DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED 09/28/2019

|                          | A SAND THE RESIDENCE TO STANDARD STANDA | ND HUMAN SERVICES   |                   |   |  | APPROVED                  |
|--------------------------|--|---|-------------------|---|--|---------------------------|
|                          | OF DEFICIENCIES  | MEDICAID SERVICES  (X1; PROVIDER/BUPFLIER/CLIA  | (MO) AU II TIEU ( | E CONSTRUCTION  |  |                           |
|                          | GORAECTION   | IDENTIFICATION NUMBER:  | A. BUILDING       |   | COMP   | LETED                     |
| D010 20 1                |  | 4953 <b>38</b>  | B. MING           |   | 10000000   | :<br>17/2019              |
| NAME OF 2                | ROVIDER OR SUPPLIER  | *   |                   | STREET ADDRESS, CITY, STATE, ZIP CODE   | ***************************************  |                           |
| 001051                   | 7.1 W 15.55 or 10115   | na  |                   | IDO WALDEN ROAD   |  |                           |
| GHACEM                   | EALTHCARE OF ABING   | ЦÚN   |                   | ABINGDON, VA 24210  | 200  |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE FRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | E  | X6)<br>COMPLETION<br>OATE |
|                          | l  | ,   |                   |   |  |                           |
| F 000                    | INITIAL COMMENTS   |   | F 000             |   | OMB NO. 0  OMB NO. 0  OMB NO. 0  OMB OMB COMPLET  COMPLET |                           |
|                          | standard survey was<br>09/17/19. One Comp<br>during the survey. C<br>compliance with 42 C<br>Term Care requireme   | edicare/Medicard abbreviated conducted 08/18/19 through plaint was investigated corrections are required for EFR Part 483 Federal Longuists.  |                   | under State and Federal law. The facility's submission of the Plan of Correction does no constitute an admission on the part of the fitth the findings cited are accurate, that the constitute a deficiency, or that the scope and determination is correct. Because the facilities such admissions, the statements made in of Correction cannot be used against the facing subsequent administrative or civil proclaken.   | not<br>acility<br>e findings<br>d severity<br>ty makes<br>the Pian<br>cility in  |                           |
| w . 20                   | B2 at the time of the a<br>consisted of 3 curren<br>(Residents #1, #2 ar<br>review (Resident #3).  | survey. The survey sample<br>t Resident reviews<br>id #4) and 1 closed record   |                   |   | 200 H 100 H  |                           |
|                          | Care Plan Timing and   |   | F 667             | F-657 Care Plan Timing and Revision   |  |                           |
| 55≈D                     | be- (i) Developed within 7 the comprehensive a. (ii) Prepared by an initiation but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practite resident and their resident reprot practicable for the resident's care plan. (F) Other appropriate  | ensive Care Plans prehensive care plan must days after completion of assessment. lardisciplinary team, that elited to— esician. with responsibility for the responsibility for the i and nutrition services staff, ticable the perticipation of esident's representative(s), be included in a resident's conticipation of the resident resentative is determined i development of the staff or professionals in |                   | #I. Resident #3 no longer resides in the facility on 9/ #2. All residents could have the potential to affected by the deficient practice. Nursing a reviewed the care plans for all residents add within the last 30 days to ensure residents in developed and accurate care plans were note #3. In-service education will be provided to interdisciplinary team and licensed nursing the Director of Nursing or Designee, on the policy and procedure for Comprehensive C. including care plan updates and revisions. Education will be completed on or prior to The Director of Nursing or Designee will re- care plan for each new resident with new or significant change in condition at the daily care #4. The Director of Nursing or Designee will five (5) Comprehensive Care Plans to ensur- residents have a developed and accurate car including 1:1 care, use of alarm(s) and payol | be tall nitted myc a pues d. the stell by fecility's are Plans (0/14/19. view the ders or a cilulcal updated. I audit c all re plan  | VDH/OLC                   |
|                          | 1000000 00 0000000 00000000 00000000 0000  | ned by the resident's needs   |                   |   |  | (XB) DATE                 |
| MOURA UM .               | THE TOR S OR FROM LINE TO  | DELNOTE MOLYCOCK (SPIA - O DICHY, AUS   | <b>5</b> //       | TITLE   |  | V-VI DAILU                |

Any deficiency statement anding with an asterick of denotes a deficiency which the institution may be excused from correcting providing it is determined that other salegiards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings extend above are decisable 90 days following the days 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 perticipation.

| CENTER<br>STATEMENT O                                     |  | D HUMAN SERVICES MEDICAID SERVICES (X1) PROVICER/SUPPLIER/CLIA (DENTIFICATION NUMBER:  |                     | E CONSTRUCTION  | FORM<br>OMB NO<br>(X3) DATE  | : 09/28/2016<br>  APPROVEC<br>  0938-0391<br> <br>  BURVEY<br>  LETED |
|---|--|--|---------------------|---|--|---|
|   |  |  | A. 35 CO            | · · · · · · · · · · · · · · · · · · ·   |  | )   |
|   |  | 495338   | B. WING             |   | 09/  | 7/2019  |
| NAME OF PROVIDER OR SUPPLIER GRACE HEALTHCARE OF ABINGDON |  | OÓN  |                     | TREET ADDRESS, CITY, STATE, ZIP CODE<br>100 WALDEN ROAD<br>ABINGDON, VA 24210   |  |   |
| (X4) ID<br>PREFIX<br>TAG                                  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIÉS<br>MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)   | ID<br>PRSFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  |  | (8X)<br>NO FELEMOD<br>ETAD  |
| F 657   | team after each asser comprehensive and quaseasments. This REQUIREMENT by: Based on staff intervireview, the facility staff the resident's comprehensive and a staff intervireview, the facility staff falled resident's CCP (Compresident's CCP (Compresident's CCP did no care, bed atarm, or the medication.  This was a closed record was reviewed in the facility staff falled resident's face at a staff falled resident's CCP did no care, bed atarm, or the medication.  This was a closed record was reviewed in the face sheet includinfarct, hemiplegia, deanxiety disorder, hypermuscle weakness, un abnormalities of gait a receated falls.  Section C (Cognitive II admission MDS (Minli with an ARD (Assession MINS (Minli with an ARD (Assession with an ARD (Assession MINS (Minli with an ARD (Assession with an ARD (Assessi | e resident.  see by the interdisciplinary sament, including both the uarterly review  is not met as evidenced  ew and clinical record  ff failed to review and revise hensive care plan for 1 of 4  3.  to review and revisa the prahensive Care Plan). The trinclude the readent's 1:1 eresident's psychotropic  ford review. The clinical on 09/17/19.  seet revealed that Resident to the facility on 08/20/19.  ded the diagnoses, carebral ementia, osteosrthritis, pransion, dysphagia, steadiness on feet.  and mobility, anemia, and  Patterna) of the resident's mum Data Set) assessment ment Reference Date) of IMS (Brief Interview for ery score of 7 out of a potition N (Medications) was | F 857               | medications if applicable, weekly for one (I) and then monthly for two months. Findings reported to the Nursing Home Administrate immediately when policy is not adhered to.  All results and findings of the audits will be by DON and reviewed in the monthly facility meeting x 3 months or until compliance is a The Quality Assurance Performance Impro Committee consists of the Administrator, D of Narsing, Assistant Director of Nursing, Development Coordinator, Minimum Data Coordinator, Rehabilitation Coordinator, Indicator, Environmental Services Director, Administrator, Environmental Services Director, Administrator, and Maintenance Director Completion date: November 4, 2019 | will be or (NHA) brought y QAPI chleved. vement irector taff Set Iedicai |   |

FORM 3MS-2567(02-99) Previous Vertions Obtolete

Event (D: T68Z11

Facility D: VA0061

If continuation sheet Page 2 of 9

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| DEPARTMENT OF HEALTH     | AND HUMAN SERVICES     |
|--------------------------|------------------------|
| CENTERS FOR MEDICARE     | & MEDICAID SERVICES    |
| TATEMENT OF DEFICIENCIES | OF PROVIDER/SUPPLIED/C |

PRINTED: 09/26/2019 FORM APPROVED QMB NQ: 0938-0391

|                          | OF DEFICIENCIES<br>CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | 1100000             |   | (X3) DATE SURVEY<br>COMPLETED                  |
|--------------------------|--|--|---------------------|---|--|
|                          |  | 495335   | B. WNG_             |   | C  |
| i.                       | ROMDER OR SUPPLIER<br>EALTHCARE OF ABING   | DON  |                     | STREET ADDRESS, CITY, STATE, ZIP 1<br>800 WALDEN ROAD<br>ABINGDON, VA 24210   | 09/17/2019<br>CODE                             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEVIENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING (RIFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDERS PLAN OF<br>[EACH CORRECTIVE ACT<br>GROSS-REFERENCED TO<br>DEFICIENT | TION SHOULD BE COMPLETION THE APPROPRIATE DATE |
| F 657                    | Provide the control of the control o | a 2<br>flors: Section P (Alarms)<br>the Resident used a bed  | F6                  | 67  |  |
|                          | revealed that the facilithis Resident on the due to "confusion at bed and attempt to stronger revealed that Re   | int's "Departmental Notes" lifty placed a 1:1 staff with late of admission (08/20/19) and attempts to get out of the and" These departmental seldent #3 had a 1:1 in | r.                  |   | J  |
|                          | mouth) BID (twice a d<br>anxiety x 7 days. Bed   | i 08/22/19 for the<br>ion "Seroquel 25 mg po (by<br>ay) prn (as needed) for<br>atarm while in bed for<br>was changed to "Seroquel                                    |                     |   |  |
| Stee                     | resident's care plan w   | nt's CCP revealed that the<br>as not revised to include the<br>dication, or the bed alarm.   |                     | 9   |  |
|                          | with the DON (Director<br>administrator, The DO<br>surveyor that the resid   | N verbalized to the  |                     | 5   |  |
|                          | that she was not award<br>regards to the bed alar<br>medication, MDS nurse<br>items were "not there."<br>On 00/17/10 at 2:50 p.  | n the surveyor and stated<br>e the Resident had a 1:1. In<br>rm and antipsychotic<br>e #1 stated that these two  |                     |   |  |

FORM CWS-2567(02-88) Previous Versions Quadiate

Event ID: T00211

Facility ID: VADO61

if continuation sheet Page 3 of 9

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

PRINTED: 09/26/2019 FORM APPROVED OMB NO: 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | THE SHARE SHARE SHARE SHARE | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED  |
|--|--|--|-----------------------------|---|--|
|  |  | 495338   | B, WING                     |   | C<br>09/17/2019  |
|  | ROVIDER OR SUPPLIER  |  | 57                          | TREET ADDRESS, CITY, STATE, ZIP CODE<br>DO WALDEN ROAD<br>BINGDON, VA 24210   | 09/1//2019   |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIES<br>NOY MUST BE PRECEDED BY FULL<br>OR LIGC IDENTIFYING INFORMATION)  | (D<br>PREPIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)   | D BE COMPLETION  |
| F 657  | resident's care plan<br>No further informati<br>provided to the surv<br>conference on 09/1   | in regarding this lesue was veyor prior to the exit  | F 657                       | · *****   |  |
| F 684<br>SS=D                                    | § 483.25 Quality of Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a rethet residents received accordance with pripractice, the compricate plan, and their Thia REQUIREMENT by:  Based on observative record review, the findings included aurgical site for 1 of the facility staff fail dressing to a surge ophysician.  The Residents face #2 had been admits there was no compact) assessment for a part of the pa | fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure the treatment and care in reference person-centered residents' choices.  NT is not met as evidenced strong staff interview and clinical facility staff falled to ensure alve treatment and care by an's order in regards to a of 4 Residents, Resident #2. | F 684                       | #1. The surgical site dressing for reside was changed by the wound care nurse. 9/16/19 and no adverse effects were not #2. The wound care nurse completed w care/treatments on 9/16/19 for all reside with orders for wound care / treatment no other resident(s) were affected. The Assistant Director of Nursing audited a Treatment Administration records on 9 and no other issues were noted related wound care/treatments.  #3. In-service education will be provide the licensed nursing staff by the Director Nursing or Designee, on the facility's p and procedure for Wound Care included physician's order, care plan, procedure documentation. Education will be compout or prior to 10/14/19.  #4. The Director of Nursing, or Designe sudit five (5) residents receiving wound including documentation weekly for on month and then monthly for two (2) me to ensure residents receive treatment at as ordered by the physician and that tr is documented based on facility policy, will be reported to the Nursing Home Administrator (NHA) immediately who is not adhered to.  All results and fludings of the audits will brought by DON and reviewed in the stracility QAPI meeting x 3 months or unitation. | on ted.  cound conts a and all: a/17/19 to  cd to br of colicy  g: and cheted  ce will care ce (1) boths nd care ceatment Findings ca policy  ill be conthly |

FORM CNS-2887(02-99) Previous Versions Obsolets .

Event ID: TBBZ11

Facility ID: VA0061

If continuation sheet Page 4 of 9

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

PRINTED 08/26/2019 FORM APPROVED OMB NO. 0938-0391

| CBITTE                   | A LACTRICATED ALVERT   | & INFOIGUID OF LAIGEO  |                    |   | DIME MC   | 1 0530 039 I               |
|--------------------------|--|--|--------------------|---|---|----------------------------|
|                          | of deficiencies<br>Figorrection  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    | CONSTRUCTION  |   | LETED                      |
|                          | Œ  | 495338   | B. WING            |   | ©<br>99/17/   |                            |
| A CONTRACTOR MATERIAL TO | ROVIDER OR SUPPLIER  | идром  | 6                  | TREET ADDRESS, CITY, STATE, ZIP CODE<br>20 WALDEN ROAD<br>BINGDON, VA 24210   | 1 40,   | 7772016                    |
| (X4) ID<br>PREFIX<br>TA3 | (EACH DEFICIE  | STATEMENT OF DEFICIENCIES<br>NCY MUST 3E PRECEDED BY FULL<br>DR LGC IDENTIFYING INFORMATION)   | D<br>PREFIX<br>TAG | PROMDER'S PLAN OF CORRECT (EACH DORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINCED FICIENCY)  | ULD BE  | (XS)<br>COMPLETION<br>DATE |
| F 884                    | document titled "Di the following diagn ulcer etage 2, muse osteoporosis, and it The resident's clinic 09/16 and 09/17/18 This clinical record "CHANGE DRESS BANDAGE) ONCE The order date was This order had bee (treatment administ every other day at revealed that the ni- documented they in on 09/14 (Saturday The resident's care area surgical woun- were not ilimited to, Physician. On 09/17/19 at app an interview with th nurse verbalized to initialed and dated care nurse then sta dressing yesterday still in place from Ti the dressing should Saturday (09/14/19 The dressing and a | d the surveyor with a agnosis/History" that included oses nypothyroidiam, pressure cle weakness, fibromyalgis. Fracture lower end of femur. Included a physicians order to ING (GAUZE AND ACE DAILY EVERY OTHER DAY." Is documented as 08/12/19. In transcribed to the TAR tration record) to be completed 7:00 a.m. A review of the TAR tration record this treatment included the problem d. Approaches Included, but treatment(s) as ordered by a complete this treatment included the problem d. Approaches Included, but treatment(s) as ordered by a complete this treatment included the problem d. Approaches Included, but treatment(s) as ordered by a complete this treatment included the complete this treatment included the problem d. Approaches Included, but treatment(s) as ordered by a complete this treatment included the problem included included the problem included | F 884              | compliance is achieved. The Quality Performance Improvement Committed the Administrator, Director of Nur Assistant Director of Nursing, Staff a Coordinator, Minimum Data Set Cor Rehabitation Coordinator, Medical Environmental Services Director, Ad Director, Dictary Manager, Social Se Director, Activity Director, Medical Director and Maintenance Director.  Completion date: November 4, 2019 | et consists raing, Development ordinator, Director, missions rvices |                            |
|                          |  | e surveyor observed wound  |                    |   | 1   |                            |

FORM CNS-2557(02-39) Previous Versions Obsolete

Event ID: 168211

Feelity ID: VAGO01

If continuation sheet Page 5 of 9

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

PRINTED: 09/26/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION           |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | (X2) MULTIP  | LE CONSTRUCTION  | (X3) CATE BURVEY<br>COMPLETED |
|--|--|--|--|--|-------------------------------|
|  | ů s  | 86   | ,  | ·  | С                             |
|  |  | 495338   | B. WNG   |  | 09/17/2019                    |
| NAME OF PROVIDER OR SUPPLIER  GRACE HEALTHCARE OF ABINGDON |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>600 WALDEN ROAD<br>ABINGDON, VA 24210 |  |                               |
| (X4) ID<br>PREFIX<br>TAG                                   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD B<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY) | E COMPLETION                  |
| SS≖D   | care on 09/17/19 at 9 On 09/17/19 at 1:42 pverbelized to the survey preventative dressing sutures from her imm. The DON (Director of issue regarding the received preventative dressing sutures from her imm. The DON (Director of issue regarding the received preventative dressing the received preventative dressing the received preventation of the survey conference on 09/17/17 treatment/Svcs to Proceed to the | a.m., the wound care nurse ayor that this was just a to protect the resident's oblitzer.  Nursing) was notified of the esident's wound care on the esident's wound care on the issue regarding that the issue regarding this issue was to prior to the exit as time of the aurvey and was regarding this issue was corprise to the exit as event/Heal Pressure Ulcer (I)(II)  whith the interest is the interest of a consistent with a of practice, to prevent one and develop pressure reducing a condition of the exit and as the consistent with a consistent unavoidable; and as the consistent in the exit and as the exit and as the consistent in the exit and as th | F 68   |  | ras<br>nd<br>nd<br>nstant     |
| 1  | w th professional stan   |  |  |  |                               |

PRINTED: 09/26/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION (X3) DATE EURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING\_ C 495338 B. WING 09/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 600 WALDEN ROAD GRACE HEALTHCARE OF ABINGDON ABINGDON, VA 24210 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (34) 10 10 EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE TAG REGULATORY OR LBC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 686. Continued From page 6 F 686 #3. In-service education will be provided to promote healing, prevent infection and prevent the licensed nursing staff by the Director of Nursing or Designee, on the facility's policy new ulcers from developing. and procedure for Wound Care including This REQUIREMENT is not met as evidenced physician's order, core plan, procedure and documentation, Education will be completed Based on observation, staff interview, resident on or prior to 10/14/19. interview, and clinical record review, the facility staff falled to ensure that necessary treatment #4. The Director of Nursing or Designee will and services were provided through physician audit five (5) residents receiving wound care ordered wound care for 1 of 4 residents, Resident including documentation, weekly for one (1) month and then monthly for two (2) months to ensure residents receive treatment and care as ordered by the physician and that treatment The findings included: is documented based on facility policy Findings will be reparted to the Nursing Home The facility staff failed to provide a physician Administrator (NHA) immediately when policy ordered wound treatment for a stage if pressure is not adhered to. ulcer. The facility nursing staff falled to apply betadine to the resident's pressure ulcer. All results and fludings of the audits will be brought by DON and reviewed in the monthly The resident's face sheet revealed that Resident facility QAPI meeting x 3 months or until #2 had been admitted to the facility on 09/12/19. compliance is achieved. The Quality Assurance Performance Improvement Committee conslats The facility provided the surveyor with a of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development document titled "Diagnosis/History" that included the following diagnoses hypothyroidism, pressure Coordinator, Minimum Data Set Coordinator, ulcer stage 2, muscle weekness, fibromyalgia, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions asteoporosis, and fracture lower and of femur. Director, Dictary Manager, Social Services Director, Activity Director, Medical Records The resident's clinical record was reviewed on Director and Maintenance Director. 09/16 and 09/17/19. Completion date: November 4, 2019 There was no completed MDS (minimum data

place, and time.

set) assessment for this resident. However, the resident was elect and orientated to person,

This clinical record included a physician's telephone order dated 09/13/19 to "Apply Betadine to Stage II on base of (R) thigh. Leave

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CL
IDENTIFICATION NUMBER

PRINTED: 09/26/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (XZ) MULTIP<br>A. BUILDING | LE CONSTRUCTION   | (X3) DATE SURVEY COMPLETED |
|--|--|--|----------------------------|---|----------------------------|
| 496338   |  | 9. WING  |                            | С   |                            |
| No. a reservation for the second                 |  | 496338   | 8. VOING                   |   | 09/17/2019                 |
|  | ROVIDER OR SUPPLIER<br>EALTHCARE OF ABINGI   | OON  |                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>600 WALDEN ROAD<br>ABINGDON, VA 24210                                  |                            |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC (DENTIFYING IMPORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETION              |
| F 866  | Continued From page  | · 7  | F 68                       | 6   |                            |
|  | (trealment administrated ly at 7:00 a.m. Are that the nursing staff had completed this tric (Saturday) and 09/15. The resident's care planea pressure ulcer's Approaches included treatment(s) as order During an interview wat 8:20 a.m., Resident aurveyor that she did betadine on her leg. On 09/17/19 at 8:38 at the wound care nurse stated the order was changed over to skin weekends, and the fit for the wound care or The DON (director of Issue regarding the reconstruction of 17/19 at 8:40 a.m., Prior to observing wo changed to read, "AP STAGE II TO BACK (EVERYDAY UNTIL M.). On 09/17/19 at 9:15 at the wound care nurse that the wound that the wo | ian included the problem tage II right thigh, but were not limited to, ed by Physician.  With Resident #2 on 09/17/19 the word to the not recall anyone putting an interview with the process of being prep, she did not work for nurses were responsible to weekends.  But the process of being prep, she did not work for nurses were responsible to weekends.  But the surveyor of the problem to the process were the process of the process of the process of the process of the process were responsible to weekends.  But the process of the problem to the process were responsible to weekends.  But the process of the problem to the process were responsible to the process were responsible to the process were the process were the process were the process which the process were the process which the process were the process were the process which the process were the process were the process which the process which the process were the process which the process which the process were the process which the process which the process were the process which the process were the process which the process were the process which the process whi |                            |   |                            |

|  |   | ID HUMAN SERVICES   |                       |   |                                   | 09/26/2019<br>APPROVED    |  |  |
|--|---|---|-----------------------|---|-----------------------------------|---------------------------|--|--|
| STATEMENT OF DE                                  | CENTERS FOR MEDICARE & MEDICAID SERVICES BYATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/BLPPLIER/CLIA IDENTIFICATION NUMBER: |   | No. 41 (868) 35 (853) | CONSTRUCTION  | OMB NO.<br>(x3) DATE 81<br>COMPLE |                           |  |  |
|  |   | 495338  | B. WNG                |   | C<br>09/4                         |                           |  |  |
|  | NAME OF PROVIDER OF SUPPLIER  GRACE HEALTHCARE OF ABINGDON  |   | 60                    | TREET ADDRESS, CITY, STATE, ZIP CODE<br>SO WALDEN ROAD<br>BINGDON, VA. 24210                                      | <b>09/17/2019</b><br>DE           |                           |  |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEF CIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION;   | PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CRO33-REFERENCED TO THE APPROPR<br>DEFICIENCY) | 56                                | KS)<br>COMPLETION<br>EATE |  |  |
| This corn not not not not not not not not not no | mpleting this treatm<br>t working during the<br>t Interviewed.<br>: 09/17/19 at 2:50 p.<br>DN were notified of t<br>ildent's wound care       | have been responsible for nent over the weekend was a time of the survey and was a.m., the administrator and the issue regarding the regarding this issue was not prior to the exit | F 698                 |   |                                   |                           |  |  |

FORM CNS-2887 (02-88) Previous Versions Obsolets

Event ID: T58211

Fedily ID: VACOS1

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