PRINTED: 05/22/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7.000,251110		R	
and the second s	- 512M2/W-90/	495358	B. MNG		05/15/2019	
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			88	30 VIRGINIA STREET		
WELLSP	RINGS AT AMELIA		A	MELIA, VA 23002		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
{F 000}		dicare/Medicaid revisit d survey conducted on	{F 000}	The completion and submission of credible allegation of compliance does constitute an admission that the facagrees with the allegations in the 2567, facility is completing the allegation compliance because it is required by	not sility The	
F	4/2/19 through 4/5/19 through 5/15/19. Cor compliance with 42 C Term Care Requirement deficiencies are identi	was conducted 5/14/19 rections are required for FR Part 483 Federal Long		and Federal law. The facility disagrees the alleged deficiencies as stated and scope and severity at which they are c Further, the facility disputes and disag with the accuracy of statements and information relied upon in support of alleged deficiencies. This includes, but is limited to, the alleged content / summal	with the ited. grees other the s not	
{F 695}	92 at the time of the s consisted of 12 currer Residents #101 throu Respiratory/Tracheos CFR(s): 483.25(i)	gh #112. tomy Care and Suctioning	{F 695}	interviews, the timing / chronolog sequence of events and contact with he care professionals, and the description of care provided to the residents. The fact reserves its right to continue disput appealing and contesting these all deficiencies and taking any action related or arising therefrom in any other forms	gical ealth f the cility ting, eged	
a	The facility must ensure needs respiratory care care and tracheal succare, consistent with practice, the comprehencare plan, the resident and 483.65 of this substitute This REQUIREMENT by: Based on observation	d tracheal suctioning. are that a resident who e, including tracheostomy tioning, is provided such professional standards of eensive person-centered ats' goals and preferences, opart. is not met as evidenced in, staff interview, clinical		professional standards of prac and the comprehensive per- centered care plan.	and with tice,	
	determined that facilit respiratory equipment two of 12 residents in Residents # 106 and 1. For Resident # 106 the mouth piece for a	t in a sanitary manner for the survey sample,		On 5/14/19 the oxygen tubing nebulizer with nebulizer tubing placed in plastic bags per facture guideline.	was 🛡 🗷 🔥	

HOMINIUMATOR Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	COMPLETED		
	ROVIDER OR SUPPLIER	495358	STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET			
WELLSPR	INGS AT AMELIA	2607 - 4.4%	A	MELIA, VA 23002		
(X4) ID PREFIX 1AG	(EACH DEFICIÉ	STATEMENT OF DEFICIENCIES NCY MUST BLE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DIBE COMPLETION	
{F 695}	a nasal cannula in The findings included. 1. For Resident # the mouth piece for manner. Resident # 106 was 10/05/2018 with do not limited to shore (1) and atrial fibrilled. Resident # 106's industrial fibrilled at set), a quarter (assessment reference Resident # 106 as assessment for more for 15, 15 - being daily decisions. Frequiring extensive member for activity. On 05/14/19 at 12 Resident # 106's # 106 was observed television. Further mouth piece for the nebulizer tubing a bed uncovered. On 05/14/19 at 22 Resident # 106's # 106 was observed television. Further piece for the nebulizer for the	107, facility staff failed to store a sanitary manner. de: 106, facility staff failed to store or a nebulizer in a sanitary as admitted to the facility on inagnoses that included but were tness of breath, hypertension ation (2). most recent MDS (minimum erly assessment with an ARD rence date) of 01/11/19, coded as scoring a 15 on the staff ental status (BIMS) of a scoreing cognitively intact for making the sident # 106 was coded as the assistance of one staff	(F 695)	Facility nursing staff will more respiratory equipment standards of practice and car and by following infection practices. III On or before, June 3, 201 DON, Unit Managers or dewill complete an educational for licensed nurses and raides, either in person phone, regarding oxygen nebulizers including: Store O2 set up in bag when not in use. Check O2 tubing when enter a room to infection control maintained. Newly hired nursing staff and again will receive this education orientation. Any PRN staff currently on FMLA, LOA or vacar receive this education prior to their next scheduled shift	per re plan control 9, the esignee review nursing or by and plastic en they ensure I is ency staff during or those ation will beginning	
	and the market of the same	rs Obsolete Event ID: TU	CX12 F	acility ID: VA0002	continuation sheet Page 2 of	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2019 FORM APPROVED OMB NO 0938-0391

	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495358	8 WING		R 05/15/2019
NAME OF P	ROVIDER OR SUPPLIER	10000		STREET ADDRESS, CITY, STATE, ZIP CODE	05/15/2019
	INGS AT AMELIA		8	830 VIRGINIA STREET AMELIA, VA 23002	50 445 004 302
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I ULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F 695}	bed uncovered. On 05/14/19 at 3:55 p Resident # 106's roor # 106 was observed I television. Further ob mouth piece for the n nebulizer tubing and I bed uncovered. The POS (physician's 106 dated 05/2019 do sulfate (3) solution for milliliter) via (by) Neb- Date: 04/11/2019." The comprehensive of 04/11/19 for Resident "Problem: Cardiac." documented, "Adminity ORDERED. Start Da On 05/14/19 at approvinterview was conduct practical nurse) # 1. piece for a nebulizer use LPN # 1 stated, " plastic bag." When a should be stored in a "To prevent contamin mouth piece for the n of Resident # 106's b 1 stated, "It should be The facility's policy "O Treatment" document plastic bag."	c.m., an observation of m was conducted. Resident ying in his bed watching observation revealed the ebulizer was attached to the hanging from the side of the coumented, "Albuterol r nebulization. 3ML (three ulizer; Inhalation. Start care plan with dated of a # 106 documented, Under "Approach" it ister medications: AS atte: 04/11/2019." Eximately 4:00 p.m., an atted with LPN (licensed When asked how the mouth should be store when not in a sked why the mouth piece plastic bag LPN # 1 stated, ation." After observing the ebulizer hanging off the side ed with this surveyor LPN #	{F 695}	Beginning May 15, 2019, the Double Unit Managers or designee conduct audits of residents oxygen and respiratory treatments to validate that the oxygen is be delivered per MD orders, toxygen/ nebulizer tubing is bag and stored under infection comprocedures. This audit will to place on 20% of the residents woxygen, 5 days per week foweek, then 2 times per week foweek then weekly for 8 weeks. Any discrepancy noted during audit will be addressed at time. Results of the audit will submitted, by the DON, mont to the QAPI (Quality Assessment Performance Improvem committee for its review recommendations. The Committee consists of the face Administrator, Director of Nursunit Managers, Infection controlled.	will on ents eing chat ged dtrol cake with r 1 or 1 the that l be chly, nent ent) and QAPI cility sing, ntrol effice ector

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

Event ID: TLKX12

Facility ID: VA0002

If continuation sheet Page 3 of 15





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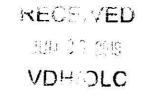
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
			A SOLEDIA			R 05/15/2019	
		495358	B. WING_				
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE		,
WELLSPE	RINGS AT AMELIA			8830 VIRGINIA STR	REET		
WELLSEN	INGS AT AMELIA			AMELIA, VA 230	02		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 695}	Continued From page	e 3	{F 69	353			
		ce president of clinical	, ,	301			
	structure, and used filters the profit electric constitution and the constitution of t	ware of the above findings.					
		,					
	No further information	n was provided prior to exit.					
	References:						
	(1) High blood pressi	ure. This information was	·			}	
	obtained from the we						
	https://www.nlm.nih.g						
	essure.html.			Ì			
	(2) A problem with th	e speed or rhythm of the					
		mation was obtained from					
	the website:					1	
	https://www.nlm.nih.g	gov/medlineplus/atrialfibrillati					
	on.html.						
		of albuterol and ipratropium					8
	100	neezing, difficulty breathing,					
		coughing in people with ulmonary disease (COPD; a	ļ				
		at affect the lungs and					
	The state of the s	onic bronchitis (swelling of					
		lead to the lungs) and					
	L 15 51 51 51 1751	e to the air sacs in the				1	
	(ipratropium combination is		49		j	
		se symptoms have not been				i I	
	controlled by a single Albuterol and ipratro						1
		ronchodilators. Albuterol and					
		tion works by relaxing and		i i			
	100	ages to the lungs to make					Į
	breathing easier. Th	is information was obtained					
	from the website:						
	https://medlineplus.g	ov/druginfo/meds/a601063.h					
	tml		e.				
	3 For Boardont # 10	7 facility staff failed to store				Į.	
	a nasal cannula in a	7, facility staff failed to store sanitary manner	İ			ļ	

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

EventID TLKX12

Facility ID: VA0002

If continuation sheet Page 4 of 15



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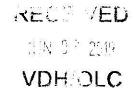
		(X1) PROVIDER/SUPPLIER/CHA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 5	(X3) DATE SURVEY COMPLETED	
		495358	B. WNG			R /15/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA 23002		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 695}	Continued From pag	*	(F 69:	5)		
	09/25/2017 with diagnot limited to heart f	admitted to the facility on gnoses that included but were ailure (1), peripheral vascular onic kidney disease (3).				
	data set), a 14-Day (assessment referer Resident # 107 as s assessment for mer of 0 - 15, 5 (five) - b for making daily dec coded as being inde only for activities of "Special Treatments	st recent MDS (minimum assessment with an ARD noce date) of 01/30/19, coded coring a 5 (five) on the staff status (BIMS) of a score eing XX impaired of cognition isions. Resident # 107 was ependent and requiring set-up daily living. Section O of Procedures and Programs of the procedures are proc			al.	
	Resident # 107's rod # 107 was observed oxygen by nasal car concentrator at two observation reveale tubing which was co oxygen cylinder atta	5 p.m., an observation of om was conducted. Resident I lying in his bed receiving anula from an oxygen diters per minute. Further d a nasal cannula and oxygen connected to the portable iched to the back of Resident was uncovered and lying in elichair.				
	Resident # 107's rou # 107 was observed oxygen by nasal cal concentrator at two observation reveale tubing which was co oxygen cylinder atta	p.m., an observation of om was conducted. Resident I lying in his bed receiving noula from an oxygen liters per minute95. Further d a nasal cannula and oxygen onnected to the portable iched to the back of Resident was uncovered and lying in				

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

Event ID: TI KX12

Facility ID: VA0002

if continuation sheet Page 5 of 15



PRINTED: 05/22/2019 FORM APPROVED OMB NO. 0938-0391

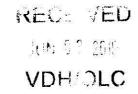
	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		<u> </u>	(X3) DATE SURVEY COMPLETED			
						R	
		495358	B. WING			05/	15/2019
	ROVIDER OR SUPPLIER			STRFET ADDRESS, CITY, STATE, 8830 VIRGINIA STREET AMELIA, VA 23002	ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
{F 695}	Resident # 107's roor # 107 was observed I oxygen by nasal cann concentrator at two lift observation revealed tubing which was concext oxygen cylinder attact # 107's wheelchair, wand lying in the seat of The POS (physician's 107 dated 05/2019 do 2L/min (two liters per cannula) s needed. So The comprehensive of 7/15/19 for Reside "Problem: Cardiac." documented, "Admini Observe oxygen pred IS O2 IN THE TANK On 05/14/19 at approximate interview was conducted practical nurse) # 1. cannula should be streated, "It should be prevent contamination observations of Residencovered sitting on wheelchair LPN # 1 second	chair. c.m., an observation of m was conducted. Resident lying in his bed receiving mula from an oxygen lers per minute. Further a nasal cannula and oxygen lers per minute. Further a nasal cannula and oxygen lers placed in a plastic bag of the wheelchair. corder sheet) for Resident # coumented, "O2 (oxygen) @ minute) via (by) NC (nasal Start Date: 04/26/2019." care plan with a target date in the 107 documented, "O17 documented, "O28 Under "Approach" it ister oxygen per orders. Cautions. BE SURE THERE EACH SHIFT." eximately 4:00 p.m., an otted with LPN (licensed When asked how a nasal one when not in use LPN # 1 placed in a plastic bag." nasal cannula should be	{F 6		JENCY)		
		pag LPN # 1 stated, "No. I		9			

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

Event1D_TLKX12

Facility ID VA0002

If continuation sheet Page 6 of 15



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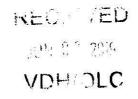
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(R)R	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495358	B. WING		R 05/15/2019		
	OVIDER OR SUPPLIER	The second secon	88	TREET ADDRESS, CITY, STATE, ZIP CODE 330 VIRGINIA STREET MELIA, VA 23002	1 05/15/2015		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
	Nasal Cannula" doc cannulas are not in not let tubing drag of the cannulas are not in not let tubing drag of the cannulas are not in not let tubing drag of the cannulas are not in not let tubing drag of the cannulas are not in not let tubing drag of the cannulas are not let tubing drag of t	"Oxygen Therapy - Mask and cumented, "When masks and use, store in plastic bag, do on the floor." So a.m., ASM (administrative vice president of clinical aware of the above findings. In the heart is no longer able the blood to the rest of the body sees symptoms to occur y. This information was vebsite: gov/ency/article/000158.htm. In aged and can't filter blood as information was obtained from gov/chronickidneydisease.htm Stem is the body's network of cludes the arteries, veins and y blood to and from the heart, he thick and stiff, a problem sis. Blood clots can clog blood flow to the heart or brain. Lessels can burst, causing body.) This information was vebsite:	{F 695}				
{F 880}	https://www.nlm.nih ases.html. Infection Prevention	n.gov/medlineplus/vasculardise	{F 880}				

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Event ID: TLKX12

Facility ID: VA0002

If continuation sheet Page 7 of 15



PRINTED: 05/22/2019 FORM APPROVED OMÉ NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495358	B. WING_			0.5	R 5/15/2019	
	ROVIDER OR SUPPLIER			8836	EET ADDRESS, CITY, STATE, ZIP CODE D VIRGINIA STREET ELIA, VA 23002	1 00	13/23/13	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R L SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	infection prevention designed to provide comfortable environ development and tradiseases and infection program. The facility must estand control program a minimum, the folio §483.80(a)(1) A systemoting, investigat and communicable staff, volunteers, visproviding services used conducted accordinaccepted national staff. Service for the pount are not limited to (i) A system of surver possible communication infections before the persons in the facility (ii) When and to whom the discontinuation of the persons in the facility (iii) When and to whom the discontinuation of the persons in the facility (iii) When and to whom the discontinuation of the persons in the facility (iii) When and to whom the discontinuation of the provided that the provided the persons in the facility (iii) When and to whom the provided that t	ontrol cablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ons. a prevention and control cablish an infection prevention (IPCP) that must include, at awing elements: tem for preventing, identifying, ing, and controlling infections diseases for all residents, itors, and other individuals upon the facility assessment g to §483.70(e) and following tandards; en standards, policies, and program, which must include, or experience designed to identify able diseases or experience of the program of the progr	(F 8		F 880 It is the practice of this faci establish and maintain an inf prevention and control prodesigned to provide a sanitary and comforment and to help provide the development and transmof communicable diseases infections. I On 5/14/19 the oxygen tubin nebulizer with nebulizer tubin placed in plastic bags per guideline. II Facility nursing staff will mare privatory equipment standards of practice and call and by following infection practices. III On or before, June 3, 20 DON, Unit Managers or dewill complete an educational for licensed nurses and aides, either in person phone, regarding oxygen nebulizers including: Store O2 set up in	fection ogram safe, ortable revent nission and ng and ng was facility naintain per plan control 19 the esignee review nursing or by n and plastic	6-3-19	
	reported; (iii) Standard and tra to be followed to pre	ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a			 bag when not in use. Check O2 tubing when enter a room to infection control maintained. 	en they ensure		

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

Event IO: TLKX12

Facility ID: VA0002

If continuation sheet Page 8 of 15

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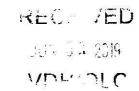
	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495358	B. WING		R 05/15/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE. 8830 VIRGINIA STREET AMELIA, VA. 23002	05/15/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
{F 880}	involved, and (B) A requirement that least restrictive possite circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syste identified under the factorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on observation record review and fact determined that facilit infection control pract in the survey sample, 1. The facility staff fail	t not limited to: ation of the isolation, infectious agent or organism It the isolation should be the pole for the resident under the sunder which the facility wes with a communicable kin lesions from direct for their food, if direct the disease; and procedures to be followed rect resident contact. In for recording incidents for the facility. It is store, process, and for prevent the spread of In the store, prevent the spread of	(F 88)	Newly hired nursing staff and agency will receive this education dorientation. Any PRN staff or currently on FMLA, LOA or vacation receive this education prior to begitheir next scheduled shift IV Beginning May 15, 2019, the Dunit Managers or designee conduct audits of residents oxygen and respiratory treatment to validate that the oxygen is beginned to delivered per MD orders, oxygen/nebulizer tubing is based and stored under infection comprocedures. This audit will place on 20% of the residents oxygen, 5 days per week for week, then 2 times per week for week then weekly for 8 weeks. discrepancy noted during the awill be addressed at that the Results of the audit will submitted, by the DON, mon to the QAPI (Quality Assessing Performance Improvem committee for its review recommendations.	luring those n will nning DON, will on tents peing that gged ntrol take with or 1 for 1 Any audit time. be thly, ment nent)	

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

Event ID: 1LKX12

Facility ID VA0002

If continuation sheet Page 9 of 15



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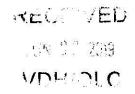
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495358	B WING_			R 05/15/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET AMELIA, VA 23002	372		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION \$		OULD BE		(X5) COMPLETION DATE
{F 880}	2. The facility staff control practices for 107's nasal cannul. The findings included 1. The facility staff control practices for 106's mouth piece. Resident # 106 was 10/05/2018 with dia not limited to short (1) and atrial fibrillar. Resident # 106's mouth grace (assessment reference Resident # 106 as assessment for me of 0 - 15, 15 - being daily decisions. Rerequiring extensive member for activition on 05/14/19 at 12. Resident # 106's mouth grace for the nebulizer tubing arbed uncovered. On 05/14/19 at 2:5 Resident # 106's mouth grace for the nebulizer tubing arbed uncovered. On 05/14/19 at 2:5 Resident # 106's mouth grace for the nebulizer for the	failed to implement infection r the storage of Resident # a. e: failed to implement infection r the storage of Resident # for a nebulizer. s admitted to the facility on agnoses that included but were ness of breath, hypertension ation (2). nost recent MDS (minimum rly assessment with an ARD ence date) of 01/11/19, coded scoring a 15 on the staff ental status (BIMS) of a score g cognitively intact for making esident # 106 was coded as assistance of one staff	{F 84	80}			

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Event ID, TLKX 12

Facility ID VA0002

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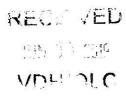
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495358	B. WING		R 05/15/2019
SOURCE STATE OF STATE	ROVIDER OR SUPPLIER		8830	FET ADDRESS, CITY, STATE, ZIP CODE VIRGINIA STREET ELIA, VA 23002	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
{F 880}	bed uncovered. On 05/14/19 at 3:55 Resident # 106's ro # 106 was observed television. Further mouth piece for the nebulizer tubing and bed uncovered. The POS (physician 106 dated 05/2019 sulfate (3) solution milliliter) via (by) Ne Date: 04/11/2019." The comprehensive 04/11/19 for Reside "Problem: Cardiac." documented, "Adm ORDERED. Start II On 05/14/19 at app interview was cond practical nurse) # 1 piece for a nebulize use LPN # 1 stated plastic bag." When should be stored in "To prevent contam mouth piece for the of Resident # 106's 1 stated, "It should The facility's policy Treatment" docume plastic bag." On 05/15/19 at 9:00	is p.m., an observation of com was conducted. Resident of lying in his bed watching observation revealed the nebulizer was attached to the distance of the of hanging from the side of the of sorder sheet) for Resident # documented, "Albuterol for nebulization. 3ML (three ebulizer; Inhalation. Start of the care plan with dated of the of the observation of the observation of the care plan with dated of the care plan with	{F 880}		

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Event ID: TLKX12

Famility ID VA0002

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OCIAICI	O F OIT WILDIGATE OF	MILDIOAID SERVICES		······································	~~OMB NO. 0938-0391
	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CI A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495358	B. WNG		R
		100000		The second secon	05/15/2019
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
WELLSDE	RINGS AT AMELIA		8830	VIRGINIA STREET	
WEELS? I	ANGS AT ANICEIA		AMI	ELIA, VA 23002	
(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 COMPLETION
/F 000)		W1002:			
{F 880}	Continued From page	e 11	{F 880}	8	
	services was made a	ware of the above findings.			
	No further information	n was provided prior to exit.			
	References:				
		re. This information was			
	obtained from the wel				
		ov/medlineplus/highbloodpr			
	essure.html.				
	And result in any analysis representation of a federal device and for every fine results.	e speed or rhythm of the			
	The first of the complete of the contract of t	nation was obtained from			
	the website:				
	https://www.nlm.nih.g on.html.	ov/medlineplus/atrialfibrillati			
	(3) The combination of	of albuterol and ipratropium			
		eezing, difficulty breathing,			
		coughing in people with			:
		ılmonary disease (COPD; a			
	group of diseases tha				
	I 1 77 1	onic bronchitis (swelling of			
	the air passages that	lead to the lungs) and			
	emphysema (damage	to the air sacs in the			
	lungs). Albuterol and i	ipratropium combination is			
	used by people whose	e symptoms have not been			
	controlled by a single				
	Albuterol and ipratrop				
		onchodilators. Albuterol and	+		
		on works by relaxing and			
		ges to the lungs to make			
i		s information was obtained			İ
	from the website:				
		v/druginfo/meds/a601063.h			
	tml.				
	2. The facility staff fai	led to implement infection			
		ne storage of Resident #			

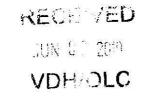
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107's nasal cannula.

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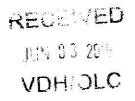
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		·	4	OMB N	O. 0938-03911
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495358			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED R 05/15/2019	
		B. WING					
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1	0.00
WELLSPRINGS AT AMELIA					0 VIRGINIA STREET		
				AM	ELIA, VA 23002		-10-
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID CH DEFICIENCY MUST BE PRECEDED 8Y FULL PREFIX ULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE	
{F 880}	Continued From page 12 Resident # 107 was admitted to the facility on 09/25/2017 with diagnoses that included but were not limited to heart failure (1), peripheral vascular disease (2) and chronic kidney disease (3).		{F 8	80}			
	Resident # 107s most recent MDS (minimum data set), a 14-Day assessment with an ARD (assessment reference date) of 01/30/19, coded Resident # 107 as scoring a 5 (five) on the staff assessment for mental status (BIMS) of a score						
	of 0 - 15, 5 (five) - be for making daily deci- coded as being inder only for activities of d "Special Treatments,	ing XX impaired of cognition sions. Resident # 107 was bendent and requiring set-up laily living. Section O Procedures and Programs" 7 as receiving "Oxygen					
	On 05/14/19 at 12:35 Resident # 107's roor # 107 was observed oxygen by nasal can concentrator at two li observation revealed tubing which was cor oxygen cylinder attack	ters per minute. Further a nasal cannula and oxygen nnected to the portable thed to the back of Resident was uncovered and lying in					
	Resident # 107's roor # 107 was observed oxygen by nasal cancentrator at two li observation revealed tubing which was cor oxygen cylinder attack	p.m., an observation of m was conducted. Resident lying in his bed receiving nula from an oxygen ters per minute95. Further a nasal cannula and oxygen inected to the portable thed to the back of Resident was uncovered and lying in					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/22/2019 FORM APPROVED

OMB.NQ. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ R B. WNG 495358 05/15/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 8830 VIRGINIA STREET **WELLSPRINGS AT AMELIA** AMELIA, VA 23002 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) JD PREFIX COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (F 880) Continued From page 13 {F 880} the seat of the wheelchair. On 05/14/19 at 3:55 p.m., an observation of Resident # 107's room was conducted. Resident # 107 was observed lying in his bed receiving oxygen by nasal cannula from an oxygen concentrator at two liters per minute. Further observation revealed a nasal cannula and oxygen tubing which was connected to the portable oxygen cylinder attached to the back of Resident # 107's wheelchair, was placed in a plastic bag and lying in the seat of the wheelchair. The POS (physician's order sheet) for Resident # 107 dated 05/2019 documented, "O2 (oxygen) @ 2L/min (two liters per minute) via (by) NC (nasal cannula) s needed. Start Date: 04/26/2019." The comprehensive care plan with a target date of 7/15/19 for Resident # 107 documented, "Problem: Cardiac." Under "Approach" it documented, "Administer oxygen per orders. Observe oxygen precautions. BE SURE THERE IS O2 IN THE TANK EACH SHIFT." On 05/14/19 at approximately 4:00 p.m., an interview was conducted with LPN (licensed practical nurse) # 1. When asked how a nasal cannula should be store when not in use LPN # 1 stated, "It should be placed in a plastic bag." When asked why the nasal cannula should be stored in a plastic bag LPN # 1 stated, "To prevent contamination." When informed of the observations of Resident # 107's nasal cannula uncovered sitting on the seat of the resident's wheelchair LPN # 1 stated, "It should have been put in a baq." When asked if he had placed the

don't know who did."

nasal cannula in the bag LPN # 1 stated, "No, I

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDII	NG	: .	R	
		495358	B WNG_	-13 Sept. 180	and and a supplying the state of the supplying the state of the supplying the state of the supplying the state of the supplying the state of the supplying the state of the supplying the state of the supplying the state of the supplying the state of the supplying the state of the supplying the supplying the state of the supplying the sup		/15/2019
NAME OF PI	ROVIDER OR SUPPLIER	50 m/s² do		STREET ADDI	RESS, CITY, STATE, ZIP CODE		11 12
WELLSPR	INGS AT AMELIA			8830 VIRGIN			
				AMELIA, VA	A 23002		,
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
(F 880)	Continued From page 14		{F 8	80}			
	Nasal Cannula" docu cannulas are not in us not let tubing drag on On 05/15/19 at 9:05 a staff member) # 3, vio services was made at No further information References: (1) A condition in whice to pump oxygen-rich lefficiently. This cause throughout the body. obtained from the well https://medlineplus.go. (2) Kidneys are dama they should. This inforthe website: https://medlineplus.go.l. (3) The vascular system blood vessels. It incluicapillaries that carry to Arteries can become called atherosclerosis vessels and block bloods.	a.m., ASM (administrative be president of clinical ware of the above findings. In was provided prior to exit. The the heart is no longer able blood to the rest of the body is symptoms to occur. This information was besite: Evilency/article/000158.htm. In your control of the body is symptoms to occur. This information was besite: Evilency/article/000158.htm. In your control of the body is network of the arteries, veins and blood to and from the heart thick and stiff, a problem is blood clots can clog out flow to the heart or brain.					
	bleeding inside the bo obtained from the well	sels can burst, causing ody.) This information was osite: ov/medlineplus/vasculardise	. s				

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