PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495144	B. WING				11/	29/2018
	ROVIDER OR SUPPLIER	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SH		SHOULD B	OULD BE COMP	
E 000	0 Initial Comments		E	00				
F 000	survey was conducted. The facility was in sulf CFR Part 483.73, Recomplaints were investigated. No encomplaints were investigated. In unannounced Mesurvey was conducted. Corrections are requirements. The Lisurvey/report will follows.	dicare/Medicaid standard d 11/27/18 through 11/29/18. red for compliance with 42 l Long Term Care fe Safety Code w. No complaints were	FC	00				
	survey/report will follow. No complaints were investigated during the survey. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 36 resident reviews. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.		F	84 F 58 1. R and Resi on 1 prov line prov 11/2	eral Tags 34 desident #93 was provided new fitted sheet on 11 ident # 89 was provided 11/30/2018. Resident for on 11/27/2018. Residuded a new mattress a 27/2018.	1/30/20 d with a #47 & #: ress and dent # 3 nd clear was pro	top she top she 158 wer clean 0 was n linen c	e

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

If continuation sheet Page 1 of 58

PRINTED: 12/05/2018 FORM APPROVED

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
	·	495144	B. WNG			11/	/29/2018
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
DETEDOO	URG HEALTHCARE CEN	iteo		2	87 EAST SOUTH BOULEVARD		
7 2 1 2 1 0 0	ONG HEALTHOARE CEN	TIER //		PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE
- 25	(ii) The facility shall exthe protection of the more theft. §483.10(i)(2) Houseke services necessary to and comfortable interiors. §483.10(i)(3) Clean being good condition; §483.10(i)(4) Private or resident room, as specially shall areas; §483.10(i)(5) Adequate levels in all areas; §483.10(i)(6) Comfort levels. Facilities initially 1990 must maintain a 81°F; and §483.10(i)(7) For the mount of the second levels. This REQUIREMENT by: Based on observation interview and facility of facility staff failed to environment for 5 resident, 30 and 98) of 36 resample. 1. For Resident #93, 1 provide a top sheet on	kercise reasonable care for esident's property from loss eeping and maintenance maintain a sanitary, orderly, for; ed and bath linens that are closet space in each cified in §483.90 (e)(2)(iv); the and comfortable lighting able and safe temperature by certified after October 1, temperature range of 71 to maintenance of comfortable is not met as evidenced in, staff interview, resident ocumentation review the insure a clean, homelike dents (Resident #93, 89, esidents in the survey	F	584	2. Current residents' mattresses waudited on 11/27/2018 by mainted designee and replacements were needed on 11/27/2018. Current rebeds were checked on 12/07/2018 linen was clean, top sheet was prelinen was in good repair by house designee. 3. Nursing personnel were educated director of nursing/ designee on homake a bed properly with a top shouse to have a bed properly with a top shouse by Administrator/designee on macleaning by 12/14/2018. Maintend designee was inserviced on when a mattress by 12/14/2018. 4. A weekly audit of facility mattreand made beds will be completed. Unit Manager/ designee times two Results from audits will be forward Quality Assurance/ Performance. Improvement Committee to ensurcompliance and the need for furth monitoring for three (3) months.	nance/ given if resident: 8 to ens esent, ar keeping ed by th ow to neet by inservic ttress ance/ to repla sses, lin by the elve wee led to the e	sure nd // ne ced ice
	For Resident #89, t provide a top sheet on	he facility staff failed to the bed.				78	2

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			100000	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
0.0		495144	B. WING		11/29/2018			
	PROVIDER OR SUPPLIER BURG HEALTHCARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		112312010		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 584	4. For Resident #30, provide a clean mattr 5. For Resident #98 provide a top sheet of The findings included 1. For Resident #93, provide a top sheet of Resident #93, a 75 yet facility on 11/2/18. Didementia, reflux, dysphypertension. The most assessment was a with an assessment reflex with a ctivities of daily on 11/27/18 at 12:35 observed in bed. Her this time, it was observed in cluded a very thin fit comforter with polka disee through. There we the daughter was ask	the facility staff failed to ess and clean linen. the facility staff failed to ess and clean linen. the facility staff failed to the facility staff failed to in the bed. the facility staff failed to in the bed. ear old, was admitted to the agnoses included seizures, shagia, diabetes, lest recent Minimum Data an admission assessment eference date of 11/9/18. Hed with moderate cognitive ed extensive assistance living. D.m., Resident #93 was daughter was visiting. At	F 58					
Λ	The bedding was obse	d sheet being very thin. erved as follows: Resident #93 in bed. A th a deer design, and the			i			

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

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 3 of 58



		AND HUMAN SERVICES					ED: 12/05/2018 RM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MA					<u> </u>	OMB N	O. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILD		ONSTRUCTION		E SURVEY RPLETED
		495144	B. WING	R	<u> </u>	4	1/29/2018
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				1/20/2010
PETERSI	BURG HEALTHCARE C	FNTED		287	EAST SOUTH BOULEVARD		
			PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 584	There was no top s 11/28/18 at 2:15 p.r bed. The bed was	comforter were observed. heet on the bed. m. Resident #93 was out of made with a fitted sheet, the rquoise blanket. There was	F	584		et.	
	11/29/18 at 9:35 a.n bed. The bed was i	n. Resident #93 was out of made with a fitted sheet, the rquoise blanket. There was bed.					- Si
80	(Employee F) was in explained that linens one time per shift. E sheets and 30 fitted shift. At this time, the available for use in tunit, 1 top sheet was	p.m., the laundry staff nterviewed. Employee F s were stocked on both units Employee F stated that 30 top sheets were stocked per nere were 32 clean top sheets the laundry room. On 100 s available for use and on the ts were available for use.			•	ĺ	#3
	conducted with Certi (CNA B). CNA B wa process for changing bed. She stated that shower days and as linens to be used inc sheet if needed, a to B was asked to obse identified that the top	a.m., an interview was ified Nursing Assistant B is asked to explain the g bed linen and making the t beds were changed on needed. She stated the duded a bottom sheet, a draw p sheet and a blanket. CNA erve Resident #93's bed. She o sheet was missing.			₹		
		eting on 11/29/18, the rector of Nursing were				}	

notified that staff were not using a top sheet when

PRINTED: 12/05/2018

PRINTED: 12/05/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ___

B. WING

495144

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

287 EAST SOUTH BOULEVARD

PETERSB	URG HEALTHCARE CENTER	PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 584	Continued From page 4 making the beds. When asked if the facility had	F	584		lg	
2	enough linens to make the bed, the Administrator stated that she had recently purchased linens. She was asked to provide the receipts. The		,,			
	Administrator provided the receipts showing that she had purchased linens. The Administrator					
#1 #3	stated that the linens were available for staff use and she felt that the issue may be a training issue.					
Đ.	2. For Resident #89, the facility staff failed to provide a top sheet on the bed.					
	Resident #89, an 86 year old, was admitted to the facility on 5/13/18. Diagnoses included Alzheimer's disease, reflux, hypertension,	:				
	depression, and dysphagia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/8/18. Resident #89 was coded with severe cognitive impairment and required extensive assistance with activities of daily living. She was	l.				
Š.	on 11/29/18 at 10:00 a.m., Resident #89 was observed lying across her bed in a fetal position. She was asleep on top of the covers. The			, 12		
1	bedding did not include a top sheet. Resident #89 lived on the 100 unit.					
	At the end of day meeting on 11/29/18, the Administrator and Director of Nursing were notified that staff were not using a top sheet when making the beds.	**			7	
K	3. For Resident #47, the facility staff failed to			¥		

11/29/2018

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495144	B. WING			11/29/2018		
347	ROVIDER OR SUPPLIER	ITER	. •	287	REET ADDRESS, CITY, STATE, ZIP CODE 7 EAST SOUTH BOULEVARD TERSBURG, VA 23805	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 584	Continued From page provide a clean mattre		F	584				
6	diagnoses included H following Cerebral Info	7 year old who was on 3/11/15. Resident #47's emiplegia and Hemiparesis arction affecting Left side, fajor Depressive Disorder.			526		Towns and the second	
	Assessment with an A of 10/11/18 was review as having a Brief Asse	et, which was a Quarterly essessment Reference Date wed. It coded Resident #47 essment of Mental Status mild cognitive impairment.	=					
	conducted with Reside Nursing (DON Employ Resident #47 stated to damaged and that he addition, another Resi placed in the sample a present. Both resident	nat his mattress was wanted another one. In dent who was identified and as Resident #158 was s stopped the surveyor in					Color of the Color of the Color of the Color of the Color of Color	
94		lained about the condition t #158 also stated that her re dirty."	*:		de T			
(3)	look at the mattress all When asked to describ mattress, the DON sta has a dark stain mayb center." The stains we in diameter, round in s color and appeared to			Įš	£2			
4	the stains, the DON stallays on that area in the cleaning." When asked	ated, "The residents butt						

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

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 6 of 58



CTATEMENT	AF DEFINIENDISA	WAL PROME CENTURE ATTICLES			- 	ī	10. 0830-0381
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		DNSTRUCTION		TE SURVEY MPLETED
		495144	B. WING		·-···	11/29/2018	
NAME OF F	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
PETERSE	BURG HEALTHCARE CE	NTED		287	EAST SOUTH BOULEVARD		1
PETEROE	BONG HEALINGARE CE			PET	ERSBURG, VA 23805		15
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)		38 C	(XS) COMPLETION DATE
F 584	F 584 Continued From page 6			584			40 A
	,	zips off." She then zipped it		004			
		ere was a hole in it. The					Ė
		iled. When asked about the					
		clean linen and a clean					!
		ated, "The importance is					
		lean linen because of					
	maintaining good skir	n condition."					100
							10
	A Carbadan #460	Al 5 1114 1 - 07 5 - 14 - 4 A					
	provide a clean mattr	, the facility staff failed to		-	w)		3
	provide a dealt matti	ess and interi.		İ			
F.01	Resident #158 was a	61 year old who was	1				
		he facility on 11/16/18.					
		noses Muscle Weakness,					
	and Chronic Obstruct	tive Pulmonary Disease.		- 1			
						0.0	
		ble to understand and be					11.00
		. She was oriented to		- 1			
19	person, place, and sit	tuation.					
40	On 11/27/18 at 11:26	A.M., an interview was					
10		ent #47. The Director of					
	Nursing (DON Employ						(2)
	Resident #47 stated t	•					
	damaged and that he	wanted another one. In					70
W	addition, another Res	ident who was identified and			*5		
	placed in the sample				3		16
		ts stopped the surveyor in					1 1
		plained about the condition					9 4
		nt #158 also stated that her					
	"bed and mattress we	re airty."	1				4
	The Director of Nursir	ng stated that she would					
17		long with the surveyor.			18		
		be the condition of the					
\equiv		ated, "The blanket needs					10
		on it. Maybe it's food. The					#
		ing. It has something white	ĺ				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	1, ,	TË SURVEY MPLETËD		
		495144	B. WING_		1	1/29/2018		
	PROVIDER OR SUPPLIER BURG HEALTHCARE CEN	NTER		STREET ADDRESS, CITY, STATE, ZIP CO 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 584 Continued From pa		e 7	F 5	84				
İ	The mattress had 2 li	nket had dark stains on it. ight colored stains that were es long on the upper left	.					
30 A	conducted. Nine resid	A.M., a Group Interview was dents attended the meeting. dents complained about clean bed linen, and a is in particular.		ε	e s	10.110		
	conducted with the Ho (Employee M). He stated monthly. He to nursing staff were sup	P.M., an interview was ousekeeping Director ated that the mattresses are further stated that the pposed to alert the mattress is soiled.	<u>.</u>		8			
	When asked about the cover, he stated, "the waterproof but not am	e holes in the mattress mattress covers are monia proof." He implied t with urine could cause a		3	a 8			
	manufacturer's instruction. Term Care Pressure Foread, "Wipe down the pre-soaked with warm detergent. Approved in							
2	material. Cover materi Stretch. Chlorine blead mattress top cover cal for laundry with water degrees F; however, it	it is recommended that the call policy to determine the						
	thermal disinfection. A	After cleaning, please avoid dusty areas. All parts should				5.4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		SURVEY PLETED		
		495144	B. WING		11/	29/2018
	ROVIDER OR SUPPLIER	CENTER	287	ET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD ERSBURG, VA 23805		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
F 584	Continued From pa	age 8	F 584		•	
	be air dried thorou	ghly before use."				
	5. For Resident # provide a top shee	98, the facility staff failed to ton the bed.	*		~.	
线		ale, was admitted to the facility			3	1 1
	Acquired absence	of right upper limb above sis, Chronic Viral Hepatitis C,				
	Gastroesophageal Hypertension.	Reflux Disease, Diabetes, and				
121	11/13/2018 was co- assessment. Resid Interview for Menta	est recent MDS with an ARD of ded as an admission dent # 98's BIMS (Brief Il Status) score was coded as gnitive impairment. Resident #			3	
	98 was coded as no one staff member to	eeding limited assistance of perform his activities of daily			*	
9		98 was coded as being able to stand, and be understood.			# Ek	
7	observation showed	1:45 AM during the initial tour, If the bed was made with no as a fitted sheet and a rd.	5 (20)	e ÷	e #8	
į	the bed was made	:30 PM, observation showed with a fitted sheet and as no top sheet. Resident # om.			1	
SEA	no top sheet on the sitting in a wheelcha complained that the	0:20 AM, observation showed bed. Resident # 98 was air in his room. Resident # 98 staff didn't "know how to sident # 98 stated there was		# # # */V		

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING					(X3) DATE SURVEY COMPLETED		
-		495144	B. WNG				111	/29/2018	
	PROVIDER OR SUPPLIER BURG HEALTHCARE CE	NTER		287	EET ADDRESS, CITY, STATE, ZIP COD EAST SOUTH BOULEVARD ERSBURG, VA 23805	DE	× F		
(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 CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD B		(X5) COMPLETION DATE		
F 584	no top sheet. On 11/98/2018 at 9:5 the bed was made wi	5 AM, observation showed th a fitted sheet and s no top sheet. Resident #	F	584					
	Resident #98 lived or On 11/28/18 at 1:15 p (Employee F) was intexplained that linens one time per shift. Er sheets and 30 fitted shift. At this time, the available for use in thunit, 1 top sheet was 200 unit, 5 top sheets On 11/29/18 at 9:45 a conducted with Certifit	the 200 unit. I.m., the laundry staff erviewed. Employee F were stocked on both units inployee F stated that 30 top heets were stocked per re were 32 clean top sheets is laundry room. On 100 available for use and on the were available for use. I.m., an interview was ed Nursing Assistant B							
W.E.	bed. She stated that I shower days and as in linens to be used inclusheet if needed, a top B was asked to observe identified that the top state Administrator and Direct notified that staff were making the beds. Whenough linens to make stated that she had rect She was asked to provide in the state of the	bed linen and making the beds were changed on eeded. She stated the ided a bottom sheet, a draw sheet and a blanket. CNA we Resident #93's bed. She sheet was missing. Iting on 11/29/18, the ector of Nursing were not using a top sheet when en asked if the facility had a the bed, the Administrator cently purchased linens.							

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

Event ID: UCWJ11

Facility ID: VA0258

RECEIVED

DEC 13 2018

VDH/OLC

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
	87	495144	B, WING_	_		1	//29/2018
	PROVIDER OR SUPPLIER BURG HEALTHCARE CEN	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			128/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	stated that the linens	e 10 were available for staff use ssue may be a training	F 5	584		1	
F 600 SS=D	CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the meglect, misappropriat and exploitation as deincludes but is not limit corporal punishment, i any physical or chemic treat the resident's me §483.12(a) The facility §483.12(a)(1) Not use physical abuse, corpor involuntary seclusion; This REQUIREMENT by: Based on observation, interview, clinical recondocumentation review, ensure that three resident.	m Abuse, Neglect, and right to be free from abuse, tion of resident property, offined in this subpart. This ited to freedom from involuntary seclusion and cal restraint not required to edical symptoms. y must- y verbal, mental, sexual, or ral punishment, or is not met as evidenced	F6	3000	1. Residents #30, #158, & #98 allegabuse were identified and investig Staff members were identified and suspended pending investigation. #30, #158, & # 98 had no further a of verbal and physically abuse as 11/29/2018. 2. Current alert and oriented residinterviewed to ensure no other rewere affected by Social Services Didesignee on 11/29/2018. Current residents had skin assessments perby Unit Managers/ designee on 11/3. Current staff were inserviced by Administrator/ designee abuse regand prevention by 12/14/2018.	gated. d Resider allegation of lents we sidents irector/ dement erformed	nts ns ere
	1. For Resident #30, the ensure that she was freabuse by CNA E. 2. For Resident #158, the should be shoul	use.				80 80 80 90 90 90 90 80 80	The second secon
			ļ		i i	ł	j

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

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 11 of 58



STATEMENT AND PLAN O	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/IDENTIFICATION		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	152	(X3) DATE SURVE COMPLETED		J381
		495144	B. WNG _					
	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			11/	/29/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD B		(X5) COMPLET DATE	TO!
	Continued From page 11 3. For Resident #98, the facility staff failed to ensure that he was free of verbal abuse by CNA E. Findings included: 1. For Resident #30, the facility staff failed to ensure that she was free of physical and verbal abuse by CNA E. Resident #30 was a 54 year old who was admitted to the facility on 10/3/17. Resident # 30's diagnoses included Dependence on Renal Dialysis, Pain, Hypertension, Gastro- Esophageal Reflux Disease, Muscle Weakness, and Major Depressive Disorder. The Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 9/27/18 was reviewed. It coded Resident #30 as having a Brief Interview of Mental Status Score of 15, indication that she was cognitively intact.		F 60	4. Alert and oriented resinterviewed weekly time ensure reports of abuse followed through on by Director/ designee. Dem have skin assessments patimes twelve to ensure a have been properly follo Unit Managers/ deisgnee audits will be forwarded Assurance/ Performance Committee to ensure conneed for further monitor months.	es twelve we have been Social Servinented residented with the last the last the last the last the last the last the last the last the last the last the last last the last last last last last last last last	proper ice idents weekly abuse gh on be rom ality aent and the	ly vill y	019
	had been physically an staff member on night s CNA was an African An On 11/28/18 at 10:42 A was conducted with Re	a.M., an interview was ant #30 who stated that she diverbally abused by a shift. She stated that the nerican woman in her 60's. M., a second interview sident #30 in her room. or (Employee A), and the	3*					
1 8 V	Director of Nursing (Em Resident #30 stated tha and physically abused t woman in her 60's who	or (Employee A), and the oppose B) were present. It she had been verbally by an "African American works on night shift." The ified Nursing Assistant as		2		8		

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	·	(X3) DATE SURVEY COMPLETED
	_	495144	B. WNG			44400
	PROVIDER OR SUPPLIER BURG HEALTHCARE CEI	NTER		STREET ADDRESS, CITY, STATE, ZIP C 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	ODE	11/29/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AF DEFICIENCY)				
3	CNA E. Resident #30 one occasion, CNA E on her arms in a pain rudely to her on sever that this had been har years, most recently of she did not want CNA Resident #30 stated to nursing supervisor (Li On 11/28/18 at 10:50 conducted with the nursing supervisor (Li On 11/28/18 at 10:50 conducted with the nursing inappropriate speaking inappropriate speaking inappropriate man manner with the residing that she reported (the front offices'. "Where the abuse alleg Nursing (Employee B) (Employee A), LPN D because I thought that On 11/29/18 at 2:00 P conducted with the Ad She was asked why the protected from further witnessed verbal abus of verbal and physical reported to the state a stated, "Staff are expender or the Director of N further stated that alleg reported to the state as	stated that on more that handled her roughly, pulled ful manner, and spoke ral occasions. She stated ppening over the past three on 11/26/18. She stated that a E to touch her anymore, hat she had informed the PN D). A.M., an interview was ursing supervisor (LPN D). If that CNA (CNA E) ely with residents. I had to I had to counsel her about the of speaking in a rough ents. (Resident #30) told (CNA E) to the 'people in en asked why she didn't ations to the Director of the or to the Administrator stated, "I didn't report it to the resident had done so."	F6			

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

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 13 of 58



PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		495144	B. WING				1 41	/29/2018	
	ROVIDER OR SUPPLIER	iTER .		2	TREET ADDRESS, CITY, STATE, ZIP CODE 87 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	<u>.</u>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	FOULD B	BE COMPLETE		
F 600	2. For Resident #158	e 13 , the facility staff failed to ree of verbal abuse by CNA	F	800					
	Resident #158's diagr	61 year old who was ne facility on 11/16/18. noses Muscle Weakness, ove Pulmonary Disease.						The second secon	
	Resident #158 was at understood by others. person, place, and site								
	she had been verbally CNA who works on nig described the CNA as African American worm	or, the Administrator DON (Employee B) that y abused a few times by a pht shift. The resident being a dark skinned an who is in her 60's. She leaks to her in a "mean and reported that the CNA ys that I'm mean." The							
	documentation. It read Exploitation Policy. Da Abuse: In the event a s accused, they will be in	te: 1/19/17. Protection from	g a				,	-12 %	
	3. For Resident #98, the ensure that he was free E and mistreatment by	of verbal abuse by CNA						2	
N.	Resident # 98, a male,	was admitted to the facility			8				2000

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 14 of 58



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION	(X3) DA	NO. 0936-03 TE SURVEY MPLETED	וש
		495144	B. WING	B. WING			1/29/2018	
33 111	ROVIDER OR SUPPLIER BURG HEALTHCARE CEI	NTER		287	REET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD TERSBURG, VA 23805			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		BY FULL PREFIX (EACH CORRECTIVE ACTION S				(XS) COMPLETIO DATE	
F 600 Continued From page 14 11/6/2018 with diagnoses of but not limite Acquired absence of right upper limb above elbow, Severe sepsis, Chronic Viral Hepa Acute Kidney Failure, Heart Failure, Gastroesophageal Reflux Disease, Diabe Hypertension. Resident # 98's most recent MDS with an 11/13/2018 was coded as an admission assessment. Resident # 98's BIMS (Brie Interview for Mental Status) score was considered indicating no cognitive impairment. Resident # 98 was coded as needing limited assistant one staff member to perform his activities		right upper limb above , Chronic Viral Hepatitis C, Heart Failure, efflux Disease, Diabetes, and recent MDS with an ARD of d as an admission nt #98's BIMS (Brief status) score was coded as itive impairment. Resident # ding limited assistance of perform his activities of daily	F	600	775	e		
40° 40° 40°	hear, speak, understal On 11/28/2018 at 10:2 Nurse) B, was observe Resident # 98. Resident # 98 facility staff "was territake care of him proper the facility staff said ver did not help him when asked which specific a stated it was one lady shift. Resident # 98 st Nursing Assistant) was care of him properly. He an "African American ver works on night shift." T Certified Nursing Assis Resident # 98 also stal shift refused to serve he room. He gave the na	ted one CNA on the 3-11 his food tray in the dining me of the CNA. Resident eat one meal in the dining						

STATEMENT	RS FOR MEDICARE & I OF DEFICIENCIES OF CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB ((X3) DA	RM APPROVE NO. 0938-039 TE SURVEY MPLETED	
		495144	B. WING	G			
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		1/29/2018	-
PETERSE	BURG HEALTHCARE CEN	NTER	η	287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE)
F 600			F 60	00			
8 .	subsequent days. Re	dining room for his meal on esident 98 stated the CNA . The Director of Nursing CNA C.					
	of how he was treated members. Resident with the Rehab staff a the administrator. Wh Resident # 98 if he ha his experiences and c and stated he had disc the administrator. Re	#98 stated he had talked about it and had talked with the nen the surveyor asked ad told the facility staff about concerns, he replied "yes" coussed some things with esident # 98 stated that he v staff were often busy but					
	# 98 with the Administ Nursing present. Resi concerns. The DON st Resident # 98 describe woman in her 60's who identified as Certified ! The DON stated the C identified by name and	as conducted with Resident trator and Director of sident # 98 repeated his stated the staff member that led as an "African American o works on night shift" was Nursing Assistant (CNA) E. CNA who Resident # 98 d complained of her not in the dining room was					
	Review of the clinical r	record was conducted on				\$15 co	

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

11/28/2018 at 2:25 PM.

Review of the nurses notes revealed no documentation of any episodes of conflict or of

On 11/28/2018 at 3 PM, an interview was conducted with the Administrator who stated she

was not aware of any complaints of staff

complaints about staff members.

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 16 of 58



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	' '		CONSTRUCTION (X	3) DATE SURVEY COMPLETED
75 - ¥6		495144	B, WNG			11/29/2018
	ROVIDER OR SUPPLIER	NTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 87 EAST SOUTH BOULEVARD ETERSBURG, VA 23805	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	provide food trays to Administrator stated a had a discussion prevexpressed by Reside sizes of food and que some of his clothing, she had never been i about allegations of varietreatment. On 11/28/2018 at 3:3 conducted with the Dinformed of any compyerbal abuse nor of next and the state of	ally abusive or refusing to Resident # 98. The she and the Social Worker riously about concerns nt # 98 that included portion estions about the location of The Administrator stated informed of any complaints	F	600	Ti Vi	
100 market 100 market	On 11/28/2018 at 5 P debriefing, the facility of Nursing were informadministrator and DC be free of verbal abus	M during the end of day Administrator and Director med of the findings. The N stated residents should se and mistreatment and abuse and mistreatment				
F 607 SS=D	the facility Administra Nurse (Admin J) pres presented to staff reg procedures. No further information Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The facility	buse/Neglect Policies (3)	F	607	F 607 1. Residents #30, & #98 allegation of were identified and investigated. St members were identified and suspending investigation. Residents #3 had no further allegations of verbal physically abuse as of 11/29/2018.	aff nded 0, & # 98

STATEMENT		MEDICAID SERVICES		OMB NO. 0938-039 ⁻		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495144	B. WING		11/29/2018	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 1112012010	
PETERSE	BURG HEALTHCARE CEI	NTER	- Ti	287 EAST SOUTH BOULEVARD		
			13	PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOWN TAG CROSS-REFERENCED TO THE APPLICATION) TAG CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOWN TAG CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOWN TAGES.				
	§483.12(b)(1) Prohibit neglect, and exploitat misappropriation of research with the second se	t and prevent abuse, ion of residents and esident property, sh policies and procedures th allegations, and training as required at is not met as evidenced in, resident interview, staff red review, and facility the facility staff failed to cies for two residents (#30 the facility staff failed to cies.	F 607	2 Current alart and oriented resid	sidents irector/ demented irformed 1/29/2018. / porting libe veeks to n properly Service idents will weekly f abuse ugh on by rom audits issurance/ ittee to	
1	Resident #30 was a 54 year old who was admitted to the facility on 10/3/17. Resident # 30's diagnoses included Dependence on Renal Diafysis, Pain, Hypertension, Gastro- Esophageal Reflux Disease, Muscle Weakness, and Major Depressive Disorder.					
	i ne Minimum Data Set Assessment with an As	, which was an Annual sessment Reference Date	20			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	1	TE SURVEY MPLETED
		495144	B. WNG			1/29/2018
100	ROVIDER OR SUPPLIER	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			1/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	as having a Brief Inte Score of 15, indicatio intact. On 11/28/18 at 10:15 conducted with Residhad been physically a staff member on night CNA was an African A On 11/28/18 at 10:42 was conducted with F The Facility Administr Director of Nursing (E Resident #30 stated the transport of the Conducted with F The Facility Administr Director of Nursing (E Resident #30 stated the Conducted the Conducted the Conducted with F The Facility Administr Director of Nursing (E Resident #30 stated the Conducted with F The Facility Administr Director of Nursing and physically abused woman in her 60's who DON identified the Conducted the Conducted with the Conducted with the nursing supervisor (LF On 11/28/18 at 10:50 A conducted with the nursing stated "I've heard"	A.M. an interview was dent #30 in that she was cognitively A.M. an interview was dent #30 who stated that she and verbally abused by a shift. She stated that the american woman in her 60's. A.M., a second interview desident #30 in her room. ator (Employee A), and the imployee B) were present, that she had been verbally if by an "African American to works on night shift." The writified Nursing Assistant as stated that on more that thandled her roughly, pulled full manner, and spoke all occasions. She stated that the E to touch her anymore. The interview was raing supervisor (LPN D).	F 607		\$2	The state of the s
	her inappropriate man manner with the reside me that she reported (the front offices'. " Whe	had to counsel her about ner of speaking in a rough ents. (Resident #30) told CNA E) to the 'people in en asked why she didn't ations to the Director of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495144	B. WNG			11/29/2018		
	PROVIDER OR SUPPLIER BURG HEALTHCARE CEN			287	REET ADDRESS, CITY, STATE, ZIP CODE 7 EAST SOUTH BOULEVARD ETERSBURG, VA 23805	Const		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 607	Nursing (Employee B), or to the Administrator (Employee A), LPN D stated, "I didn't report it because I thought that the resident had done so." On 11/29/18 at 2:00 P.M., an interview was conducted with the Administrator (Employee A). She was asked why the residents hadn't been protected from further abuse after the supervisor witnessed verbal abuse, and why the allegations of verbal and physical weren't investigated or reported to the state agency. The Administrator stated, "Staff are expected to report allegations to her or the Director of Nursing (Employee B). She further stated that allegations are supposed to be reported to the state agency and investigated, but that she and the DON hadn't been aware of the allegations. On 11/29/18 a review was conducted of facility documentation. It read, "Abuse, Neglect and Exploitation Policy. Date: 1/19/17. Protection from Abuse: In the event a staff member has been accused, they will be interviewed by the Executive Director and be immediately escorted from the facility."		F 607			The state of the s		
	2. For Resident #98, the facility staff failed to implement abuse policies. Resident #98, a male, was admitted to the facility 11/6/2018 with diagnoses of but not limited to: Acquired absence of right upper limb above elbow, Severe sepsis, Chronic Viral Hepatitis C, Acute Kidney Failure, Heart Failure, Gastroesophageal Reflux Disease, Diabetes, and Hypertension.				. On	910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION DUILDING				E SURVEY IPLETED
		495144	B. WING_				4	/29/2018
	ROVIDER OR SUPPLIER	NTER		287 EAS	ADDRESS, CITY, STAT ST SOUTH BOULEVA SBURG, VA 23805	RD		2012010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	,	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD I ED TO THE APPROPR FICIENCY)	3E	(XS) COMPLETION DATE
	Resident # 98's most 11/13/2018 was code assessment. Resider Interview for Mental S 14 indicating no cogni 98 was coded as need one staff member to pliving. Resident # 98 hear, speak, understal On 11/29/18 at 11:10 reported to the survey (Employee A) and the had been verbally about who works on night staff the CNA as being a data American woman who that the CNA speaks to hateful manner. He re Rehab staff about the the CNA as being CN/On 11/29/18 a review documentation. It read documentation. It read accused, they will be in Director and be immediacility."	recent MDS with an ARD of d as an admission in #98's BIMS (Brief status) score was coded as litive impairment. Resident # ding limited assistance of perform his activities of daily was coded as being able to and, and be understood. A.M., Resident #98 for, the Administrator DON (Employee B) that he used a few times by a CNA lift. The resident described and skinned African is in her 60's. He stated to him in a "mean and exported that he told the CNA. The DON identified A.E. was conducted of facility I, "Abuse, Neglect and ste: 1/19/17. Protection from staff member has been interviewed by the Executive diately escorted from the	F	307				The same management of the same of the sam
10 10 10 10	the allegation prior to a Administrator and DON failure of the facility state policies of investigation Several staff members 98's allegation of abuse 98's allegation of abuse				5		95	TO THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TO THE PERSON NAMED IN COLUM
11	No further information	was provided.			- 4			19

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
į.		495144	B. WNG		11/29/2018
	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	TER	;	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	11/28/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 609 SS=D	CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or		F 609	1. Residents #30, #158, & #98 allegables abuse were identified, investigate to the appropriate agencies. Staff were identified and suspended perinvestigation.	d, and sent members nding
	involving abuse, negled mistreatment, including source and misappropare reported immediate hours after the allegate that cause the allegate serious bodily injury, of the events that cause abuse and do not result the administrator of the officials (including to the adult protective service for jurisdiction in long-	act, exploitation or g injuries of unknown priation of resident property, ely, but not later than 2 ion is made, if the events on involve abuse or result in or not later than 24 hours if the allegation do not involve elt in serious bodily injury, to e facility and to other ne State Survey Agency and es where state law provides		2. Current alert and oriented residinterviewed to ensure no other rewere affected by Social Services Didesignee on 11/29/2018. Current residents had skin assessments perby Unit Managers/ designee on 11/3. Current staff were inserviced by Administrator/ designee abuse repand prevention by 12/14/2018. 4. Alert and oriented residents will interviewed weekly times twelve we ensure reports of abuse have been	sidents irector/ demented rformed /29/2018. orting be reeks to
	designated representa accordance with State Survey Agency, within incident, and if the alle appropriate corrective This REQUIREMENT by: Based on observation interview, clinical recordocumentation review, ensure that two reside	dministrator or his or her tive and to other officials in law, including to the State 5 working days of the ged violation is verified action must be taken. is not met as evidenced resident interview, staff d review, and facility the facility staff failed to nts' (#30 and #98) and verbal abuse by staff, f 36 residents were		followed through on by the Social S Director/ designee. Demented resi have skin assessments performed we times twelve to ensure any signs of have been properly followed throug Unit Manager/ designee. Results from will be forwarded to the Quality As Performance Improvement Commi- ensure compliance and the need for monitoring for three (3) months.	dents will veekly abuse gh on by om audits surance/

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, , 50 10 17	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
-		495144	B. WING		11/29/2	2018		
	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER	287	EET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD TERSBURG, VA 23805	ű			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(XS) EXPLETION DATE		
F 609	Continued From page	22	F 609					
		he facility staff failed to s of abuse were reported to						
		the facility staff failed to s of abuse were reported to						
	Findings included:							
		he facility staff failed to s of abuse were reported to		¥ 6				
2	diagnoses included De Dialysis, Pain, Hyperte	on 10/3/17. Resident # 30's		# E				
	Assessment with an A of 9/27/18 was reviewed as having a Brief Inter-	ot, which was an Annual ssessment Reference Date ed. It coded Resident #30 view of Mental Status that she was cognitively			i ė	1 may 1 may		
	had been physically ar staff member on night	A.M., an interview was ent #30 who stated that she ad verbally abused by a shift. She stated that the merican woman in her 60's.		₩ ₩				
1	was conducted with Re	A.M., a second interview esident #30 in her room.		**				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	020	495144	B. WNG_			11/	/29/2018	ĺ
31	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				9	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	D BE COMPLETIO		28
F 609	Resident #30 stated to and physically abused woman in her 60's who DON identified the CecNA E. Resident #30 one occasion, CNA E on her arms in a paint rudely to her on sever that this had been hap years, most recently dishe did not want CNA Resident #30 stated to nursing supervisor (LFOn 11/28/18 at 10:50 conducted with the number stated "I've heard speaking inappropriate man manner with the resident that she reported (the front offices'." Who	imployee B) were present. that she had been verbally d by an "African American o works on night shift." The intified Nursing Assistant as stated that on more that handled her roughly, pulled ful manner, and spoke al occasions. She stated opening over the past three an 11/26/18. She stated that E to touch her anymore. That she had informed the DN D). A.M., an interview was rsing supervisor (LPN D). I that CNA (CNA E) bely with residents. I had to I had to counsel her about ner of speaking in a rough ents. (Resident #30) told CNA E) to the 'people in en asked why she didn't	F 6	309				The second secon
唐 彰	Nursing (Employee B) (Employee A), LPN D because I thought that On 11/29/18 at 2:00 P. conducted with the Ad She was asked why the protected from further witnessed verbal abus of verbal and physical reported to the state a stated, "Staff are expender or the Director of N	ations to the Director of , or to the Administrator stated, "I didn't report it the resident had done so." M., an interview was ministrator (Employee A). e residents hadn't been abuse after the supervisor e, and why the allegations weren't investigated or gency. The Administrator cted to report allegations to lursing (Employee B). She pations are supposed to be					The second secon	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7.1	FIPLE CONSTRUCTION NG		SURVEY	
		495144	B. WNG_		1 44	/29/2018	
98	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER		STREET ADDRESS, CITY, STATE, ZIP COL 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		29/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	Continued From page	24	Fé	309		-	
	reported to the state a that she and the DON allegations.	agency and investigated, but I hadn't been aware of the		3			10.00
	::						
		the facility staff failed to s of abuse were reported to		al a			
	11/6/2018 with diagno Acquired absence of r elbow, Severe sepsis, Acute Kidney Failure,	Chronic Viral Hepatitis C,					
	11/13/2018 was coded assessment. Residen Interview for Mental St 14 indicating no cognit 98 was coded as need one staff member to po- living. Resident # 98 v					Company of the control of the contro	
-	A who stated he witnes Resident # 98 and CN. 11/26/2018 in the dinin Resident # 98 was rud tray. CNA A stated he conflict with Resident #	Certified Nursing Assistant) seed an incident between	- Fit			The second secon	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED			
		495144	8. WNG			11/	29/2018			
	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		7 EAST SOUTH BOULEVARD					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE COMPLETION				
F 609	Continued From page	25	F	809						
	C worked 3-11 shift a	nd that he saw her clock in talk with the surveyor.			*					
	C had just written a w suspended pending the stated CNA C was up: Resident # 98 did not had done the right thin	like her and thought she								
	revealed statements " He were in the dining After lunch, everyone finished his meal I ask	Statement from CNA Cis very confrontational. (sic) room eating lunch. else had left, so once he led him if he needed to go								
	but he got upset and s he is a human being I other staff member to	e him from the dining room aid I don't unlock his chair asked him, so I asked the transport him to his room			© .					
	each other. After that and ask them to transproom So that it would a because I know he do come to the dining roo	thing said out of the way to I would go to other staff port him out of the dining not be any confrontation esn 't like me. He would m and make all kinds of			報 数 数	:				
ļ	wrong because I asked him from the dining roo never refused to do an	. I did think I did anything d another staff to transport om to his room. I had ything for(Resident #			*					
	his room to "keep any of from occurring." On an									

PRINTED: 12/05/2018 FORM APPROVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			×	(X3) DATE SURVEY COMPLETED		
		495144	B. WNG_			ĺ	11/	29/2018	
	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER	¥	287	EET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD TERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETIC DATE	
F 609	come in the dining roof food and how this plate over this weekend he about me finally a resumade a statement to a least one person who he was talking about a him. I did say that you any kind of way." CNA members who were woccasions."	om complaining about the ce is getting his money. It kept making remarks ident spoke up for me. He as co-worker that he know at want to poison him. I knew me but I just kept ignoring are not going to talk to me A C listed four staff itnesses "on some of these O PM, an interview was	F6	609	Si Vi				
54	who stated she had no problems with Resider was not aware of any and any staff members she worked, but had "I the 11-7 shift talking a him." LPN D stated did concerns listed on the	nt # 98. LPN D stated she conflict with Resident # 98 s on the 3-11 shift on which heard staff members from bout issues of conflict with I not know see any of those care plan.					j	The second secon	
	2018 from CNA (Certificated that on 11/17/20 very verbally abusive a entire shift. He made and spoke to me aggreaccused me of not propand blamed me for thir shift! askedtvery rude to her and the hallway." The state 98 "threatened to call the state of the	ras presented to the ent dated November 20, ied Nursing Assistant) E of the present of the pres		a			© (+)		

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

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 27 of 58



PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495144	B. WNG_		11/29/2018	
	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETION	
F 609	conducted with RN (R stated that on 11/20/2 reported to the her that that staff was rude to care. RN C stated she talking with the night sproblems with Reside did report the informa Nursing. RN C stated did not find any evider allegation. Review of the facility of clinical record reveale	tegistered Nurse) C who stagistered Nurse) C who stagistered Nurse) C who stagistered Nurse) C who stagistered the report by shift who stated they had no ant #98. RN C stated she stion to the Director of after her investigation she ance to substantiate the documentation and the documentation of	F6	09	The state of the s	
F 641 SS=D	or DON prior to the su on 11/28/2018. On 11/29/2018 at 3:50 presented a copy of the that was submitted to 11/28/2018 at 12:15 P Resident # 98. The Adwas suspended pending was already on suspendent the FRI form. On 11/29/2018 at 4:00 Administrator and DOI findings. The DON ag	M after the meeting with dministrator stated CNA C ng investigation and CNA E nsion as per documented PM, the facility N were informed of the ain stated she was ion of verbal abuse and 28/2018.	F 64	F 641 1. Resident #3 had a modificat on 11/28/2018 to include the MDS coordinator/ designee.	1.00 mm [15]	

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

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 28 of 58



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	2		
		495144	B. WNG	_	11/29/2018		
	PROVIDER OR SUPPLIER BURG HEALTHCARE CE	NTER	7/	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC	+	
F 641	§483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on staff intervolved to the commentation reviewed an accurate a residents sampled (R. Vistaril (an antianxiet resident's assessment. The findings included Resident #3 was admitiagnoses that included dementia with behavious psychosis. A review of the resided January 2018 through order for Vistaril 25 m psychosis. A review of administration record 2018 showed that the daily as ordered. A review of the Food a package insert for Vistaril is of the comment of	of Assessments. It accurately reflect the To is not met as evidenced riew and facility w, the facility staff failed to assessment for 1 of 38 Resident #3) by not including by medication) in the nt. It: nitted 1/23/2014 with led: traumatic brain injury, loral disturbance, and ent's physician orders for a June 2018 showed an hilligrams twice a day for of the resident's medication for February 2018 and May by Vistaril was administered and Drug Administration taril (located at ta.fda.gov/drugsatfda_docs/	F 841		d to ensure y coded by MDS 12/14/2018. e educated by the n requirements 18. on N of the MDS d that week) for 12 ed by the MDS edications are twelve weeks by signee. Results rded to the Quality improvement upliance and the	9	
ii N	disease states in which	s an adjunct in organic th anxiety is manifested." prior Minimum Data Set		i de la companya de l			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE COMP			
27		495144	B. WING _		118	29/2018	
5.	PROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 641	assessment dated 5/2 assessments, Section zero days the residen medication. On 11/28/2018 at 12:3 held with RN #1, the fill She was shown the morecords for February 2 MDS assessments date 05/29/2018 and asked	26/2018, and a quarterly 29/2018. For both of these 29/2018. For both of these 29/2018. For both of these 29/2018. For both of these 20/2018. An interview was acility MDS coordinator. 20/2018 and May 2018, and the	F 64	1	2		
	11/28/2018 at 1:20 PN surveyor and reported been corrected, and it to the federal databas A review of the Long-Tassessment Instrument Effective October 2011 coding instructions for Code medication's therapeur pharmacological class For example, although prescribed for use as a	f, RN #1 returned to the that both assessments had be corrections transmitted be. Ferm Care Facility Resident at (RAI) User's Manual for shows the following field N0410B: The N0410 according to the bit category and/or ification, not how it is used.		5	S 2		
F 645 SS=D	section, it would be co medication and not as No further information PASARR Screening fo CFR(s): 483.20(k)(1)-(§483.20(k) Preadmissi	ded as an antianxiety a hypnotic. was provided prior to exit. r MD & ID 3) on Screening for al disorder and individuals	F 64	F 645 1. Resident #94 & #49s PASA completed by the Social Service 11/28/2018.			

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

	TO TOTT MEDIONITE OF	MEDIOVID SELAICES				OWR M	<u>ച. വഴം</u>	<u>10-U3</u>	JŞ T
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			***************************************
	16	495144	B. WNG_			11/	/29/20	118	
NAME OF P	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		13	(b)	
					87 EAST SOUTH BOULEVARD				
PETERSE	BURG HEALTHCARE CEN	ITER			PETERSBURG, VA 23805				E
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ULD BE COMPL			***
F 645	§483.20(k)(1) A nursing or after January 1, 199 (i) Mental disorder as (i) of this section, unles authority has determing independent physical performed by a person State mental health as (A) That, because of the condition of the individual recondition of the individual recon	§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability		645	2. Current residents' PASARRs wand updated on 12/14/2018 by Service Director/ designee. 3. Social Services and admissions educated on PASARR requiremer Administrator/ Designee on or be 12/14/2018. 4. Weekly audits of new resident will be completed to ensure resident will be completed by the Social S Director/ Designee. Results from be forwarded to the Quality Assult Performance Improvement Commensure compliance and the need monitoring for three (3) months.	swill be nts by efore s' PASAR lents have eeks this ervice audits wrance/nittee to for furthe	RRs ave is will		9
兽	the level of services prand (B) If the individual requirements services, whether the inspecialized services for \$483.20(k)(2) Exception section— (i) The preadmission separagraph(k)(1) of this for determinations in the	individual requires or intellectual disability. ons. For purposes of this creening program under a section need not provide the case of the readmission an individual who, after nursing facility, was a hospital. ose not to apply the					01/07/		

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

Event ID: UCWJ11

Facility ID: VA0258

if continuation sheet Page 31 of 58



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495144	8. WNG		11/29/2018
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 845	Continued From pag	e 31	F 645		4
3 3	to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nur condition for which the hospital, and (C) Whose attending before admission to the condition of the hospital of the hos	nis section to the admission of an individual- to the facility directly from a sign acute inpatient care at the sing facility services for the e individual received care in the physician has certified, the facility that the individual is than 30 days of nursing			
23	§483.20(k)(3) Definiti section- (i) An individual is cor	on. For purposes of this asidered to have a mental all has a serious mental 3.102(b)(1).	39 384		
	(ii) An individual is co intellectual disability a or is a person with a redescribed in 435.1010 This REQUIREMENT by: Based on staff intervireview and clinical red failed to obtain a PAS the facility for two resi # 49) in a survey sam	nsidered to have an ithe individual has an its defined in §483.102(b)(3) related condition as its not met as evidenced ew, facility documentation cord review, the facility staff ARR prior to admission to dents (Residents # 94 and ple of 36 residents.		# ::	
* ::	obtain a PASARR scre the facility.	the facility staff failed to eening prior to admission to he facility staff failed to r to admission to the			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION		MB NO. (3) DATE S COMPLI	URVEY	038
		495144	B. WING	\$4 28	i	11/2	9/2018	
	ROVIDER OR SUPPLIER BURG HEALTHCARE CE	ENTER	28	REET ADDRESS, CITY, STATE, ZIP CODE 7 EAST SOUTH BOULEVARD TERSBURG, VA 23805	8		7/2010	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		T BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHE				(X5) COMPLE DATE	TION
F 645	Continued From pag	ge 32	_ F 645	s:				A 100 A 100
	Findings included:							
	For Resident # 9- obtain a PASARR so the facility.	4, the facility staff failed to reening prior to admission to						A STATE OF THE STA
2	8/18/2017 with diagr Encephalopathy, Dys Tracheostomy, Acute Failure, Gastrostomy	dmitted to the facility on closes of but not limited to: sphagia, Bipolar Disorder, and Chronic Respiratory Tube, Convulsions, a State and Hypertension.						
a 33	On 11/28/2018 at 2:3 record was conducte	0 PM, review of the clinical d.						
r		record revealed there was Screening in the electronic rd.						The state of the s
	On 11/29/2018 at 11: conducted with the S Business Office did n	00 AM, an interview was ociał Worker who stated the ot have a PASARR						
8	debriefing, the Admin	0 PM during the end of day istrator and Director of d of the findings of no t # 94.						No.
	conducted with the So completed the PASAF	5 PM, an interview was ocial Worker who stated she RR screening for Resident #			15			
	94 on 11/28/2018. The Administrator and Direct advised that residents	he Social Worker, ector of Nursing were			1 6		1	1
	admission. The Admir	istrator stated the facility al records and had begun				3		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	(X3) DATE SUI COMPLET		Y				
9		495144	B. WING	_	·				The standard
1	ROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		87 EAST SOUTH BOULEVARD	11/29/20		18	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	ONE	X5) PLETIC MTE	-
F 645	completing PASARR already admitted to the completed screening, stated the facility staff admissions had a PA	screenings on all residents ne facility without a . The Administrator also f would ensure all future SARR prior to admission.	Fé	345					The second secon
	obtain a PASARR prid facility. Resident #49 was a 7 admitted to the facility diagnoses included D	the facility staff failed to or to admission to the 70 year old who was on 3/31/06. Resident # 49's liabetes Mellitus Type 2, lajor Depressive Disorder.			85				A CONTROLL OF A CONTROL OF THE PROPERTY OF THE
	Assessment with an A of 1/18/18 coded Resiseverely impaired cog On 11/29/18, a review #49's clinical record. TPASARR.	was conducted of Resident The record did not contain a			38	C. M. C. W. C.	and the second s	Property of Control	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	not have a PASARR, I was supposed to be d	cility Administrator (sked why Resident #49 did the Administrator stated, "It one prior to the resident facility." She stated the				The control of the co		A COLUMN TO A COLU	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391: STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WNG 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 Continued From page 34 F 656 F 656 Develop/Implement Comprehensive Care Plan F 656 F 656 CFR(s): 483.21(b)(1) SS=D 1. Resident # 89's careplan was updated with targeted behaviors supporting use of §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and Seroquel on 12/07/2018. Resident # 98's implement a comprehensive person-centered careplan was updated to include verbally care plan for each resident, consistent with the abusive behaviors on 11/28/2018. resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable 2. Current residents careplans were audited objectives and timeframes to meet a resident's by UM/ designee on 12/14/2018 to ensure medical, nursing, and mental and psychosocial residents behaviors were reflected in their needs that are identified in the comprehensive assessment. The comprehensive care plan must careplans. describe the following -3. License nurses will be educated on (i) The services that are to be furnished to attain comprehensive careplans by DON/designee or maintain the resident's highest practicable physical, mental, and psychosocial well-being as on or before 12/14/2018. required under §483.24, §483.25 or §483.40; and 4. Weekly audits times 12 weeks will be (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not completed on careplans by UM/designee to provided due to the resident's exercise of rights ensure behaviors are addressed in each under §483.10, including the right to refuse resident's careplan. Results from audits will treatment under §483,10(c)(6). (iii) Any specialized services or specialized be forwarded to the Quality Assurance/ rehabilitative services the nursing facility will Performance Improvement Committee to provide as a result of PASARR ensure compliance and the need for further! recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its monitoring for three (3) months. 01/07/2019 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate

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

Event ID: UCW/I11

Facility ID: VA0258

If continuation sheet Page 35 of 58

PRINTED: 12/05/2018



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SUR COMPLETE			
		495144	B. WING_			11/29/2	0040
1	ROVIDER OR SUPPLIER	INTER		STREET ADDRESS 287 EAST SOUTH	1112312		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD IS-REFERENCED TO THE APPROPE DEFICIENCY)	BE 🔯	(XS) INPLETION DATE
F 656	entities, for this purp (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMENT by: Based on observation record review the fact revise the comprehencesidents (Resident # 1 in the survey sample 1. For Resident #89 supporting the use of on the comprehensiv 2. For Resident # 98 develop and implement	in the comprehensive care in accordance with the sh in paragraph (c) of this T is not met as evidenced on, staff interview and clinical cility staff failed to review and nsive care plan for 2 #89 and #98) of 36 residents the targeted behaviors is Seroquel were not included	F6	58		The contract of the contract o	
	facility on 5/13/18. D Alzheimer's disease, depression, and dysp Minimum Data Set as assessment with an a of 11/8/18. Resident cognitive impairment assistance with activit not coded to have bel	year old, was admitted to the iagnoses included reflux, hypertension, hagia. The most recent is essment was a quarterly issessment reference date #89 was coded with severe and required extensive ties of daily living. She was haviors.	•			The second secon	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/05/2018 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** <u>OMB NO. 0938-0391</u> STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ B. WNG 495144 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 656 Continued From page 36 F 656 Resident #89's clinical record included two orders dated 6/6/18 for Seroquel: 1. Seroquel 50 milligrams 1 tablet by mouth at bedtime for psychosis. 2. Seroquel 50 milligrams 1 tablet three times a day for psychosis. The November 2018 Treatment Administration Record (TAR) included the order, "Complete behavior progress note, if resident has behaviors during your shift. Every shift." The targeted behaviors were not included on the TAR. Resident #89's comprehensive care plan was reviewed. A focus area dated 10/3/17 read. has potential to demonstrate physical behaviors r/t (related to) Dementia. The interventions were dated 10/3/17 and included the following: analyze triggers, places, times and what de-escalates behavior, assess needs, evaluate side effects of meds, intervene before agitation escalates. document behavior, psych consult as needed. This focus was added to the care plan after Resident #89 tried to hit the CNA on 10/2/17. The care plan also included the focus dated i į 1/23/18 that read, Use of Psychotropic drug places resident at risk for drug related side effects. Antidepressant: Lexapro, Antipsychotic: Seroquel. Specify Diagnosis for which drug has been prescribed: psychosis and depression. The

interventions dated 1/23/18 included: administer medications as prescribed by the physician and implement the behavior interventions, evaluate on a periodic basis for gradual dose reduction or discontinuation, if applicable. The care plan did not include the types of behaviors that were exhibited by Resident #89 supported the use of

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURV COMPLETE			
		495144	B. WNG		11/29/20	018	3		
	ROVIDER OR SUPPLIER BURG HEALTHCARE CEN	ITER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 87 EAST SOUTH BOULEVARD PETERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) PLE DATI		
F 658	Seroquel.		F	356	*3 2*	Laboratoria de la composición dela composición de la composición de la composición de la composición de la composición dela composición del composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de la composición de l			
i		d of day meeting, the care red with the Administrator g.							
odi.	2. For Resident # 98, the facility staff failed to develop and implement a comprehensive care plan to include "verbally abusive behaviors" until 11/28/2018. Resident # 98, a male, was admitted to the facility				SI SI	-			
	11/6/2018 with diagno Acquired absence of relbow, Severe sepsis, Acute Kidney Failure,	ses of but not limited to: ight upper limb above Chronic Viral Hepatitis C,					# 1		The state of the s
, !	11/13/2018 was coded assessment. Residen Interview for Mental St 14 indicating no cognit 98 was coded as need one staff member to pe	t # 98's BIMS (Brief atus) score was coded as ive impairment. Resident # ling limited assistance of erform his activities of daily vas coded as being able to			<u>s</u>		Processing and American		
.5	one CNA on the 3-11 s food tray in the dining r of the CNA. Resident one meal in the dining would not serve him what room for his meal on si 98 stated the CNA did	O AM, Resident # 98 stated hift refused to serve his room. He gave the name # 98 stated he did not eat room one day and CNA hen he went to the dining absequent days. Resident not treat him right. The ntified the CNA as CNA C.		S. S.		The state of the s			The second section of the second seco

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

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 38 of 58



PRINTED: 12/05/20 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETE A. BUILDING_ 495144 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 656 Continued From page 38 F 656 Resident #98 stated the facility staff was aware of how he was treated by the nursing staff members. Resident #98 stated he had talked

On 11/28/2018 at 4:00 PM, an interview was conducted with CNA Certified(d Nursing Assistant) A who stated he witnessed an incident between Resident # 98 and CNA C on Monday, 11/26/2018 in the dining room. CNA A stated Resident # 98 was rude to CNA C about the food tray. CNA A stated he had never experienced any conflict with Resident # 98 and was surprised at the interaction he witnessed. CNA A stated CNA C worked 3-11 shift and that he saw her clock in prior to his coming to talk with the surveyor.

with the Rehab staff about it and had talked with the administrator. When the surveyor asked Resident #,98 if he had told the facility staff about his experiences and concerns, he replied "yes" and stated he had discussed some things with the administrator. Resident # 98 stated that he understood the facility staff were often busy but

he deserved to be treated right.

On 11/28/2018 at 4:25 PM, the DON stated CNA C had just written a witness statement and was suspended pending the investigation. The DON stated CNA C was upset because she felt Resident # 98 did not like her and thought she had done the right thing by ignoring his comments and asking a coworker to work with him instead.

Review of the Witness Statement from CNA C revealed statements "_____is very confrontational. He were in the dining (sic) room eating lunch. After lunch, everyone else had left, so once he finished his meal I asked him if he needed to go to therapy he said no so I unlocked his w/c

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING					TE SUR		
		495144	B. WNG					412012	40	
	PROVIDER OR SUPPLIER BURG HEALTHCARE CEI	NTER		287	EET ADDRESS, CITY, S EAST SOUTH BOUL ERSBURG, VA 23	EVARD	!	1/29/2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRI	T'S PLAN OF CORRECTI ECTIVE ACTION SHOUL ENCED TO THE APPROI DEFICIENCY)	D BE		(X5) PLETH DATE	ON
F 656	(wheelchair) to remove but he got upset and he is a human being to other staff member to so it would not be any each other. After that and ask them to trans room So that it would because I know he do come to the dining roomermarks to me and abignoring his comments wrong because I aske him from the dining roomermarks.	re him from the dining room said I don't unlock his chair asked him, so I asked the transport him to his room withing said out of the way to I would go to other staff aport him out of the dining not be any confrontation the san't like me. He would som and make all kinds of yout me. I just started so I did think I did anything did another staff to transport oom to his room. I had	F	856				And the state of t	And the second s	And the second of the second o
	never refused to do ar 98) or any other reside reiterated that she ask transport Resident # 9 his room to "keep any from occurring." On ar statement, CNA C stat come in the dining roo food and how this plac Over this weekend he about me finally a resident made a statement to a least one person who he was talking about m him. I did say that you any kind of way." CNA	nything for(Resident # ent when asked." She sed her coworker to 8 out of the dining room to confrontational situations nother page of the witness sed Resident # 98 "would m complaining about the se is getting his money. kept making remarks dent spoke up for me. He co-worker that he know at want to poison him. I knew se but I just kept ignoring are not going to talk to me	70							
3	who stated she had ner problems with Resident was not aware of any c	icensed Practical Nurse) D					3	Control of the Contro	A Comment of the Comm	***************************************

	OF OF THE BOOK IN TEL	MEDICAID SERVICES					<u> </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT:FICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY PLETED
[495144	B. WING			11	/29/2018
i	PROVIDER OR SUPPLIER	WTFR	• -	287	REET ADDRESS, CITY, STATE, ZIP CODE PEAST SOUTH BOULEVARD	•	
		——————————————————————————————————————		PE	TERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 656	she worked, but had the 11-7 shift talking a him." LPN D stated d concerns listed on the On 11/29/2018 at 12: the care plan for Resicare plan revealed or have episodes where behaviors r/t (related The date initiated was 11/28/2018. Resident # 98 was accare plan was initiated on 11/16/2018 for urir 11/26/2018 for focus a status, Gastroesopha disease. There was resident was relative to the control of the cont	"heard staff members from about issues of conflict with id not know see any of those is care plan." 10 PM, received a copy of ident # 98. Review of the in page 7 of 10, Focus-"often the exhibits verbally abusive to) poor impulse control. is: 11/28/2018, Revision: Imitted on 11/6/2018, the id on 11/13/2018 and revised thary incontinence, on concerns of cardiovascular geal and cardiovascular no mention of behaviors as	F	656			
St. Section Communication del.	2018 from CNA (Certi stated that on 11/17/2 very verbally abusive entire shift. He made and spoke to me aggraccused me of not pro and blamed me for thi shift! asked_very rude to her and to the hallway." The state 98 "threatened to call building shut down an	D PM, a copy of an was presented to the lent dated November 20, fied Nursing Assistant) E 1018, Resident # 98 was and very demanding the various racial comments ressively and with angry. He operly taking care of him langs that happen on another to work with him. He was herew a pillow which came in lement also said Resident # the police and get this d get the state involved."		a			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLET				
	e)	495144	B. WNG		11/29/	/20	18		
1	ROVIDER OR SUPPLIER	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	, , , , ,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE . C		(X5) IPLE DATE	TION	
F 656	Continued From page 41 behaviors yesterday." The DON stated the care plan should have included any behaviors noted during the assessment period. During the end of day debriefing, the facility Administrator and DON were informed of the findings. No further information was provided.		F 65	6		the second secon			
F 690 SS=D	Bowel/Bladder Incontil CFR(s): 483.25(e)(1)- §483.25(e) Incontinent §483.25(e)(1) The factoresident who is contine admission receives semaintain continence uncondition is or become not possible to maintal §483.25(e)(2)For a resincontinence, based of	nence, Catheter, UTI (3) ce. ility must ensure that ent of bladder and bowel on envices and assistance to nless his or her clinical es such that continence is in.	F 694	1. Resident # 92's catheter bag words off the floor on 11/28/2018. 2. Current resident with a foley catheter all checked to ensure they will the floor on 11/28/2018. 3. Nursing staff will be educated of foley catheter bags off the floor be DON/designee on or before 12/14. A weekly audit times twelve of	otheter bag were not on on keeping y b/2018.		The second secon		*** *** *** *** *** *** *** *** *** **
The second secon	ensure that- (i) A resident who enter indwelling catheter is resident's clinical condicatheterization was need indwelling catheter or sist assessed for removations as possible unless the demonstrates that cathe and (iii) A resident who is in receives appropriate transport indwelling catheter or sist assessed for removations as possible unless the demonstrates that cathe and (iii) A resident who is in receives appropriate transport in the catheter of the cath	ers the facility without an not catheterized unless the lition demonstrates that cessary; ers the facility with an subsequently receives one al of the catheter as soon resident's clinical condition leterization is necessary; encontinent of bladder eatment and services to fections and to restore		who have a foley catheter bag will completed by the Unit Manager/densure catheter bags are off the fl Results from audits will be forward Quality Assurance/ Performance Improvement Committee to ensur compliance and the need for furth monitoring for three (3) months.	lesignee to oor. ded to the	37.	/20	219	

		ND HUMAN SERVICES				FORM AP	PRO	ZU VE
CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SUR COMPLETE		
100		495144	8. WNG			11/29/2	018	11
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		SI	TREET ADDRESS, CITY, STATE, ZIP CODE	1112014	0.0	
PETERSE	BURG HEALTHCARE CE	NTER			87 EAST SOUTH BOULEVARD ETERSBURG, VA 23805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE C	(X8) NPLET DATE	
F 690	Continued From page	e 42	F	3 9 0	i			
	ensure that a resident receives appropriate restore as much norm possible. This REQUIREMENT by: Based on observation record review the fact catheter bag was main prevent the spread of (Resident #92) of 36 is sample.							
1 1	floor. The findings included	·			**************************************	1 (100 mm) 1 (10		
	the facility on 11/1/18. diabetes, peripheral v hyperlipidemia, reflux depression, and chromost recent Minimum a 5 day assessment w reference date of 11/8 coded with severe cogrequired extensive assessments.	, hypertension, dysphagia, nic kidney disease. The Data Set assessment was	13					and the second s

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

On 11/28/18 at 8:15 a.m., Resident #92 was observed sleeping in bed. The bed was in the lowest position. The catheter bag was in a

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , , , , , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			URV		The state of the s
0 0	*	495144	B. WNG_			11/29	3/20	18	
	ROVIDER OR SUPPLIER	ITER		287	EET ADDRESS, CITY, STATE, ZIP CODE EAST SOUTH BOULEVARD IERSBURG, VA 23805				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	- 1	CON	(X5) PLETI DATE	
F 690	Continued From page		F6	90					
	bottom 1/3 of the privilege.	from the bed frame. The acy bag was touching the			20 -			700000000000000000000000000000000000000	
	On 11/28/18 at 1:30 p observed on the floor	.m. the catheter bag was							
3 × ±	Administrator and Din were notified that Res was observed on the	eting on 11/28/18, the ector of Nursing (DON) sident #92's catheter bag floor. The DON stated the ot be on the floor due to risk							
	reviewed. The policy Associated Urinary Tr common adverse eve urinary catheters, incl asymptomatic." Secti section read, "Check	on V of the Catheter Care that collection bag is not on ng properly and secured					100 000 000 000 000 000 000 000 000 000		
F 755 SS=D	Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(§483.45 Pharmacy Se The facility must provi drugs and biologicals them under an agreen §483.70(g). The facility personnel to administe	ervices de routine and emergency to its residents, or obtain nent described in ty may permit unlicensed	F 7	1 1 2 6 N	F 755 1. Resident #92 flagyl was administed 10/07/2018. 2. Current residents MARs were autensure medications were available Manager/ designee on 11/30/2018. 3. Nursing staff will be educated on the state of the	udited to by Unit 3. n what to			
1 1		s. A facility must provide es (including procedures			do if a medication is not available of the control of Nursing/ designee by 12/14/2018.	oy tne 			

OLIVIE	10 I OIL MEDICARE 8	MEDICAID SERVICES				OMB N	J. 093	<i>1</i> 8-03!
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144				CONSTRUCTION	(X3) DATE		EY
1	+	495144	B, WING			1 44	129/20	40
	ROVIDER OR SUPPLIER	NTER	1.	2	TREET ADDRESS, CITY, STATE, ZIP CODE 87 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		23/40	-0
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMP	(XS) PLETICA XATE
F 755	that assure the accurdispensing, and admission biologicals) to meet to \$483.45(b) Service Comust employ or obtain pharmacist who- \$483.45(b)(1) Provide aspects of the provision facility. \$483.45(b)(2) Established in the provision of the provis	rate acquiring, receiving, inistering of all drugs and the needs of each resident. Consultation. The facility in the services of a licensed es consultation on all ion of pharmacy services in shes a system of records of an of all controlled drugs in	F	755	4. A weekly audit of residents' rewill be completed to ensure the available times twelve weeks by Manager/designee. Results from the forwarded to the Quality Ass Performance Improvement Components compliance and the need monitoring for three (3) months	y are y the Unit m audits w urance/ mittee to f for furthe	aH.	/201
No. 15 Notices of	sufficient detail to end reconciliation; and \$483.45(b)(3) Determ order and that an accis maintained and per This REQUIREMENT by: Based on observation record review and fact the facility staff failed available for administ	nines that drug records are in count of all controlled drugs riodically reconciled. is not met as evidenced n, staff interview, clinical cility documentation review to ensure medications were						in the second second second second second second second second second second second second second second second
The state of the s	the facility on 11/1/18. diabetes, peripheral va	ear old, was re-admitted to Diagnoses included	ε				The second secon	The state of the s

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			TE SURVEY MPLETED	
		495144	8. WING		- 1	1/29/2018
	ROVIDER OR SUPPLIER	NTER	287 (ET ADDRESS, CITY, STATE, ZIP CO EAST SOUTH BOULEVARD ERSBURG, VA 23805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5)/A CCAMPLETION DATE
F 755	Continued From pag	e 45	F 755	9:	\$5.00 \$2.00 \$2.00	
The second secon	most recent Minimun a 5 day assessment reference date of 11/	onic kidney disease. The n Data Set assessment was with an assessment 8/18. Resident #92 was organitive impairment and				
American and the second and the seco	required extensive as daily living. He was catheter.	ssistance with activities of coded to have an indwelling			Ed _e	The state of the s
ŷ.	the hospital to the faction and the faction of the	•				
	Administration Recordoes of Flagyl was no	ober 2018 Medication of (MAR), on 10/5/18 the first ot administered. A "9" was MAR indicating "Other/ See	M sz			
		ntinued on 10/6/18. The and started on 10/7/18.			83	
	Administrator and Dir were asked about the	nd of day meeting, the rector of Nursing (DON) e Flagyl orders. It was eN that it appeared that the led because it was		82) 3		
	was provided by the 1 "10/04/2018- Readmi 10/06/2018- Awaiting was not in first dose. D/C'D (discontinued) when medication arrival.	tted back to facility for Flagyl from Pharmacy MD (doctor) made aware same day and was to restart			#	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
į	495144	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		11/29/2018
NAME OF PROVIDER OR SUPPLIER PETERSBURG HEALTHCARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
box was requested a listed as a medication from the stat box. No further information Free from Unnec Psy CFR(s): 483.45(c)(3) §483.45(e) Psychotron §483.45(c)(3) A psychaffects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehence identify many composition of the psychotropic drugs are unless the medication specific condition as continuous in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventio	available in the facility stat and provided. Flagyl was a available for administration was provided. Archotropic Meds/PRN Use (e)(1)-(5) Appic Drugs. Anotropic drug is any drug that a associated with mental Arior. These drugs include, drugs in the following ansive assessment of a anust ensure that— ants who have not used are not given these drugs a is necessary to treat a diagnosed and documented ants who use psychotropic and dose reductions, and	F 75		ate diagnosis for swere update attempted on d by the ared to ensure they targeted why a GDR was ee by viced on propriate rs in careplans,
	rsuant to a PRN order	114	Facility ID: VA0258	continuation sheet Page 47 or



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE		
ř	4.8	495144	B. WNG	4	11/29/2	018	
	ROVIDER OR SUPPLIER URG HEALTHCARE CEN	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805			
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) MPLE DATE	
	in the clinical record; a §483.45(e)(4) PRN or are limited to 14 days. §483.45(e)(5), if the aprescribing practitione appropriate for the PR beyond 14 days, he or rationale in the resider indicate the duration for the state of	ders for psychotropic drugs Except as provided in Itending physician or Itending physician physician or Itending physician or Itending physician or Itending physician physician physician physician physician physician phy	F 75	4. A weekly audit of residents bei administered antipsychotics will be completed times twelve by Unit M/designee to ensure appropriate dare used, targeted behaviors are incareplan, and GDRs are being attended to the complete to ensure Quality Assurance/ Performance Improvement Committee to ensure compliance and the need for furth monitoring for three (3) months.	e lanager liagnosis n the mpted. ded to the	//20)19
	The findings included: Resident #89, an 86 ye facility on 5/13/18. Dia	ear old, was admitted to the gnoses included					

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
1 4		495144	B. WING_		11/29/2018
1 1	ROVIDER OR SUPPLIER URG HEALTHCARE CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CYMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
	depression, and dys Minimum Data Set a assessment with an of 11/8/18. Resident cognitive impairment assistance with activ not coded to have be On 11/29/18 at 10:00 observed lying acros She was asleep on t Resident #89's clinic dated 6/6/18 for Sero 1. Seroquel 50 millig day for psychosis The following statem accessed on 12/3/18 National Alliance on https://www.nami.org "Psychosis is a symp The following informa accessed on 12/3/18 and Drug Administrat https://www.fda.gov/o/ ucm089126.pdf "SEROQUEL may ca including: 1. risk of death in 1 Medicines like SERO	reflux, hypertension, phagia. The most recent assessment was a quarterly assessment reference date at #89 was coded with severe and required extensive ities of daily living. She was chaviors. 2 a.m., Resident #89 was a her bed in a fetal position. The poor of the covers. 2 all record included two orders or or or or or or or or or or or or or	F7	,	
	or death in elderly pe (dementia). SEROQL psychosis in the elde	rly with dementia."		ž. 29	

RECEIVED
DEC 13 2018
VDH/OLC

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		37	(X3) DATE : COMPL		o-∪:	
13		495144	B. WNG			44	/29/20		
1 1	PROVIDER OR SUPPLIER BURG HEALTHCARE CEI	ITER	21	TREET ADDRESS, CITY, STATE, ZIF 37 EAST SOUTH BOULEVARD ETERSBURG, VA 23805	CODE	11	123120		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	THE APPROPRIA	E ME	COMP	X5) ATE	
F 758	"What is SEROQUEL SEROQUEL is a prestreat: schizophrer or older bipolar disorder disorder manic episodes disorder alone or with long-term treatm lithium or divalproex manic episodisorder in children ag The November 2018 1 Record (TAR) included	cription medicine used to ia in people 13 years of age ider in adults, including: ides associated with bipolar is lithium or divalproex ent of bipolar I disorder with ides associated with bipolar I ies 10 to 17 years old" Treatment Administration If the order, "Complete In it resident has behaviors It is yeshift." Targeted	F 758	*					
	On 11/29/18 at the end staff were asked to probehavior monitoring. Twere provided by the E 1/16/18- Resident can wheelchair kicking and passing trays, resident her food 10/8/17- Resident was morning. Resident was without assistance, and	I of day meeting, the facility ovide documentation of The following nursing notes Director of Nursing (DON): The out of room in swinging at CNA who was yelling that she wanted getting agitated this a trying to get out of bed by yelling at roommate. I yelling at roommate. I will not she wanted the strying to get out of bed by yelling at roommate. I will not she wanted the strying to get out of bed by yelling at roommate. I will not she wanted the strying to get out of bed by yelling at roommate.							

PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRO CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495144 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 **SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 50 F 758 10/5/17- Resident stated that there were rocks in her mouth and in her bed. Crying throughout the night and increased anxiety. pm Ativan administered. 10/2/17- Resident trying to hit Certified Nursing Assistant (CNA) and throw water. Resident given pm medication 8/17/17- Resident standing at the bedside of roommate, pulling on roommate and telling her, "get out of my bed" According to the behavior notes provided by the DON, the most recent documented behavior was nine month ago in January 2018. The DON stated that Resident #89 had hallucinations. She referenced the note from 10/5/17 where Resident #89 stated she had rocks in her mouth and bed. It was reviewed with the DON that this note was written 13 months prior. Resident #89's comprehensive care plan was reviewed. A focus area dated 10/3/17 read. has potential to demonstrate physical behaviors r/t (related to) Dementia. The interventions were dated 10/3/17 and included the following: analyze triggers, places, times and what de-escalates behavior, assess needs, evaluate side effects of meds, intervene before agitation escalates,

document behavior, psych consult as needed.
This focus was added to the care plan after
Resident #89 tried to hit the CNA on 10/2/17 as

documented in the nursing note above.

The care plan also included the focus dated 1/23/18 that read, Use of Psychotropic drug places resident at risk for drug related side

PRINTED: 12/05/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT		νEΥ	11.	2
19	Ì		495144	B. WING		<u> </u>	44	l lack	أممأ		
	PROVIDER OR SUPP		TER	24	2	STREET ADDRESS, CITY, STATE, ZIP CODE 187 EAST SOUTH BOULEVARD PETERSBURG, VA 23805		1/29/2	910		
(X4) ID PREFIX TAG	(ÉACH DI	EFICIENC	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		co	(X5) MPLE DATE	iC	
F 758	effects. Antido Seroquel. Spot been prescribe interventions of medications a implement the a periodic bast discontinuation. On 11/4/18, the	epressa ecify Dia ed: psyc lated 1/ s presci behavious is for group, if app	nt: Lexapro, Antipsychotic: agnosis for which drug has ahosis and depression. The 23/18 included: administer abed by the physician and or interventions, evaluate on adual dose reduction or	F	758			the same may depend here. The same same same same same same same sam			The state of the s
	pharmacist ma "Federal guide should have al reduction (GDI 2 different qua attempts, then "This resident mg (milligram) (6/2018) withou dose reduction is on the lowes indicate respon	ide the standard stan	following recommendation, ate antipsychotic drugs of at a gradual dose per year for the first year in the at least 1 month between by thereafter." In taking SEROQUEL 50 our times per day) since R. Could we attempt a sime to verify this resident le dose? If not, please w:" An "X" was marked						A COLUMN TO THE RESIDENCE OF THE PROPERTY OF T		90 taken memberahan 100 taken 100 ta
	durations and in appropriate; fur contraindicated left blank. The physician. It was Director of Number of	ndication ther rectification the total due to form was not dising (AL 4/18. 11:00 a rocess ons. Shift the pummends						A THE STREET OF			

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 52 of 58



	OF DEFICIENC F CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SU COMPLE				
	1		495144	B. WING_			11/29	1/20	118		
1	PROVIDER OR S		TER		21	TREET ADDRESS, CITY, STATE, ZIP CODE 87 EAST SOUTH BOULEVARD ETERSBURG, VA 23805	11720				
(X4) ID PREFIX TAG	(ÉAC	CH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		CON	(XS) IPLE DATE	ΠC	100 100 100 100 100 100 100 100 100 100
F 758	the ADON physician the recommend wrote a nudeclined. physician declining time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time the relationship time time time time time time time time	documented mendation. Irsing note in It was review needed to do he pharmac ecommendation, Resident e diagnosis. There were ed in the clination provided recent behaves the episodet the episodet mendation econtect.	was asked where the a rationale for declining. The ADON stated that she adicating that it was wed with the ADON that the ocument the reasons for a recommendation at the ion was declined. #89 did not have an to support the use of no targeted behaviors ical record. According to do by the facility, Resident avioral incident occurred ampted to kick a CNA edocumented on 10/5/17, ed instances of	F7	758	F 760 1. Resident # 92's Flagyl was admin on 10/07/2018. A medication erro					
	hallucination on the lower Residents (CFR(s) 48 The facility §483.45(f)(medication This REQU by: Based on record reviet the facility serior.	ons or delusit a GDR to vest effective are Free of 3.45(f)(2) must ensure 2) Residents errors. IIREMENT observation, sw and facilistaff failed to 32) of 36 residents affect from second	ons. Lastly, the facility did verify that the resident was dose. Significant Med Errors	F 7	60	was completed. 2. Current residents' medications was audited to ensure they were availand 11/30/2018 by Unit Manager/ Designation is unavailable by Direct Nursing/ Designee on or by 12/14/4. A weekly audit of residents' medication by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by the Unit Manager/ Designation is unavailable by Direct Nursing/ Designation is un	ble on gnee. I on to do if a cor of colons ations are signee audits will ince/		//2	01:	9

D. C.			MEDICAID SERVICES					RM APP		
STATEMENT			(X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II TIDI	E CONSTRUCTION		OMB N		- 1	櫸
AND PLAN O			IDENTIFICATION NUMBER:		ECONSTRUCTION	_	(X3) DAT	APLETE!		
			495144	B. WING	7/4		1	1/29/20)18	
NAMEOFP	ROVIDER O	R SUPPLIER		1	STREET ADDRESS, CITY,	STATE, ZIP CODE	•	100		T
PETERSE	BURG HEA	LTHCARE CEN	ITER		287 EAST SOUTH BOUL PETERSBURG, VA 23					
(X4) ID			TEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION			(X8)	Ħ
PREFIX TAG			/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX		RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)			IPLET DATE	
F 760	0				10	<u> </u>				╫
F /60	until 10/	ed From page 7/18.	53	F 760)	4				
i "	The find	ings included:								
										Ш
			ear old, was re-admitted to Diagnoses included		13				12	
	diabetes	, peripheral va	ascular disease,							
2.	hyperlipi	demia, reflux,	hypertension, dysphagia,							
ľ			ic kidney disease. The Data Set assessment was	5				4	i	
	a 5 day	assessment w	rith an assessment		1					
(1)			/18. Resident #92 was Initive impairment and							
ľ	required	extensive ass	sistance with activities of					1		
il, Ki	daily living catheter.		oded to have an indwelling		10.	*)				
	On 10/4/	18 Pesident	#92 was re-admitted from							
1	the hosp	ital to the facil	ity with an order for Flagyl		}			1 4		
120 E.S.	100 millig	grams daily fo	r 7 days.							
			per 2018 Medication		ļ					
J	does of F	ration Record Flagvi was not	(MAR), on 10/5/18 the first administered. A "9" was							
78	documen	ited on the MA	AR indicating "Other/ See							1
	Nurse No	otes."								
E 1	The Flag	yl was disconi	tinued on 10/6/18. The					11		
			nd started on 10/7/18.		2 2					
And the second s	On 11/28	/18 at the end	of day meeting, the	ĺ						
	were ask	acor and Direct ed about the f	ctor of Nursing (DON) Flagyl orders. It was							
li	reviewed	with the DON	that it appeared that the				24	1		
	Flagyi wa unavailab		d because it was							
	On 11/20	/18 the follow	ing tuned comment and							
<u>_</u>	was provi	ded by the fac	ing typed summary note cility staff:							

PRINTED: 12/05 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRO <u>CENTERS FOR MEDICARE & MEDICAID SERVICES</u> OMB NO. 0938-03 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ 495144 B. WING 11/29/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG HEALTHCARE CENTER PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) 1 ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 760 Continued From page 54 F 760 "10/04/2018- Readmitted back to facility 10/06/2018- Awaiting for Flagyl from Pharmacy was not in first dose. MD (doctor) made aware D/C'D (discontinued) same day and was to restart when medication arrive. 10/07/2018- Medication arrived and Flagyl started. A list of medications available in the facility stat box was requested and provided. Flagyl was listed as a medication available for administration from the stat box. F 761 No further information was provided. 1. The B-1 100 milligram capsules were F 761 Label/Store Drugs and Biologicals F 761 CFR(s) 483.45(g)(h)(1)(2) SS=D removed from the medication cart on 11/28/2018. §483.45(g) Labeling of Drugs and Biologicals 2. Facility medication carts were audited on Drugs and biologicals used in the facility must be labeled in accordance with currently accepted 11/28/2018 to ensure no expired professional principles, and include the medications were present on 11/28/2018 by appropriate accessory and cautionary instructions, and the expiration date when Unit Manager/ designee. applicable. 3. Licensed nurses will be educated on the use of the manufacturers' expiration dates §483.45(h) Storage of Drugs and Biologicals by Director of Nursing/ Designee on or by §483.45(h)(1) In accordance with State and 12/14/2018. Federal laws, the facility must store all drugs and

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

biologicals in locked compartments under proper

temperature controls, and permit only authorized

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for

storage of controlled drugs listed in Schedule II of

the Comprehensive Drug Abuse Prevention and

Control Act of 1976 and other drugs subject to

personnel to have access to the keys.

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet

4. A weekly audit of medication carts will be

completed to ensure no expired medications

are in use by the Unit Manager/ Designee times twelve weeks. Results from audits will

be forwarded to the Quality Assurance/

monitoring for three (3) months.

Performance Improvement Committee to

ensure compliance and the need for further

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN		(X3) DATE SURV COMPLETED				
- 1		495144	B. WNG_			İ	441		<u> </u>
ME OF	OF PROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		11/	29/201	8
TERS	BURG HEALTHCARE CEN	ITER		287 EAST SOUTH					1
X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PETERSBURG, \	/A 23805			1 1	77.00
REFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORE CORRECTIVE ACTION S REFERENCED TO THE AF DEFICIENCY)	HOULD BE	E	COMPL CAT	
F 761	Continued From page	55	F 76		-				
	abuse, except when the	ne facility uses single unit		''}			j		-
	package drug distribut	ion systems in which the		1					-
	be readily detected.	mal and a missing dose can		1	\$.				
	This REQUIREMENT	is not met as evidenced	-				ļ		į
	by: Based on observation	and staff interview, the							1
	facility failed to ensure	that expired drugs were	ľ		29]		-
	not in use.								
ı	Findings include:								
			1	1]		
	On 11/28/2018 at 2 PM	l, an inspection was made or the 100 hall. Note: This	j	1					
177	provider uses bulk stoo	k medications for		Í					,
	commonly used drugs;	i.e. the provider uses a							
ŀ	large bottle of Acetamir who take the standard	lopnen for all residents dose.			79				1
	This medication and an	# 1	1		8		1		
i	B-1 100 milligram caps	ntained a bottle of Vitamin	1	}			8		1
- 1	Gericare, serial # 851P	04) with a manufacturer's							-
	expiration date of 10/20	18.	}]					Athenanda
	At 2:15 PM on 11/28/20	18, Employee B (the		143				+ 1	ĺ
	Director of Nursing) was was asked what the exp	shown this bottle. She							And house
- 1	medication was, and sh	e stated "October 2018,	}						1
	this is expired."						1		And the Party of the Land
	A review of the provider	s Medication		<					
- 14	Administration Policy sh	owed no process to audit] [0					
[1	the medication carts and medications.	remove any expired							
	i				19				
812	No further information w	as provided prior to exit.							
S=E (-000 Procurement, Store CFR(s): 483.60(i)(1)(2)	/Prepare/Serve-Sanitary	F 812						1

Event ID: UCWJ11

Facility ID: VA0258

If continuation sheet Page 56



TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY COMPLETED
	495144	B. WNG		44/20/2044
ME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/29/2018
ERSBURG HEALTHCARE CEI	NTER	- 1	287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	
EFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	DBE COMPLET
state or local authoritic (i) This may include for from local producers, and local laws or regulation of the included for from local producers, and local laws or regulation of the included from consuming from gardens, subject to consuming foods from consuming foods from consuming foods §483.60(i)(2) - Store, produced from consuming foods §483.60(i)	e food from sources ed satisfactory by federal, es. od items obtained directly subject to applicable State lations. Is not prohibit or prevent oduce grown in facility impliance with applicable -handling practices. Is not preclude residents not procured by the facility. In the ice machine in the against the floor drain. In place. In took place on 11/27/18 Dietary Manager. Upon archine, it was observed from the ice machine was rain. There was no air r back flow from the drain.			ited on an air gap ctor/ staff will be air gap ore d by the ensure es times will be e/ ittee to



PRINTED: 12/05/2018

ATEMENT OF DEFICIENCIES D PLAN OF CORRECT ON		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULT A. BUILDI	TIPLE CONS	-	(X3) DATE SURVEY COMPLETED		
		495144	B. WNG_				1.	412010040
E OF PROVIDER OR SUPPLIER TERSBURG HEALTHCARE CENTER				STREET 287 EAS PETERS		11/29/2018		
ID FIX G	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF CORRECT CTIVE ACTION SHOL NCED TO THE APPRO DEFICIENCY)	II D RE	COMPLETE DATE
Ma the eler was pro	pipe was supp vate the pipe of there next to t bably got knock	page 57 that there was a wire fixture that posed to rest on in order to fit the drain. She stated that it the pipe. She thought it ked out of place, leaving the inst the floor drain.	F8	12	en o de ve en		52	
Adn	he end of day r ninistrator and fied of the issu	meeting on 11/28/18, the Director of Nursing were e.						The state of the s
								The second secon
						ξ,		
						61		
					# < c	3.5		
						35)	£*	