PRINTED: 02/24/2020 FORM APPROVED OMB NO 0938-0301

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MI II 2	ID: Continue	OMB NO	0938-039
ND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DA	TE SURVEY MPLETED
IAME OF ODOLLARS	495252	B. WING_		1	С
ATTLEFIELD PARK HEALTI (X4) ID SUMMARY ST			STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805] 02	/12/2020
TREETA I LEAGN DEFICIENT	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	0.00	COMPLETION DATE
One complaint was survey. The survey Residents. Accuracy of Assessr CFR(s): 483.20(g) §483.20(g) Accuracy The assessment muresident's status. This REQUIREMEN' by: Based on staff intervreview and clinical refailed to accurately coset) assessment for the and Resident #2) in a Residents. The findings included: 1. For Resident #4, the assess the Resident's Resident's Resident's Resident #4 was a 67 to the facility in 2018. I included but were not Dementia, Psychosis.	dedicare/Medicaid Abbreviated and 2/11/2020 through tions are required for CFR Part 483 Federal Long tents. Investigated during the sample consisted of 4 ments of Assessments, at accurately reflect the is not met as evidenced iew, facility documentation cord review the facility staff and an MDS (minimum data wo Residents (Resident #4 survey sample of 4 medical facility staff failed to cognitive functioning.	F 641	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to compl with all applicable state an federal regulatory requirements. F-641 1.) Resident #4 and #2 cognitive patterns evaluated and completed, if changes identified then care plan revision(s) completed. 2.) MDS Coordinator/designee to review current resident's most recent assessments to identify residents that have the potentia to be affected. If any resident assessments identified with dashes in Section C, resident's cognitive pattern evaluated and documented in resident's chart. 3.) Regional Resident Care Coordinator re-educated MDS staff on the timely completion or interviews in Section C per the R manual.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

NAME OF PROVIDER OR SUPPLIER BATTLEFIELD PARK HEALTHCARE ((X4) ID PREFIX (EACH DEFICIENCY MUST BEGULATORY OR LSC IDENT) F 641 Continued From page 1 The Minimum Data Set, win Assessment with an Assess of 1/8/2020 was reviewed, have the cognitive assessment assistance of one staff personally Living (ADLs). Review of the Clinical record	OF DEFICIENCIES E PRECEDED BY FULL "IFYING INFORMATION) nich was a Quarterly sment Reference Date Resident # 4 did not nent assessed.	A. BUILDING B. WING	TREET ADDRESS, CITY, STATE, Z 50 FLANK ROAD ETERSBURG, VA 23805 PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY 4.) Resident Assessment and/or designee to	OZ TIP CODE CORRECTION ION SHOULD BE HE APPROPRIATE Y)	ATE SURVEY DMPLETED C 2/12/2020 (X5) COMPLETION DATE
(X4) ID SUMMARY STATEMENT (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENT) F 641 Continued From page 1 The Minimum Data Set, wh Assessment with an Assess of 1/8/2020 was reviewed. have the cognitive assessm Resident # 1 was coded as assistance of one staff pers Daily Living (ADLs). Review of the Clinical record	OF DEFICIENCIES E PRECEDED BY FULL "IFYING INFORMATION) Thich was a Quarterly sment Reference Date Resident # 4 did not nent assessed.	iD PREFIX TAG	FLANK ROAD ETERSBURG, VA 23805 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY 4.) Resident Assessment	CORRECTION ION SHOULD SE HE APPROPRIATE Y)	(X5) COMPLETION
(X4) ID SUMMARY STATEMENT (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENT) F 641 Continued From page 1 The Minimum Data Set, wh Assessment with an Assess of 1/8/2020 was reviewed. have the cognitive assessm Resident # 1 was coded as assistance of one staff pers Daily Living (ADLs). Review of the Clinical record	OF DEFICIENCIES E PRECEDED BY FULL "IFYING INFORMATION) nich was a Quarterly sment Reference Date Resident # 4 did not nent assessed.	ID PREFIX TAG	FLANK ROAD ETERSBURG, VA 23805 PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCY 4.) Resident Assessment	CORRECTION ION SHOULD SE HE APPROPRIATE Y)	(X5) COMPLETION
F 641 Continued From page 1 The Minimum Data Set, wh Assessment with an Assess of 1/8/2020 was reviewed. have the cognitive assessm Resident # 1 was coded as assistance of one staff pers Daily Living (ADLs). Review of the Clinical recom	E PRECEDED BY FULL "IFYING INFORMATION) nich was a Quarterly sment Reference Date Resident # 4 did not nent assessed.	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE Y) nt Coordinator	COMPLETION
The Minimum Data Set, wh Assessment with an Assess of 1/8/2020 was reviewed. have the cognitive assessm Resident # 1 was coded as assistance of one staff pers Daily Living (ADLs).	sment Reference Date Resident # 4 did not nent assessed.	F 641	4.) Resident Assessmen	nt Coordinator	
2/12/2020. Review of the Minimum Data revealed Resident # 4 was a cognitive functioning on this 1/8/2020. Review of Resident #4's MD 1/8/2020 revealed that in se C0100-C0500, the Resident been conducted and a dash Review of section C, question also had a dash (-) entered. C0600-C1000 are in regards assessment for mental status	d was conducted on a Set Assessment not assessed for assessment on S with an ARD of ction C, items interview had not (-) had been entered. ns C0600-C1000, Questions to a staff		C of ten MDS assess x 3 weeks then ten I assessments month with results present Committee for revie recommendations. 5.) 3/17/2020.	Sments weekly MDS Section C ly x 3 months sed to OAP!	
2. For Resident # 2, the facility assess the Resident's cognition the Minimum Data Set Quarter 1/22/2020. Resident #2 was a 58 year of to the facility in 2018. Resident included but were not limited the same as the facility in 2018.	ve functioning on early Assessment on did who was admitted			,	

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Total con-		OMB NO	0.0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILO	TIPLE CONSTRUCTION UNING	(X3) DA	TE SURVEY
		495252	B. WING		1	С
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STAT	02	/12/2020
BATTLE	EFIELD PARK HEALT	HCARE CENTER	1	250 FLANK ROAD PETERSBURG, VA 23805		
(X4) ID PREFIX TAG	I CACH DEFICIENT	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 641	The Minimum Data Assessment with a of 1/8/2020 was re have the cognitive Resident # 1 was o	A Set, which was a Quarterly in Assessment Reference Date viewed. Resident # 4 did not assessment assessed. Redded as requiring total staff person for Activities of	F 64			
i i	Review of the Minin revealed Resident	num Data Set Assessment 4 was not assessed for g on this assessment on				
	Review of Resident 1/8/2020 revealed t C0100-C0500, the F been conducted and	regards to a staff				
ti	rasess tue Hesideut.	the facility staff failed to s cognitive functioning on et Quarterly Assessment on				
in	lesident #2 was a 5 the facility in 2018. Included but were not afarction.	8 year old who was admitted Resident # 2's diagnoses limited to Cerebral	Proposition and American Springer			
Ti As	he Minimum Data So ssessment with an A	et, which was a Quarterly assessment Reference Date				

STA	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII:	TIDI E CON	STRUCTION	OMB NO. 0938-0391		
AND	PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		STRUCTION	(X3) DA	TE SURVEY	
		495252	B Who				С	
NAI	ME OF PROVIDER OR SUPPLIER	494232	B. WING			02	2/12/2020	
	TTLEFIELD PARK HEALTH	CARE CENTER		250 FLA	ADDRESS, CITY, STATE, ZIP CODE NK ROAD SBURG, VA 23805	1 02	31212020	
PF	LEFIX LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION CONTROL OF CORRECTIVE ACTION SHOULT PROSS-REFERENCED TO THE APPROVIDENCE OF CONTROL OF CONT	Dec	(X5) COMPLETION DATE	
F	ASAP system A ditem was not assess	items allow a dash (-) value ubmitted to the MDS QIES lash value indicates that an sed. This most often occurs ischarged before the item	F 64	1			The second secon	
	Attempt to conduct the residents. This interview has not conduct to the conduct the conduc	3.0 Manual CH 3: Overview of page C2 read, "Coding Tips: he interview with ALL view is conducted during the he Assessment Reference of contingent upon item Understood, the resident inducted within the look-back e day before or the day of) must be coded 1, Yes, and rmation" code (a dash "-") intinterview items. Do not interview items. Do not interview inducted, but was not done."						
	During the end of day the facility Administrat were informed of the	debriefing on 2/12/2020, for and Director of Nursing findings.		make a make the conditions of				
F 6	No further information Tube Feeding Mgmt/F CFR(s): 483.25(g)(4)(Restore Eating Skills	F 693	F-69		d		
	percutaneous endosco enteral fluids). Based	and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and on a resident's		2.)	for resident #1 with RP and MD notification of medication not administered timely. Resident experienced no adverse effects. Current residents requiring tube feeding administration reviewed to identify those that have the potential to be affected.	***************************************		

AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		E CONSTRUCTION	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
		495252	B. WING	3			С
BATTL	F PROVIDER OR SUPPLIER EFIELD PARK HEALTH			25	TREET ADDRESS, CITY, STATE, ZIP CODE 50 FLANK ROAD ETERSBURG, VA 23805	<u> 0</u>	2/12/2020
(X4) ID PREFIX TAG	LACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	§483.25(g)(4) A resist eat enough alone or enteral methods unknown condition demonstrated arresident; and §483.25(g)(5) A resist means receives the asservices to restore, if and to prevent complicated including but not limit diarrhea, vomiting, deabnormalities, and national transport of a complaint staff failed to ensure preding water flushes for residuals were addresident (Resident #1 residents. This happed the Findings included 1. For Resident #1, the administer physician of flushes, and enteral featimely as ordered. This occasions. Resident #1 was a 64 to the facility on 11/8/fincluded but were not Infarction, Aphasia, Dy	dent who has been able to with assistance is not fed by ess the resident's clinical test that enteral feeding was ad consented to by the lent who is fed by enteral appropriate treatment and possible, oral eating skills lications of enteral feeding ed to aspiration pneumonia, ehydration, metabolic is not met as evidenced iew, clinical record review ation review and in the investigation, the facility ohysician ordered enteral and enteral feeding checks in a survey sample of 4 oned on multiple occasions.	F6	593	 3.) All licensed nurses re-educated by DON/ADON on 6 rights of medication administration with emphasis on timely/accurate medication administration and documentation. 4.) Director of Nursing/ designee to audit MARs and documented time of administration on 5 residents regarding tube feeding to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) 3/17/2020. 	e	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/24/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495252 B. WING NAME OF PROVIDER OR SUPPLIER 02/12/2020 STREET ADDRESS, CITY, STATE, ZIP CODE **BATTLEFIELD PARK HEALTHCARE CENTER** 250 FLANK ROAD PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 693 Continued From page 5 F 693 Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 12/23/19 was reviewed. Resident #1 was coded as having severe cognitive impairment. Resident # 1 was coded as requiring total assistance of one to two staff persons for Activities of Daily Living (ADLs). Review of the clinical record was conducted on 2/11/2020 and 2/12/2020 Resident #1's signed physician orders read: "Enteral Feed Order every 4 hours for PEG tube. Check for residual, if residual is 100 ml (milliliters)

D/C 2/1/2020*

or more hold feeding for 4 hours and recheck, if still greater than 100 milliliters, continue to hold and notify MD (medical director). D/C 2/1/2020 **

*Enteral Feed Order every 6 hours Flush PEG tube with 200 milliliters of water every 6 hours

Review of the Medication Admin Audit Report

administration. There were 7 medications on each of the first 61 pages and 4 on the last page

scheduled time revealed 62 pages of instances of medications administered late indicating outside

According to review of the Medication Administration Records for November 2019 through February 2020, the water flushes and checks for residual were not administered timely as ordered by the physician on several occasions.

from 11/1/2019-2/11/2020 of only late administration greater than 1 hour after

the one hour window of acceptable

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/24/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495252 B. WING NAME OF PROVIDER OR SUPPLIER 02/12/2020 STREET ADDRESS, CITY, STATE, ZIP CODE BATTLEFIELD PARK HEALTHCARE CENTER 250 FLANK ROAD PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 693 | Continued From page 6 F 693 equaling 431 times that medications were administered past the one hour time of acceptable range. Thorough review revealed documentation of several instances where Enteral Feed orders for flushes and Enteral Feed order to check for residual were administered more than one hour after the scheduled time of administration. There were many instances of more than an hour and a

Some examples of late administration included but were not limited to:

half past the time of scheduled administration.

On 11/19/2019 due at 12 noon, Administered at 14:24 (2:24 PM), Page 13 of 62 Enteral Feed Order every 6 hours Flush PEG tube with 200 milliliters of water every 6 hours

On 11/7/2019 due at 9:00 AM, administered at 11:29 AM, Page 8 of 62
Enteral Feed Order every 4 hours for PEG tube.
Check for residual, if residual is 100 ml (milliliters) or more hold feeding for 4 hours and recheck, if still greater than 100 milliliters, continue to hold and notify MD (medical director)

On 11/9/2019 due at 9:00 AM, administered at 11:07 AM, Page 10 of 62
Enteral Feed Order every 4 hours for PEG tube.
Check for residual, if residual is 100 ml (milliliters) or more hold feeding for 4 hours and recheck, if still greater than 100 milliliters, continue to hold and notify MD (medical director)

On 11/23/2019 due 12 noon, administered at 14:27 (2:27 PM), Page 15 of 62 Enteral Feed Order every 6 hours Flush PEG

Event ID: PJC611

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		495252	B. WING	Page 1		С
	PROVIDER OR SUPPLIER	ICARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 250 FLANK ROAD PETERSBURG, VA 23805	ODE 02	/12/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC!	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL: SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULDE	(X5) COMPLETION DATE
	On 11/24/2029 due 10:50 AM, Page 15 Enteral Feed Order Check for residual, i or more hold feeding still greater than 100 and notify MD (mediand notify MD (mediand notify MD) Page 14:11 (2:11 PM) Page Enteral Feed Order of tube with 200 millilite On 11/24/2019 due at 19:59 (7:59 PM) Page Enteral Feed Order of tube with 200 millilite On 11/24/2019 due at 11:14 AM Foujeo SoloStar Penmilliliter (Insulin Glargs subcutaneously one to Diabetes On 11/24/2019 due at 14:11 (2:11 PM) on Enteral Feed Order of tube with 200 milliliter On 12/4.2019 Due at 12	at 9:00 AM, administered at of 62 every 4 hours for PEG tube. If residual is 100 ml (milliliters) g for 4 hours and recheck, if o milliliters, continue to hold cal director) at 12 noon, Administered at the 16 of 62 every 6 hours Flush PEG ers of water every 6 hours at 6:00 PM, Administered at the 40 of 62 every 6 hours Flush PEG ers of water every 6 hours at 9:00 AM administered at the 19:00 AM administered at 12:00 noon, administered at 12:00 noon, administered Page 16 of 62 every 6 hours Flush PEG ever	F 69			
1 E	1:01 AM, Page 20 o interal Feed Order ev theck for residual, if r	f 62 /ery 4 hours for PEG tube. residual is 100 ml (milliliters) for 4 hours and recheck if				

STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) 1/8/	u Tu	Di E agrico	OMB N	O. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILL		PLE CONSTRUCTION G	(X3) D/	ATE SURVEY DMPLETED
		495252	B. WING	i			С
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	0;	2/12/2020
BATTLE	FIELD PARK HEALTH	CARE CENTER		:	250 FLANK ROAD		
(X4) ID	SIBMADY STA	TEMENT OF ACTION			PETERSBURG, VA 23805		
PREFIX	LEACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	BOOK	COMPLETION DATE
F 693	Continued From pag	10.8					
		milliliters continue to hold	F6	93			
	Toujeo SoloStar Pen milliliter (Insulin Glare	-Injector 300 units nor					
	11:09 AM, Page 21 of Enteral Feed Order e Check for residual, if or more hold feeding	very 4 hours for PEG tube. residual is 100 ml (milliliters) for 4 hours and recheck, if milliliters, continue to hold					
	14:05 (2:05 PM), Pagi Enteral Feed Order ev	12 noon Administered at e 23 of 62 very 6 hours Flush PEG s of water every 6 hours					
e le	io:55 (1:56 PM), Page Enteral Feed Order ev	12 noon Administered at 2 23 of 62 ery 6 hours Flush PEG 5 of water every 6 hours					
E C os	1:50 AM, Page 26 & 2 interal Feed Order ev theck for residual, if re it more hold feeding for	ery 4 hours for PEG tube. esidual is 100 ml (milliliters) or 4 hours and recheck, if					
O Pl	n 12/26/2019 due at 8 M on Page 43 of 62	5 PM, administered 7:03					

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MH H TIDI	E CONSTRUCTION		O. 0938-039
AND FEAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED
NAME OF		495252	B. WING	entrelegische bytecht vertro. 20 g. Sprophologische vertro bild b. Antonio		С
BATTLE	PROVIDER OR SUPPLIER FIELD PARK HEALTH		25	TREET ADDRESS, CITY, STATE, ZIP (60 FLANK ROAD ETERSBURG, VA 23805	CODE 02	2/12/2020
(X4) ID PREFIX TAG	: (CAUM DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CHOIDE	(X5) COMPLETION DATE
	or more hold feeding still greater than 100 and notify MD (media 13:48 (1:48 PM), Pare tube with 200 millilite On 12/30/2019 due a 13:55 (1:55 PM), Pare tube with 200 millilite On 12/31/2019 due a 13:55 (1:55 PM), Pare tube with 200 millilite On 12/31/2019 due a 13:25 PM, Page 3:Enteral Feed Order e ube with 200 millilite On 1/2/2020 due at 1:4:14 (2:14 PM), Page and 1/2/2020 due at 1:4:14 (2:14 PM), Page and 1/5/2020 due at 1:3:54 (3:54 AM) Page and 1/5/2020 due at 1:3:51 (3:54 AM) Page and 1/5/2020 due at 1:3:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:3:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:4:11 AM) Page 45 of onteral Feed Order evalue with 200 milliliters on 1/6/2020 due at 1:4:4:4:4:4:4:4:4:4:4:4:4:4:4:4:4:4:4:4	every 4 hours for PEG tube. If residual is 100 ml (milliliters) If of 4 hours and recheck, if I milliliters, continue to hold ical director) at 12 noon Administered at Ige 30 of 62 In every 6 hours Flush PEG Interest of water every 6 hours at 12 noon Administered at Ige 30 of 62 Invery 6 hours Flush PEG Interest of water every 6 hours at 12:00 (noon), Administered If of 62 Invery 6 hours Flush PEG Interest of water every 6 hours at 12:00 (noon), Administered If of 62 Invery 6 hours Flush PEG Interest of water every 6 hours at 10:00 (noon) Interest of water every 6	F 693	DEFICIENCY		

	STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	D. 0938-0391
			ADEDEO		· sandanaman danima dan	"	OMPLETED C
I	NAME OF	PROVIDER OR SUPPLIER	495252	B. WING		02	2/12/2020
		FIELD PARK HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 250 FLANK ROAD PETERSBURG, VA 23805		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	# D OF	(XS) COMPLETION DATE
	i di	On 1/8/2020 due at 1 02:03 (2:03 AM) Page Enteral Feed Order of tube with 200 millilite. On 1/7 2020 due at 1 14:03 (2:03 PM), Page Enteral Feed Order of tube with 200 millilite. On 1/11/2020 due at 2 PM on Page 33 of 62 Enteral Feed Order of Check for residual, if or more hold feeding still greater than 100 mand notify MD (medical for more hold feeding for more hold fe	le midnight, Administered at le 45 of 62 every 6 hours Flush PEG rs of water every 6 hours 2 noon, Administered at le 2 of 62 every 6 hours Flush PEG rs of water every 6 hours 5 PM, administered at 7:03 every 4 hours for PEG tube. residual is 100 ml (milliliters) for 4 hours and recheck, if milliliters, continue to hold all director) 1:00 AM, Administered at 1:50 of 62 every 4 hours for PEG tube. esidual is 100 ml (milliliters) or 4 hours and recheck, if milliliters, continue to hold all director) PM, an interview was licensed Practical Nurse) B look at the Medication to determine the times luled to be administered. Ions should be a hour before or after the inistration.	F 69			

AND PLA	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DA	<u>U. 0938-0391</u> ATE SURVEY DMPLETED
		495252	B. WING	***************************************		С
BATTL	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COR 250 FLANK ROAD PETERSBURG, VA 23805	02	2/12/2020
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	MINDE	COMPLETION DATE
SS=D	physician/provider or solution, amount, frestop times and flush nurse will administer for the enteral tube." On 2/12/2020 at apprinterview was conducted why tube feeding checks had not been Director of Nursing stadministered as order informed of the facility Administration of medications several traviewed. No further information Physician Visits-Frequency §483.30(c) Frequency §483.30(c) The responsible of the safter admission of	rder is required to include equency, rate, intermittent ing procedures. A licensed nutritional feeding and care roximately 4:05 P.M., an cted with the Director of byee B). She was unable to no flushes and residual administered timely. The tated medications should be red by the physician. The tated the nurses should edication administration at all immediately after dications. The end of day debriefing, and at least once every devery 30 days for the first on, and at least once every	F 69	93		
					1	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/24/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 495252 B. WING NAME OF PROVIDER OR SUPPLIER 02/12/2020 STREET ADDRESS, CITY, STATE, ZIP CODE BATTLEFIELD PARK HEALTHCARE CENTER 250 FLANK ROAD PETERSBURG, VA 23805 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 712 | Continued From page 12 F 712 §483.30(c)(3) Except as provided in paragraphs 3.) Executive Director educated (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. Medical Director on timely physician visits per regulatory §483.30(c)(4) At the option of the physician. standards. required visits in SNFs, after the initial visit, may 4.) Medical records/ designee to alternate between personal visits by the physician audit 5 charts to ensure and visits by a physician assistant, nurse compliance 3x a week x 3 weeks practitioner or clinical nurse specialist in then monthly x 3 months with accordance with paragraph (e) of this section. results presented to QAPI This REQUIREMENT is not met as evidenced Committee for review and recommendations. Based on staff interview, clinical record review 5.) 3/17/2020. and facility documentation review and in the course of a complaint investigation, the facility staff failed to ensure timely physician visits for one resident (Resident # 4) in a survey sample of 4 residents. The Findings included: For Resident # 4, the facility staff did not ensure visits every 60 days. There were 89, 92 and 86 days between visits. Resident #4 was a 67 year old who was admitted to the facility in 2018. Resident # 4's diagnoses included but were not limited to Dysphagia, Dementia, Psychosis, Seizures, Atrial Fibrillation, Transient Ischemic Attack, Hypertension and Cerebral Infarction. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date

Daily Living (ADLs).

of 1/8/2020 was reviewed. Resident # 4 did not have the cognitive assessment assessed. Resident # 4 was coded as requiring total assistance of one staff person for Activities of

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER FIELD PARK HEALTHO		D. WING	STREET ADDRESS, CITY, STA 250 FLANK ROAD PETERSBURG, VA 2380		02	/12/2020		
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1 1 1 2 2 2 2 T 6 T 1 T 1.	2/12/2020. Review of Physicians Practitioner Progress Resident # 4 were my visits three times beth February 2020. The dates of visits by Practitioner were: 3/19/2019 5/16/2019 -89 days sin/22/2019 10/23/2019 10/23/2019 1/17/2020-86 days bin/2020 1/1/2020	Progress Notes and Nurse Notes revealed visits for ore than 60 days between ween March 2019 and the Physician or Nurse note previous visit.	F7	DEFIC	PENCY)				
in N	terview was conducte ursing who stated all the electronic clinica ursing stated Physicia	ximately 3:35 PM, an ed with the Director of of the Physician visits were I record. The Director of an visits should be timely.				4 eilem Graden fre-			
DI	uring the end of day of	lebriefing, the							
	no mak bu								

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(YO) MIRT	DI F GOLDER	OMB NO	0. 0938-039
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SS=E	Administrator and D informed of the failu Practitioner to visit to The Administrator at the Physician or Nurtimely, at least every No further information Residents are Free (CFR(s): 483.45(f)(2) The facility must ens §483.45(f)(2) Reside medication errors. This REQUIREMENT by: Based on staff intervant facility document course of a complaint staff failed to ensure of a survey sample of ignificant medication multiple times. The Findings Included for Resident # 1, the faminister Diabetic Moressure medications hysician. This happenesident #1 was a 64 the facility on 11/8/1 cluded but were not if farction, Aphasia. Dy	prirector of Nursing were re of the Physician or Nurse the resident every 60 days. The resident every 60 days and Director of Nursing stated are Practitioner should visit of 60 days. In was provided. The significant of Significant Med Errors are free of any significant of si	F 760		completed and MD ion not desident e effects. iring insulin id to e the l. ducated by of ion with urate ion and ignee to ented time esidents o ensure 3 weeks s with	

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F 760	Continued From page	sa 15					
	of 12/23/19 was reviewed as having several Resident # 1 was consistence of one to Activities of Daily Living Review of the clinical 2/11/2020 and 2/12/2 Review of the Physici for medications for Dialy Living Review of the Physici for medications for Dialy Living Review of the Physici for medications for Dialy Living Review of the Physici for medications for Dialy Living Review of the Physician Review of the Phy	Set, which was a Quarterly Assessment Reference Date ewed. Resident #1 was ere cognitive impairment, ded as requiring total two staff persons for ing (ADLs). record was conducted on 020. ans Orders revealed orders labetes and Hypertension. leview of the Medication d revealed check marks for dministered. The	F 7	60			
A A p. lo	administered. Heview administration Record administration Report age 1 of 1 revealed decation of where insuldministered and the a	of the Medication I entitled Location of for 2/1/2020 thru 2/29/2020 locumentation of the in injections were actual times administered.					
2/ In: Gi	111/2020 at 2300 (11 sulin Glargine 2/9/20; iven at 11:04 AM (3 h ext dose due 2/9/202	PM) 20 scheduled at 8 am ours late) 0 scheduled at 5 PM					
Re No Ph	ven at 16:04- on time se given. Eview of the clinical re otes revealed no docu	ecord including Nurses Imentation that the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-0391		
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F 760	Continued From page	ge 16	F 76	30				
	Further review of the orders for Medication	e clinical record revealed valid ins for Diabetes-						
	time a day 9 AM.	ution Pen-injector 300 units 10 units subcutaneously one						
	the morning every F							
	incinasa;	cations for Hypertension						
1	tune one time a day	for hypertension illigrams via PEG tube two						
	Review of the Medica revealed documentati medications to include	ation Administration Record ion of late administration of e:			4			
	documented as admir 8 of 62	O AM medications were histered at 11:29 AM, Page						
n s	Losartan 100 milligrar ube one time a day fo Foujeo SoloStar Pen-I nilliliter (Insulin Glargi subcutaneously one ti Diabetes	njector 300 units per						
N		ligrams via PEG tube two						
1	0 01 02	en 11:07- 11:10 AM, Page						
tu	osartan 100 milligram Ibe one time a day fo	s give 1 tablet via PEG hypertension						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY		
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tu Ti m	Toujeo SoloStar Permilliliter (Insulin Glarsubcutaneously one Diabetes Metoprolol give 50 m times a day On 11/24/2019 the 9: between 10:47-10:50 Losartan 100 milligra tube one time a day f Metoprolol give 50 mitimes a day On 11/24/2019 due at 11:14 AM Toujeo SoloStar Penmilliliter (Insulin Glargisubcutaneously one times a day Foujeo SoloStar Penmilliliter (Insulin Glargisubcutaneously one times a day Toujeo SoloStar Penmillililiter (Insulin Glargisubcutaneously one times a day Toujeo SoloStar Penmillililiter (Insulin Glargisubcutaneously one times a day for insulin Glargisubcutaneously one times a day for insuling Pen-Injector 1.	n-Injector 300 units per gine) inject 100 units time a day for Type 1 milligrams via PEG tube two 100 AM meds administered 100 AM, Page 15 of 62 ms give 1 tablet via PEG or hypertension illigrams via PEG tube two 100 AM administered at 100 units per ine) inject 100 units me a day for Type 1 ms give 1 tablet via PEG tube two 100 units per ine) inject 100 units me a day for Type 1 ms give 1 tablet via PEG rhypertension 100 units me a day for Type 1 ms give 1 tablet via PEG rhypertension 5 milligrams per 0.5 grams subcutaneously in ay 9 AM.	F 760					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA	(VO) AND TO	DI # 00.00	OMB NO	OMB NO. 0938-0391		
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ti Ca and the Control of the Control	milliliter (Insulin Glassubcutaneously one Diabetes On 12/6/2019 Medica Administered 11:09-Losartan 100 milligratube one time a day Trulicity Pen-Injector milliliters inject 1.5 mthe morning every From Metoprolol give 50 millimes a day On 12/22/2019 Medica administered at 11:50 Metoprolol give 50 millimes a day On 12/26/2019 Medica diministered 7:00 PM Metoprolol give 50 millimes a day on 12/26/2019 Medica diministered at 11:17 rulicity Pen-Injector 1 illiliters inject 1.5 millie morning every Friden 12/31/2019 Medica diministered at 10:56 millimes and at 10:56	rgine) inject 100 units time a day for Type 1 rations due at 9:00 AM, 11:13 AM, Page 20 of 62 ams give 1 tablet via PEG for hypertension 1.5 milligrams per 0.5 milligrams subcutaneously in iday 9 AM, illigrams via PEG tube two cations due at 9:00 AM, DAM, Page 26 & 27 of 62 milligrams via PEG tube two cations due at 5 PM, 1-7:03 PM on Page 43 of 62 milligrams via PEG tube two cations due at 9 AM, AM, Page 30 of 62 milligrams per 0.5 milligrams p	F 760					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-039	
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BATTLE	PROVIDER OR SUPPLIER FIELD PARK HEALTH	ICARE CENTER		STREET ADDRESS, CITY, STATE, Z 250 FLANK ROAD PETERSBURG, VA 23805	IP CODE	2/12/2020	
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Si iii 11 22 33 44 55 66 CO co m by the doc m Di Aci inf	On 1/11/2020 Medicadministered at 7:07 Metoprolol give 50 million administered at 7:07 Metoprolol give 50 million administered used for proguidance was given Fundamentals of Nuprevent medication administer medication administer medication administer medication administer medication administer medications can be linked, inconsistency in adheast of the right medication. The right patient of the right document important of 12/12/2020 at 3:40 onducted with the Direction of 12/12/2020 at 3:40 ond	cations due at 5 PM, PM on Page 33 of 62 nilligrams via PEG tube two ing cited Lippincott as the ofessional nursing standards. from Lippincott, rsing, which reads: "To errors, follow the six rights of ation consistently every time cations. Many medication in some way, to an ering to these rights: tion PM, an interview was rector of Nursing who stated administered as ordered Director of Nursing stated a medications on time and y after administration of debriefing, the facility ector of Nursing were s. was provided.	F 760				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/24/2020 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495252 B. WING NAME OF PROVIDER OR SUPPLIER 02/12/2020 STREET ADDRESS, CITY, STATE, ZIP CODE **BATTLEFIELD PARK HEALTHCARE CENTER** 250 FLANK ROAD PETERSBURG, VA 23805 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5)TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 770 Continued From page 20 F 770 F 770 **Laboratory Services** F 770 SS=D | CFR(s): 483.50(a)(1)(i) F-770 §483.50(a) Laboratory Services. 1.) Resident #4 labs were obtain on §483.50(a)(1) The facility must provide or obtain 2/4/2020. MD and RP were laboratory services to meet the needs of its notified of the result. Resident #4 residents. The facility is responsible for the quality cognitive patterns evaluated and and timeliness of the services. if changes identified care plan (i) If the facility provides its own laboratory services, the services must meet the applicable revision(s) completed. requirements for laboratories specified in part 493 2.) Current residents requiring of this chapter. labs/stat labs reviewed to identify This REQUIREMENT is not met as evidenced those that have the potential to be affected. Based on staff interview, clinical record review 3.) All licensed nurses educated by and facility documentation review and in the DON/ADON on timely lab draws. course of a complaint investigation, the facility 4.) Director of Nursing/ designee to staff failed to ensure Laboratory services were audit Labs on 5 residents provided to meet the needs of one resident regarding lab draws compliance (Residents # 4) in a survey sample of 4 residents. 3x a week x 3 weeks then monthly The Findings Included: x 3 months with results presented to QAPI Committee for review 1. For Resident # 4, the facility staff failed to and recommendations obtain a Complete Blood Count and Complete 5.) 3/17/2020 Metabolic Profile as ordered to be drawn on 2/1/2020. Resident #4 was a 67 year old who was admitted to the facility in 2018. Resident # 4's diagnoses included but were not limited to Dysphagia,

Cerebral Infarction.

Dementia, Psychosis, Seizures, Atrial Fibrillation, Transient Ischemic Attack, Hypertension and

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 1/8/2020 was reviewed. Resident # 4 did not have the cognitive assessment assessed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391		
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2 A d d O of	Assistance of one standard plant Living (ADLs). Review of the Clinica 2/12/2020. Review of the Nurse Notes revealed document of the Nurse Notes revealed document of the Plant Pla	ded as requiring total aff person for Activities of all record was conducted on Practitioner's Progress mentation of O PM]-Nursing requested the feeding. Assessment at CXR (Chest X-ray, CBC nt], CMP [Complete orrow. Hold tube feeding ed. Passessment and Plan: s-CBC, CMP not resulted in last night Seessment and Planson Levaquin, labs not ht Signature of the complete orrow. Hold tube feeding ed. Planson Levaquin, labs not ht	F7	770	DEFICIENCY)		OAIE	
dra	inei) and CBC (Comr	prehensive Metabolic plete Blood Count) were AM, received 2/4/2020 at 2/2020 at 2:36 PM.				Miller, Harry N. Processing Complete Complete and the		
Fu	rther review of the cli	nical record revealed no						

ND PLAN	T OF DEFICIENCIES					
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	on 2/1/2020 as order documentation on the Practitioner being information on the Practitioner being information on signature or chad been reviewed. On 2/12/2020 at 3:30 conducted with the Nicolated with the Nicolated Fraction of the Practical Pra	e nursing staff notifying the at the labs were not drawn red. There was no e form of the Nurse ormed of the results. There date documenting the results PM, an interview was urse Practitioner (Employee at labs were supposed to be 4 on 2/1/2020. Employee E e blood work along with	F 77			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIN	34 P 004 10701	OMB NO	0. 0938-039
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i. rouse and the specific control of the specific cont	Administrator was a approximately two w survey. The Administrator stathrough the different Administrator present Contract. Review of the Nursing Agreement: Under 1. Responsibilitaboratory) DCommon tests U/A's, PT'swill be a 24- hour period. For easonably be reported above,will reported by the provide Statuation) service for cover day, 365 days per esting will be reported f available STAT testing will provide type autually agreed method south will provide type autually agreed method south will be phone to vailable."	rate office for a copy. The new employee of eeks at the time of the ated she had been looking files to find a copy. The ted a copy of the Laboratory are files of(Name of the Laboratory are files of(Name of such as chemistries, CBC's, typically be reported within or tests that cannot and in the time frames listed art results as soon as fith industry standards. STAT (life threatening linical lab services 24 hours year. Laboratory STAT I within 5 hours. The menusis attached. It times before 8:00 am and Wonday through Saturday dinal reports through a d. Critical and STAT the facility when they are	F 770			

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	Review of the STAT 2018.7.0 revealed th	Test List Exhibit B version e tests available included:				
	Chemistry 1. Comprehensive M	etabolic Panet (CMP)			1	
	Hematology & Coagu 1. Complete Blood Co	ulation ount				1
And the second of the second o	a day, 365 days and I within 5 hours. The I laboratory blood work weekends, None of th	AT laboratory sentings were	Adjunyan		• • • • • • • • • • • • • • • • • • • •	
1.1	THE FACILITY ADMINISTRA	debriefing on 2/12/2020, tor, Director of Nursing and informed of the findings.				
and the contribution of the first of the fir	No further information	was provided.	to an year		,	
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