and by the Unit Managers of all enteral fluids). Based on a resident's current residents with tube-feeding comprehensive assessment, the facility must orders, to ensure that orders are ensure that a residentbeing carried out accordingly. §483.25(g)(4) A resident who has been able to 3. Education was provided to nursing eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical staff by the Nurse Practice condition demonstrates that enteral feeding was Educator related to the Tube clinically indicated and consented to by the Feeding Administration policy, to resident; and include appropriate positioning in §483.25(g)(5) A resident who is fed by enteral bed while tube feed is running and means receives the appropriate treatment and following physician's order for

services to restore, if possible, oral eating skills

and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,

diarrhea, vomiting, dehydration, metabolic

abnormalities, and nasal-pharyngeal ulcers.

Tube Feed administration.

4. Unit Managers will monitor/audit

residents with tube feedings 3 X

PRINTED: 12/18/2017

	TMENT OF HEALTH	AND H N SERVICES				FORM	12/18/2017 APPROVED 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495246	B. WING			i	C 08/2017
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	IONT 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	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 693	This REQUIREMENT by: Based on observat document review ar was determined, the administer a tube fe physician for one of sample, Resident #5 The facility staff left running during a phy of 10:00 a.m. until 2 The findings include Resident #56 was a with diagnoses that to; dementia, a gast feeding directly into vascular disease (po high blood pressure swallowing, anemia irregular heartbeat, a Resident #56's most set), a quarterly asse (assessment referer coded Resident #56 the questions on the mental status) and the	ion, staff interview, facility and clinical record review, it is facility staff failed to reding as ordered by the 29 residents in the survey 56. Resident #56's tube feeding ysician prescribed downtime :00 p.m.	F6	693	week for 6 weeks, and ran thereafter, to ensure that o followed accordingly. Ret these audits will be brough the QAPI Committee mon review.	rders ar sults of nt befor	e

of daily living.

Resident #56;

decisions regarding task of daily life. Resident #56 was coded as being dependent with activities

12/5/17 8:55 a.m. - Resident #56 lying on back in the bed with tube feeding infusing at 60 ml / hour.

The following observations were made of

DEPART	MENT OF HEALTH	AND HOWAN SERVICES & MEDICAID SERVICES				FOR	M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495246	B. WING		,	1	2/08/2017
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	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 693	Head of bed at app elevation. 12/06/17 09:31 a.m tube feeding infusir bed elevated at app 12/06/17 11:36 a.m tube feeding runnin 12/06/17 12:28 p.m run at 60 ml / hour. A review of Resider revealed, in part, the physician order 2017; "6/11/17 Jevivia gast-tube (gastr hour) 20 hrs/day (h down at 10 am. Fluevery 4 hours." Further review of Revery 4 hours." A review of Resider physician on 11/20/60 ml / hour 20 houpm. Total volume of nut hours." A review of Resider plan dated 1/3/17 redocumentation; "For feeding tube to med (pressure ulcer). Decreated on: 12/24/Aspiration precautic Check patency and before administering tube to medical plan dated on: 12/24/Aspiration precautic Check patency and before administering tube to medical plan dated on: 12/24/Aspiration precautic Check patency and before administering tube to medical plan dated on: 12/24/Aspiration precautic Check patency and before administering tube to medical plan dated on: 12/24/Aspiration precautic Check patency and before administering tube to medical plan dated on: 12/24/Aspiration precautic Check patency and before administering tube to medical plan dated on: 12/24/Aspiration precautic Check patency and before administering tube to medical plan dated on: 12/24/Aspiration precautic Check patency and tube tube tube tube tube tube tube tube	roximately 30-degree 1 Resident # 56 lying in bed, and at 60 ml / hour. Head of proximately 30 degrees 1. Resident # 56 lying in bed, and at 60 ml / hour 1 tube feeding continues to the following physician order on summary dated December ty (a brand of tube feeding) 1.5 ric tube) at 50 ml/hr (milliliters / ours per day) - up at 2pm and ush tube with 200 ml of water desident # 56's clinical record armacy, signed by nurse and 17; "Tube feeding Jevity 1.5, ars / day, downtime 10 am - 2 of flush 1200 ml /24 hours; rient + flush - 2400 ml /24 Int # 56's comprehensive care evealed, in part, the following pocus: Resident has an enteral ent nutritional needs, sacral PU pated initiated 8/15/2017 (2012. Interventions: ons, Date Initiated: 7/19/2017. I placement of tube daily and ag feedings and meds	F	693			
	hours " A review of Resider plan dated 1/3/17 redocumentation; "For feeding tube to mer (pressure ulcer). Description of the control of the	ont # 56's comprehensive care evealed, in part, the following ocus: Resident has an enteral et nutritional needs, sacral PU pated initiated 8/15/2017 (2012. Interventions: ons, Date Initiated: 7/19/2017.					

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DEPARTMENT OF HEALTH AND HUNN 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:	, ,		COM	E SURVEY IPLETED C
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PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE EDEDICKSRURG VA 22405		
				.,	1
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOUL	BE	(X5) COMPLETION DATE
doctor) orders. Headegrees during feed On 12/06/17 at 01:0 conducted with LPN #12, the floor nurse #12 was asked to efeeding. LPN #12 on Jevity 1.5 at 60 and she vomits ease every 24 hours on rasked what the sch tube feeding. LPN # #56) has her tube feeding. LPN # #56) has her tube feeding the tube feeding the tube feeding the tube feeding was responsible to the nurse was responsible to the nurse was responsible to the feeding was running the tube feeding was running whether or not the tube feeding was running whether or not the tube feeding) at this time (Resident #56) was morning and so I die for 25 minutes may #56) medications. I tube feeding) at aborunning since that time the running since that time the feeding was asked ordered a 4-hour break as ordered a 4-hour break as ordered a 4-hour break was asked ordered was asked	ad of bed elevated 30-45 ding." 199 p.m. an interview was N (licensed practical nurse) of caring for Resident #56. LPN explain Resident #56's tube stated, "She (Resident #56) is ml/ hr (she has a lot of reflux sily), we change out the syringe night shift." LPN #12 was redule was for Resident #56's #12 stated, "She (Resident reding off for a four-hour ray, from 10 am to 2 pm." LPN to was responsible for ube feeding. LPN #12 stated resident #56's tube feeding. LPN #12 further rect her (Resident #56's tube g. LPN #12 entered Resident rerved Resident #56's tube g. LPN #12 was asked ube feeding was supposed to me. LPN #12 stated, "She vomiting at 7:30 a.m. this seconnected the tube feeding be. I then gave her (Resident hooked her back up (to the rout 8am and it has been me." LPN #12 was asked dent #56 had received the 4 red. LPN #12 stated that of received a four-hour break. If why Resident #56 was reak, LPN #56 stated, "I don't that's all I know. I would	F 69	3		
					WALL THE PARTY OF
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa doctor) orders. Her degrees during feed On 12/06/17 at 01:0 conducted with LPN #12, the floor nurse #12 was asked to e feeding. LPN #12:0 on Jevity 1.5 at 60:0 and she vomits ease every 24 hours on r asked what the sch tube feeding. LPN # #56) has her tube fo period during the da #12 was asked who disconnecting the to the nurse was respi stated, "We disconn (the tube feeding) at time this writer and #56's room and obs feeding was running whether or not the to be running at this tin (Resident #56) was morning and so I di for 25 minutes may #56) medications. I tube feeding) at abor unning since that ti whether or not Resi hour break as order Resident #56 had n LPN #12 was asked ordered a 4-hour br know. It is ordered, assume it is because	OF CORRECTION IDENTIFICATION NUMBER: 495246 PROVIDER OR SUPPLIER ONT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	A BUILDIN B. WING	DENTIFICATION NUMBER: A BUILDING B. WING	### A BUILDING ### A

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 258 of 348

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DEPART	MENT OF HEALTH	AND HUMÁN SERVICES & MEDICAID SERVICES		Marsin Marson	O!		PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ` ´	IPLE CONSTRUCTION IG		(X3) DATE	SURVEY LETED
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F 693	Continued From pa		F 69	03		W Annonimo A WHENDER AND THE THE POP A	
	conducted with LPN was asked to describe resident receiving to what to do in regard LPN #3 stated, "We would tell us when when to take down The order would also administration, and Sometimes it (the coven the amount to "We follow the instruction of day meet at 4:45 p.m. with AS	24 a.m. an interview was N #3, a floor nurse. LPN #3 ribe the process followed for a ube feeding and how he knew ds to tube feed administration. It would have an order that to put it (tube feeding) up and or if it is to be continuous. It is to be continuous or include the rate per hour for the type of tube feed. If the calories or be delivered. If LPN #3 stated, ructions provided in the order. It is was conducted on 12/7/17 SM #1, the executive director.					
	#3, the clinical qual #2 and ASM #3 we	n director of nursing, and ASM ity specialist. ASM #1, ASM re made aware of the above policy for tube feedings was me.					
	by Pump" revealed documentation; "7. feeding. If nausea, 17.1 Stop feeding; according to ordere Bolus schedule, into	lity policy titled, "Administration, in part, the following Monitor patient tolerance to vomiting, or diarrhea occur: 9. Disconnect feeding ed schedule (e.g. (example) ermittent schedule, cyclic e for continuous schedule.)"					
F 695 SS=E	the survey process. Respiratory/Trache	ion provided prior to the end of ostomy Care and Suctioning	F 69	95		er Ferentes (A Visite et promote della trocket i sella teste e	
	§ 483.25(i) Respira	tory care, including	TO THE THE PARTITION AND THE P			de contrado de este contrado como contrado de este contra	

DEPARTMENT OF HEALTH AND HOWAN SERVICES

PRINTED: 12/18/2017

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

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NOMBELS	A. BUILL	MNG _		0	;
		495246	B. WING			12/0	8/2017
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405		
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F 695	tracheostomy care The facility must er needs respiratory of care and tracheal s care, consistent wi practice, the comp care plan, the resident and 483.65 of this This REQUIREME by: Based on observat document review, was determined th appropriate respirate residents in the sui #36, #286, #184, # 1. The facility staff order was in place oxygen for Resident 2. The facility staff 36's oxygen accord 3. The facility staff 286's oxygen accord 4. a. The facility staff 286's oxygen accord 4. b. The facility staff per the physician p #184.	and tracheal suctioning. Insure that a resident who care, including tracheostomy suctioning, is provided such th professional standards of rehensive person-centered dents' goals and preferences, subpart. NT is not met as evidenced ution, staff interview, facility and clinical record review, it e facility staff failed to provide atory care services for six of 26 rvey sample; Residents #234, 9, and #43. If failed to ensure a physician's prior to the administration of		695	from the facility. Resider has an oxygen order in pla Resident #36 is receiving per order, Resident #286 ilonger in the facility. Resident #36 is respiratory equipment in a clean and sanitary material Resident #43 is receiving per order at the correct flow These corrections were material to be affected. As was completed by the United Managers of all current resutilizing oxygen to ensure orders were in place, 2) can in place 3) orders being from the correctly and correct flow administered, and 4) approximates. 3. Education was provided the staff by the Nurse Practice Educator on Oxygen Administration to include setting flow rate, and oxygen equipment storage. 4. Unit Managers to monitor	at # 234 ace. oxygen is no ident #9 stored inner. oxygen ow rate. ade by gen have n audit it esidents that 1) are plans ollowed rate opriate o nursing e orders, gen	
	manner for Reside	ent #184 o, facility staff failed to maintain			residents receiving oxyge week for 6 weeks and ran		
	D. FUI NESIGETIL #3	, radinty diam randa to mannam.	.ii				/

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

Facility ID: VA0279

DEPARTMENT OF HEALTH AND HOLLAN SERVICES CENTERS FOR MEDICARE & MEDICAID 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			
		495246	B. WING_		12	C / 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 DEFICIENC	IMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE			
F 695	oxygen equipment 6. The facility staff the physician's pre per minute for Res The Findings includ 1. The facility staff order was in place oxygen for Resident Resident #234 was 12/4/17 with the dia MRSA (methicillin- aureus) [1] in a wor Pulmonary Disease opiate addiction, chaortic valve endocaset) assessment have review of the admis dated 12/4/17 docu cognitively intact. as being able to paliving. The resident having a PICC (per catheter) [2] line ar On 12/08/17 at 09: observed with oxyg per minute) via nas A review of the admidated 12/4/17 docu on oxygen 2 liters/re	failed to administer oxygen at scribed flow rate of two liters ident # 43. de: failed to ensure a physician's prior to the administration of nt #234. s admitted to the facility on agnoses of but not limited to: resistant Staphylococcus und, Chronic Obstructive e, chronic back pain, scoliosis, nronic pain syndrome, and arditis. A MDS (minimum data and not yet been completed. A ssion nursing assessment amented the resident as being The resident was documented rticipate in activities of daily t was also documented as ripherally inserted central and requiring oxygen therapy. 12 a.m., Resident # 234 was gen on at 1.75 liters/min (liters all cannula. hission nursing assessment mented Resident # 234 was gen on at 1.75 liters/min (liters all cannula.	F 69	thereafter to ensure that followed accordingly of flow rates and that respectively equipment is stored approached the Results of these audits brought before the Quantum Assurance and Perform Improvement Committee for review.	with correct piratory propriately. will be ality nance	1/17/18			

	TMENT OF HEALTH	AND H N SERVICES				FORM): 12/18/2017 1 APPROVED): 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/08/2017				
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NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE					
WOODMONT 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE			
F 695	On 12/08/17 at 09:4 #2 (Registered Nurs required for the adn stated the nurses si was not an order in they went in the roo and it wasn't on the Administration Reco A review of the facili Via Nasal Cannula" therapy via nasal ca ordered by a physic physician's order" On 12/8/17 at 10:14 Staff Member - the id and ASM #3 (the co Specialist) were main on 12/8/17 at 10:50 Executive), was main No further information the survey. [1] MRSA stands for Staphylococcus auro infection that is resis antibiotics. There ar Hospital-associated health care settings.	No a.m. in an interview with RN se), she stated an order is ninistration of oxygen. RN #2 hould have recognized there place for the oxygen when m and saw him on oxygen, MAR (Medication ord). Ity policy, "Oxygen Therapy documented, "Oxygen innula will be administered as ianProcedure: 1. Verify a.m., ASM #2 (Administrative interim director of nursing) rporate Clinical Quality de aware of the findings; and	F 6	95						

*Practice good hygiene

MRSA

skin-to-skin contact with others, such as athletes

*Keep cuts and scrapes clean and covered with a

Infection control is key to stopping MRSA in hospitals. To prevent community-associated

involved in football and wrestling.

DEPARTMENT OF HEALTH AND HE...AN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: 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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 695 F 695 Continued From page 262 bandage until healed *Avoid contact with other people's wounds or bandages *Avoid sharing personal items, such as towels, washcloths, razors, or clothes *Wash soiled sheets, towels, and clothes in hot water with bleach and dry in a hot dryer If a wound appears to be infected, see a health care provider. Treatments may include draining the infection and antibiotics. Information obtained from https://medlineplus.gov/mrsa.html [2] PICC stands for peripherally inserted central catheter. Along catheter that extends from an arm or leg vein into the largest vein (superior vena cava or inferior vena cava) near the heart and typically provides central IV access for several weeks. Unlike a standard intravenous catheter (IV) which is for short term use, a PICC is more durable and does not easily become blocked or infected. It may remain in place for several months so that blood can be repeatedly drawn or medication and nutrients can be routinely injected into the patient's bloodstream. Information obtained from https://www.radiologyinfo.org/en/info.cfm?pg=vas c access 2. The facility staff failed to administer Resident # 36's oxygen according to the physician's orders. Resident # 36 was readmitted to the facility on 10/18/17 with diagnoses that included but were not limited to: pneumonia, heart failure, diabetes mellitus (1), altered mental status, high blood

pressure and Parkinson's disease (2).

Resident # 36's most recent MDS (minimum data set), an admission assessment with an ARD

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HE...AN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С 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 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 695 F 695 Continued From page 263 (assessment reference date) of 10/18/17, coded Resident # 36 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 being moderately impaired of cognition for making daily decisions. Resident # 36 was coded as requiring extensive assistance of one staff member for activities of daily living and supervision of one staff member for eating. On 12/04/17 at approximately 11:55 a.m. Resident # 36 was observed in bed receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the oxygen concentrator flow meter documented the flow rate at between one and a half liters per minute. On 12/05/17 at approximately 8:53 a.m. Resident # 36 was observed in bed eating breakfast. Resident # 36 was receiving oxygen by nasal cannula from an oxygen concentrator. Observation of the oxygen concentrator flow meter documented the flow rate at between one and one and a half liters per minute. On 12/05/17 at approximately 4:00 p.m. Resident #36 was observed in in bed, awake. Resident # 36 was receiving oxygen by nasal cannula from the oxygen concentrator. Observation of the oxygen concentrator revealed the oxygen flow rate between one and one and a half liters per

On 12/06/17 at approximately 9:05 a.m. Resident # 36 was observed in bed watching television. Resident # 36 was receiving oxygen by nasal

cannula from an oxygen concentrator.

Observation of the oxygen concentrator flow meter documented the flow rate at one and a half

minute.

		AND HE AN SERVICES			Mary now of	FORM): 12/18/2017 (I APPROVED): 0938-0391
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 264	Fe	95			abookultuuriddhaa o o'dwolekuu
	# 36 documented, "liters per minute) via liters per minute) via The MAR (medicatidated "Dec" (Decendocumented, "O2 a review of the MAR is receiving oxygen at 12/01/17 through 12 7:00 a.m. shift, the and on the 3:00 p.m. The comprehensive dated 10/23/17 doc (oxygen) as ordered Created on: 10/23/10 On 12/06/17 at appinterview was condupractical nurse) # 4 rate for Resident # the oxygen flow rate LPN # 4 stated, "The should pass through indicate the liters per her position to the creading the flow rate and get level with the When asked how or rate is checked, LP time I go into the redocumented on the administration reconwhat the oxygen flow	roximately 2:10 p.m. an ucted with LPN (licensed regarding the oxygen flow 36. When asked how to read e on an oxygen concentrator, he liter line on the flow meter in the middle of the float ball to be minute." When asked about oxygen concentrator when e, LPN # 4 stated, "I get down he flow meter to read it." Iften the resident's oxygen flow N # 4 stated, "I check it every sident's room and it's MAR (medication rd) each shift. When asked we rate for Resident # 36's					
	what the oxygen flor oxygen should be, I	w rate for Resident # 36's PN # 4 referred to the Resident # 36 and stated, "It					

should be two liters per minute." LPN # 4 was

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HE AN 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 COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING _ 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 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 695 | Continued From page 265 F 695 then asked to accompany this surveyor to Resident # 36's room. Upon entering the room LPN # 4 was then asked to read the oxygen flow rate on the oxygen concentrator for Resident # 36. LPN # 4 stated, "It's set at one and a half liters. It should be at two liters." LPN # 4 immediately adjusted Resident # 36's oxygen flow rate to two liters per minute. On 12/06/17 at approximately 5:00 p.m. ASM (administrative staff member) # 1, executive

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

director, ASM # 2, interim director of nursing and ASM # 3, clinical quality specialist, were made

No further information was obtained prior to exit.

(1) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/

The facility staff failed to administer Resident # 286's oxygen according to the physician's orders.

Resident # 286 was admitted to the facility on 02/15/17 with a readmission date of 11/18/17. Diagnosis include but were not limited to muscle weakness, prostate cancer, secondary cancer to bone, type 1(one) diabetes mellitus (1) and

(2) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdi

aware of the findings.

References:

001214.htm.

sease.html.

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 266 of 348

DEPARTMENT OF HEALTH AND HUMAN 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 _ С 12/08/2017 B. WING 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 DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 695 Continued From page 266 F 695 kidney disease. 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 requiring extensive assistance to being totally dependent of one staff member for activities of daily living and supervision of one staff member for eating. On 12/04/17 at approximately 11:55 a.m. Resident # 286 was observed in bed receiving oxygen by nasal cannula (2) from an oxygen concentrator. On 12/04/17 at approximately 3:25 p.m. an observation revealed Resident # 286 was in bed receiving oxygen by nasal cannula from an oxygen concentrator. Further observation of the flow meter on the oxygen concentrator revealed the flow rate was at one and a half liters per minute. On 12/05/17 at approximately 9:40 a.m. an observation revealed Resident # 286 was in bed receiving oxygen by nasal cannula from an oxygen concentrator. Further observation of the flow meter on the oxygen concentrator revealed the oxygen flow rate was set at between one and

a half and two liters per minute.

On 12/05/17 at approximately 4:05 p.m. an observation revealed Resident # 286 was in bed receiving oxygen by nasal cannula from an oxygen concentrator. Further observation of the

		AND HOWAN SERVICES			Marine and or a state of the st	FORM	APPROVED . 0938-0391
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F 695	flow meter on the of the oxygen flow rate liters per minute." On 12/05/17 at approbservation revealed bed receiving oxygen concentrated flow meter on the oxygen flow rate liters per minute." On 12/06/17 at approbservation revealed bed eating breakfast oxygen via nasal cast concentrator. Furth meter on the oxygen oxygen flow rate was half and two liters per minute. The physician's Teledocumented, "Oxygen flow rate was half and two liters per minute." The physician's Teledocumented, "Oxygen flow rate was half and two liters per minute." The physician's Teledocumented, "Oxygen flow flow of the resided dated 11/29/17 failed address oxygen. The MAR (medication flow flow flow flow flow flow flow flow	e was set at one and a half roximately 10:53 a.m. an	F6	595			

with LPN (licensed practical nurse) # 4 regarding

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	PLE CONSTRUCTION IG		MPLETED C
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	PROVIDER OR SUPPLIER ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP COL 11 DAIRY LANE FREDERICKSBURG, VA 22405	E	
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F 695	the oxygen flow rate asked how to read oxygen concentrate line on the flow met middle of the float it minute." When asked oxygen concentrate LPN #4 stated, "I ge flow meter to read it resident's oxygen flow meter to read it resident's room and (medication administ When asked what the Resident # 286 's or referred to the phys 286 and stated, "It is minute." Resident was out with his fan with LPN #4 and Impoxygen concentrate conducted. When I above previous obsoxygen flow rate, LF been set at two liter. On 12/06/17 at appropriate to the finding No further information. References: (1) A chronic disease regulate the amount information was obtined.	e for Resident # 286. When the oxygen flow rate on an or, LPN # 4 stated, "The liter er should pass through the wall to indicate the liters per ed about her position to the or when reading the flow rate, et down and get level with the structure is checked, LPN # 4 very time I go into the I it's documented on the MAR stration record) each shift, he oxygen flow rate for exygen should be, LPN # 4 ician's order for Resident # should be two liters per # 286 was not in his room and mily at the time of the interview mediate observation of the ervations of Resident # 286's PN # 4 was informed of the ervations of Resident # 286's PN # 4 stated, "It should have sometime in the per minute." Toximately 5:00 p.m. ASM in member) # 1, executive interim director of nursing and ality specialist, were made				

DEPARTMENT OF HEALTH AND HOMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 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 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG DEFICIENCY) F 695 Continued From page 269 F 695 001214.htm. 4. a. The facility staff failed to obtain a physician order for the use of oxygen for Resident #184. Resident #184 was admitted to the facility on 11/30/17 with diagnoses that included, but were not limited to: fracture of the left humerus, chronic obstructive pulmonary disease (general term for chronic nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)), atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria (2)), pulmonary fibrosis (pulmonary fibrosis is a condition in which the tissue deep in your lungs becomes scarred over time. This tissue gets thick and stiff. That makes it hard for you to catch your breath, and your blood may not get enough oxygen (3)), diabetes and high blood pressure. There was no completed MDS (minimum data set) assessment as of the dates of the survey. The Initial Nursing Assessment, dated 11/30/17, documented Resident #184 was alert and oriented to person, place and time. The form documented under "Respiration - regular Method: oxygen via nasal." The review of the care plan failed to evidence any documentation related to the use of oxygen for

Resident #184.

Observations were made of Resident #184's room on 12/04/17 at 11:45 a.m. There was an oxygen concentrator in the room with the nasal cannula tubing lying on the bed, not covered. The

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

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		E SURVEY PLETED
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F 695	resident was not in A review of the cliniphysician's order for On 12/04/17 at 4:30 observed asleep in nasal cannula at 4 On 12/05/17 at 8:44 sitting on side of be (oxygen) at 4L/min On 12/06/17 at 10:17 reviewed and a new 12/6/17 documented (liters) via nasal can the nurse's notes of documented in part at 4L/min with good. The nurse's note of documented in part at N/C (nasal can that go into the nos	the room at this time. cal record failed to evidence a proxygen. D. p.m., Resident # 184 was his bed, with oxygen on via L/Min (liter/minute). 4 a.m., Resident # 184 was ad eating breakfast with O2 running via nasal cannula. 55 a.m. the clinical record was by physician order dated, ad, "O2 (oxygen) @ (at) 2 Lennula." dated 12/2/17 at 10:30 p.m. at, "Resident continues on O2 if effect." ated, 12/3/17 at 2:30 p.m. at, "Pt (patient) on 2L (liters) O2 nula - a tube with two prongs trils)."	F	895			
	practical nurse) #4 asked if a physicia LPN #4 stated "Yes the nurse documer oxygen flow rate, L on the MAR (medic Resident # 184's M and she stated, "I ji on oxygen and I ch	on 12/6/17 at 2:06 p.m. When n order is required for oxygen, Ma'am." When asked where its checking a residents PN #4 stated it is documented atton administration record). AR was reviewed with LPN #4 list noticed it today that he was ecked the orders and there tygen." When asked if she has					

PRINTED: 12/18/2017 **AN SERVICES** DEPARTMENT OF HEALTH AND HILL 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 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 ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 695 F 695 Continued From page 271 taken care of him since last Thursday, LPN # 4 stated, "Yes, I took care of him Monday." When asked if she noticed this on Monday, LPN #4 stated, "Honestly, I couldn't remember if he had it Monday." LPN #4 stated, "I went in this morning and he was set at 4L/min so I went to check the chart and found no order." An interview was conducted with LPN #3 on 12/6/17 at 2:34 p.m. When asked if a physician's order is required for the use of oxygen, LPN #3 stated, "Yes, absolutely." The facility policy, "Oxygen Therapy via Nasal Cannula" documented in part, "Oxygen therapy via nasal cannula will be administered as ordered by a physician and will include correct flow rate, mode of delivery and frequency...Procedure: Verify physician's order." According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of

Administrative staff member (ASM) #1, the executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m.

medication administration also pertain to oxygen

No further information was obtained prior to exit.

administration."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 695	Continued From pa	age 272	The second of th	695				
	4.b. The facility star per the physician p #184.	ff failed to administer oxygen rescribed rate for Resident	MANAGAR AND THE STATE OF THE ST					
	reviewed and a nev	55 a.m. the clinical record was w physician order dated, ed, "O2 (oxygen) @ (at) 2 L nnula."	e management communication and the communica					
	observed in bed, re cannula connected concentrator flow r. The ball of the flow top of the ball on the the ball was on the #184 stated when wheelchair, they put just resting in bed.	22 p.m., Resident # 184 eciving oxygen by nasal I to a concentrator. The ate was set at 1.5 - 2 l/min. I meter was observed with the ne line for 2 and the bottom of Iline for 1.5 l/min. Resident the goes to therapy in the ut it up to 4 l/min. Since he's it should be 2 liters/min but tates he puts it up to 4l/min walking around.						
	observed in bed, Coxygen concentrate ball of the flow met L/min. The top of the control of the c	1 p.m., Resident # 184 was 02 on via nasal cannula. The or flow rate was set with the ter set between 1.5 and 2 the ball was observed on the ottom of the ball was on the					The state of the s	
	Resident # 184's c failed to evidence coxygen.	are plan was reviewed and documentation for the use of	HARAFARANAN MANAGAN MA				odza a ipopujeją "— adada mokumominiama	
	12/6/17 at 2:06 p.n	conducted with LPN #4 on n. When asked how to read an .PN #4 stated you check the and the ball. You put the ball	·					

		I AND HOAN SERVICES					FORM	12/18/2017 APPROVED
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F 695	with the line passing ball. When asked h is checked by the n checks it each time time LPN #4 accom Resident #184's roc concentrator. LPN oxygen concentrator	ig through the middle of the now often the oxygen flow rate nurse, LPN #4 stated she is she enters the room. At this inpanied this surveyor into om to read his oxygen #4 looked at Resident #184's or flow meter and stated, "It title bit more, the line isn't	F 6	395				
	manual documenter read the flow meter rate line on the flow	ntrator manufacturer's user ed, under "NOTE: To properly r, locate the prescribed flow w meter. Next, turn the flow ises to the line. Now, center n. line prescribed"		лент положения п				
	executive director, A	member (ASM) #1, the ASM #2, the interim director of #3, were made aware of the 12/7/17 at 4:45 p.m.		чессина в применения в примене				
A STATE OF THE STA	No further informati	ion was obtained prior to exit.			TO COCCOUNT AND		AND THE PROPERTY OF THE PROPER	Accommentation of the control of the
The second secon	4. c. The facility stated equipment and nebumanner for Residen	ff failed to store oxygen ulizer equipment in a sanitary nt #184.		May and registrate to the control of				
the Text of the second	was observed. The observed lying on th	45 a.m., Resident #184's room Oxygen (O2) tubing was he bed. A nebulizer mask was as sitting on nightstand.		manur an manur de l'este communication de la desta de la desta de la delaction			torona e emperatura de construir de construi	·
n november of the second secon	On 12/04/17 at 02:2 Nebulizer mask was uncovered.	21 p.m., Resident # 184's s observed on the night stand,					— h.br. даў флёр: — прикадання пра	

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F 695	tubing, not covered, hanging and touchii On 12/04/17 at 3:07	3 p.m., an oxygen tank with O2 , had the nasal cannula just	F	i 195			
	On 12/04/17 at 4:30) p.m., Resident # 184 was ith oxygen on via nasal					
	sitting on side of be 4L/min running via r on top of night stand	l a.m., Resident #184 was d eating breakfast. O2 at nasal cannula. Nebulizer mask d, uncovered. O2 tubing on wheelchair uncovered, uching floor.					
:	was observed. The the night stand unco	55 a.m. Resident #184's room nebulizer was on the top of overed. The oxygen tubing ed around the concentrator,				·	
	A New order was no (at) 2L(liters)/NC (no saturation every shi	oted for 12/6/17 for Oxygen @ asal cannula) with O2 ft.					
	was observed. The	a.m., Resident #184's room nebulizer machine mask and on the bed, uncovered.					
	practical nurse) #4 (asked where oxyger	onducted with LPN (licensed on 12/6/17 at 2:06 p.m. When on tubing is stored when it's not ed that all respiratory					

equipment should be bagged when not in use." When asked why it should be bagged, LPN #4

DEPAR	TMENT OF HEALTH	AND HE AN SERVICES				: 12/18/2017 APPROVED
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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY APLETED
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WOODM	IONT CENTER			FREDERICKSBURG, VA 22405		
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F 695		age 275 on control purposes."	F 695	5	·	
	Disinfection/Cleanir	Respiratory Equipment ng" did not address storing the ent in bags when not in use.				
	Patricia A. Potter ar Inc; Page 648. "Bo Health Care-Associ	of Nursing" 7th edition, 2009: nd Anne Griffin Perry: Mosby, ox 34-2 Sites for and Causes of iated Infections under - Contaminated respiratory				
ngi veningi pranta anazara ana	executive director, A	member (ASM) #1, the ASM #2, the interim director of #3, were made aware of the 12/7/17 at 4:45 p.m.				
A-Allia edde y manny a day o y o y o y o y o y	5. For Resident #9, store oxygen equipr	ion was obtained prior to exit. facility staff failed to properly ment in a plastic bag and rom touching the floor.				
	9/14/16 and readmit that included but we cancer, muscle wea right buttock, type to hypothyroidism. Re (minimum data set) assessment with an date) of 11/09/17. Fe being moderately im	dmitted to the facility on litted on 8/11/17 with diagnoses ere not limited to: pancreatic akness, pressure ulcer to the wo diabetes, and esident #9's most recent MDS assessment was a quarterly a ARD (assessment reference Resident #9 was coded as a paired in cognitive function to on the BIMS (brief interview				,

for mental status) exam. Resident #9 was coded as requiring extensive assistance from two or more staff members with transfers, bed mobility, and toileting, and extensive assistance from one staff member with dressing and personal hygiene.

DEPARTMENT OF HEALTH AND HOWAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION ADDITION OF CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X8) MULTIPLE CONSTRUCTION (X9) MULTIPLE CONSTRUCTION (X1) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIP

	COTOR MEDIO, and		[T101	T AANOTO JOTION	(V2) DAT	E CHOVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY IPLETED
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		495246	B. WING			12/	08/2017
	PROVIDER OR SUPPLIER ONT CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	made of Resident # including the nasal on top of the conce was not placed in a could not be found On 12/05/17 at 08: made of Resident # including the nasal on top of the conce was not placed in a could not be found On 12/06/17 07:58 made of Resident # observed on the flor found in her room. Review of Resident # observed on the flor found in her room. Review of Resident # observed on the flor found in her room. On 12/06/17, "Oxygen to 10/22/17, "Oxygen to 10/22/1	21 p.m., an observation was 49. Her oxygen tubing cannula was uncovered sitting ntrator. Her oxygen tubing plastic bag. A plastic bag in her room. 11 a.m., an observation was 49. Her oxygen tubing cannula was uncovered sitting ntrator. Her oxygen tubing plastic bag. A plastic bag in her room. a.m. an observation was 49. Her oxygen tubing was or. A plastic bag could not #9's physician telephone following order initiated on via nasal cannula titrate up to oxygen sats (saturations) at or 12 a.m., an interview was 14 (licensed practical nurse) #8. xygen should be stored when stated, "Oxygen is wrapped in 19 is changed out on Saturdays.	F	695			
	date and label it with room number." LPt should be stored in infections. On 12/06/17 at 3:10	They change the bag as well, in the resident's name and N #8 stated that oxygen tubing a plastic bag to prevent p.m., an interview was			·		
	conducted with LPN	#2 Resident #9's nurse				•	

		AND HOAN SERVICES			FORM): 12/18/2017 MAPPROVED
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	(X3) DA). 0938-0391 TE SURVEY MPLETED
		495246	B. WING)	12	C 2 /08/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	IONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 277	F 69	5		
	when not in use, LP tubing should be sto (resident) name on the date when chan changed every Satuoxygen tubing shou LPN #2 stated, "Shopurposes." This wright Resident # 9's room observed about Resident # 20 stated the o	exygen tubing should be stored PN #2 stated, "02 (oxygen) ored in a plastic bag with their it, liters of 02 (oxygen), and iged. Tubing should be urday." When asked why lid be stored in a plastic bag, ould be stored for sanitary iter accompanied LPN #2 to in. When asked what LPN #2 sident #9's oxygen tubing, oxygen tubing was on the floor. she could not find a plastic				
	made of Resident # of oxygen via nasal not in Resident #9's	6 p.m., an observation was 9. Resident #9 was on 2 liters cannula. A plastic bag was room. A date of when the d could not be found on the				
	staff member) #1, the interim DON (Di	p.m., ASM (administrative ne executive director, ASM #2, rector of Nursing) and ASM ty specialist were made aware rns.				
TO A COMMISSION OF THE PARTY OF		"Respiratory Equipment g," did not address the above			÷	

No further information was presented prior to exit. 6. The facility staff failed to administer oxygen at the physician's prescribed flow rate of two liters per minute for Resident # 43.

Resident # 43 was admitted to the facility on 7/8/17 and readmitted on 9/19/17 with diagnoses

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

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE	SURVEY PLETED
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		(
		495246	B. WING			12/0	08/2017
	PROVIDER OR SUPPLIER ONT CENTER			11	TREET ADDRESS, CITY, STATE, ZIP CODE I DAIRY LANE REDERICKSBURG, VA 22405		
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F 695	that included but we congestive heart fa hyperlipidemia, and Resident # 43's moset) assessment, a an ARD (assessment) as able to under was coded as being daily decisions, so (brief interview for a Review of a physician most recently signed documented, "OXY CANNULA CONTIL December 2017 Mathematical December 2017 Mathematical Plantage 120/17.	ere not limited to: anemia, ilure, hypertension, diabetes, ciety, and depression. est recent MDS (minimum data Quarterly Assessment, with ent reference date) of 10/15/17 as understood by others erstand others. Resident # 43 g cognitively intact for making aring 15 out of 15 on the BIMS	F	695			•
	of the following: Un or is at risk for resp to history of CHF (of (pneumonia) and s Initiated 09/28/17"	der "Focus: Resident exhibits irratory complications related congestive heart failure), PNA easonal allergies. Date Under "InterventionsO2 as annula. Date Initiated	THE				
	The following obse Resident # 43's oxy	rvations were made of /gen:	NAMES OF THE PROPERTY OF THE P				Kooney and the control of the contro
	was observed set a - 12/04/17 05:48 p was observed set a	.m. Resident # 43's oxygen at 1.5 liters/minute .m. Resident # 43's oxygen	AND AND THE PROPERTY OF THE PR				

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND H(**N SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED 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 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 695 Continued From page 279 F 695 - 12/06/17 07:10 a.m. Resident # 43's oxygen observed set at set at 1.5 liters/minute 12/06/17 09:12 a.m. Resident # 43's oxygen was observed set at 1.5 liters/minute During an interview on 12/6/17 at 2:07 p.m. with LPN (licensed practical nurse) # 2, LPN # 2 was asked to view the oxygen setting on Resident # 43's concentrator flow meter. LPN # 2 stated the flow meter was set at 1.5 liters/minute (the center of the ball in the flow meter was centered on the 1.5 L/min. line). LPN # 2 was asked to view the physician order and confirmed the physician ordered the oxygen be set to 2 liters/minute. LPN # 2 then presented the MAR and when the MAR

was reviewed there was documentation that Resident # 43's oxygen was to be set to 1 liter per minute. Documentation on the December 2017 MAR is as follows: "O2 @ 1L/min via nasal cannula Continuous" dated 9/20/17. LPN # 2 had no explanation for the discrepancy between the physician order and the MAR. LPN # 2 was asked who the Unit Manager was and stated that

During an interview on 12/6/17 at 2:18 p.m. with ASM (Administrative Staff Member) # 1, the Executive Director, ASM # 2, the Interim Director of Nurses, and ASM # 3, the Clinical Quality Specialist, this observation was revealed. A request was made for the policies related to oxygen administration, following physician orders, and manufacturer's information for the oxygen concentrator on the setting of the flow meter.

During the end of day interview on 12/6/17 at 5:20 p.m. this concern was again shared with ASM # 1, ASM # 2, and ASM # 3 and a requested the facility policy on following physician orders.

there was no unit manager.

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

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION			E SURVEY IPLETED
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	PROVIDER OR SUPPLIER ONT CENTER			STREET ADDRESS, CITY 11 DAIRY LANE FREDERICKSBURG			
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F 695	During an interview ASM # 3, the corpo facility policy for foll discussed. ASM # policy specifically for ASM # 3 stated, "The practice are the corporation of company has a tear own standard." The facility policy, "Cannula" document via nasal cannula where the corporation of delivery and verify physician and word of delivery and verify physician's or the oxygen concentrate line on the flow meter rate line on the flow knob until the ball rithe ball on the L/mir No further information. No further information of the delition, put the delition of the delit	on 12/7/17 at 10:05 a.m. with rate clinical specialist, the owing physician orders was 3 stated she could find no or following physician orders. The facility's standards of inpany's policies. The methat writes and creates its and creates its. Oxygen Therapy via Nasal led in part, "Oxygen therapy fill be administered as ordered will include correct flow rate, defrequencyProcedure: and the prescribed flow meter. Note: To properly, locate the prescribed flow meter. Next, turn the flow ses to the line. Now, center in line prescribed" on was provided prior to exit. mentals of Nursing, Perry and loage 1122, "Oxygen should be that dangerous side effects, or oxygen toxicity. As with the or concentration of oxygen isly monitored. The nurse lock the physician's orders to its receiving the prescribed.	F	95			

Facility ID: VA0279

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	X2) MULTIPLE CONSTRUCTION 1. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495246	B. WING _			12/	08/2017	
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				11 D	EET ADDRESS, CITY, STATE, ZIP CODE AIRY LANE DERICKSBURG, VA 22405			
(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 698 F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must en require dialysis recewith professional stacomprehensive persthe residents' goals This REQUIREMENT by: Based on observatif document review ar was determined the dialysis care and sein the survey sample. The facility staff faile were in place for Redialysis and for the conditions and for the dialysis are the conditions and renal impurities are remove special machine. The	sure that residents who eive such services, consistent andards of practice, the son-centered care plan, and and preferences. IT is not met as evidenced on, staff interview, facility and clinical record review, it facility staff failed to provide rvices for one of 29 residents e., Resident #39. End to ensure physician orders sident #39 who was receiving eare of his dialysis access. Idmitted to the facility on sis that included but were not of pressure, diabetes, seizure knee amputation, infection of and end stage renal failure sis. In occedure used in toxic failure in which wastes and the diffusion and the provided iffusion and the	F 696		Resident #39 now has a Physician's order that include name of the Dialysis Center. Resident #39 care plan was updated to include Dialysis caneeds. Resident # 39 has a Dialysis Communication boo goes back and forth from facito Dialysis Center. Resident # has current documentation of monitoring on the MAR. The corrections were made by the Managers. The center now had Dialysis Contract in place, initiated by the Administrator All residents on Dialysis have potential to be affected. An at was completed by the Unit Managers of all current reside on Dialysis to ensure that the was an appropriate physician order, care plan, documentation monitoring and Dialysis Communication in place. Dialysis Center Contracts are in place. The Nurse Practice Educator provided education to License Nursing Staff on Dialysis Management to include orders care plans, documentation of	k that lity #39 ese Unit as a the dit ents e s on of		

DEPARTMENT OF HEALTH AND	 	SERVICES
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PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495246	B. WING _		12	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 CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	assessment), a Medwith an assessment coded the resident amake daily decision Treatments, Proced resident was coded resident was coded resident at the facility Review of the physic was no physician or documentation of the contact information, was to go to dialysis pick up documentated documentation of with Resident #39 had in documented regard. The December 2017 administration record (Tuesday), Th (Thur No name of the dialy information. The December 2017 administration record external hemodialys signs of complication documented on the 12/1/17 - 6:00 a.m. to 12/5/17 - 8:00 a.m. to 12/6/17 - 10:00 a.m. There were no physical the nurse's notes frowere reviewed and face and the side of	dicare 60-day assessment, the reference date of 11/28/17, as being cognitively intact to so a being cognitively intact to so and Programs, the as receiving dialysis while a sty. It cian's orders revealed there der for dialysis. There was note dialysis center name, days of the week the resident so and or any transportation ion. In addition, there was note type of dialysis access place and there was nothing ing its care. TAR (treatment d) documented, "Dialysis on Tosday) and Sat (Saturday)." There was nothing is catheter every 2 hours for its catheter	F 69	monitoring on the MARs Dialysis Communication Forms/Books. 4. Unit Managers will audit residents on Dialysis weeks and randomly ther ensure documentation on and Dialysis Communica place. Results of these au be brought before the Quantum Assurance and Performant Improvement Committee for review.	all kly x 6 eafter, to MARs ion is in dits will lity ce	1/17/18	

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 283 of 348

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DEPARTMENT OF HEALTH AND H AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495246	B. WING			12	/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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	10/13/17, failed to e related to the reside An interview was co p.m. with LPN (licen When asked if you r LPN #3 stated, "Yes times a week." Whe dialysis access is do should be document how often a dialysis LPN #3, stated it should be document how often a dialysis LPN #3, stated it should be document how often a dialysis LPN #3, stated it should be document that had been stated that they need dialysis. When asked Resident #39 had for has a catheter in his staff document that haccess is checked, LMAR." The MAR for It did document the complications, but we as observed. Also do "Smooth Clamps at the room was checked was located on the b When asked the care Resident #39's dialys	rehensive care plan dated, vidence any documentation int being on hemodialysis. Inducted with 12/6/17 at 2:25 ised practical nurse) #3. Inducted an order for dialysis, you need to have how many in asked where checking a cumented, LPN #3 stated it's led on the MAR. When asked access check is performed, build be checked every shift. Inducted with LPN #4 on When asked if the facility order for dialysis, LPN #4 or dorders for transportation to divide type of access or dialysis, LPN #4 stated he chest. When asked where Resident #39's dialysis LPN #4 stated, "It's on the Resident #39 was reviewed. Observation of the external are every 2 hours for signs of as not consistently signed off ocumented on the MAR was bedside at all times." The with LPN #4 and the clamp ulletin board next to the bed. In plan should include	F	698			
;	•	nitor for a resident on ed, "Yes, I would think so."				**************************************	

							12/18/2017
DEPART	MENT OF HEALTH	AND H. AN SERVICES					APPROVED 0938-0391
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (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		1		ET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER		1		NRY LANE DERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DESIGIENC)	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)	LD BE	(X5) COMPLETION DATE
F 698	executive director, nursing, and ASM # above concern on on the care for a re requested.	ige 284 member (ASM) #1, the ASM #2, the interim director of #3, were made aware of the 12/7/17 at 4:45 p.m. A policy sident receiving dialysis was ion was obtained prior to exit.	F 698				
	(1) Barron's Diction Non-Medical Reads Chapman; page 26 Posted Nurse Staff CFR(s): 483.35(g)(§483.35(g)(1) Data must post the followbasis: (i) Facility name. (ii) The current data (iii) The total number by the following cat unlicensed nursing resident care per si (A) Registered nursi	eary of Medical Terms for the er, 5th edition, Rothenberg and 6. ing Information 1)-(4) Staffing Information. requirements. The facility ving information on a daily e. er and the actual hours worked regories of licensed and staff directly responsible for hift:	F 732	2.	in place per regulation. Nursing Supervisors and Ut Managers will ensure that to posting is posted according regulations and updated accordingly each shift to reaccurate staffing. Education was provided to nursing leadership team and administrator by the Region	nit he staff to flect the d the	
	vocational nurses ((C) Certified nurse (iv) Resident census §483.35(g)(2) Post (i) The facility must specified in paragradaily basis at the bottom (ii) Data must be post (A) Clear and readates.	as defined under State law). aides. is. ing requirements. post the nurse staffing data aph (g)(1) of this section on a eginning of each shift. osted as follows:		4.	Nurse on the requirements regulation. Director of Nursing or Administrator to monitor 5 per week x 3 weeks then rathereafter to ensure posting place per regulation. Result these audits will be brought	days ndomly is in ts of	

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

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495246	B. WING		1:	C 2/08/2017	
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				STREET ADDRESS, CITY, STATE, Z 11 DAIRY LANE FREDERICKSBURG, VA 224	ZIP CODE	12/06/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	residents and visito §483.35(g)(3) Publi staffing data. The fivitten request, ma available to the public exceed the commul §483.35(g)(4) Facili requirements. The posted daily nurse s 18 months, or as reis greater. This REQUIREMENT by: Based on observat document review, it staff failed to ensure timely. The findings include On 12/07/17 at 3:35 revealed the daily st printed 12/7/17 at 7: not posted before th 7a.m3p.m. shift. A	ic access to posted nurse facility must, upon oral or ake nurse staffing data polic for review at a cost not to unity standard. Ity data retention a facility must maintain the staffing data for a minimum of equired by State law, whichever NT is not met as evidenced tion, staff interview and facility to was determined the facility the the Staff Posting was posted e:	F7	the Quality Assurant Performance Impro-Committee monthly	vement	1/17/18	
not been updated to include shift census information for		o include the 3p.m11p.m. ation for staffing, and in es to the pre-printed staffing 3p.m11p.m. shift had not 4 p.m., an interview was			i.		
74.180/441C-247-001-001-004	Member - the corpor	ited the staffing should be					

	TMENT OF HEALTH					FORM	: 12/18/2017 APPROVED	
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN		ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER		1		ET ADDRESS, CITY, STATE, ZIP CODE			
WOODM	ONT CENTER			-	NRY LANE DERICKSBURG, 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)	LD BE	(X5) COMPLETION DATE	
F 732	Continued From pa	ge 286	F 73	2			The second secon	
	end-of-day meeting	oximately 5:00 p.m. at the , ASM #1 (the Administrator), or of Nursing) and ASM #3 of the findings.		**************************************		, i		
	staff posting was m	4 a.m., a review of the daily ade again. The posting for inted until 8:14 a.m., after the m3p.m. shift.	**************************************					
	documented, "3. Th completed on a dail	ity policy, "Posting Staffing" e posting should be:3.2 y basis at the beginning of adjusted either upward or changes."		en en estados como menerales en entre a la capación de la capación				
	Staff Member - the in and ASM #3 (the conspecialist) were man on 12/8/17 at 10:50 Director), was made	a.m., ASM #2 (Administrative interim director of nursing) rporate Clinical Quality de aware of the findings; and a.m., ASM #1 (the Executive aware of the findings that the ain, even after being notified 2/7/17.			•			
F 755 SS=D	the survey. Pharmacy Srvcs/Pro CFR(s): 483.45(a)(b		F 75	5 1.	Residents #83 and #234 are currently receiving all orde medications. Resident #56 been discharged from the fa	red has		
	drugs and biological them under an agree §483.70(g). The fac personnel to adminis	vide routine and emergency s to its residents, or obtain		2.	All residents have potential affected. An audit of curre residents was completed by Unit Managers, to ensure the medications were available.	to be nt the neir		

	TMENT OF HEALTH				· ·	FORM	: 12/18/2017 APPROVED : 0938-0391
TATEMENT	RS FOR MEDICARE FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
	ļ	495246	B. WING	ì			C <mark>/08/2017</mark>
NAME OF I	PROVIDER OR SUPPLIER			ŀ	FREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER		:	l .	DAIRY LANE REDERICKSBURG, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	a licensed nurse. §483.45(a) Procedupharmaceutical senthat assure the accidispensing, and adribiologicals) to meet §483.45(b) Service must employ or obtapharmacist who- §483.45(b)(1) Providespects of the provident facility. §483.45(b)(2) Established for the facility. §483.45(b)(2) Established for the facility and disposition and for the facility and facility document review, it was determensure medications administration as on three of 29 residents Residents #83, #56 1. The facility staff for the accidity document review facility staff for the facility staff for	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. Consultation. The facility ain the services of a licensed ides consultation on all ision of pharmacy services in colishes a system of records of tion of all controlled drugs in mable an accurate rmines that drug records are in account of all controlled drugs in incount of all controlled drugs in the services. The interview, staff interview, view and clinical record mined the facility staff failed to a were available for redered by the physician for s in the survey sample, and #234. If alled to acquire and the facility staff failed to acquire and the facility staff failed to acquire and the fail	F 7	тем не се	administered per order. 3. Education was provided to Licensed Nursing Staff by the Nurse Practice Educator on Medication Administration to include the process for obtain medications from pharmacy, up pharmacy or back up box needed. 4. Unit Managers to audit MAR week for six weeks and rando thereafter to ensure medication are available and administrate according to order. Results of these audits will be brought by the Quality Assurance and Performance Improvement Committee monthly for review	back as as 3 x omly ons ed f efore	1/17/18

2. The facility staff failed to obtain Resident #56's

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 4	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495246	B. WING	i		1;	C 2/08/2017	
	NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER			11 1	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405	CODE		
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F 755	prescribed Medihor honey used to treat wound for a period of the second	ney [2] (a medically certified t wounds) to apply to her of eight days. failed to ensure a medication was available for Resident #234. e: failed to acquire and at #83's medications per		755				
		ission orders dated 11/2/17: mg daily vice a day daily 0 mg every night	The second section was a second section and second section and section and section as se					
	(medication adminis resident was not adr doses of levocetirizir vesicare on 11/3/17 administered the sch	#83's November 2017 MAR stration record) revealed the ministered the scheduled ne, lyrica, bisoprolol and at 9:00 a.m. and was not heduled dose of carisoprodol .m. as evidenced by the		THE PROPERTY OF THE PROPERTY O	•			

DEPARTMENT	OF HEALTH	AND H	N SERVICES	
CENTERS FOR			ID SERVICES	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
	nurses circling their back of the MAR do AM Meds (medicati practitioner) aware. A pharmacy manife Resident #83's levo vesicare were not of 11/3/17 at 11:18 p.m. contain information medications. Review of the facilit box containing varie accessed if a reside been delivered) investoes were not in the STAF (including nurses' inform) failed to reveat facility on 11/3/17. Nurse) #4 did docur under a medication a.m.; however, an in 12/8/17 at 9:07 a.m. wrote "LOA." LPN awas in the facility or Resident #83's comon 11/6/17 documer exhibits or is at risk comfortIntervention ordered for painFor risk for respiratory of AsthmaIntervention	rinitials on the MAR. The ocumented "11/3/17 9AM NO ons) given. NP (Nurse " st dated 11/3/17 revealed ocetirizine, bisoprolol, and delivered to the facility until in. The manifest did not regarding the other y STAT (immediate) box (a pus medications that can be ent's medications have not entory list revealed all the that were not administered in the that were not administered in the that were not administered in the lote LPN (licensed practical ment "LOA" (leave of absence) that was scheduled at 9:00 interview with that nurse on revealed she accidentally the confirmed Resident #83 in 11/3/17. prehensive care plan revised in the prehensive care plan revised in the cous: Resident exhibits or is at omplications related to ins: Administer aerosol as focus: Resident exhibits or is	F 7	55				

		AND HE AN SERVICES				FORM	12/18/2017 APPROVED	
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	r				0938-0391	
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495246	B. WING			C 12/08/2017		
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODM	ONT CENTER				I 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCE)	D BE	(X5) COMPLETION DATE	
,,,,					DEFICIENCY)			
F 755	Continued From pa		F7	55			PA-PAZARANA PA-PAZ	
A CONTRACTOR OF THE CONTRACTOR	symptomsInterve (medications) as or	ntions: Administer meds dered"					**************************************	
	interview was cond- resident stated she	oximately 2:14 p.m. an ucted with Resident #83. The did not get her medications	A constant and the cons	OOO AMBROOK STREET, ST			**************************************	
		oming back from hospital.	Acceptance of the Control of the Con				ABBARA PARAGAMENTAL PARAGAMENTA	
	On 12/7/17 at 10:23 a.m. a telephone interview was conducted with LPN (licensed practical nurse) #6 (the nurse responsible for						Anamata Fananca Anamata	
	administering the 9 to Resident #83 on	:00 p.m. dose of Advair diskus 11/3/17). LPN #6 was asked	чичен маления менен м	***************************************			POODER PROPERTIES TO FOODERS AND TO	
And the second s	their medications up	e to ensure residents receive pon readmission. LPN #6	A CONTRACTOR A CON	OCCUPATION OF THE PERSON OF TH			occupants and a proposition of the state of	
	sure they match the	d review the MARs and make e admission medication list		* FOR WAS A STATE OF THE STATE			ooveran modelle on a first	
	medications are no	ers. LPN #6 stated if the tavailable then nurses should	na con propagativo porta propa				And the second s	
The state of the s	the medications will	now and call the pharmacy so be delivered on the next I #6 stated the pharmacy	меньности и чести по станова и				√	
	delivers medication	s in the afternoon and late at many medications can also	novement with the service				MA NOVE AND ADDRESS OF THE PROPERTY OF THE PRO	
	be obtained from th	e facility Omni cell (STAT asked what is meant by circled	Samuel Constitution of the				manufaccoccons and sports or posturations	
en e	initials on the MAR.	LPN #6 stated it usually refused the medication, the	Address was Andread State Control of the Control of					
	medication was not	in the facility or the resident by. LPN #6 was made aware					TORONO PARAMETERS FOR THE STATE OF THE STATE	
	she initialed and cir	cled medications that were ninistered to Resident #83	A-C				anus voca account delibro	
,	during the evening day shift nurse initia	of 11/3/17 in addition to the along and circling medications.	NAME OF THE PERSON OF THE PERS				Address discovering a single-party and a single-par	
a per constant of the constant	LPN #6 stated she of the facility. LPN	assumed the resident was out #6 was made aware there	NOOPAWARIAN ————————————————————————————————————				The state of the s	
S. Landing Co.	was no documental was out of the facili	ty on 11/3/17. LPN #6 stated een an order to hold	AMAZINE CONTRACTOR				Permissional account after mining after	

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		AND HOND IN SERVICES			<u> </u>		FORM	APPROVED . 0938-0391
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WOODMONT CENTER SUMMARY STATEMENT OF DEFICIENCIES				ł	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 PREF TAG	ΊX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 755	medications because scheduled to go out made aware there were medications. LPN # Those are the only in the medications to Residuate the medications to Residuate the medications of the recurrence the medications if the medication of the medication list is #4 stated once a residual she writes out the medication list is #4 stated she also used to make the medication list is #4 stated if schedule omni cell does not a #4 stated if schedule omni cell and have pharmacy then she on 12/7/17 at 2:23 pmember) #1 (the exinterim director of not clinical quality special pove concern. The facility policy titl Shortages/Drugs Not "When medication of the med	se the resident may have been t for a procedure. LPN #6 was was no order to hold #6 stated, "I'm not sure. things I remember." 4 a.m. an interview was N #4 (the nurse responsible for :00 a.m. and 1:00 p.m. ident #83 on 11/3/17). LPN #4 done with a resident's esident is sent to the hospital. waits to see if the resident is pital and once admitted, she is ions to the pharmacy. LPN #4 ent is readmitted to the facility, nedication orders and faxes armacy. LPN #4 stated the elivers the medications by the but this depends on what time is faxed to the pharmacy. LPN uses the Omni cell but the contain all medications. LPN ed medications aren't in the n't been delivered by the calls the physician. p.m. ASM (administrative staff recutive director), ASM #2 (the ursing) and ASM #3 (the ialist) were made aware of the	F	755				

initiate action in cooperation with the attending physician and the pharmacy provider. All

DEPARTMENT OF HEALTH AND HEALTH AND 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	
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	PROVIDER OR SUPPLIER ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 755	be managed with us shortage is discove hours: 2.1 A license and speaks to a reg determine the statu place the order or mext scheduled delivery causes delipatient's medication from the administer the dose available in the emet the pharmacist and delivery" No further informati (1) levocetirizine is allergies. This inforwebsite: https://medlineplus.tml (2) lyrica is used to information was obthttps://medlineplus.tml (3) bisoprolol is use This information wa https://medlineplus.tml (4) carisoprodol is uselieve pain. This information the website:	unavailable to the patient will regencyIf a medication red during normal pharmacy of nurse calls the pharmacy gistered pharmacist to so of the order. If not ordered, e-order to be sent with the every. 2.2. If the next available ay or missed dose in the	F 7	55			

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HE **N SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 755 Continued From page 293 F 755 (5) Vesicare is used to treat overactive bladder. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a605019.h 2. The facility staff failed to obtain Resident #56's prescribed Medihoney [2] (a medically certified honey used to treat wounds) to apply to her wound for a period of eight days. Resident #56 was admitted to the facility 12/21/12 with diagnoses that included, but were not limited to; dementia, a gastrostomy (a tube to deliver feeding directly into the stomach), peripheral vascular disease (poor circulation to the legs), high blood pressure, depression, difficulty swallowing, anemia (low red blood cell count), an irregular heartbeat, and difficulty speaking. Resident #56's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/13/2017 coded Resident #56 as being unable to answer the guestions on the BIMS (brief interview for mental status) and the staff assessment coded Resident #56 as being severely impaired to make decisions regarding task of daily life. Resident

through tube feeding.

#56 was coded as being dependent with activities of daily living. Resident #56 was also coded as receiving greater than 50% of her nutrition

revealed, in part, the following orders for a stage 2 pressure ulcer on Resident #56's lower left leg; "11/28/17. Cleanse (L) outer calfe (sic) stg. (stage) 2 ulcer [1] (Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis.) NS (normal saline) wound cleanser, dry, apply

A review of Resident #56's clinical record

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1 ' '		E CONSTRUCTION	(X3) DAT	0938-0391 E SURVEY IPLETED		
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	DING		1	С		
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PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROF DEFICIENCY)		DATE		
F 755	Continued From pa	ge 294	F	755					
	Medihoney [2] (med	lically certified honey for use							
	with wound healing) and then silicone dsg y day)." Signed and dated by					!		
	the nurse practition	er on 11/29/17.							
		:							
	On 12/6/17 at 12:30) p.m. LPN (licensed practical thed this writer and stated she					į		
	was ready to provid	e wound care for Resident #							
	56. As LPN #12 ga	thered her supplies she stated							
	the pharmacy I PN	dihoney had not arrived from I was asked when the							
	Medihonev was ord	ered. LPN #12 stated, "It was			ar underhande				
	ordered - I don't kno	ow - I want to say the 30th or			s 3177-7-7-1		1		
	the 1st." LPN #12	was asked what she normally					{ 		
	did if she didn't have	e what she needed for a t. LPN #12 stated, if another							
	resident on the hall	has the same prescription I			1 				
	will use another res	ident's supply until I get what I			a unique				
	need from the phar	macy." LPN #12 was asked if							
	anyone had contact	ted the pharmacy. LPN #12 now of. I don't know why the							
	stated, Not that I ke	en contacted. I didn't know	La procession de la constanta della constanta de la constanta de la constanta de la constanta						
	anything about it ye	sterday because all the	THE STATE OF THE S				A 400 cm		
	treatments were do	ne when I came on shift. I	-						
	assumed that her (I	Resident # 12's) supplies were							
	here so I didn't que:	stion it." LPN #12 was asked to do next. LPN #12 stated,							
	"I am going to conta	act the pharmacy and see if							
	they've sent it. I know	ow they got the order because					nos a Lavor Romanos		
į	I received a fax con	firmation." At this time LPN							
	#12 went to verify th	ne fax order went to the							
	pharmacy. LPN #1:	2 was unable to locate the fax e order was sent to the			· ·				
		e order was sent to the 2 reviewed the order and			The time of time of time of the time of ti		on the state of th		
TAX COMMISSION	stated she was the	one who had signed off on the			Contraction of the Contraction o		A 1111		
***************************************	order. LPN #12 fur	ther stated, "It looks like it was							
THE PERSON NAMED AND ADDRESS OF THE PERSON NAMED AND ADDRESS O	not "taken off" but I	remember sending it to the			The second secon				
TARAS	pharmacy it must no	ot have gone through." When					4		
200	asked when the ord	er for Medihoney was							

	TMENT OF HEALTH	AND HON SERVICES				•	FORM	12/18/2017 APPROVED 0938-0391
TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DAT COM	E SURVEY IPLETED
		495246	B. WING	<u>}_</u>			i	08/2017
NAME OF	PROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE,	ZIP CODE		
WOODMONT CENTER					11 DAIRY LANE FREDERICKSBURG, VA 22	2405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FΙΧ	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 755	received by nursing 11/29/17 the Medihic received." LPN #12 treatment on 11/30/ unable to determine the treatments between the treatments between the treatment of the treatment	LPN #12 stated, "On oney was ordered and not 2 was asked who did the 17. LPN #12 stated she was 2. When asked who completed the 12/2 - 12/5/17, LPN #12 ts were signed off as being 2N who was no longer with the 1st asked what had the staff of the prescribed order. LPN aff have been using another	F	75	55			

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

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 1	C 2/08/2017
495246 B. WING	2/08/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755 Continued From page 296 ASM #2, the interim DON, and ASM #3, the clinical quality specialist. ASM #1, ASM #2 and ASM #3 were made aware of the above concerns. No further information was provided prior to the end of the survey process. [1] This information was obtained from the following website; http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagesca tegories/. [2] This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC26 886330/ 3. The facility staff failed to ensure a physician ordered medication was available for administration for Resident #234. Resident #234 was admitted to the facility on 12/4/17 with the diagnoses of but not limited to: MRSA (methicillin-resistant Staphylococcus aureus) [1] in a wound, Chronic Obstructive Pulmonary Disease, chronic back pain, scoliosis, opiate addiction, chronic pain syndrome, and aortic valve endocarditis. An MDS (minimum data set) assessment dated 12/4/17 documented the resident as being cognitively intact. The resident was documented as being aplet to participate in activities of daily living. The resident was also documented as having a PICC (peripherally inserted central catheter) [2] line and requiring	

DEPART	MENT OF HEALTH	AND HUN SERVICES				FORM.	12/18/2017 APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED C			
	495246) 08/2017
NAME OF F	PROVIDER OR SUPPLIER			ĺ	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE		
WOODM	ONT CENTER			1 .	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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	Continued From pa	ge 297	F	755			
	Practical Nurse) rep Resident # 234 was and that physician-	30 p.m., LPN #7 (Licensed ported to the survey team that is a new admission on 12/4/17 ordered medication had not administration since admission.	A CANADA				
	A review of the clini "Discharge Medical undated, revealed a 100 mg (milligrams review of the admis medication was also A review of the MAI Record) on 12/7/17 Theophylline had no	cal record revealed the tion List" from the hospital, an order for Theophylline [3]) by mouth twice daily. A sion orders revealed this o on facility admission orders. R (Medication Administration at 04:00 p.m., revealed the ot been administered since sident had missed 6 doses					
	8:30 a.m. revealed "Order Clarification" Theophylline 100 m	e clinical record on 12/8/17 at an order dated 12/7/17 for which documented the g tab was not available per to start 300 mg tabs, give half buth twice daily.					
	12/7/17 at 1:50 p.m theophylline 100 mg (pharmacy). RX wa not carry theophylling 300mg and 400mg theophylline 300mg	se's notes revealed one dated . documented, "Pt (patient) g did not get delivered from rx as called and stated they do ne 100mg they only carry . A new order was written for tablet 1/2 (half) tab (tablet)"					

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DEPART	MENT OF HEALTH	AND HUNN SERVICES & MEDICAID SERVICES				FORM OMB NO	D: 12/18/2017 M APPROVED D. 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 755	Continued From pa B. Minocycline [4]: Further review of the	ne "Discharge Medication List"	Tanananaooodeephaa a a a consension a consension of productivities	755			
	from the hospital, u Minocycline [4] 100 twice daily. A revie revealed this medic admission orders. that the Minocycline 9:00 p.m. on 12/6/ doses of this medic were no nurse's no notification of the No of the 4 missed do medication not bein of the pharmacy de Minocycline was fill delivered to the fact	andated, revealed an order for mg (milligrams) by mouth aw of the admission orders cation was included on facility. A review of the MAR revealed e was not administered until 17. The resident had missed 4 cation since admission. There are documenting the status or dinocycline. (See F580). Two ses were missed due to the mg delivered timely. (A review delivery manifest revealed the led on 12/4/17 but was not call the led on 12/5/17 at 5:48 p.m.).					
	#2 (Registered Nuradmission orders to them off. RN #2 standard should have done the MAR's were provided was probably not or make it to the MAR missed doses. RN taken place, the number sooner that arrived as it was not arrived as it was not arrive timely the pharmacy to find of would have then the stated that regarding MAR been verified.	rse), she stated she wrote the put was not the one that took tated that the evening shift a MAR-to-order check when inted. She stated that this step lone as the medication did not R, and thus contributed to the I #2 stated that had this step urses would have realized the Theophylline had not ot available to administer, and would have occurred much ated when the Theophylline did e nurse should have called the out why it was not sent, and that iggered the clarification. RN #2 against the orders, the have then been added as					Decay 200 of 24

DEPARTMENT OF HEALTH AND H				FORM APPROVED	
	CAID SERVICES VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	495246	B. WING		C 12/08/2017	
NAME OF PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODMONT CENTER		1	11 DAIRY LANE FREDERICKSBURG, VA 22405		
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F 755 Continued From page 299 required and the resident was many doses once it arrive resident should not have haw without his medications. A review of the facility policy Shortages/Drugs Not Availal "When medication orders are unavailable, the licensed nut initiate action in cooperation physician and the pharmacy medication orders unavailable be managed with urgency." On 12/8/17 at 10:14 a.m., As Staff Member - the director of #3 (the corporate Clinical Quande aware of the findings; 10:50 a.m., ASM #1 (the Exemade aware of the findings. No further information was puthe survey. [1] MRSA stands for methicil Staphylococcus aureus. It can infection that is resistant to suntibiotics. There are two types Hospital-associated MRSA health care settings. CommuMRSA happens to people with skin-to-skin contact with other involved in football and wresulfication control is key to sto hospitals. To prevent commuMRSA	ed. She stated the d to go 3 to 4 days for "Medication ole" documented, e not received or rese will immediately with the attending provider. All le to the patient will SM #2 (Administrative of nursing) and ASM vality Specialist) were and on 12/8/17 at ecutive Director), was arovided by the end of lin-resistant auses a staph everal common pes of infection. Inappens to people in unity-associated to have close ers, such as athletes thing. Inpping MRSA in	F 75			

bandage until healed

*Practice good hygiene
*Keep cuts and scrapes clean and covered with a

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F 755	bandages *Avoid sharing pers washcloths, razors, *Wash soiled sheet water with bleach al If a wound appears care provider. Treat the infection and an Information obtained https://medlineplus. [2] PICC stands for catheter. A long cat arm or leg vein into vena cava or inferio and typically provide several weeks. Unlii catheter (IV) which is more durable and blocked or infected. several months so t drawn or medication routinely injected int Information obtained https://www.radiolog c_access [3] Theophylline is u wheezing, shortness tightness caused by emphysema, and ot and opens air passa easier to breathe. Information obtained	other people's wounds or onal items, such as towels, or clothes s, towels, and clothes in hot nd dry in a hot dryer to be infected, see a health ments may include draining tibiotics. d from gov/mrsa.html peripherally inserted central theter that extends from an the largest vein (superior r vena cava) near the heart es central IV access for ke a standard intravenous is for short term use, a PICC I does not easily become It may remain in place for hat blood can be repeatedly n and nutrients can be o the patient's bloodstream. d from pyinfo.org/en/info.cfm?pg=vas sed to prevent and treat s of breath, and chest asthma, chronic bronchitis, her lung diseases. It relaxes ages in the lungs, making it	F 7	755			

[4] Minocycline is used to treat infections caused

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DEPARTMENT OF HEALTH AND H N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED C 12/08/2017 STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE ENEMBRICAS STATE ADDRESS STATE ADDR

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F 755	by bacteria including respiratory tract infective skin, eye, lymph urinary systems; an are spread by ticks, animals. Information obtained https://medlineplus.tml Label/Store Drugs at CFR(s): 483.45(g)(https://medlineplus.tml Label/Store Drugs at CFR(s): 483.45(g)(https://medlineplus.tml Label/Store Drugs at CFR(s): 483.45(g)(https://medlineplus.tml Drugs and biological labeled in accordant professional principle appropriate accessed instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In accessed in locked temperature controls personnel to have at labeled in locked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distribution quantity stored is milbe readily detected.	g pneumonia and other ections; certain infections of natic, intestinal, genital, and d certain other infections that lice, mites, and infected d from gov/druginfo/meds/a682101.h and Biologicals n)(1)(2) g of Drugs and Biologicals als used in the facility must be ce with currently accepted les, and include the bry and cautionary expiration date when of Drugs and Biologicals accordance with State and cility must store all drugs and I compartments under proper s, and permit only authorized	F 761		carts Ithe Unit on was #2 cation tial to be ets are ing to audits. by the to the on carts. itor/audit weeks to ensure cure when hese

DEPART	MENT OF HEALTH	AND HON SERVICES				FORM	12/18/2017 APPROVED 0938-0391
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F 761	document review, to one of six medication on the Martin hallway with the Martin hallway with endication admir conducted on 12/05 Martin hallway with #1. LPN #1 went to LPN #2 was standing entered room a residoor. LPN #1 follow closed the door lear unlocked and out or nursing assistant) with eart when it was returned to the cart later and immediated. An interview was cop.m. with LPN #1. Ver the medication cart anytime I'm not the have locked the car stated, "Yes I should on 12/7/17 at 4:45 member) #1, the exinterim director of note that the sinterim director of the six member in the six member in the existence of the six member in the existence of the six member in the existence of the existence	tion, staff interview and facility he facility staff failed to ensure on carts was secured when servation, the medication cart ay. To lock the medication cart on when the cart was out of the nurse. The interview is a secured when the cart was out of the nurse. The interview is a secured was out of the nurse. The interview is a secured practical nurse of the medication cart where ing. LPN #2 then left the cart, ident room and closed the wed LPN #2 into the room and ving the medication cart if line of sight. A CNA (certified was observed standing next to its left unlocked. LPN #1 approximately 35 seconds aly locked the cart. The interview is a secured was observed standing next to its left unlocked. LPN #1 approximately 35 seconds aly locked the cart. The interview is a secured when it is a secured was observed standing next to its left unlocked. LPN #1 approximately 35 seconds aly locked the cart.		761	Quality Assurance and Performance Improvement Committee monthly for rev	iew.	1/17/18

PRINTED: 12/18/2017

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND H **N 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 _ 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 SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 761 F 761 Continued From page 303 Review of the facility's policy titled, "Medication Administration: General" documented, "PURPOSE. To provide a safe, effective medication administration process. PRACTICE STANDARDS. 1. Maintain security of cart and keys at all times." No further information was provided prior to exit. F 773 Lab Srvcs Physician Order/Notify of Results F 773 CFR(s): 483.50(a)(2)(i)(ii) SS=D 1. Resident # 184 no longer resides at §483.50(a)(2) The facility mustthe center. (i) Provide or obtain laboratory services only when 2. All residents with orders for labs ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in have potential to be affected. An accordance with State law, including scope of audit was completed by the Unit practice laws. Managers, of all current residents (ii) Promptly notify the ordering physician, with lab orders in the last 30 days physician assistant, nurse practitioner, or clinical to ensure that labs were obtained nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance per order. with facility policies and procedures for notification of a practitioner or per the ordering 3. Education was provided to the physician's orders. Licensed Nursing Staff by the This REQUIREMENT is not met as evidenced Nurse Practice Educator on the Lab Process. Based on staff interview, facility document

12/1/17 for Resident #184.

review, and clinical record review, it was

The facility staff failed to obtain a HgA1C

determined the facility staff failed to obtain a

physician ordered laboratory test for one of 29

residents in the survey sample, Resident #184.

(hemoglobin A1C), CBC (complete blood count)

and BMP (basic metabolic panel) ordered on

4. The Clinical Nurse Management

Meeting 5 days per week, to

Team will review all new orders

for labs in the Clinical Morning

ensure that labs are added to the

lab tracking form and carried out

per order. Results of these audits

will be brought before the Quality

DEPARTMENT OF HEALTH AND HEALTH AND HEALTH AND SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	Resident #184 was 11/30/17 with diagram not limited to: fractuous chronic nonreversible a combination of embronchitis (1)), atrial characterized by ray the atria of the hear the ventricles and recoutput and frequent (2)), pulmonary fibrocondition in which the becomes scarred on and stiff. That make breath, and your blooxygen (3)), diabete. There was no composet) assessment as The Initial Nursing Adocumented Reside oriented to person, put the physician order "HgA1C*, CBC**, and "HgA1C*, CBC**, and "HgA1C is a lab test of blood sugar (glucomonths. It shows how your diabetes. Altern Hemoglobin - glycos "A complete blood of the following: The nursing the sugar (glucomonths. The nursing the nursing the sugar (glucomonths. It shows how your diabetes. Altern Hemoglobin - glycos "A complete blood of the following: The nursing the sugar (glucomonths. The nursing the sugar (glucomonths. It shows how your diabetes. Altern Hemoglobin - glycos "A complete blood of the following: The nursing the sugar (glucomonths. The sugar (glucomonths. The sugar (glucomonths. The sug	admitted to the facility on loses that included, but were ure of the left humerus, chronic ary disease (general term for ble lung disease that is usually inphysema 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 losis (pulmonary fibrosis is a line tissue deep in your lungs wer time. This tissue gets thick is it hard for you to catch your lood may not get enough less and high blood pressure. In the dates of the survey. Assessment, dated 11/30/17, and #184 was alert and place and time. Indiadad, 12/1/17, documented, and BMP*** in am (morning)." It that shows the average level lose) over the previous 3 and well you are controlling thative Names include:	F 7	Assurance and Per-Improvement Comfor review.		1/17/18

		AND HEAN SERVICES			FORM): 12/18/2017 // APPROVED
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F 773	***The basic metable blood tests that probody's metabolism. Review of the clinic documentation of the HgA1C, CBC and B. The comprehensive documented in part diagnosis of diabete hypoglycemia/hyperhigh blood sugars (documented in part ordered and report doctor)." The December 201 administration recorn HgA1C, CBC, BMP 12/2/17. The box w. An interview was copractical nurse) #4 was asked about obtaining physician #4 stated the nurse the computer, in the write down the acquite computer, you get the number on the telepcomes early in the metalogical property in the metalogical property in the metalogical property and the telepcomes early in the metalogical property and the computer of the telepcomes early in the metalogical property and the computer of the telepcomes early in the metalogical property and the computer of the telepcomes early in the metalogical property and the computer of the telepcomes early in the metalogical property and the computer of the telepcomes early in the metalogical property and the computer of the telepcomes early in the metalogical property and the computer of the telepcomes early in the metalogical property and the computer of the compute	olic panel (BMP) is a group of vides information about your (6) all record failed to evidence the completed laboratory tests; iMP. a care plan dated, 12/6/17, the resident has a the second of the	F 77	3		

obtaining the test results, LPN # 4 stated, "The 3-11 staff get the results and hand them out to the nurses or call the physician." When asked how you know a laboratory test documented on a residents TAR was completed, LPN #4 stated you

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	IPLE CONSTRUCTION		COMPLETED	
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F 773	need to check to so A copy of Resident for the CBC, BMP: 12/1/17 were requeinterim director of relinical quality specifical qua	#184's laboratory test results and HbA1C ordered on ested from executive director, nursing and the corporate sialist, on 12/6/17 at 5:00 p.m. a.m. administrative staff the clinical quality specialist, ian order dated, 12/7/17 to dered laboratory tests. ASM (laboratory test) was missed. It to be drawn tomorrow, onducted with LPN #3 on m. When asked about the or obtaining physician ordered IN #3 stated, "You take the ne laboratory program on the the requisition number and put order and write it on the MAR." taff knows the lab test was d you look at the MAR." Diagnostic Tests/Results inted in part, "Policy: including laboratory, radiologic ved testing (finger stick hemoccult testing) will be edProcedure: 1. Verify the laboratory, diagnostic testing porting. 2. Notify diagnostic or test. 3. Obtain report of lotify physician of all abnormal	F 77				

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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 of following website: https://medlineplus.g(4) This information of following website: http://www.nlm.nih.go/03640.htm (5) This information of following website: http://www.nlm.nih.go/03640.htm (6) This information of following website: http://www.nlm.nih.go/0362.htm (7) Barron's Dictionar Non-Medical Reader, Chapman; pages 281 Menus Meet Residen CFR(s): 483.60(c) Menus an Menus must-	ASM #2, the interim director of 3, were made aware of the 2/7/17 at 4:45 p.m. On was obtained prior to exit. In y of Medical Terms for the r., 5th edition, Rothenberg and was obtained from the r., 5th edition, Rothenberg and was obtained from the rov/pulmonaryfibrosis.html. In was obtained from the rov/medlineplus/ency/article/0 was obtained from the rov/medlineplus&query=CBC&x= was obtained from the rov/medlineplus&query=CBC&x= was obtained from the rov/medlineplus/ency/article/0 y of Medical Terms for the 5th edition, Rothenberg and and 285. It Nds/Prep in Adv/Followed (7) It d nutritional adequacy.			planned menu for each meal. Changes to the menu are revie and approved by the Registere	ewed	
	SUMMARY STAY (EACH DEFICIENCY REGULATORY OR LS) Continued From page 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 of following website: https://medlineplus.g (4) This information of following website: http://www.nlm.nih.go.03640.htm (5) This information of following website: http://www.nlm.nih.go.03640.htm (5) This information of following website: http://www.nlm.nih.go.03640.htm (7) This information of following website: http://www.nlm.nih.go.03462.htm (7) Barron's Dictionar Non-Medical Reader, Chapman; pages 281 Menus Meet Residen CFR(s): 483.60(c) Menus and Menus must-	A95246 PROVIDER OR SUPPLIER MONT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 307 executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 124. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 11 DARY LANE FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 307 executive director, ASM #2, the interim director of nursing, and ASM #3, were made aware of the above concern on 12/7/17 at 4:45 p.m. No further information was obtained prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55. (3) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/0 03462.htm (5) This information was obtained from the following website: http://www.nlm.nih.gov/medlineplus/ency/article/0 03462.htm (7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55. 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(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 55. (3) This information was obtained from the following website: http://www.inm.nih.gov/invisimo/cgi-bin/query-meta*7v/sAproject=medineplus&query=CBC&x=248y=17 (6) This information was obtained from the following website: http://www.inm.nih.gov/medlineplus/ency/article/0 03462.htm (7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 52 and 285. (8) This information was obtained from the following website: http://www.inm.nih.gov/invisimo/cgi-bin/query-meta*7v/sAproject=medlineplus&query=CBC&x=248y=17 (6) This information was obtained from the following website: http://www.inm.nih.gov/medlineplus/ency/article/0 03462.htm (7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; pages 281 and 285. Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must.

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

PRIN	TED:	12/18	/2017
FC	DRM.	APPR	OVED
OMB	NO.	0938	<u>-0391</u>

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		С		
		495246	B. WING 12/08				
NAME OF F	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE			
			_	1 DAIRY LANE			
WOODM	ONT CENTER			PROVIDER'S PLAN OF CORRECTION	ON (X5)		
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F 803	residents in accord guidelines.; §483.60(c)(2) Be possible standard standar	lance with established national prepared in advance; collowed; ect, based on a facility's, the religious, cultural and experience resident population, as well as a resident and resident updated periodically; reviewed by the facility's linically qualified nutrition utritional adequacy; and thing in this paragraph should be the resident's right to make the inces. ENT is not met as evidenced ation, resident interview, staff ity document review, it was a facility staff failed to followed to the residents. There is enemy during the dinner hour de:		 All residents have potential affected. Food production will be in place and follow the cooks. Education provided to the Staff by the Regional Dieta Services Manager regarding regulation and process for following Posted Menus. Education provided to the Dietary Services Director Regional Dietary Services Manager regarding process making changes to posted Administrator and Register Dietician to audit meals 5 week to ensure menus are followed accordingly. Ass Weekend Managers On Draudit one meal on Saturday Sunday to ensure that men followed. Administrator to with Dietary Services Direweekly to ensure that food meets all menu requirement Results of these audits will brought to the Quality Ass and Performance Improve Committee monthly for re 	sheets ed by Dietary ary ag facility by the s for menu. red days per signed, uty to y and us are o meet ector supply nts. l be surance ment		
	mashed potatoes.	, glazed pork chop, puree egetables, roasted Brussels	di-di-				

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	MONT CENTER	•		11	1 DAIRY LANE REDERICKSBURG, VA 22405		
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	sprouts, sliced carro following items were roasted vegetables, Swiss roast beef, had An observation was until 7:05 p.m. of the service to the reside 5:30 p.m. the food it the steam oven to be required temperatur began plating the foresidents on the floor remaining OSM (othexecutive chef, state beef and mashed pohis process was who OSM #2 stated he wand OSM #2 was obpotatoes. OSM #2 to loin and ran out of the plates. OSM #2 repham. At 6:35 p.m. the mixed vegetable the director of dining small mixed salads to salads consisted of tomatoes. OSM #2 vesidents are made at to the meal being se trays out. OSM #2 s get something out, if send it back and we otherwise we just se	ots, Swiss roast beef. The e served; glazed pork chop, , garlic mashed potatoes,	F 8	803			
200 Aug.	conducted with OSM OSM #13 was asked	#13, the dietary manager. d if any of the residents were d changes that had been		HALL THE PARTY OF		ото штого общения, основнующей под техности.	

	TMENT OF HEALTH	AND HOAN SERVICES & MEDICAID SERVICES				FORM	: 12/18/2017 APPROVED : 0938-0391
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WOODM	ONT CENTER			i i	I1 DAIRY LANE FREDERICKSBURG, VA 22405	· · · · · · · · · · · · · · · · · · ·	
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	made because the label beef and vegetables think so. When asked out of beef and mixed stated she did not knowled look into it. Owhat happened and most of the time the on the menu." OSM for residents to choostated the residents per week, usually do following week." Ostated the residents per week, usually do following week." Ostated the residents OSM #13 further stated the residents OSM #13 further stated the residents out of beef because that say how much to describe the proceed with OSM to describe the proceed to substitute on a log woosm #13 provided to substitute on a log woosm #13 provided to 12/4/17 documented mixed vegetables." provided. A policy wo substituting menu item An end of day meeting 4:45 p.m. with ASM (#1, the executive did ASM #3, the clinical states and mixed vegetables."	kitchen had run out of roast s. OSM #13 stated she didn't ed why the kitchen had run ed vegetables. OSM #13 now what had happened and OSM #13 stated, "I don't know why carrots were not served, y (the residents) get what's I #13 was asked the process ose their menus. OSM #13 fill out their request one time one on a Friday for the one on a Friday for the one on a Friday for the the what they choose. OSM #13 should get what they choose. I what they choose on they have production charts o make. I #13. OSM #13 was asked they should not have run they have production charts o make. I #13. OSM #13 was asked the state of the state of the should items then we write the which then comes to me." The log and an entry for It is substitute carrots for No other information was was requested regarding	F	803			

No further information was provided prior to the

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

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	LTIPLE CONS	STRUCTION	(X3) DATE SURVEY COMPLETED		
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, , , , , , , , , , , , , , , , , , , 	PROVIDER OR SUPPLIER			11 DAIR	ADDRESS, CITY, STATE, ZIP CODE Y LANE RICKSBURG, VA 22405		<u></u>
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F 812 SS=F	CFR(s): 483.60(i)(1) §483.60(i) Food safe. The facility must - §483.60(i)(1) - Proceapproved or conside state or local author (i) This may include from local producers and local laws or reg (ii) This provision do facilities from using gardens, subject to safe growing and food (iii) This provision do from consuming food §483.60(i)(2) - Store serve food in accord standards for food serve food in accord serve food in accord standards for food serve food in accord	store/Prepare/Serve-Sanitary (1)(2) fety requirements. cure food from sources ered satisfactory by federal, rities. e food items obtained directly is, subject to applicable State igulations. ces not prohibit or prevent produce grown in facility compliance with applicable iod-handling practices. coes not preclude residents in other produced by the facility. e, prepare, distribute and dance with professional		1	Kitchen 1. Expired, undated, unlaberand uncovered items had discarded. Food Service have been cleaned. Commachine and surrounding have been cleaned. The Food Storage area floor been cleaned, boxes and removed from the floor of this was completed by facility Dietary Services Director. 2. All residents have potent be affected. Kitchen is maintained with food be stored, prepared, distribution and served in accordance professional standards of service safety. Education provided to distaff by the Regional Dimensager regarding the pand schedules for cleaning the kitchen and equipment storage of food in accordance with professional standards food service safety.	ave been e Carts ffee ing area e Dry r has d bread : All by s ntial to being eing outed ce with of food lietary process ing of ent, dance	
	two refrigerators in the					more a spart	

DEPARTMENT OF HEALTH AND	H. AN SERVICES
CENTERS FOR MEDICARE & ME	EDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
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	The findings included at the findings included the freezer reveal green beans that we to air in the freezer. #13, the dietary man should have been set stated, "We are cool review of the menual service verified green beans were regiven to OSM #13 was the green beans were regiven to OSM #2, the knot in the top of the the freezer. On 12/5/17 at 9:30 at of the refrigerator in the freezer. On 12/5/17 at 9:30 at of the refrigerator in the top of the the freezer. On 12/5/17 at 9:30 at of the refrigerator in the freezer. On 12/5/17 at 9:30 at of the refrigerator in the freezer.		F&	Jietician will audit the last X week for 6 weeks ar 2 X per week thereafter ensure that Kitchen is maintained in a clean an sanitary manner and that storage is in accordance professional standards of service safety. Results of audits will be brought be the Quality Assurance are Performance Improveme Committee monthly for review. Nursing 1. Both Unit Refrigerators were cleaned and all unlabeled, uncommon and expired items were discared by Unit Managers. 2. Director of Nursing instituted nightly cleaning process for the Pantry Refrigerators to ensure they are maintained in a manner that meets the professional standards for food safety and service. 3. Education was provided to the	d food with food f these fore ad nt 1/17/18 lated ded a e that er
	OSM #13 removed tr them in the trash.	le green beans and threw		Nursing Staff by the Nurse	

		AND HOND SERVICES			The state of the s	FORM	APPROVED . 0938-0391
STATEMENT	RS FOR MEDICARE TOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATI COM	E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				DAIRY LANE EDERICKSBURG, VA 22405		
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F 812	Further inspection of following items; - A tub of butter that no lid (open to air), butter appeared opan and a label or day and date and not contain a label or day and date and not contain a label or day and date and not contain a label or day and date and not contain a label or day and date and not contain a label of day and date and not contain a label of day a label of day and date and a label of day and delivery can be a label of the contain a label of the contain a label of the label of	at was approximately half full, no label and no date. The aque in some areas. It is a many mapped in saran wrapped in sarall items should have been and dated. a.m. an inspection of the onducted with OSM #19, and gareas/equipment were found in machines a large amount of ains was observed on the chine. art with large amount of spills art and used packs of sugar	F 8 ⁻	###	Practice Educator on maintain the refrigerators on the units, include labeling and dating of items, and discarding expired unlabeled items. Social Servito provide notification to reside and family members regarding process of labeling and dating food items brought into the facility. Unit Managers to audit pantry refrigerators 3 X week for 6 weeks, and then randomly thereafter to ensure they are maintained in a manner that me the professional standards of for safety and service. Results of a taudits will be brought before to QAPI Committee monthly for review.	to f all and ices dents g the g all neets cood these	1/17/18

On 12/5/17 at approximately 1:30 p.m. OSM #13 was made aware of the dry storage room, the serving carts and the table beneath the coffée

and dates."

DEPARTMENT OF HEALTH AND HOLAN SERVICES
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PRINTED: 12/18/2017 FORM APPROVED OMB NO. 0938-0391

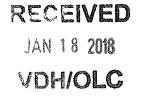
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	machine. OSM #13 responsible for clear stated the dietary stated and the faciliary Goods" revealed documentation; "All appropriately stored (food and drug admitems will be stored above the floor." A review of the faciliary condition of the faciliary contamination of the faciliary condition. The faciliary condition of the faciliary condition of the faciliary condition. The faciliary condition of the faciliary condition of the faciliary condition. The faciliary condition of the faciliary condition of the faciliary condition. The faciliary condition of the faciliary condition of the faciliary condition. The faciliary condition of the faciliary condition of the faciliary condition. The faciliary condition of the faciliary condition of the faciliary condition of the faciliary condition. The faciliary condition of the faciliary condition of the faciliary condition of the faciliary condition. The faciliary condition of the fa	3 was asked who was aning in the kitchen. OSM #13 taff were supposed to be in. ity policy titled "Food Storage: ed, in part, the following dry goods will be in accordance with the FDA hinistration) Food Code. 1. All on shelves at least 6 inches ity policy titled, "Food Storage: ed, in part, the following All foods will be stored covered containers, labeled anged in a manner to prevent in." ity policy titled "Environment" e following documentation; in areas, food service areas, ill be maintained in a clean and in the kitchen is maintained ary manner, including floors,	F8	12			
	#3, the clinical qualit #2 and ASM #3 were concerns. No further information	ty specialist. ASM #1, ASM e made aware of the above on was provided prior to the					
	end of the survey pr	ocess.		7000			

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

Event ID: DGWI11

Facility ID: VA0279

If continuation sheet Page 315 of 348



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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		TE SURVEY MPLETED
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F 812	Continued From pa	ge 315	F8	12			designation of the state of the
		f failed to store food safely in the hallway pantries.	TTTT and the state of the state				a description and description
	refrigerators in the 2 approximately 8:15 - Applesauce - no I - Opened Gatorade - Container of unknown label - Container of unknown 12/4/18, contents apple - An unsecured pizzof pizza - no date/ no - A bag containing for 1/2 pitcher of orangel	abel / not dated e - no date eown substance - no date/no eown substance date of eopeared spoiled za box with a have eaten slice					
	nurse) #3 was asket the Unit 200 pantry above. LPN #3 was items should have b #3 stated that they s was asked who was refrigerators in the united he did not know.	a.m. LPN (licensed practical d to accompany this writer to and shown the items listed asked whether or not the een labeled and dated. LPN hould have been. LPN #3 supposed to manage the nit pantries. LPN #3 stated		Мехопиченной в воливост в Афр обторы и тиво тиво помента постаности помента в обще пиванести помента помента п			
	refrigerator in the 10 8:30 with LPN #3: - Applesauce no lab	vations were made in the 0-unit pantry on 8/8/17 at el/ date ee creamer - no label / no		AMBORA PORTOCOLO — — — — — — — — — — — — VI LANDONINI PARAGONINI LA (VILL. — — VI LA.			

A half a loaf of bread - no label / dateA half pack of liverwurst opened in a zip lock

PRINTED: 12/18/2017

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 812	salad sandwiches of Paper plate with a a roll, no label / no label	ner filled with two layers of egg open to air - no label / no date a half-eaten egg sandwich and date and open to air whether or not each item appropriately / safely stored. hey were not. LPN #3 was not opened items should have lated, LPN #3 stated yes. LPN ther or not open items should y covered. LPN #3 stated yes. a.m. an interview was (registered nurse) #2, the staff linator, RN #2 was asked who rensuring that food was stored a unit pantries. RN #2 stated, ok and forth between dietary ss that nursing is responsible ras asked whether or not the dot be labeled and dated. RN #2 a.m. an interview was M (other staff member) #13, er. OSM #13 was asked who refood in the unit pantry #13 stated the nursing staff refood items placed in the not come from the kitchen. ed about the egg salad 100-unit pantry refrigerator. at activities had a party so it		312				
	sandwiches in the 1 OSM #13 stated that was probably left over they should have be uncovered. OSM #	100-unit pantry refrigerator.						

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DEPARTMENT	OF HEALTH.	AND f(AN	SERVICES
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 812	safe food handling, know. OSM #13 was food storage in the A review of the facil in for Patients/Resident following documents refrigeration must be resident's name and in. Food items must container to prevent An end of day meet 4:45 p.m. with ASM ASM #2, the interim #3, the clinical qualif #2 and ASM #3 were concerns. A facility patime.	OSM #13 stated she did not as asked to provide a policy on unit refrigerators. Ity policy titled "Food Brought dents" revealed, in part, the ation; "Food items that require e labeled with patient's / d date the food was brought to be stored in a closed contamination." Ing occurred on 12/7/17 at #1, the executive director, director of nursing, and ASM by specialist. ASM #1, ASM e made aware of the above policy was requested at this	F 8:	12		
	end of the survey provided the survey person or agency out arrangement described to the survey person or agreement (2) of this section.	ources)(2)	F 84	1. Resident #63 received care offsite on 12/21/1/ #185 discharged back to community on 12/14/1/ Contracts with the outp dialysis centers where in #39 & #74 are receiving were initiated and exect Administrator, and both continue to reside at the stable condition.	7. Resident to the 7. Datient residents g treatment uted by the h residents	

DEPARTMENT OF HEALTH	I AND HON SERVICES			Pf		12/18/2017 APPROVED
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DREELY (FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
assumes responsit (i) Obtaining servic standards and prin professionals provi and (ii) The timeliness of This REQUIREMED by: Based on staff intereview, it was determaintain contracts of 29 residents in the #39, 185, 74 and # 1. The facility staff with the dialysis cereceiving treatment facility. 2. The facility staff with the dialysis cereceiving treatment facility. 3. The facility staff with the dialysis cereceiving treatment facility. 4. The facility staff with a podiatrist who facility for Resident The findings includ 1. Resident #39 was 10/3/17 with diagnor	ecify in writing that the facility bility for- es that meet professional ciples that apply to ding services in such a facility; of the services. NT is not met as evidenced erview and clinical record rmined the facility staff failed to for outside resources for four he survey sample, Residents 63. failed to maintain a contract enter that Resident #39 was at at, while a resident at the failed to maintain a contract enter that Resident #185 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #74 was at at, while a resident at the failed to maintain a contract enter that Resident #75 was at at, while a resident #76 was at at, while a resident #77 was at at a contract enter that Resident #78 was at at a contract enter that Resident #78 was at	F 840	3.	All residents requiring hemodialysis and podiatry se have the potential for being affected. Administrator secured the ser of a community-based podiate effective 1/11/18 and a contral was executed. Administrator ensure that contracts are executed with all outpatient dialysis ce where current residents are receiving treatment. Administrator will share this information regarding Use of Outside Resources at the mor QAPI Committee meeting for education and review purpose and will review twice annually ensure continued compliance.	rvices rist act will cuted nters onthly r es, ly to	1/17/18

PRINTED: 12/18/2017

		AND HOAN SERVICES			FOR	D: 12/18/2017 M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY
		495246	B. WING_		12	C 2/08/2017
	PROVIDER OR SUPPLIER ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	the right lower leg a requiring hemodialy. Hemodialysis is a proconditions and rena impurities are removed as a dialyzer when ultrafiltration, wasted. The most recent ME assessment), a Median with an assessment coded the resident a make daily decisions. Treatments, Proceduresident was coded resident at the facilit. There was no physical The December 2017 administration records.	knee amputation, infection of nd end stage renal failure sis. rocedure used in toxic I failure in which wastes and wed from the blood by a he blood is shunted to and re, through diffusion and a are removed." (1) OS (minimum data licare 60-day assessment, reference date of 11/28/17, as being cognitively intact to s. In Section O - Special ures and Programs, the as receiving dialysis while a y.	F 84	40		
		ry of Medical Terms for the r, 5th edition, Rothenberg and				
ĺ	11/30/17 with diagno	s admitted to the facility on ses that included but were the knee amputation,	·			A management of the state of th

shortness of breath, fall diabetes, and end stage

There was no completed MDS (minimum data set) assessment completed as of the survey.

renal disease requiring hemodialysis.

DEPART	MENT OF HEALTH	AND HOWAN SERVICES		-		FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495246	B. WING	;		1:	2/08/2017
NAME OF F	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER			l .	11 DAIRY LANE		
WOODIN				L	FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECT	TION	(VE)
(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 APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 840	Continued From pa	ge 320	F	840	0		
•	The Initial Nursing a documented in part oriented to person,	Assessment, dated 11/30/17, t, the resident was alert and place and time.	ANNO MANAGEMENT AND				
•	The physician orde in part, "Dialysis - N F (Friday)."	r dated, 11/30/17, documented // (Monday) - W (Wednesday) -	рокомурация прикадан, которожийну — дакурала				
	1/13/17 and readm	as admitted to the facility on itted on 10/11/17 with the of limited to end stage renal rsis, disease, atrial fibrillation, ession.					
	quarterly assessme Reference Date) of coded as being mo make daily life deci possible 15 on the Mental Status) exa Treatments, Proces	DS (Minimum Data Set) was a ent with an ARD (Assessment 11/6/17. The resident was derately impaired in ability to sions, scoring a 7 out of a BIMS (Brief Interview for m. In Section O - Special dures and Programs, the d as receiving dialysis while a ity.					
	physician's order da	ical record revealed a ated 10/12/17 for "Dialysis sday/Thursday/Saturday)."	Sventiššies verijaja vijajajajajajajajajajajajajajajajajajaja				
	approximately 11:3 the administrator for	e conference on 12/4/17 at 0 a.m. a request was made of or the list of residents who were A list was provided with the idents.	Commission and the commission of the commission				
	An interview was co	onducted with the executive tive staff member (ASM) #1,					No season and the sea

on 12/7/17 at 12:20 p.m. When asked if he had

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	RTMENT OF HEALTH	AND HOAN SERVICES			FORM.	: 12/18/2017 APPROVED : 0938-0391
STATEMENT	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		495246	B. WING			C 08/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	MONT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	DBE	(X5) COMPLETION DATE
F 840	Continued From page	age 321	F 840			
	stated, "There is no found a contract wit asked if any of his recenter, ASM #1 stat should have an agrecenters." A request residents who go ou and which centers the Con 12/8/17 the exection.	cutive director presented a list				
Anna Pales and Anna Anna Anna Anna Anna Anna Anna	each attend. They a of dialysis centers be	listed with the dialysis centers all attend the same company out at three different locations.	-		Special of the second s	
THE PROPERTY OF THE PROPERTY O		ctor was made aware of the 12/7/17 at 12:23 p.m.	VVNiminoliii.		Albungton bermungsterraman	
in the second se	No further information	on was provided prior to exit.	An distillability or an analysis of the second		-	
		ailed to maintain a contract performed services in the #63.	s prime illiminate de la constantina della const		dell'e transministration delle	
Addition	4/2/05. Resident #6 were not limited to: o major depressive dis	idmitted to the facility on 63's diagnoses included but diabetes, low back pain and sorder. Resident #63's most um data set), a quarterly	On the second se		m - y biber y dem nance, un my coren - siglette - man in in annexe	

hygiene.

assessment with an ARD (assessment reference

cognitively intact. Section G coded Resident #63 as requiring extensive assistance of one staff with bed mobility, dressing, eating and personal

Resident #63's comprehensive care plan revised on 9/24/17 documented, "Focus: The resident

date) of 10/24/17, coded the resident as

has a diagnosis of diabetes: Insulin

		AND HOAN SERVICES				FORM	: 12/18/2017 I APPROVED
STATEMEN'	RS FOR MEDICARE TOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			. 0938-0391 TE SURVEY MPLETED
		495246	B. WING	G		1	C /08/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE		
WOODM	ONT CENTER			1	REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 840	DependentIntervedaily. Observe feet noting alteration in stemperature, and cl shape, length and consider the resident was lass 8/9/17. On 12/4/17 at 2:40 conducted with Resident was lass stated she would like and she had told staweeks that her toen Resident #63 was utold and reported shin her room. When by a podiatrist, Resident was a long tim #63's feet were stick sheet while the resident #63's toen toenails on both fee resident #63's toen toenails on both fee resident's toes. The were the longest and one forth inch past to the conducted with RN was asked how staff are cared for. RN # are monitored daily toenails get long, greather ordinary occurs nurse or unit management.	entions: Diabetic foot check /toes/ankles/soles/heels skin integrity, color, eanliness. Toenails for color" #63's clinical record revealed at seen by the podiatrist on p.m. an interview was ident #63. The resident e to get her toenails trimmed aff for the past two or three ails needed to be trimmed, mable to state who she had he had told staff who had been asked if she had been seen dent #63 stated she had but it e. At this time, Resident king out of the bottom of the dent was lying in bed. ails were observed. All t were grown out past the toenails on the great toes d were grown approximately	F	840			

to the facility once a month.

RN #1 stated the podiatrist is supposed to come

DEPARTMENT OF HEALTH AND H	, "	AN	SERVICES	
CENTERS FOR MEDICARE & MED	າໄດ້	ΔID	SERVICES	

AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495246	B. WING_		1:	C 2/08/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 11 DAIRY LANE FREDERICKSBURG, VA 2240	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
	On 12/6/17 at 12:58 were observed with resident's toenails r stated Resident #63 be seen by the podi previous month but cancelled. When as made for the podiat date, RN #1 stated responsible for hand arrangements. RN sure Resident #63's be seen by the podi facility nurses do no toenails. On 12/6/17 at 5:31 p conducted with ASM member) #1 (the ex stated the podiatrist August. ASM #1 stated the podiatrist August. ASM #1 stated the podiatrist had to be re-credentialed. AS communication with stated the podiatrist to the facility in Octobe stated the podiatrist to the facility during cancelled. ASM #1 of pursuing another communicates with he may see if the resfacility to see a podiatrist see a	Rn #1. Rn #1 confirmed the leeded to be cut. Rn #1 swas assisted out of bed to atrist one day during the then the podiatrist called and sked if arrangements were rist to schedule a make-up the executive director was dling the podiatry #1 stated she would make name was still in the book to atrist. Rn #1 stated the trim diabetic residents' b.m. an interview was I (administrative staff ecutive director). ASM #1 last came to the facility in ated he received in the facility's compliance trist had an issue with his e had cleared but the reinstated and M #1 stated he was in the podiatrist. ASM #1 was scheduled to come to r but didn't show up. ASM #1 was also supposed to come the previous week but stated he was in the process podiatrist. ASM #1 stated he Resident #63's daughter so sident could go out of the	F 84	10			

	TMENT OF HEALTH	AND HON SERVICES				FORM	: 12/18/2017 I APPROVED : 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
	<u></u>	495246	B. WING _			1	C /08/2017	
NAME OF	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE			
WOODM	ONT CENTER				RY LANE ERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	/ (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	And the second s	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 840	conducted with ASM not produce a podia podiatrist. ASM #1 getting a new podiar residents on a regul there should have b podiatrist while he whe (ASM #1) was ur contract. ASM #1 was concern.	M#1. ASM #1 stated he could try contract for the former stated he was working on trist credentialed to see ar basis. ASM #1 stated een a contract with the former was performing services and naware of there being a was made aware that this was	F 84	.0				
F 842 SS=E	Resident Records - CFR(s): 483.20(f)(5) §483.20(f)(5) Reside (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so. §483.70(i) Medical resident must maintain medical that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically of \$483.70(i)(2) The facall information contains.	ent-identifiable information. release information that is to the public. elease information that is to an agent only in ontract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted ds and practices, the facility cal records on each resident nented; le; and	F 84		Resident #47 has expired Physician and Responsible have been notified that me for resident #83 was not a scheduled; this notificated documented in resident # medical record. Nurse has documented that Glucago given and documented in record for resident #286. Managers ensured these corrections were made. #286 is no longer in the fall residents with change condition have potential traffected. Audit was compunit Managers by review. Hour Report and eInteract Changes of Condition for	le Party edication given as on was 83 s n was medical Unit Resident acility. s of b be bleted by ing 24		

		AND HAN SERVICES				FORM	: 12/18/2017 APPROVEC
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				T	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION:	(X3) DATE SURVEY COMPLETED	
		495246	B. WING			I	C 08/2017
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 121	00/2017
INMINE OF I	THO VIDER OF COLORS				AIRY LANE		
WOODM	ONT CENTER			FRE	EDERICKSBURG, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	(ii) Required by Law (iii) For treatment, p operations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial an law enforcement pu purposes, research medical examiners, a serious threat to h by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medicator- (i) The period of time (ii) Five years from there is no requirem (iii) For a minor, 3 ye legal age under State	en release is- or their resident re permitted by applicable law; or, nayment, or health care sitted by and in compliance le; n activities, reporting of abuse, or violence, health oversight did administrative proceedings, rposes, organ donation purposes, or to coroners, funeral directors, and to avert realth or safety as permitted re with 45 CFR 164.512. Incility must safeguard medical regainst loss, destruction, or all records must be retained re required by State law; or the date of discharge when rent in State law; or rears after a resident reaches re law.	F 843	en de de la composition della	30 days, to ensure that approphocumentation has been completed. Education was provided to the licensed nursing staff by the Practice Educator regarding Physician and Responsible paractication and medication documentation. Management team will audit Hour Report in morning clinication meetings 5 days per week, to ensure that appropriate notification have been completed and document. Unit Manager or Supervisor will audit the MA for incomplete documentation daily. Results of audits will be brought to the QAPI Commit for follow up monthly.	ne Nurse arty 24 cal cation R's	1/17/18
		edical record must contain- tion to identify the resident;		-	,		

provided;

(ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services

and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed

professional's progress notes; and

(iv) The results of any preadmission screening

		AND HE AN SERVICES					FORM	12/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		(X3) DAT COM	E SURVEY PLETED
		495246	B. WING				1	C 08/2017
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
WOODM	ONT CENTER				1 DAIRY LANE REDERICKSBURG, VA 22	405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	į.	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 842	(vi) Laboratory, radiservices reports as This REQUIREMENDY: Based on observate document review as was determined the acomplete and according of 29 residents in the #47, #83 and #286. 1. The facility staff of #47's representative catheter was placed 2. The facility staff on 11/3/17. 3. The facility staff on 11/3/17. 3. The facility staff on 11/3/17. 3. The facility staff on 11/3/17. 4. The facility staff on 11/3/17. The facility staff on 11/3/17. The facility staff on 11/3/17. Resident #286 receordered by the physical trade of 11/3/17 and readment was placed 11	iology and other diagnostic required under §483.50. NT is not met as evidenced ion, staff interview, facility and clinical record review, it facility staff failed to maintain the curate clinical record for three is survey sample, Residents ailed to document Resident was notified when a urinary in the resident. ailed to document an sident #83 was not reation scheduled for 9:00 p.m. ailed to document that ived glucagon on 12/4/17 as sician. a: ailed to document Resident was notified when a urinary in the resident. ailed to document that ived glucagon on 12/4/17 as sician. a: ailed to document Resident was notified when a urinary in the resident. dmitted to the facility on nitted on 11/22/17. Resident luded but were not limited to: dney disease and adult failure #47's most recent MDS, a five day Medicare ARD (assessment reference	F	342				
	1. The facility staff fa #47's representative catheter was placed Resident #47 was a 10/26/17 and readm #47's diagnoses inc diabetes, chronic kie to thrive. Resident a (minimum data set), assessment with an date) of 11/29/17, co	ailed to document Resident was notified when a urinary I in the resident. dmitted to the facility on hitted on 11/22/17. Resident luded but were not limited to: dney disease and adult failure #47's most recent MDS has a five day Medicare						

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DEPARTMENT OF HEALTH AND HEAN SERVI	CES
CENTERS FOR MEDICARE & MEDICAID SERVIO	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495246	B. WING			C 12/08/2017	
	PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, Z 11 DAIRY LANE FREDERICKSBURG, VA 224	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A Terres en la companya de designa	Resident #47 as h. (1). Review of Resider a physician's order catheter. Further r (including nurses' i #47's representation new catheter order. On 12/7/17 at 3:30 conducted with LP (the nurse response catheter order). LF Resident #47's repwounds and remercatheter. LPN #7 document notification asked if she should #7 stated, "Probable On 12/7/17 at 4:53 member) #1 (the exinterim director of r clinical quality special processes above concern. The facility policy tithe Health Status" documents the decision information regarding statusDocument: explanations of health Care decision informations of health care i	aving an indwelling catheter at #47's clinical record revealed at dated 11/5/17 for a urinary review of the clinical record motes) failed to reveal Resident are was notified regarding the by. p.m. an interview was N (licensed practical nurse) #7 hible for noting the 11/5/17 PN #7 stated she called resentative regarding new mbered telling her about the confirmed she did not on of the catheter. When I have documented this, LPN	F 842				

		AND HON SERVICES					FORM	12/18/2017 APPROVED
STATEMENT	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	Or Or	(X3) DAT COM	0938-0391 E SURVEY PLETED
		495246	B. WING					C 08/2017
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE,	ZIP CODE		
WOODM	ONT CENTER				1 DAIRY LANE REDERICKSBURG, VA 22	2405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 842	information was obto https://medlineplus. 2. The facility staff to explanation why Readministered medic on 11/3/17. Resident #83 was a 9/24/17 and readministered medic on 11/3/17. Resident #83 was a 9/24/17 and readministered medic on 11/3/17. Resident #83 was a 9/24/17 and readministered medic on 11/3/17, compain in the right knew blood pressure. Re(minimum data set) assessment with ar date) of 11/28/17, cognitively intact. Review of Resident the following readministers.	tained from the website: gov/ency/article/003981.htm failed to document an esident #83 was not eation scheduled for 9:00 p.m. admitted to the facility on ested on 11/2/17. Resident cluded but were not limited to: se, muscle weakness and high esident #83's most recent MDS as a 30 day Medicare a ARD (assessment reference oded the resident as #83's clinical record revealed esission orders dated 11/2/17: 00 mg (milligrams) every night 50 micrograms/50	F8	42				
	Review of Resident (medication administresident was not ad of the above medication of the above medication of the interest of	#83's November 2017 MAR stration record) revealed the ministered the 9:00 p.m. dose ations as evidenced by the itials on the MAR. There was on the back of the MAR, the atment administration record tes that Resident #83 was out xplain why the medication						
		a.m. a telephone interview LPN (licensed practical e responsible for						

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

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

PTATEMENT OF PERIOR	NOITE	1	1		4			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		IDENTIFICATION NUMBER.		FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		B. WING			C 12/08/2017			
NAME OF PROVIDER O	R SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
WOODMONT CEN				11 DAIRY LANE				
WOODMONT CENT	EK			FREDERICKSBURG, V	A 22405			
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION IVE ACTION SHOULD E ED TO THE APPROPRI FICIENCY)	BE COMPLETION	•	
Resident what sho their med stated nu sure they and phys medicatic let the su the medic pharmacy can also (STAT (immedicatio by circled usually medicatio or the resmade awathat were Resident #6 stated the facility no docum out of the could have because to go out the aware the LPN #6 st things I redocument when she the MAR, On 12/7/1 conducted administer	ering the 9 #83 on 11 uld be don lications ul rses shoul match the lician's ord pervisor kr cations will r run. LPN pe obtaine mediate) ns). LPN initials on eans the r n, the mediate she ini supposed #83 during she assur LPN #6 entation to facility on e been an he resider or a proce re was no ated, "I'm member." why a me initials and LPN #6 sta r at 11:24 with LPN ing the da	ge 329 :00 p.m. medications to /3/17). LPN #6 was asked the to ensure residents receive pon readmission. LPN #6 Id review the MARs and make the admission medication list the admission medication wand call the pharmacy so the delivered on the next the stated many medications deform the facility Omni cell the admission was not in the facility the MAR. LPN #6 stated it the sident refused the dication was not in the facility not in the facility. LPN #6 was tialed and circled medications to be administered to the evening of 11/3/17. LPN the evening of 11/3/17. LPN the evening of 11/3/17. LPN the evening of the evening the evening of the stated there order to hold medications the may have been scheduled didure. LPN #6 was made order to hold medications. Those are the only When asked if she should dication is not administered dicircles the medication on ated, "Yes." a.m. an interview was #4 (the nurse responsible for y shift medications to 3/17). I PN #4 stated the		12				

PRINTED: 12/18/2017 DEPARTMENT OF HEALTH AND HUMÁN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED 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 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 842 | Continued From page 330 F 842 resident's medications were not available for administration during her shift so she documented this on the back of the MAR and notified the nurse practitioner. On 12/7/17 at 3:31 p.m. an interview was conducted with LPN #7. LPN #7 was asked what it meant when a medication was initialed and circled on the MAR. LPN #7 stated, "That means it wasn't given. Then I turn the MAR over and explain why it wasn't given. 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.

the nurses' notes..."

the website:

The facility policy titled, "Medication

Shortages/Drugs Not Available" documented, "Document missed dose on the Medication Administration Record (MAR) or Treatment Administration Record (TAR) with explanation in

No further information was presented prior to exit.

https://medlineplus.gov/druginfo/meds/a682578.h

(2) Advair diskus is used to treat asthma. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=4eeb5f6a-593f-4a9e-9692-adefa2caf8fc

(1) carisoprodol is used to relax muscles and relieve pain. This information was obtained from

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	200/2000 00 0/100/150	495246	B. WING			12	/08/2017
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZI 11 DAIRY LANE FREDERICKSBURG, VA 2240			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	ION SHOULD HE APPROPE	BE	. (X5) COMPLETION DATE
F 842	3. The facility staff Resident #286 rec sugar of 42 on 12/physician. Resident #286 was 2/15/17 and readm diagnoses that inc diabetes, stroke, hid disease, prostate of the resident #286's in data set), an admis (assessment referencesident #286 as interview for mental -15, 15 being cogrequiring extensive dependent of one stailly living and supfor eating. An observation was 12/4/17 at approximal resident was 15/4/17 at 15	age 331 failed to document that eived glucagon for a low blood 4/17 as ordered by the s admitted to the facility on hitted on 11/18/17 with luded but were not limited to igh blood pressure, heart cancer and arthritis. nost recent MDS (minimum esion assessment with an ARD ence date) of 11/25/17, coded scoring a 15 on the brief al status (BIMS) of a score of 0 hitively for making daily ht # 286 was coded as a sasistance to being totally estaff member for activities of ervision of one staff member s made of Resident #286 on mately 7:10 p.m. when the ay was delivered. The	F8	42			
The state of the s	wake up Resident a bed with deep snor	d the staff he was unable to #286. The resident was lying in ing. LPN (licensed practical the resident's blood sugar. ading was 42 (1).					
The second secon	(registered nurse) # the physician and re (2) to be given to R intramuscularly or s	eximately 7:15 p.m., RN #2, the staff educator called eceived an order for glucagon esident #286 either subcutaneously (RN #2 had the palm of her hand and				e de la constante de la consta	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495246	B. WING			ľ	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	(FACH 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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Review of Resident dated 11/18/17 doc protocol standing or blood sugar) protocol Review of the hyporocol documented, "TRE Unconscious. Performeasurement. If lest ordered low paramed Glucagon 1 mg (mi DOCUMENTATION MAR (if indicated)." Review of the Dece administration recoglucagon had been #286 on 12/4/17. An interview was concerned by the parameter was the particular day this partner was the	ge 332 #286's physician's orders umented, "Hypoglecemic (sic) rders for hypoglycemic (low ol." glycemic protocol ATMENT Symptomatic orm fingerstick blood glucose as than 70 or physician eter immediately administer Iligram) IM (intramuscularly). I Glucagon administration on	F 8	342			
	p.m. I gave him the my other medication another nurse and told his blood sugar asked who gave the #2 stated, "(Name of have learned from the	ince dinner comes around 5:30 insulin and then I went to give hs. Then I was called to help then around at 7:00 p.m. I was had dropped to 42." When a resident the glucagon, LPN of LPN #4). LPN #2 stated, "I his. I would never do this make sure I check them."					

DEPARTMENT OF HEALTH AND HOAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1''	ING		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			1 1210012011		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 842	On 12/7/17 at 1:50 staff member) #1, the interim director corporate clinical signature concern. An interview was cop.m. with LPN #4, the glucagon injection asked how she had LPN #4 stated, "Su asked where she histated she had forgomedication. An interview was cop.m. with ASM (admitted interim director where staff should ASM #2 stated in the No further information. (1) Low blood sugal low blood glucose owhen the level of	p.m. with ASM (administrative he executive director, ASM #2, of nursing and ASM #3, the pecialist were made aware of conducted on 12/7/17 at 2:30 he nurse who administered ion to Resident #286. When I administered the medication, bq (subcutaneously)." When ad documented it LPN #4 potten to document the conducted on 12/7/17 at 2:45 ministrative staff member) #2, of nursing. When asked document their medications he MAR. Ion was obtained prior to exit. In the interpretation of the property of the problems	F 8	42				

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	700270	15: 11:10-	67	(DEET ADDRESS CITY OTATE TO CORE	12/	08/2017
	ONT CENTER			11	FREET ADDRESS, CITY, STATE, ZIP CODE 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)		PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	development and tran diseases and infection §483.80(a) Infection p program. The facility must estable and control program (I a minimum, the following services und arrangement based up conducted according to accepted national stan §483.80(a)(2) Written sprocedures for the probut are not limited to: (i) A system of surveilla possible communicable disease reported; (iii) When and to whom communicable disease reported; (iiii) Standard and trans	atrol olish and maintain an and control program safe, sanitary and ent and to help prevent the smission of communicable is. revention and control olish an infection prevention PCP) that must include, at ing elements: In for preventing, identifying, and controlling infections leases for all residents, rs, and other individuals er a contractual on the facility assessment of \$483.70(e) and following dards; standards, policies, and gram, which must include, ance designed to identify ediseases or can spread to other	F8	880	 Resident #286 discharged to the hospital on 12/14/17 and has not returned to the facility. Reside expired at the facility on 1/5/18 Resident #184 discharged to he 12/16/17. All staff will consisted practice good hand-washing durneal service. All oxygen supple be stored observing appropriate infection control practices. House audit completed by Administrator of all oxygen supstorage in resident rooms to ensure appropriate infection control steplace. House audit completed I Managers to ensure that oxyger supplies were stored appropriate. Education was provided to nurse by the Nurse Practice Educator Nursing Supervisor related to ghandwashing practice during meservice, oxygen practice standarcare of oxygen equipment. Unit Managers and Shift Superwill audit staff good handwashing practice during meal time 3 timeweek for 6 weeks and then rand thereafter. Unit Managers and Shift Superwill Managers and Shift Superw	ot nt #9 3. ome on ently uring ies will be orage if or the ood eal ords and visors ng es a omly Shift	
	(iv)When and how isolatesident; including but	ation should be used for a	TO THE PROPERTY PRODUCTION OF THE PROPERTY OF		Supervisor will perform room ro and audit oxygen equipment 3 t		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/20/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 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** (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 335 F 880 week for 6 weeks and then randomly (A) The type and duration of the isolation. depending upon the infectious agent or organism thereafter to ensure safety. Results of audits will be brought to the Quality (B) A requirement that the isolation should be the Assurance and Performance Improvement least restrictive possible for the resident under the 1/17/18 Committee for follow up monthly. circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined the facility staff failed to maintain infection control practices during a meal observation and for three of 29 residents in the survey sample and during the dining observation. Resident #286, #9 and #184.

1. The facility staff failed to sanitize their hands after removing gloves and touching their face prior to serving residents their meal on 12/4/17 at

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(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				
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F 880	the main dining roo 2. The facility staff 286's lunch in a sar 3. The facility staff foxygen equipment is prevent infection. 4. The facility staff frequipment and nebmanner to prevent infection. The findings include 1. A dining observation of the residents in the main of the residents. CNA and the residents. CNA after removing her graph of the residents. CNA after removing her graph of the residents lunch. An interview was cop.m. with RN (regist when staff washed to knew that when you have washed my hawash their hands, R control."	lunch dining observation in m. failed to serve Resident # itary manner. ailed to store Resident #9's n a sanitary manner to ailed to store oxygen ulizer equipment in a sanitary nfection for Resident #184.	F 88	30				

		AND HOWAN SERVICES				FORM	12/18/2017 APPROVED 0938-0391	
STATEMEN	TOF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495246	B. WING				C 08/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE			
WOODM	ONT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 224	05		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 880	washed their hands after anything." Whetheir hands after restated, "Yes." When they touch their face hands." When aske hands, CNA #10 stagerms." On 12/7/17 at 4:45 member) #1, the exinterim director of nucorporate quality spathe findings. Review of the facility Washing" document is performed freque washing technique. spread of disease. Fears, nose, or mout task to another. 4. Unot replace proper has hot further information. The facility staff if 286's lunch in a san Resident # 286 was 02/15/17 with a reach Diagnosis include by weakness, prostate	When asked when staff, CNA #10 stated, "Before and en asked if staff were to wash moving their gloves, CNA #10 asked what staff should do if e, CNA #10 stated, "Wash my d why staff washed their ated, "To keep from spreading p.m. ASM (administrative staff ecutive director, ASM #2, the ursing and ASM #3, the ecialist were made aware of y's policy titled, "Hand ted, "POLICY Hand washing ntly and using correct hand PURPOSE To minimize the PROCESS 1.2 Touching hair, h; 1.7 When moving from one Use of disposable gloves does hand washing."	F	380				

Resident # 286's most recent MDS (minimum data set), an admission assessment with an ARD

	TMENT OF HEALTH				FORM	: 12/18/2017 I APPROVED
STATEMENT	RS FOR MEDICARE TOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495246	B. WING		C 12/08/2017	
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	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	Resident # 286 as a interview for mental - 15, 15 being cognidecisions. Resident requiring extensive dependent of one sidaily living and superformental extensive dependent of one sidaily living and superformental extensive dependent of one sidaily living and superformental extensive dependent of Resident CNA (count of Resident Were observed and OSM (other state student were observed extensive extensive dependent extensive	nce date) of 11/25/17, coded scoring a 15 on the brief status (BIMS) of a score of 0 itively for making daily t # 286 was coded as assistance to being totally taff member for activities of ervision of one staff member roximately 12:40 p.m. and dent # 286's room was ertified nursing assistant) # 7 fff member) # 11, nursing yed in Resident # 286's room. # 11 were observed ent # 286 in his bed to prepare # 7 and OSM # 11 were both ter Resident # 286 was pulled to premove the sink in the own, removed her gloves and OSM # 11 while still wearing trieved the over the bed table # 286's lunch tray. OSM # 11 while still wearing trieved the over the bed table # 286's room, removed her # 286. She then went to # 286's room, removed her	F8	80		

Event ID: DGWI11

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER'SUPPLIER'CLIA IDENTIFICATION NUMBER:		1''	TIPLE CONSTRUCTION	COMPLETED C		
		495246	B. WING		1	12/08/2017
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 2240	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
***************************************	On 12/07/17 at apinterview was conditioned interview was conditioned interview. Was conditioned into the control concern of this surveyor. Whe education regarding stated, "The nursing infection control proprior to their field post of their field post of the conducted with OS nursing student from College) in the preserving infection of gloves, OSM # 10 if she recalled assistant) # 7 with agreed that she has repositioning Residuals while wearing gloven next OSM # 11 states the bed table with fit and began to ope # 11 further stated gloves after repositioning has before serving his in should have taken (Resident # 286) him On 12/06/17 at app (administrative staff director, ASM # 2, 10 in the condition of the condi	proximately 8:20 a.m. an ducted with OSM (other staff sistant Professor of (Name of e) regarding an infection a nursing student observed by en asked about the student's ig infection control OSM # 12 in students are educated about actices and the use of gloves lacement." O a.m. an interview was sim (other staff member) # 11, im (Name of Community sence of OSM #12, Assistant e of Community College). In had received training control practices and the use in stated, "Yes." When asked sting CNA (certified nursing Resident #286. OSM # 11 d assisted CNA # 7 in lent #286 for lunch in his bedies. When asked what she did ted she then moved the over Resident # 286's lunch tray on en the lunch containers. OSM ishe had not removed her ioning Resident # 286 and unch. OSM # 11 stated, "I off my gloves before serving is lunch." Proximately 5:00 p.m. ASM if member) # 1, the executive the interim director of nursing all quality specialist, were	F8			

DEPARTMENT OF HEALTH AND HE AN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA 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 CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 880 Continued From page 340 F 880 No further information was obtained prior to exit. 3. The facility staff failed to store Resident #9's oxygen equipment in a sanitary manner to prevent infection. Resident #9 was admitted to the facility on 9/14/16 and readmitted on 8/11/17 with diagnoses that included but were not limited to: pancreatic cancer, muscle weakness, pressure ulcer to the right buttock, type two diabetes, and hypothyroidism. Resident #9's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 11/09/17. Resident #9 was coded as being moderately impaired in cognitive function scoring 09 out of 15 on the BIMS (brief interview for mental status) exam. Resident #9 was coded as requiring extensive assistance from two or more staff members with transfers, bed mobility, and toileting, and extensive assistance from one staff member with dressing and personal hygiene. On 12/04/17 at 03:21 p.m., an observation was made of Resident #9. Her oxygen tubing including the nasal cannula was uncovered sitting on top of the concentrator. Her oxygen tubing was not placed in a plastic bag. A plastic bag could not be found in her room. On 12/05/17 at 08:11 a.m., an observation was made of Resident #9. Her oxygen tubing including the nasal cannula was uncovered sitting on top of the concentrator. Her oxygen tubing was not placed in a plastic bag. A plastic bag could not be found in her room.

On 12/06/17 07:58 a.m. an observation was made of Resident #9. Her oxygen tubing was observed on the floor. A plastic bag could not

PRINTED: 12/18/2017

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 '	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495246	B. WING		12	C 12/08/2017	
	NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER			STREET ADDRESS, CITY, STATE, 11 DAIRY LANE FREDERICKSBURG, VA 22	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	· · · · · · · · · · · · · · · · · · ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	orders revealed the 10/22/17, "Oxygen of 5 liters to maintain of above 92 percent." On 12/06/17 at 11:3 conducted with LPN When asked how on the incomplete of the property o	#9's physician telephone following order initiated on via nasal cannula titrate up to oxygen sats (saturations) at or 2 a.m., an interview was I (licensed practical nurse) #8. xygen should be stored when stated, "Oxygen is wrapped in its changed out on Saturdays. They change the bag as well, in the resident's name and I #8 stated that oxygen tubing a plastic bag to prevent p.m., an interview was #2, Resident #9's nurse. cygen tubing should be stored N #2 stated, "02 (oxygen) red in a plastic bag with their t, liters of 02 (oxygen), and ged. Tubing should be rday." When asked why dibe stored in a plastic bag, uld be stored for sanitary er accompanied LPN #2 to When asked what LPN #2 ident #9's oxygen tubing, cygen tubing was on the floor. The could not find a plastic sp.m., an observation was	F	380			
		Resident #9 was on 2 liters annula. A plastic bag was			THE STREET, A LABOR.		

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DEPARTMENT OF HEALTH AND	AN SERVICES
CENTERS FOR MEDICARE & ME	DICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495246	B. WING				C / 08/2017
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE I DAIRY LANE REDERICKSBURG, VA 22405	1	0012011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		BE .	(X5) COMPLETION DATE	
	not in Resident #9's tubing was changed tubing. On 12/06/17 at 5:30 staff member) #1, the interim DON (Di #2, the clinical quali of the above concer Facility policy titled, Disinfection/Cleaning concerns. No further information was a stiff. That makes breath, and your block tubing was condition in which the becomes scarred ov and stiff. That makes breath, and your block tubing.	room. A date of when the decould not be found on the p.m., ASM (administrative ne executive director, ASM #2, rector of Nursing) and ASM ty specialist were made aware	F 8	80			
	There was no compl	eted MDS (minimum data					

DEPARTMENT OF HEALTH AND H AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		495246	B. WING			C 2/08/2017		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE	2/00/2017		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880		=	F 88	30				
	The Initial Nursing A documented the resto person, place and under "Respiration nasal." On 12/04/17 at 11:4 was observed. The observed lying on the not covered, and was On 12/04/17 at 02:2 Nebulizer mask was	Assessment, dated 11/30/17, sident was alert and oriented d time. The form documented regular Method: oxygen via 5 a.m., Resident #184's room Oxygen (O2) tubing was as sitting on nightstand.						
	tubing, not covered, hanging and touchin On 12/04/17 at 3:07	p.m., an oxygen tank with O2 had the nasal cannula just ng the floor. p.m., The clinical record was no documented physician		•				
	On 12/04/17 at 4:30	p.m., Resident # 184 was th oxygen on via nasal						
	sitting on side of bed 4L/min running via n on top of night stand	a.m., Resident #184 was I eating breakfast. O2 at asal cannula. Nebulizer mask , uncovered. O2 tubing on wheelchair uncovered, ching floor.						
-	was observed. The r	5 a.m. Resident #184's room nebulizer was on the top of vered. The oxygen tubing		To the second se		Management (International Control		

DEPART	MENT OF HEALTH	AND MAN SERVICES & MEDICAID SERVICES				FORM	12/18/2017 APPROVED 0938-0391
STATEMENT	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WING			12/	08/2017
NAME OF F	PROVIDER OR SUPPLIER			i .	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE		
WOODM	ONT CENTER				REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	9	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	uncovered.	ge 344 ed around the concentrator, oted in the clinical record	F	880			
	dated 12/6/17 for O	xygen @ (at) 2L(liters)/NC n O2 saturation every shift.					
	was observed. The	a.m., Resident #184's room e nebulizer machine mask and on the bed, uncovered.					
	practical nurse) #4 asked where oxyge in use, LPN #4 stat equipment should to When asked why it	onducted with LPN (licensed on 12/6/17 at 2:06 p.m. When in tubing is stored when it's not ed that all respiratory be bagged when not in use." should be bagged, LPN #4 on control purposes."					
	Disinfection/Cleaning	Respiratory Equipment ng" did not address storing the ent in bags when not in use.	SEZZANNAMIZZANIMA PROPRINTA T-F-B-V-B-V-B-V-B-V-B-V-B-V-B-V-B-V-B-V-B				out and control of the control of th
	Patricia A. Potter au Inc; Page 648. "Bo Health Care-Assoc	of Nursing" 7th edition, 2009: and Anne Griffin Perry: Mosby, ox 34-2 Sites for and Causes of iated Infections under - Contaminated respiratory					
	executive director, nursing, and ASM #	member (ASM) #1, the ASM #2, the interim director of #3, were made aware of the 12/7/17 at 4:45 p.m.	The state of the s				
	References: (1) Barron's Diction Non-Medical Read Chapman; page 12	ary of Medical Terms for the er, 5th edition, Rothenberg and 4.	THE THE PROPERTY OF THE PROPER				

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
		495246	B. WING			C 12/08/2017	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP OF 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
SS=B	(2) Barron's Dictional Non-Medical Reader Chapman; page 55. (3) This information following website: https://medlineplus.grequired In-Service CFR(s): 483.95(g)(1) \$483.95(g) Required aides. In-service training mage shape sh	ary of Medical Terms for the er, 5th edition, Rothenberg and was obtained from the gov/pulmonaryfibrosis.html. Training for Nurse Aides)-(4) d in-service training for nurse nust- fficient to ensure the nce of nurse aides, but must ours per year. e dementia management abuse prevention training. ss areas of weakness as aides' performance reviews ent at § 483.70(e) and may needs of residents as cility staff. It is aides providing services gnitive impairments, also the cognitively impaired. It is not met as evidenced triews and facility document nined the facility staff failed to in-service training for the	F 84	Certified Nurse A have not received hours of mandator	their 12 ry, annual ve the the potential 100% audit d Nurses ted by the ucator, to l not atory 12 Educator rack the conthly, he Director Educator week for 6 domly of audits at QAPI	1/17/18	

		AND MAN SERVICES				FORM	: 12/18/2017 APPROVED : 0938-0391
STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	B. WING			12/08/2017	
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WOODM	ONT CENTER				REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 947	Continued From pa year except for CN past year. The findings include	As who had been hired in the	F 9	47			
	During the extende evidence of the CN requested on 12/5/	d survey a request for A competency training was 17 at 5:10 p.m. from ASM f member) #2, the interim				,	
	A request for any e	ducation on oxygen safety for ed at that time.	overe a madre versa de foldere a accepto e v				
	stated, "We don't h	a.m. RN (registered nurse) #2 ave any annual competencies be the same as the ones we do	mouri estabativos mandolostados vivestes vergenes de estabativos de estabatitante de estabativos de estabativos de estabativos de estabativos	NAMES OF THE PROPERTY AND ADDRESS OF THE PROPERTY OF THE PROPE			
e.	A review of the CN/ not evidence documeducated on oxyge	A competencies booklet did nentation that the CNAs were n safety.	majana-cijoja menatara kanakanangan	ACCORDANGE AND			
	a.m. with ASM (adm the executive direct CNA competencies months and months got one and then sh it's (name of RN #2	onducted on 12/6/17 at 9:00 ninistrative staff member) #1, tor. When asked about the ASM #1 stated, "We went is without a nurse educator. I ne left after two months. Now a.)." ASM #1 verbalized oncern and the education					
	a.m. with ASM #2, t When asked the preducation, ASM #1	conducted on 12/8/17 at 9:40 the interim director of nursing. ocess for providing CNA stated, "Normally at least on new need to be done once a	ndory valida ir placitis manonal molinocova mater a multa vanta conditional.	tráculos * (a e eleminorimente desimbro escreta dolume			

year."" When asked why the education was

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

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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 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 PROVIDER'S PLAN OF CORRECTION (X PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 947	skills are up-to-date needs of the reside at that time.	age 347 2 stated, "So we know their e and up to par to meet the ents. The concern was shared ion was provided prior to exit.	FS	947				
				ar melius soome				

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

Event ID: DGWI11

Facility ID: VA0279

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