STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/8/19 through 10/10/19. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/08/2019 through 10/10/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated. Life Safety Code report will follow. The census in this 216 certified bed facility was 205 at the time of the survey. The survey sample consisted of thirty-five (35) current resident reviews, and two (2) closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		11/22/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/25/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on dining observation, resident interview, and staff interview, the facility staff failed to ensure a dignified dining experience in one of three dining room in the facility. Approximately twelve residents residing on the Season's unit (a memory care unit), were seated together at two tables and served at different times. Findings were: On 10/08/2019 at approximately 11:30 a.m., during initial tour of the facility, the dining room/kitchen area of the Season's unit was	F 550	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan or correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 observed. The dining area contained two rectangular tables. There was a kitchen area with a warming table used to keep food hot when brought from the main kitchen. LPN (licensed practical nurse) #4, was asked how meal time was handled. She stated, "The trays for the 'feeders' come down from the kitchen already prepared. We bring them to the dining room first and give them their trays. Then the kitchen brings down pans of food for everyone else. We plate that up and serve it in the dining room. At approximately 1:00 p.m., the trays and food in pans was delivered from the main kitchen. Residents needing assistance/supervision were in the dining room and seated at various places around the two rectangular tables. Approximately six residents were brought to the dining room for the initial seating. At approximately 1:05 p.m., additional residents were assisted to the dining area. Those residents were seated at empty chairs/spaces around the two tables. The residents were seated with other residents who were either eating or being fed by facility staff. Resident #75 raised her hand and said, "Feed me!". She was asked if she was hungry. She stated, "Yes, I want some food." Resident #166 was sat next to Resident #167 who was already eating. Resident #166 reached over Resident #167's plate and took her coffee. She then proceeded to sip the coffee. Resident #166 then slid Resident #167's plate over to herself and started to eat. She was redirected by staff and a new plate was obtained for Resident #167. Resident #164 was brought in and seated at the	F 550	Corrective Action: Residents #76, 151, 164, 166, and 167 were served in a dignified manner during their dining experience. Identification: Resident□s residing on the affected unit have the potential to be affected by this practice. Changes: Nurses and CNAs on the affected unit will be re-educated on providing a dignified dining experience. Specifically, staff will ensure that residents are seated in the dining room prior to the start of the dining service and staff will provide necessary assistance as needed to meet each residents□ individual needs. Monitoring: The Nurse Manager, Director of Nursing, or designee will supervise and record observations daily x 2 weeks, weekly x 4 weeks, and monthly x 2 months of the dining experience on the affected unit. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3	F 550		

head of the table between two residents (#167 and #151) who had already been served. She sat with her hands folded on the table and looked back and forth between the two residents who were eating. She stated, "I'm going to be polite and not eat, I don't think there is enough." She then pushed her utensils towards the center of the table. She then looked over at Resident#151's food which was in individual bowls. She reached over and took his bowl of lima beans and his coffee. She picked up her fork and began to eat the lima beans and drink the coffee.

LPN #4 was informed of the above observation. She took the limas and coffee and told a CNA (certified nursing assistant) to serve Resident #164 next.

After all of the residents were served, at approximately 1:20 p.m.. lemonade was served to the residents who did not have coffee.

LPN #4 was asked if the dining observations regarding the way residents were served was the norm. She asked, "What do you mean?" The observations of residents taking other residents food and drink was discussed. She stated, "You saw that we served them next after they did that...do you know a better way?"

On 10/09/2019 at approximately 9:00 a.m., breakfast was observed on the Season's Unit. Resident #166 was observed using her fork to scrape the remaining crumbs off of her plate. She then licked her finger and ran it al over her plate to pick up the remaining crumbs and put them in her mouth. She was asked if she was still hungry. She stated "Yes." Ten residents were seated around the two tables. The first table had four

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 residents seated, three were eating, one was not served. The other table had six residents, two eating, four had not yet been served. Resident #76 stated, "I'm hungry! Where's mine?" Resident #164 was observed sitting in the common area by herself, facing a book case. She was eating alone. During an end of day meeting on 10/09/2019 the above dining observations were discussed with the DON (director of nursing) and the administrator. On 10/10/2019 during an end of the day meeting the administrator and the DON were asked if they had observed the dining concerns. The administrator stated, "We did go over there and look at it. We have some ideas about maybe getting different tables, maybe sitting all of the residents who need assistance at the same table so the other residents aren't watching them eat as they wait for their food." No further information was obtained prior to the exit conference on 10/10/2019.	F 550		
F 584 SS=D	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	F 584		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX 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 5 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. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to ensure a safe, homelike environment on two of five nursing units. A resident room on unit 2 had constantly running water in the sink, a malfunctioning bathroom door, holes in the bathroom wall and a broken air freshener holder. A resident room on unit 1 had a broken/missing toilet paper holder	F 584	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan or correction prepared for this deficiency was executed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX 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 6 and holes in the bathroom wall. The findings include: On 10/8/19 at 11:30 a.m., the bathroom in room 106 was inspected. There were multiple holes in the bathroom wall. The toilet paper bracket was broken and missing on one side with the toilet paper positioned in the floor. A private sitter (other staff #2) working in this room was interviewed about the broken bathroom item. The sitter stated the toilet paper bracket had been broken for about 3 weeks. The sitter stated she previously reported the broken bracket but it had not been fixed. On 10/8/19 at 11:53 a.m., Resident #135 was interviewed about quality of life in the facility. The resident stated the bathroom door in his room scraped on the floor each time it was opened/closed making a screeching sound. Resident #135 stated the bathroom door did not close all the way and required a hard push to get the door latched. The door was inspected at this time and was observed to scrape the floor when opened/closed making a harsh sound. The door did not close all the way when shut, hanging on the door frame. There were multiple holes in Resident #135's bathroom wall where brackets had been removed and not repaired. There was also an air freshener holder near the ceiling over the commode. The cover on the holder was hanging open and broken. With spigot handles turned off, water was constantly running in the sink in Resident #135's room. On 10/10/19 at 9:38 a.m., accompanied by the maintenance supervisor (other staff #4), the above items were observed. The maintenance	F 584	solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action: Repairs were made to the sink, door, bathroom wall, and air freshener holder to resident room on affected unit. Repairs were made to the toilet paper holder and bathroom wall to resident room on affected unit. Identification: Affected unit will be assessed for running sinks, malfunctioning doors, holes in bathroom walls, and broken air freshener holder with repairs made accordingly. Affected unit will be assessed for broken/missing toilet paper holders and holes in bathroom walls with repairs made accordingly. Changes: EVS staff will be re-educated on conducting environmental room rounds, specifically identifying and reporting running sinks, malfunctioning doors, holes in bathroom walls, broken air freshener holders, and broken/missing toilet paper holders. Monitoring: EVS Lead, Team Coordinator, or designee will audit 20% of completed environmental round reports on affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX 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 7 director stated he was not aware of the broken items or needed repairs. The maintenance supervisor stated staff members were supposed to enter work orders for any needed repairs or verbally report broken items to maintenance staff. The maintenance supervisor stated no work orders had been previously entered regarding the broken and/or malfunctioning items on unit 1 and unit 2. The maintenance supervisor attempted to close the air freshener holder but the cover would not stay shut. This finding was reviewed with the administrator and director of nursing during a meeting on 10/10/19 at 12:45 p.m.	F 584	units monthly. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 8 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to develop a baseline care plan for tube feeding for one of 37 Residents, Resident #396. The findings Include: Resident #396 was admitted to the facility on 9/30/19. Diagnoses for Resident #396 included; Alzheimer's disease, dementia, diabetes, and placement of a gastrostomy tube (feeding tube). The most current MDS (minimum data set) was not completed at the time of the survey due to Resident #396 being a new admission.	F 655	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan or correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action: Resident #396'□s baseline care plan was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 9 On 10/9/19 Resident #396's medical record was reviewed and indicated that Resident #396 was newly admitted with a feeding tube. Review of Resident #396's baseline care plan documented a check mark beside feeding tube, but did not indicate any goals or interventions for the care of Resident #396's feeding tube. On 10/09/19 at 9:26 AM, MDS coordinator (registered nurse, RN #1) was interviewed. RN #1 stated that an initial MDS had not been completed as Resident #396 was a new admission and that after the MDS was complete then a comprehensive care plan would also be completed. Until the comprehensive care plan was complete, the facility was to be using Resident #396's baseline care plan. On 10/09/19 at 4:12 PM, the survey team met with the administrator and director of nursing (DON). The DON was shown a copy of Resident #396's baseline care plan. After review of the care plan the DON stated that the care plan was not complete. No there information was presented prior to exit on 10/10/19.	F 655	updated to include goals and interventions related to the care of a feeding tube. Identification: New residents that are admitted to the facility with a feeding tube on the affected unit could potentially be affected. Changes: Nurses on the affected unit will be re-educated on facility policy entitled, "Baseline Care Plans". The existing baseline care plan document will be edited to include goals and interventions related to the care of feeding tubes. Monitoring: Nurse Manager, MDS Coordinator, or designee will audit baseline care plans on the affected unit weekly to ensure that goals and interventions are in place for the care of those with feeding tubes. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 10 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to review and revise a comprehensive care plan for 1 of 37 in the survey sample. Resident #15's care plan was not revised to reflect the discontinued nutritional shake. The findings include: Resident #15 was admitted to the facility on 05/31/18 with diagnoses that included hypertension, diabetes, Non-Alzheimer's Dementia, left-side hemiplegia, and seizures. The most recent minimum data set (MDS) dated 09/25/19 was a quarterly assessment and assessed Resident #15 has having long and short term memory problems, severely impaired	F 657	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan or correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action: Resident #15'□s comprehensive care plan was revised to reflect the discontinued nutritional shake.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 11 for daily decision making, and having continuous periods of inattention and disorganized thinking. Resident #15's clinical record was reviewed on 10/09/19 at 9:45 a.m. Observed on the current physician order sheet was the following order: "TX: HIGH KCAL SHAKE W/LUNCH FOR WT MANAGEMENT." A line was drawn through the order and "D/C 9/27/19" was handwritten beside the order. A telephone order was observed dated 09/27/19 to discontinue the high-kcal shake at lunch. A review of Resident #15's comprehensive care plan (CCP) documented the following: "Original Date: 06/20/18. MT015-NUTRITIONAL-IBW (ideal body weight) 140#. Updated 10/4/19. The CCP included goals and interventions for Resident #15 to have a stable weight. Observed was the following handwritten intervention: "07/26/ ...High cal shake with lunch." Resident #15's CCP had not been reviewed and revised to reflect the changes in the plan of care. On 10/09/19 at 2:00 p.m., the unit manager (RN #2) who was responsible for updating the care plans was interviewed. RN #2 stated the high kcal shake had been discontinued on 09/27/19 and the care plan should have been updated to reflect the change in the plan of care. These findings were reviewed with the administrator and director of nursing during a meeting on 10/09/19 at 3:45 p.m. No additional information was provided to the survey team prior to exit on 10/10/19 at 2:00 p.m.	F 657	Identification: Resident□s with physician orders to discontinue nutritional shakes on the affected unit could potentially be affected. Changes: Charge Nurse, Nurse Manager, and MDS Coordinator on affected unit will be re-educated on the facility policy entitled, "Comprehensive Person-Centered Care Planning". Monitoring: Nurse Manager, MDS Coordinator, or designee will audit physician orders with specific attention provided to the discontinuation of a nutritional shake weekly to ensure that the care plan has been reviewed and revised appropriately. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12	F 684		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to apply physician ordered protective sleeves for one of 37 residents in the survey sample (Resident #13); and failed to follow professional standards of practice for medication administration for one of 37 residents in the survey sample (Resident #345). The findings include: 1. Resident #13 was admitted to the facility on 5/31/17 with diagnoses that included coronary artery disease, congestive heart failure, dementia, high blood pressure and chronic knee pain. The minimum data set (MDS) dated 7/2/19 assessed Resident #13 with severely impaired cognitive skills and as requiring the extensive assistance of one person for dressing. On 10/8/19 at 1:45 p.m., Resident #13 was observed in bed. The resident had no protective "geri-sleeves" on her forearms. The resident was observed again on 10/8/19 at 4:20 p.m. and on 10/9/19 at 2:00 p.m. without geri-sleeves in place.	F 684	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan or correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statements, the facility states that: Corrective Action: Resident #13'□s physician ordered protective sleeves were applied. Resident #345'□s route of administration for ordered antibiotic was changed from IM to IV (via PICC line). Identification: Observation on affected unit was isolated to Resident #13. No other residents on affected unit with physician ordered	11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 13 Resident #13's clinical record documented a physician's order dated 9/30/19 for "gerisleeves on arms as tolerated for skin protection." The resident's plan of care (revised 10/3/19) listed the resident was at risk of skin breakdown, bruises and skin tears. The plan listed the resident had experienced skin tears to her arms and/or hands on 10/3/18, 11/14/18, 2/5/19, 3/31/19, 7/16/19, and 7/30/19. Interventions listed for prevention of skin tears/bruising included, "Geri-sleeves for arms as tolerated." There was no documentation indicating the resident refused to wear the geri-sleeves. On 10/9/19 at 2:08 p.m., the certified nurses' aide (CNA #3) caring for Resident #13 was interviewed about the geri-sleeves. CNA #3 stated the resident wore geri-sleeves "at one time" but she was not sure if she still required them. On 10/9/19 at 2:19 p.m., accompanied by CNA #3, Resident #13 was observed in her room without the protective geri-sleeves in use. CNA #3 looked in Resident #13's room for the protective sleeves, finding only one sleeve in the bedside table drawer. CNA #3 stated she did not know where the other sleeve was located and was not sure if the resident still required the sleeves. On 10/9/19 at 2:21 p.m., the licensed practical nurse (LPN #6) caring for Resident #13 was interviewed. LPN #6 stated the resident was supposed to wear the geri-sleeves to protect her from skin tears. This finding was reviewed with the administrator and director of nursing during a meeting on 10/9/19 at 4:00 p.m.	F 684	protective sleeves. There were no other residents identified, aside from Resident #345, that were receiving an IM route of administration for ordered antibiotics that had PICC line access. Changes: Nurses and CNAs on affected unit will be re-educated on following a physician order for plan of treatment specifically for protective sleeves. Nurses will utilize the physician orders and treatment administration record for reference while CNAs will utilize the communication books to confirm such resident centered information. Nurses on affected unit will be re-educated on the review of admission physician orders with attention placed on the route of antibiotic medication administration specifically IM should PICC line access be present. Monitoring: Charge Nurse, Nurse Manager, or designee on affected unit will observe residents with physician ordered protective sleeves and record findings daily x 2 weeks, weekly x 4 weeks, and monthly x 2 months. Nurse Manager, Director of Nursing, or designee will review admission physician orders with attention placed on route of antibiotic medication administration specifically IM should PICC line access be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 14 2. Resident #346 was admitted to the facility on 10/07/19 with diagnoses including, but not limited to: CAD (coronary artery disease), high blood pressure, diabetes mellitus-insulin dependent, cellulitis of the right foot, osteomyelitis of the right foot, and a positive MRSA (methicillin resistant staphylococcus aureus) screen. The most current MDS (minimum data set) was an entry assessment dated 10/07/19, this MDS did not provide complete information on the resident. The resident's admission assessment dated 10/07/19 and timed 5:00 PM was reviewed and documented, "...reason of admission: therapy/ABT [antibiotics]...osteomyelitis (R) foot, PAD [peripheral artery disease]...MRSA [Methicillin-resistant Staphylococcus Aureus] ..." The resident was assessed as being alert and oriented to person, place, time and situation. A medication pass and pour observation was conducted on 10/09/19. LPN (licensed practical nurse) #5 prepared the medications, which included two separate insulin injections. Also prepared were two vials, 1 mg (milligram) per vial of Ceftazidime (antibiotic). The Ceftazidime box had a pink piece of paper taped on top with a hand written label that documented, "Ceftazidime 2gm (#2, 1 gm vials) Reconstitute each 1 gram vial w/ 3ml of sterile water OR 1% lidocaine. Use 2 of the 1 GM vials to equal the 2 GM dose." The hand written label was not signed. LPN #5 stated that she did not know who wrote the label and taped it to the box. LPN #5 reconstituted each vial with 3 ml (milliliters) of 1% Lidocaine, prepared the two syringes for IM (intramuscular) injection, donned gloves and gown and entered the room.	F 684	present. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 15	F 684		

Resident #346 was observed with a single lumen PICC line in his right antecubital area. LPN #5 stated that the resident gets his vancomycin through the PICC. LPN #5 administered the insulin injections first into the resident's abdomen and then asked the resident to turn over on his side for the two IM injections of the antibiotic.

Resident #346 turned on his side and made the comment that he did not know how many more of these IM injections he would be able to take as he was getting a lot and they hurt. LPN #5 reassured the resident that these two injections should be better as she reconstituted with the Lidocaine. The resident agreed to the injections and the LPN gave both IM injections into the resident's right hip area. LPN #5 was asked how many injections the resident was getting and LPN #5 stated that he was getting six IM injections daily, along with his insulin injections.

On 10/09/19 at 11:54 AM, LPN #5 was interviewed regarding Resident #346 complaining of pain with the IM injections and that the antibiotic being reconstituted with Lidocaine on the earlier observation. LPN #5 stated that the resident had been complaining of the injections hurting and stinging and that is why she mixed it with the lidocaine. LPN #5 was asked to look at the MARs (medication administration records). The medication was listed on the MAR as an IM injection, but did not have any reconstitution instructions for the medication. LPN #5 was asked how anyone would know what the previously administered injections were mixed with if there are no instructions on the MAR or orders, and no a place to document what reconstitution was used. LPN #5 stated, "You wouldn't."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16	F 684		

The actual pharmacy label included Resident #346's name along with the following: " ...2 gm IM use 2 vials of the 1 gm to equal 2 gm every 8 hours d/t osteomyelitis right foot." The pharmacy label did not provide reconstitution instructions for an IM injection.

The medication box with manufacturer's instructions documented, "For IM or IV use to prepare IM, add 3 ml of an approved diluent, IV add 10 ml of sterile solution." No package insert was located in the box or in the medication cart for this medication to provide instructions on specific IM reconstitution.

On 10/09/19 at 2:25 PM, Resident #346 was interviewed. The resident stated that the injections hurt, but he knew he had to have them. Resident #346 again stated that he didn't know how much longer he would be able to take all of the injections, as they are painful. Resident #346 was asked about this morning's injections that included the lidocaine. Resident #346 stated that it was a lot better, not as painful, and stated that he thought today was the first day that anyone had used lidocaine because it didn't hurt as bad as before.

Resident #346's physician's orders were then reviewed and included an order for: vancomycin HCL 1 gram 1.75 gram IV (intravenous) every 12 hours for osteomyelitis and an order for Ceftazidime 1 gram/2 gram IM every 8 hours for osteomyelitis. There were no orders for reconstitution of the medication.

The resident's hospital discharge summary dated 10/06/19 documented both antibiotics, but did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17	F 684		

document any adverse reactions and/or contraindications for administering both of the antibiotic medications through the PICC line (either together or separately).

The resident's CCP (comprehensive care plan) was reviewed and documented, "...IV [intravenous] medication: Type: antibiotic vanc, fortaz as ordered...Location: PICC line...dressing change: q [every] 7 days...Antibiotic: for osteomyelitis IV...nursing to provide patient centered care at receiving IV antibiotic therapy for osteomyelitis...Resident is on isolation related to MRSA in wound..."

On 10/10/19 at 9:01 AM, the UM (unit manager) and LPN (Licensed Practical Nurse) #5 were interviewed and asked why this resident was receiving so many IM injections and why this antibiotic medication was not also given IV through the resident's PICC line. LPN #5 stated that is how it was ordered and she didn't think to question it and that is how the pharmacy supplied it. LPN #5 stated that the pharmacy was not able to provide a 2 mg vial, so they received two, 1 mg vials. The UM stated that she did not know why the resident was getting so many IM injections. LPN #5 was asked how long the medication was ordered for and the LPN stated that the resident was supposed to receive both antibiotics (IV and IM) through 11/25/19.

The UM was asked if they had a drug reference book. The UM stated there was and presented the drug reference book. Both antibiotics were referenced and no documentation was found to evidence any type of reaction between the two medications. LPN #5 stated she would call the pharmacy to see if there may be an interaction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 between the medications. On 10/10/19 at approximately 09:30 AM, LPN #5 called the pharmacy and spoke with the pharmacist. LPN #5 stated that the pharmacist confirmed that there were no interactions between the medications and did not see why both of these medications couldn't be given through the PICC line at separate intervals. LPN #5 stated that the pharmacy requires a physician's order to give the ordered IM antibiotic medication in IV form. On 10/10/19 at 12:40 PM, the administrator and DON (director of nursing) were made aware of concerns in a meeting with the survey team. At approximately 1:30 PM, the administrator stated that the resident's attending physician while at the hospital was called for clarification of the above orders. The administrator stated that the attending physician did not discharge the resident, and therefore did not write the discharge orders, but stated that the Ceftazidime should have been ordered IV instead of IM. No further information and/or documentation was presented prior to the exit conference on 10/10/19 at 2:15 PM.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow physician's orders for treatment and care of skin integrity for two of 37 resident's. Resident #86 did not have heels floated or elbow protector while in bed per physician o5rders, and Resident #13 did not have a properly functioning air matress in place. The Findings Include: 1. Resident #86 was admitted to the facility on 3/28/18. Diagnoses for Resident #86 included: Hemiplegia, sepsis, bed confinement status, and cerebrovascular accident. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 8/13/19. Resident #86 was assessed as moderately cognitively intact. On 10/9/19 Resident #86's medical record was reviewed. An active physician's order set dated 10/1/19 through 10/31/19 included orders to use "heel protectors on while in bed" and to apply an "Elbow Protector to LT [left] Elbow While In Bed." On 10/9/19 at 9:30 AM and again at 1:50 PM Resident #86 was observed laying in bed without heel protectors or left elbow protector.	F 686	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Corrective Action: Resident #86's heels were floated and elbow protector to L elbow was applied. Resident #13's air mattress was replaced. Identification: Residents on affected unit with physician orders to float heels and wear elbow protectors could potentially be affected. Residents on affected unit with an air mattress could potentially be affected. Changes: Nurses and CNAs on affected unit will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20 On 10/09/19 at 2:45 PM, certified nursing assistant (CNA #1, assigned to Resident #86) was asked to observe Resident #86. Resident #86's heels did not show signs of skin break down. Resident #86's left elbow did show some redness and Resident #86 complained of some pain when the elbow was moved. CNA #1 then looked around the room and was not able to find the heel protectors or the elbow protector. CNA #1 stated that she was unaware that Resident #86 needed the protectors and the nurses usually ensures treatments were in place. On 10/09/19 at 3:03 PM, license practical nurse (LPN #2, assigned to do treatments) was interviewed. LPN #2 stated she did not realize that the protectors were not in place and thought they had been put on. On 10/09/19 at 4:12 PM, the above information was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 10/10/19. 2. Resident #13 was admitted to the facility on 5/31/17 with diagnoses that included coronary artery disease, congestive heart failure, dementia, high blood pressure and chronic knee pain. The minimum data set (MDS) dated 7/2/19 assessed Resident #13 with severely impaired cognitive skills. On 10/8/19 at 4:20 p.m., Resident #13 was in bed. The control box for the resident's alternating mattress pad was switched on but there was no light indicating the unit was functioning. Resident #13 was observed in bed again on 10/9/19 at	F 686	re-educated on following a physician order for plan of treatment specifically for floating heels and applying elbow protectors. Nurses will utilize the physician orders and treatment administration record for reference. CNAs will utilize the communication books to confirm such resident centered information. EVS staff will be re-educated on facility policy entitled, "Bed Entrapment Assessment" with specific focus on testing functionality of equipment to ensure that it is in good condition. Monitoring Charge Nurse, Nurse Manager, or designee on affected unit will record observations for resident's with physician orders to float heels and wear elbow protectors daily x 2 weeks, weekly x 4 weeks, and monthly x 2 months. EVS staff on affected unit will observe, test, and record functionality of air mattresses weekly. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 2:00 p.m. with the alternating air mattress not functioning. Resident #13's clinical record documented a physician's order dated 9/30/19 for an alternating pressure pad to bed for the prevention of pressure ulcers. The resident's plan of care (revised 10/3/19) listed the resident had a history of pressure ulcers, including a healed pressure ulcer on her sacrum. Interventions for pressure ulcer prevention included an alternating air mattress pad to bed and avoidance of pressure to any bony prominence for extended time. On 10/9/19 at 2:08 p.m., the certified nurses' aide (CNA #3) was interviewed about the functioning of the resident's alternating air mattress. CNA #3 stated she knew the green light was supposed to be on the mattress control box. CNA #3 stated sometimes the light was not on but it usually came back on if she "shoved" the plug back into the wall outlet. On 10/9/19 at 2:21 p.m., accompanied by licensed practical nurse (LPN #6), Resident #13 was observed in bed with the alternating air mattress not functioning. LPN #6 stated the green light was supposed to be on, indicating the unit was functioning. The green light on the mattress control box went on and off when the plug was manipulated in the wall outlet. LPN #6 stated the malfunctioning mattress needed to be reported to maintenance. This finding was reviewed with the administrator and director of nursing during a meeting on 10/9/19 at 4:00 p.m.	F 686		
F 687	Foot Care	F 687		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687 SS=D	Continued From page 22 CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, family interview, resident interview and clinical record review, the facility staff failed to ensure podiatry services for one of 37 residents, Resident #110. Findings were: Resident #110 was admitted to the facility on 02/26/2019, with the following diagnoses, but not limited to: Alzheimer's, Parkinson's, hypertension, and peripheral vascular disease. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 08/19/2019, assessed Resident #110 as severely impaired in his cognitive status with a summary score of "05". On 10/08/2019 at approximately 11:55 a.m., Resident #110 was observed sitting in the day room with his wife. They were interviewed regarding life at the facility. Resident #110's wife stated, "It is lovely here, we are very pleased with his care. The staff is wonderful. The only	F 687	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Corrective Action: Resident #110 has since received podiatry services. Identification: Residents residing on affected unit in need of podiatry services could potentially be affected. Changes:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 23 problem I have is that they ordered him new shoes and they haven't gotten here yet. They've been at the foot doctor's office for five weeks...they said his shoes he has are too tight and he can't walk in them...they split them down the side and now she [foot doctor] wont bring his shoes...I don't know if she [foot doctor] is on vacation or what, but he needs those shoes...the nurses here told me that the doctor has to put the shoes and socks that she said he needs on him to be sure they are right." Resident #110 was wearing a pair of brown shoes. He and his wife were asked about them. She stated, "Those are his...she [foot doctor] said those are no good, that he needs a softer sole shoe to help him walk better...I don't understand why if it is so important it is taking so long to get them here to him." Resident #110 stated, my right foot hurts below my little toe...it feels like it is going to fall off." On 10/09/19 at approximately 11:30 a.m., the clinical record was reviewed. LPN (licensed practical nurse) # 1 and the unit manager were interviewed regarding Resident #110's shoes that had been discussed the previous day and she was asked if she was aware of anything on his right foot that would cause him pain. LPN #1 called the doctor's office and stated that she had been told that the doctor had been in the facility last week but had run out of time to see Resident #110 due to add-ons to her schedule. She stated that the doctor had 3-4 different types of shoes here last week for Resident #110 to try but had been at the facility until after 6:00 p.m., and just didn't get to him. The doctor was scheduled to return to the facility on 10/17/2019 and would bring the resident his shoes at that time. At approximately 11:45 a.m., Resident #110's feet	F 687	Consultant podiatrist will see scheduled residents first with additional requests to be satisfied as able. Monitoring: Unit Secretaries or designee will prepare consultant podiatry visit list monthly and will confirm resident appointment needs have been addressed. Any missed podiatry appointments will be reported to the Nurse Manager and or Director of Nursing for additional follow up. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 24	F 687		

were observed with the unit manager. An area was observed on the padding of his right foot below his right pinky toe. The area was tannish in color with an area on the outer edge and in the center that was a darker brown. The unit manager stated, "That looks like a callus to me."

The podiatry notes were reviewed. The area observed on the right foot was not mentioned in the notes. Both podiatry notes, 08/09/2019 and 08/27/2019 contained the following entry: "NO CALLUSES/CORNS..." The podiatry notes were discussed with the unit manager. She stated, "I'll get the wound nurse to look at it."

The wound nurse came to the unit at approximately 11:50 a.m., and looked at Resident #110's foot. She felt around the area, the edges were slightly lifted. She stated, "I think that is a callus...I would recommend using skin prep on it." The wound nurse was asked what she thought had caused the callus since it was not mentioned on the podiatry notes. She reviewed the record and stated, "I think it was probably caused by his shoes...the podiatrist recommended a wider toebox and a softer sole shoe...he is ambulating with restorative so his shoes may be rubbing that area."

The above information was discussed during an end of the day meeting on 10/09/2019 with the DON (director of nursing) and the administrator.

On 10/10/2019 during an end of the day meeting the administrator stated that Resident #110's wife had been contacted and was agreeable for Resident #110 to wait until the podiatrist returned on 10/17/2019 with Resident #110's shoes. The DON stated, "We are also looking at her schedule

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 687	Continued From page 25 to make sure that she doesn't have add-ons that will interfere with her seeing the residents she is scheduled to see on the days of her visit." No further information was obtained prior to the exit conference on 10/10/2019.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to implement fall interventions to prevent accidents for 1 of 37 in the survey sample. Resident #15, who was identified as having a history of falls was observed without a fall mat beside the bed. The findings include: Resident #15 was admitted to the facility on 05/31/18 with diagnoses that included hypertension, diabetes, Non-Alzheimer's Dementia, left-side hemiplegia, and seizures. The most recent minimum data set (MDS) dated 09/25/19 was a quarterly assessment and assessed Resident #15 has having long and short term memory problems, severely impaired for daily decision making, and having continuous periods of inattention and disorganized thinking.	F 689	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Corrective Action: Resident #15's fall mat was placed beside his bed. Identification: Residents on affected unit with current	11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26 Further review of the 09/25/19 MDS revealed under Section G - Functional Status, Resident #15 was assessed as not ambulating in his room or on the unit; as being total dependent for transfers, bed mobility, dressing, eating, hygiene, bathing and locomotion on and off the unit. Resident #15's clinical record was reviewed on 10/09/19 at 9:45 a.m. Observed was a fall assessment dated 05/31/19 which assessed Resident #19 with a score of 26. The assessment documented a score of 16 or higher indicated a risk of falling. A review of the comprehensive care plans documented the following: "04/2/19. Fall from bed." Interventions included the following: "...4/2/19. Sent to ER (emergency room) for eval (evaluation) post fall, low bed, fall matt) ..." On 10/09/19 at 10:28 a.m., Resident #15 was observed in bed sleeping with the right side of the bed against the wall. There was one fall mat observed propped against the wall behind the door leading into the resident's room. There was no mat observed on the left side of the bed. On 10/09/19 at 10:30 a.m., the licensed practical nurse (LPN #3) was asked who was providing care for Resident #15. LPN #3 identified the certified nursing assistant (CNA) #2 and stated he was assisting another resident at the time. LPN #3 stated she would be able to assist with any concerns regarding Resident #15. LPN #3 entered Resident #15's room and was asked if Resident #15 was a fall risk and she replied yes. LPN #3 was interviewed regarding the fall mat as an intervention. LPN #3 stated the fall mat was	F 689	interventions of a fall mat could potentially be affected. Changes: CNAs on affected unit will be re-educated on the use of the communication book to confirm resident centered information, such as the intervention of fall mats. Monitoring: Charge Nurse, Nurse Manager, or designee on affected unit will record observations of residents with current fall mat interventions daily x 2 weeks, weekly x 4 weeks, and monthly x 2 months to ensure they are in place as appropriate. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 an intervention, however she wasn't sure if it was required all the time when the resident was in the bed. LPN #3 was observed removing the fall mat from behind the door of the room and placing it on the floor of the left side of Resident #15's bed. LPN #3 stated she would find out how often the mat was supposed to be used and would follow-up. On 10/09/19 at 12:30 p.m., CNA #2 was interviewed regarding the fall intervention for Resident #15. CNA #2 stated he forgot to put the fall mat down after providing care to Resident #15 and the fall mat was supposed to be used at all times when Resident #15 was in the bed. These findings were reviewed with the administrator and director of nursing during a meeting on 10/09/19 at 3:45 p.m. No additional information was provided to the survey team prior to exit on 10/10/19.	F 689		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure physician's orders for the care and maintenance of a PICC (Peripherally inserted central catheter) line for one of 37	F 694	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on	11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 28 residents, Resident #346. Findings include: Resident #346 was admitted to the facility on 10/07/19 with diagnoses including, but not limited to: CAD (coronary artery disease), high blood pressure, cellulitis of the right foot, osteomyelitis of the right foot, positive MRSA (methicillin resistant staphylococcus aureus) screen and diabetes mellitus. The most current MDS (minimum data set) was an entry assessment dated 10/07/19, this MDS did not provide complete information on the resident. Resident #346's admission assessment dated 10/07/19 and timed 5:00 PM was reviewed and documented, "...reason of admission: therapy/ABT [antibiotics]...osteomyelitis (R) foot, PAD [peripheral artery disease]...MRSA..." Resident #346 was assessed as being alert and oriented to person, place, time and situation. A medication pass and pour observation was conducted on 10/09/19, which included Resident #346. LPN (Licensed Practical Nurse) #5 stated that the resident was on contact isolation and that a gown and gloves must be worn when entering into the room. LPN #5 prepared the medications, donned gloves and gown and entered the room. Resident #346 was observed with a PICC line in his right antecubital area. LPN #5 stated that the resident gets his vancomycin through the PICC. Resident #346's physician's orders were reviewed and did not include any orders for the care and/or maintenance of the resident's PICC line.	F 694	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Corrective Action: A physician order for the care and maintenance of Resident #345's PICC line were obtained to match plan of care. Identification: Absence of physician orders for the care and maintenance of a PICC line was found to be an isolated observation. Changes: Nurses on affected unit will be re-educated on the review of admission physician orders for residents with PICC lines to ensure that orders are obtained for the care and maintenance of the PICC line. Monitoring: Nurse Manager, Director of Nursing, or designee will review admission physician orders as received to ensure that residents with PICC lines have orders that address the care and maintenance of the PICC line. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 29	F 694		

The CCP (comprehensive care plan) was reviewed and documented, "...IV [intravenous] medication: Type: antibiotic vanc, fortaz as ordered...Location: PICC line...dressing change: q [every] 7 days...Antibiotic: for osteomyelitis IV...nursing to provide patient centered care at receiving IV antibiotic therapy for osteomyelitis...Resident is on isolation related to MRSA in wound..."

On 10/10/19 at 8:44 AM, RN (Registered Nurse) #3, who was the UM (unit manager) was interviewed and asked if the resident had any other physician's orders. RN #3 stated that Resident #346 did have routine and emergency standing orders. The orders were reviewed and did not include any orders for the care and maintenance of a PICC line. The telephone orders were reviewed and did not include any orders for the care and maintenance of a PICC line for Resident #346.

RN #3 was asked for the resident's MARs/TARs (medication administration/treatment administration records). The MARs and TARs were reviewed for Resident #346 and did not reveal any orders or instructions for the care and maintenance of the resident's PICC line.

On 10/10/19 at 9:01 AM, the UM and LPN #5 were interviewed and asked about care for the resident's PICC line. The UM stated, "We have a policy." The UM and LPN #5 were asked about physician's orders for the PICC line. The UM and LPN #5 both stated that there were no orders for the care and maintenance of the resident's PICC line.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 30	F 694		

The UM again stated that they have the facility policy that pharmacy gives to take care of a PICC line or central line and that is kept at the nurses station. The UM stated that each unit has the policy. Again, the UM stated, "We don't have any orders for the PICC line and we don't get PICC lines very often."

LPN #5 was asked how she cared for the residents PICC line when administering medication. LPN #5 stated, that she will clean the port, flush with a 10 ml (milliliter) prefilled normal saline syringe. LPN #5 stated that she will then hook the IV medication and when the medication is finished, she will unhook, clean again and attach a new cap on port. LPN #5 was asked how she knew to do that; where did the instruction come from. The LPN stated, "I was trained to do that as a nurse, not here, as a nurse in general."

On 10/10/19 at 09:10 AM, the policy was presented and reviewed. The policy titled, "Peripherally Inserted Central (PICC)" documented, "...Flush orders must be obtained from physician...flush with 0.9% sodium chloride 10 ml before and after each use and every 12 hours when catheter is not in use...flush with 5 ml heparin (10 unit/ml) after each use and every 12 hours when catheter is not in use...Use 10 ml or larger syringes to prevent accidental rupture of catheter...lumens not in use should be clamped...if the daily amount...flushes exceed 30 ml/24 hours the use of preservative free...sodium chloride is recommended..."

The administrator and DON (director of nursing) were made aware of the above information and concerns that Resident #346 was not getting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 694	Continued From page 31 correct flushes per LPN #5 and there was no evidence to determine what other nurses were doing for the care and maintenance of the PICC line. No further information and/or documentation was presented prior to the exit conference on 10/10/19.	F 694		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 32 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical	F 842	The preparation of the following plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 33 record review, the facility staff failed to ensure an accurate clinical record for one of 37 residents in the survey sample. Resident #13's clinical record inaccurately documented a physician's order for restorative dining services. The findings include: Resident #13 was admitted to the facility on 5/31/17 with diagnoses that included coronary artery disease, congestive heart failure, dementia, high blood pressure and chronic knee pain. The minimum data set (MDS) dated 7/2/19 assessed Resident #13 with severely impaired cognitive skills. On 10/9/19 at 8:30 a.m., Resident #13 was observed eating breakfast in her room, unattended by staff. Resident #13's clinical record documented a physician's order signed by the physician on 9/30/19 for restorative dining services. The MDS assessment dated 7/2/19 listed the resident required set up and cueing only for eating. On 10/9/19 at 2:08 p.m., the certified nurses' aide (CNA #3) caring for Resident #13 was interviewed about restorative dining. CNA #3 stated Resident #13 usually ate meals in her room and had not been in restorative dining recently. CNA #3 stated residents in restorative dining were taken to the dining room and assisted with eating by restorative aides. CNA #3 stated Resident #13 was not currently included in restorative dining. On 10/10/19 at 8:00 a.m., the licensed practical nurse (LPN #7) responsible for restorative	F 842	correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because its required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Corrective Action: A physician order to discontinue Resident #13's restorative dining services was obtained to match current plan of care. Identification: The absence of a physician order discontinuing restorative dining services was an isolated observation. Changes: Restorative Nurse and Nurse Managers will be re-educated to obtain a physician order to discontinue restorative dining services when plan of care is complete. Monitoring: Restorative Nurse, Nurse Manager, or designee will audit restorative dining caseload monthly to ensure physician orders are obtained for those whose services have ended and are therefore discontinued. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 34 services was interviewed about Resident #13's physician order for restorative dining. LPN #7 stated Resident #13 had been out of restorative for "a long, long time." LPN #7 stated the order for restorative dining was in error. On 10/10/19 at 8:17 a.m., the registered nurse unit manager (RN #8) was interviewed about the restorative order for Resident #13. RN #8 stated the order was inaccurate as the resident was no longer a candidate for restorative dining. This finding was reviewed with the administrator and director of nursing during a meeting on 10/10/19 at 12:45 p.m.	F 842	The QA Committee will determine when to discontinue this practice.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure appropriate infection control practices to identify and control infections for two of 37 residents, Resident #195 and Resident #346. Findings include: Resident #195 was admitted to the facility on 09/04/19. Diagnoses for this resident included, but were not limited to: High blood pressure, osteoporosis, history of prostate cancer, high blood pressure, history of colon cancer, BPH (benign prostatic hypertrophy) with obstructive uropathy, chronic indwelling Foley catheter and ESBL (extended spectrum beta-lactamase) infection. The most current MDS (minimum data set) was a 14 day admission assessment dated 09/18/19. This MDS assessed the resident as having a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring extensive assistance of one for toileting and hygiene. The resident was also assessed as having an indwelling catheter. Resident #346 was admitted to the facility on 10/07/19. Diagnoses included, but were not limited to: CAD (coronary artery disease), high	F 880	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Corrective Action: To ensure appropriate infection control practices, a room transfer was facilitated for Resident #195. Identification: The observed inappropriate infection control practice involving Resident's #195 and #346 was found to be an isolated occurrence. Changes: The Admission Committee will be re-educated on facility policy entitled, "Multi-Drug Resistant Organisms", with emphasis placed on room assignment/placement. Monitoring:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 blood pressure, DM (diabetes mellitus), PAD (peripheral artery disease), cellulitis of the right foot, osteomyelitis of the right foot, and a positive MRSA (methicillin resistant staphylococcus aureus) screen upon admission. The most current MDS (minimum data set) was an entry assessment dated 10/07/19, this MDS did not provide complete information on the resident. Resident #346 admission assessment dated 10/07/19 and timed 5:00 PM was reviewed and documented, "...reason of admission: therapy/ABT [antibiotics]...osteomyelitis (R) foot, PAD [peripheral artery disease]...MRSA..." Resident #346 was assessed as being alert and oriented to person, place, time and situation. Resident #346 was assessed as being continent of bowel and bladder and as using the toilet for elimination. On 10/08/19 at approximately 11:00 AM, during the initial tour of the facility, Resident #195 and #346 were observed in the same semi-private room. A contact isolation sign was posted outside of the residents' room and an isolation cart was at the entrance of the door. CNA (certified nursing assistant) #6 was asked which resident was on isolation. CNA #6 stated that she thought that it was Resident #195. At approximately 11:20 AM, LPN (Licensed Practical Nurse) #4 was then asked which resident was on isolation. LPN #4 stated that Resident #346 was on isolation. At approximately 3:35 PM, Resident #195 was observed in the hallway, in a wheelchair, along with his wife and daughter. Resident #195 had a	F 880	Infection Preventionist, Nurse Manager, or designee will record observations of room assignments for residents with multi-drug resistant organisms weekly to ensure appropriate infection control practices are sustained. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38	F 880		

Foley catheter in a privacy bag hanging on the wheelchair frame. The resident's wife stated that she did not know if the isolation was for her husband or for the other resident. The wife was asked if she and her daughter had been educated regarding entering the isolation room and what was expected. The resident's wife stated that staff had called her on Saturday (October 5th) and told her that her husband had an infection in his urine, but wasn't exactly sure what that meant. The wife stated that staff instructed them on wearing the PPE (personal protective equipment) prior to entering the room and hand washing. The resident's wife again stated that she wasn't sure if the isolation was for her husband or the other resident and stated, "I guess if it was for him [her husband] they [staff] wouldn't allow him to roam up and down the halls."

Resident # 195's clinical record was observed and documented that an order was written for a urine culture and sensitivity on 10/02/19. The urine specimen was collected on 10/03/19 and the resident was started on an antibiotic at that time.

According to nursing notes, the following was documented:

10/06/19 12 PM "MD [medical doctor] made aware of resident's final urine results that stated urine was growing escherichia coli...consult pharmacy..."

10/06/19 1 PM "Pharmacy called...resident should be [intravenous antibiotics] obtain a urinalysis after 10 days..."

10/06/19 4:16 PM "MD gave order to d/c

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39	F 880		

[discontinue] bactrim...RR [resident representative] aware..."

10/08/19 7 PM "...Foley intact and draining. IV intact to L [left] AC [antecubital]..."

Resident # 195's final lab result was reviewed dated 10/07/19 and time 6:58 AM documented, "...ESBL...should be considered resistant to penicillin...unusual resistance pattern...consult pharmacy or an infectious disease specialist..."

Resident #346's clinical record revealed this resident was admitted on 10/07/19 at approximately 5:00 PM for osteomyelitis of the right foot.

Resident #346's CCP (comprehensive care plan) was reviewed and documented, "...IV [intravenous] medication: Type: antibiotic vanc, fortaz as ordered...Location: PICC line...dressing change: q [every] 7 days...Antibiotic: for osteomyelitis IV...nursing to provide patient centered care at receiving IV antibiotic therapy for osteomyelitis...Resident is on isolation related to MRSA in wound..."

On 10/09/19 at 8:30 AM, a medication pass and pour observation was completed on Resident #346. LPN #5 was asked where Resident #346's roommate Resident #195, was since he was not in the room. LPN #5 stated that he had been moved to another room, that the family had concerns.

The infection control policy was presented and reviewed. The policy documented, "...Isolation Precautions...to protect other residents, employees and visitors from the spread of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40	F 880		

confirmed or suspected infection or contagious disease...will be instituted if there is risk of spreading infection...controlling the spread will be determined by the characteristics of the pathogen...will be explained to the resident and family...A private room with a toilet is desirable if resident has an enteric pathogen and is on contact precautions and uses the toilet for isolation...appropriate resident placement is a significant component of isolation precautions...when possible a resident that is highly contagious should be placed in a private room with a bathroom to reduce opportunities...residents infected with the same organism can share a room...when an infected resident shares a room with a non infected resident, it is also important that residents, staff and visitors take care...roommates are carefully selected...Contact precautions...MRSA...ESBL...Resident placement...place resident in a room with a resident(s) who has active infection with the same microorganism, but with no other infection (cohorting)...limit the movement and transport of the resident from room to essential purposes only...A resident with a multidrug resistant organism may need to be separated from a roommate who has any of the following: a device as an indwelling catheter...intravenous access line, a ulcer or other open wound...ESBL's often emerge in those receiving extensive antibiotic therapy...prompt identification and physician notification of the presence of an ESBL organism..."

On 10/09/19 at 4:24 PM, LPN #5 and RN (Registered Nurse) #4, were interviewed regarding residents admitted from the hospital with active infections. Resident #346's hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41	F 880		

discharge summary and D/C (discharge) orders were reviewed with LPN #5 and RN #4. Resident #346 had a diagnosis of acute osteomyelitis in the right 5th toe and also had a status post debridement of ulcers and incision and drainage of the right lateral foot abscess, MRSA screen was positive on the D/C instructions. This D/C summary was noted by RN #5. LPN #5 was asked who that was. LPN #5 stated that she was in the infection control department. RN #4 and LPN #5 both stated that looking at these orders and D/C summary for Resident #346 with the above information listed, indicated that the resident is to be put on isolation precautions.

On 10/10/19 at 8:19 AM, RN #5 was interviewed. RN #5 was asked what the sign off meant on Resident #346's D/C summary and orders. RN #5 stated that she will sign off then fax the orders to pharmacy. RN #5 stated that for orders from the hospital that have MRSA listed, she will tell RN #6, who is the infection control preventionist. RN #6 stated that this tells us to put the resident on isolation/contact precautions. RN #5 stated Resident #346 got to the facility during second shift. RN #6 stated that staff didn't get the results of Resident #195's urine until Monday, October 7th and that they moved Resident #195 late on Tuesday evening.

Resident #195's nursing notes documented the move to another room on 10/08/19 at 5:00 PM.

RN #6 stated that it is protocol to keep them on contact isolation until they have completed antibiotics and also to get three negative cultures, one a week for three weeks after completion of antibiotics. RN #6 was asked about these two residents co-horting. RN #6 stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 42 unfortunately it was an oversight. RN #6 stated that Resident #195's Foley catheter had been taken out and then put back in and they didn't realize it had been put back in. RN #6 was asked about the policy. RN #6 stated that it didn't make a difference if Resident #195 had a Foley catheter or not, he also had an infection, and that they needed to be separated. RN #6 stated that should not have happened and went on to say the infection control department doesn't assign rooms. No further information and/or documentation was presented prior to the exit conference on 10/10/19 to evidence the facility staff appropriately identified infections for Resident #195 and Resident #346 to prevent the spread of infections.	F 880		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to perform a bed safety inspection prior to installation of a specialty mattress for one of 37 residents in the survey sample. A specialty air mattress was installed and in use by Resident #13 without a prior	F 909	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction	11/22/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 43 inspection for bed safety to minimize entrapment risks. The findings include: Resident #13 was admitted to the facility on 5/31/17 with diagnoses that included coronary artery disease, congestive heart failure, dementia, high blood pressure and chronic knee pain. The minimum data set (MDS) dated 7/2/19 assessed Resident #13 with severely impaired cognitive skills. On 10/10/19 at 7:50 a.m., Resident #13 was observed in bed with specialty air mattress in use. Quarter length side rails were in the raised position on both sides near the head of the bed. Resident #13's clinical record documented a physician's order dated 10/9/19 to discontinue use of an alternating air pressure pad and initiate use of an air mattress. A nursing assessment for bed rails use was documented on 9/6/19. The record documented no review for bed safety prior to installation of the physician ordered air mattress on 10/9/19. On 10/10/19 at 9:53 a.m., the environmental services director (other staff #3) was interviewed about any inspection for bed safety prior to Resident #13's use of the air mattress. The environmental services director stated Resident #13's air mattress was installed by her staff "around 5:00 to 6:00 p.m." yesterday (10/9/19). The environmental services director stated the shop performed annual checks for all beds regarding safety including entrapment risks and checks were performed as requested by nursing when special mattresses were installed. On	F 909	prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that: Corrective Action: A bed safety inspection was performed on Resident #13's mattress. Identification: The incomplete bed safety inspection of Resident #13's mattress was found to be an isolated observation. Changes: EVS department will be re-educated on the facility policy entitled, "Bed Entrapment Assessment", with specific emphasis on the evaluation of equipment section. EVS staff to "confirm that the mattress fits relative to the width and height of any rails on the bed according to manufacturer or FDA guidelines". Monitoring: EVS employee, EVS Team Coordinator, or designee will record completion of bed entrapment assessment when a mattress is changed. Audit findings will be reported to the Quality Assurance (QA) Committee for additional oversight and recommendation. The QA Committee will determine when to discontinue this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495372	A. BUILDING _____ B. WING _____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENTARA WOODVIEW	103 ROSEHILL DRIVE SOUTH BOSTON, VA 24592

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 909	Continued From page 44	F 909		

10/10/19 at 10:00 a.m., the environmental services director obtained the bed number from Resident #13's bed frame. The environmental services director checked her records and stated Resident #13's air mattress was installed on the evening of 10/9/19 but had not been inspected yet for safety and/or entrapment risks.

On 10/10/19 at 8:17 a.m., the administrator was interviewed about bed safety checks. The administrator stated the bed/mattress inspections were supposed to be performed at the time of installation and prior to resident use.

The facility's policy titled Bed Entrapment Assessment (effective 11/28/17) documented, "...Prior to using any model of bed in the facility, the bed is evaluated by a designated, appropriately trained staff member. The staff member is responsible to...Ensure compatibility of the bed, mattresses intended to use with the bed, side rails and any accessories...Confirm that the mattress fits relative to the width and height of any rails on the bed according to manufacturer or FDA guidelines...resident beds, mattresses and attached equipment (including side rails) are assessed on an annual or as needed basis..."

This finding was reviewed with the administrator and director of nursing during a meeting on 10/10/19 at 12:45 p.m.